Indiana's Needs Assessment for the Maternal, Infant and Early Childhood Home Visiting Program

September 2010

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The 2000 release of *From Neurons to Neighborhoods* by the National Research Council and the Institute of Medicine provided the scientific evidence of the complexity of early childhood development and its importance in ensuring that children arrive at school ready to learn. As a result of this seminal document, expanding research and growing public awareness of the critical importance of a "good start" for young children in developmental, educational and emotional areas underscore what policy makers in Indiana have been working toward for a long time. Indiana has demonstrated its commitment to a high quality, comprehensive early childhood system that promotes a positive environment and promotes health, development and positive parent child relationships for the maternal, infant and early childhood populations, especially for those who are the most at-risk for poor outcomes.

Part 1: State of the State

Indiana became the 19th state of the United States in 1816. Often referred to as the "Crossroads of America", Indiana has a population of 6,423,113 (2009 est.) which represents a 5.6% growth since the 2000 census. Indiana has a total of 35,867 square miles with a population density of 179.1 per square mile. Indiana is the smallest state in the continental United States west of the Appalachian Mountains. Its capital and largest city is Indianapolis which ranks as the 13th largest city and 11th largest metropolitan area in the United States. Seventy percent of the population lives in a metropolitan area while the remaining 30% live in rural areas.

The median age in Indiana based on 2009 population estimates is 36.8. Thirty-nine percent (39%) of the population is 45 and older. The preschool population represents 6.9% and the school age population represents 17.8% of the total population.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of 94.5%. Indiana's overall Hispanic population is 5.5%, its white, non-Hispanic population is 87.8%, and its black non-Hispanic population just over 9.2%. This contrasts highly with Indiana's largest county, Marion County, which has a black population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

While Indiana is primarily considered a manufacturing state, there is a significant agricultural component to its economy. Indiana is located within the U.S. corn and grain belts with corn and soybeans as major cash crops. Indiana is also home to the international headquarters of Eli Lilly, a major pharmaceutical company which is the state's largest corporation. Indiana is also the world headquarters of Mead Johnson Nutritionals. Indiana ranks fifth among all states in total sales and shipments of pharmaceutical products and the second highest in the number of biopharmaceutical related jobs. Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufacturers than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%).

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of "at will" employment, whereby an employer can terminate an employee for any or no reason, is in force. Indiana is also home to many insurance home offices and has a high rate of self insured policies.

Family Economic Self-sufficiency

While Indiana has not experienced as severe an economic crisis as other states, the challenges faced by Indiana families is significant. The 2009 state unemployment rate was 10.1% with a range of 6% to 18%. In 2008, 17.9% of children lived in poverty. In 2009, 41.8% of children qualified for free or reduced lunch and 34.31% of children (birth to six) were enrolled in Medicaid. In 2009, 11.09% of families qualified for food stamps and 1.73% of families were on Temporary Assistance for Needy Families (TANF). Ten percent (10%) of Indiana families were single parent households.

Education is a major factor in economic well-being. In Indiana, 73% of adults have graduated from high school. The percentage of adults with a college education is 22%. The 2009 drop-out rate for grades 7-12 was 13.86%.

Birth Outcomes

In Indiana, from 2002 through 2006, there has been a decline in the percentage of women who have received prenatal care within the first trimester each year in all races and ethnicities. The overall percentage dropped from 80.6% in 2003 to 77.6% in 2006. The percentage for whites decreased from 82.1% in 2003 to 79.2% in 2006 while the percentage for blacks decreased from 68.2% in 2003 to 65.6 % in 2006. The Hispanic population actually alternated between increases and decreases each year, but in 2006 was lower (62.8%) than the percentage in 2003 (64.6%)

Another way of defining prenatal care is the Kotelchuck Index, also known as the Adequacy of Prenatal Care Utilization (APNCU) Index. The Kotelchuck Index combines the month prenatal care began with the number of prenatal visits from the start of prenatal care up to the delivery and compares it with a standard number of visits. The overall percentage of women in Indiana who received Adequate/Adequate Plus Care declined from 2002 to 2006. The rate in 2002 was 74.3%, but the average over the next three years from 2003-2005 was below that number at 72.6%. In 2007 the rate dropped to 70.3%, and provisional 2008 data shows even a further drop to 69.8% of Indiana residents having adequate prenatal care. In the white population, the 2002 rate was 76.9%, but decreased over the next three years with the 2003-2005 average being 76.4% of women receiving Adequate/Adequate Plus Care in Indiana. The APNCU of the black population also decreased over this time period from 64.2% to 63% of women receiving Adequate/Adequate Plus Care in Indiana. The Hispanic population is the most unstable group, with their percentage moving up and down over this time, but the 2003-2005 average was a very low 58.2% of women receiving Adequate/Adequate Plus Care in Indiana.

Using the same Kotelchuck Index, Indiana has a high rate of women receiving Inadequate Care, which is less than 50% of expected visits. Over 1 out of 4 (25.5%) Hispanic women in Indiana did not receive adequate care between 2003 and 2005. Nearly one out of four (22.9%) black women in Indiana also received inadequate care in these years. One out of ten white women (10.2%) received Inadequate Care between 2003 and 2005 in Indiana. The overall percentage of women who received inadequate care in Indiana from 2003-2005 was 12.9%.

In 2003 the percentage of women in Indiana who smoked while pregnant was 18.5, and decreased to 17.3 in 2006, before increasing back to 18.5% in 2007. The white prenatal smoking population decreased between 2002 and 2006 from 19.9% to 18.1%, before increasing to 19.6% in 2007, and is still the highest among race and ethnicity. The black population made in improvement between 2003 and 2007 from 15.2% to 13.3%. The Hispanic is once again the lowest among race and ethnicity with 3.8% in 2003 and 4.1% smoking while pregnant in 2006.

Another population that has a high smoking rate is the percent of pregnant women on Medicaid. This is alarming since 51% of pregnant women in Indiana were on Medicaid in 2007. For 2007, birth records for Medicaid recipients were reviewed. Women that indicated smoking during pregnancy were grouped according to the county of residence on the Medicaid eligibility file at time of pregnancy. The majority of counties (68 out of 92) have 30% or more women attesting to smoking during pregnancy in 2007. The overall percentage of women on Medicaid who smoked during pregnancy was 27%, compared to 17.3% for all pregnant women in Indiana.

Indiana has shown a steady increase in the rate of mothers who ever breastfed their infants between 1990 and 2007. In 1990, less than half of new mothers (47.2%) breastfed their infants. In 2007, the rate grew to 67.1%. The rate of black mothers who ever breastfed their infants grew from 34.5% in 1990 to 47.6% in 2007.

In 2006, 89,404 infants were born to Indiana residents. The number of live births represents a 2.7% increase from 2005 (87,088). In 2006, there were 9,726 live births to mothers under 20 years of age–10.9% of the total number of live births. Of these, 7,618 were born to white women under age 20 (9.9% of the white births) and 2,038 were born to black women under age 20 (19.6% of the black births). The age-specific birth rate for women ages 15-19 was slightly higher in 2006 (43.8%) than in 2005 (43.2%). Slightly over two fifths (41.2%) of all live births in Indiana in 2006 were to unmarried parents. Significantly more black mothers (78.2%) than white mothers (36.8%) were not married to the infant‘s father at the time of the birth. In FFY 2010, Indiana’s Office of Medicaid policy and Planning reported that 14.9% (36,902) of women enrolled in Medicaid gave birth. Of that number, 2,554 women (6.9%) received prenatal care coordination.

Indiana has shown an increase in low birth weight (infants born less than 2500 grams) over the past 5 years. In 2003, the percentage of babies born low birth weight was 7.9%, but then steadily increased up to 8.3% in 2005 before increasing more to 8.5% in 2007. The white population shows the same trend as the total, increasing from 7.2% in 2003 up to 7.6% in 2005 before increasing more to 7.8% in 2007. The black low birth weight percentages have steadily increased every year from 13.3% in 2003 up to 14.4% in 2007. The Hispanic rate also has steadily increased from 5.9% in 2003 slightly up to 7.2% in 2007.

Indiana‘s total percentage of infants being born at very low birth weight stayed steady between 2002 and 2006 at 1.4% before increasing to 1.5% in 2007. Both the white (1.4% in 2002 and 2006) and the Hispanic (1.2% in 2002 to 1.1% in 2006) also stayed steady**,** until 2007, (white 1.3%, Hispanic 1.3 %.) The black very low birth weight percentage did increase significantly between 2002 and 2007 from 2.6% to 3.3%.

In 2006, 13.2% of live births in Indiana were premature. This represents a 23% increase from 1996. The rate of preterm birth in Indiana is highest for black infants at 18.6% followed by Hispanics at 13% and whites at 11.3%.

The Infant Mortality Rate (IMR) in Indiana showed an increase in 2004 to 8.1 from 7.4 in 2003 and stayed steady through 2006. In 2007 the IMR decreased to 7.5 in Indiana. The white IMR in Indiana increased between 2003 and 2005 from 6.4 up to 6.9, and then decreased to 6.5 in 2007. The black IMR in Indiana increased every year, from 15.9 in 2003 to 18.1 in 2006, before decreasing to 15.7 in 2007. The Hispanic IMR in Indiana fluctuated every year between 2003 and 2007, peaking at 9.0 in 2004 and dropping to as low as 5.2 in 2006, but then increasing to 6.8 in 2007.

Child Health and Safety

There are 313,049 children age 0-5 who are enrolled in Medicaid. Of that number, 93.5% (292,768) have a primary care provider and 56.7% (177,372) received an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen.

From 2003 to 2006 in Indiana, 227 infants died due to unintentional and intentional injuries. More than two-thirds of all injury deaths (68.3% or 155/227) were due to suffocation. Of the suffocation deaths, 89.0% (138/155) were unintentional. The rate of injury death for black infants during 2003-2006 was 175.7 per 100,000, which is more than three times higher compared to white infants (53.4 per 100,000). The primary cause of hospital admissions for infants was falls. Injuries due to falls accounted for 25.6% of all hospitalizations (139/543).

In the 2006-07 school year, data were collected from 1833 schools in Indiana. Data collection included information on 255,346 kindergarten, first grade, and sixth grade students. This covered over 85% of the schools in Indiana. Ninety-six percent of students enrolled at reporting schools completed the immunizations necessary according to state requirements. There was an increase of five percentage points from the previous assessment year.

In the 2009 Youth Risk Behavior Surveillance System (YRBSS) report for Indiana, 12.8% of youth reported they are obese (at or above the 95th percentile for their age, sex and Body Mass Index (BMI), which is down from 15% in 2005. The data show that 15.9% of youth are overweight (between 85th and 94th percentile), which is a full percent and a half higher than the 14.3% in 2005. The 2009 YRBSS report also showed a decrease in the number of youth who ate five or more servings of fruits and vegetables in the past week (16.1%), compared to 2003 data (20.3%). This change was significant. Milk consumption has also decreased since 2003 from 21.2% to 14.2%, which is also a significant change. The data also show that over a third (35.6%) of youth drank at least one serving of soda a day over the past week in 2007, but decreased to 29.7% in 2009. This result is also statistically significant.

In 2007, there was a significant increase in students in Indiana who were physically active at least 60 minutes a day, 5 days a week at 43.7%. This compares to 32.2% in 2005 but decreased in 2009 to 40.6%, which was a significant decrease. The percentage of students (29.0%) who reported watching three or more hours of television per day in 2009 also decreased compared to 2003, which was 32.9%.

In Indiana, over the past three years, there has been a slight decrease in the prevalence of asthma in children under 18 years of age. In both 2005 and 2006 the prevalence was 8.4% of children in Indiana currently suffered from asthma. In 2007 that percentage dropped to 8.0%. The percentage of white children also decreased over these years from 9.2% in 2005 to 7.6% in 2007. The percentage of black children with asthma has increased over this time period from 12.7% in 2005 to 15.2% in 2007.

From 2003 to 2006, the leading cause of injury death in Indiana for preschool aged children (ages 1 to 4) was unintentional injuries (185 deaths). Preschool aged children received more than half of the fatal injuries from motor vehicle traffic-related incidents and drowning (58 deaths and 41 deaths, respectively). The rate of death for males was 18.6 per 100,000, while the female rate of death was slightly less at 16.3 per 100,000. The top three causes of hospital admissions for 1 to 4 year olds were falls, fire and poisoning. Each cause accounted for 23.2% (369/1,592); 20.6% (328/1,592); and 16.6% (263/1,592), respectively of all hospitalizations.

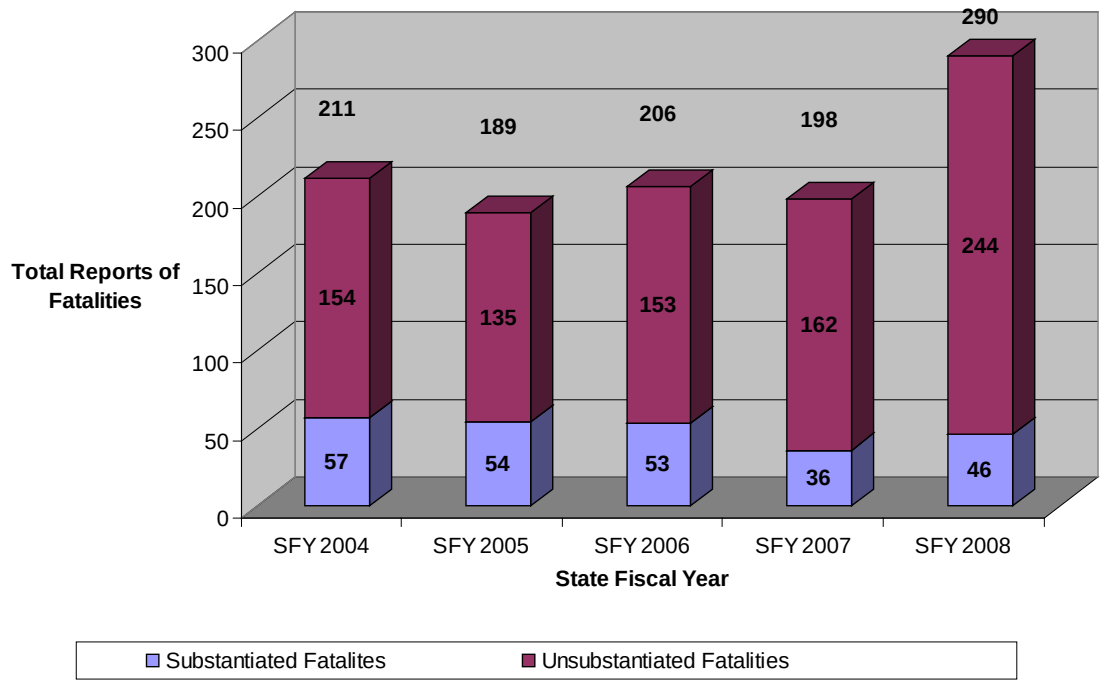
Elementary school age children (ages 5 to 9 years) are more susceptible to motor vehicle crashes, bicycle crashes, pedestrian injuries, and dog bites. Children in this age group are often unable to judge if an environment is safe and are more likely to demonstrate risky behaviors stimulated by impulse. From 2003 to 2006, there were 121 injury deaths for elementary school age children. Children aged 5 to 9 had the lowest age-specific rate of death compared to all other age groups. Males aged 5 to 9 had an age-specific death rate of 8.1 per 100,000, and females had an age-specific death rate of 5.8 per 100,000. The leading cause of death was unintentional injuries (100 deaths). Elementary school aged children received more fatal injuries from motor vehicle traffic-related incidents, which accounted for 25.9% of all unintentional injury deaths (48/185). Although fall-related injuries within this age group accounted for approximately one-third (27.9% or 375/1,345) of hospitalizations, this injury mechanism is not among the top five leading causes of death. Motor vehicle crash (MVC) injuries were the 2nd leading cause of inpatient hospitalization and accounted for 21.0% of all injuries in this age group (282/1,345).

Child Abuse and Neglect

Between July 1, 2008 and June 30, 2009, there were 114,907 reports of abuse or neglect. Of the total number of reports, 21.5% or 24,754 reports were substantiated. Of the 114,907 reports,

31,641 were for suspected abuse. Thirteen percent (7,053) of the suspected abuse reports were substantiated. This is a decline from 20.9% in 2008. There were 83,266 reports for neglect and 17,701 reports (21.2%) were substantiated. In 2008 the percentage of substantiated neglect reports was 18.8%. In 2008 the child abuse and neglect rate per 1000 children was 11.1. In 2008, there were 3,895 children served in domestic violence emergency shelters.

There were 46 abuse and neglect fatalities substantiated in State Fiscal Year (SFY) 2008. Of the 46 fatalities, 24 (52%) were due to abuse and 22 (48%) were due to neglect. This reflects an overall increase in the total number of fatalities from SFY 2007 in both abuse and neglect. However, when looking at the trend over five years, there has been an overall decrease in fatalities resulting from abuse or neglect [2004 (57), 2005 (54), 2006 (53), 2007 (36), 2008 (46)]. Child fatalities from abuse increased from 17 in SFY 2007 to 24 in SFY 2008, while child fatalities from neglect increased from 19 in SFY 2007 to 22 in SFY 2008.



Seventy-eight percent (78%) of the abuse and neglect fatalities for SFY 2008 occurred among children 5 and under. Further, 85% occurred amongst children ages 8 and younger. As was true in the prior year, the majority of abuse and neglect victims for SFY 2008 were under 1 year of age. However, SFY 2008 reflected a percentage decrease in victims under 1 year of age compared to SFY 2007. Overall, child victims under one year of age comprised 30% of the total

46 fatalities in SFY 2008 compared to 39% in SFY 2007. Children within this age range accounted for 8 of the total 24 abuse deaths in SFY 2008 compared to 7 in SFY 2007. Child victims under one year of age accounted for 6 of the total 22 neglect deaths in SFY 2008. This is a slight decrease from SFY 2007, which reported 7 within this age range.

Public Safety/Risky Behaviors

There were 43,902 total juvenile arrests in 2007 representing 3.8% of the juvenile population. There were 2,587 juvenile possession arrests for a rate of 224 arrests per 100,000 people and there were 50 juveniles arrested for a driving under the influence offense. The rate of violent crime in 2007 is 143 violent crime arrests per 100,000 people (9,127 arrests). The rate of property crime was 550 property crime arrests per 100,000 people (34,931 property crime arrests).

Domestic violence is also an issue in Indiana. In the year that ended in June of 2009, there were 3,895 children served in domestic violence emergency shelters. There were 4,461 adults served in the shelters. In the same time frame, 1,574 domestic violence victims were denied shelter. There were 101,679 calls to domestic violence crisis lines.

In the 2009 YRBSS report for Indiana, high school students were asked about their tobacco, alcohol and drug use. The percentage of teens who reported they had ever tried cigarettes was 52.2%. The percentage of students who reported they has smoked cigarettes on at least one day during the 30 days prior to the survey was 23.5% and 11.8% reported they smoked cigarettes on 20 or more days in the same time frame. The percentage of students who reported that they smoked cigarettes, smoked cigars, cigarillos, or little cigars or used chewing tobacco, snuff or dip on at least one day in the 30 day time frame before the survey was 29.3%. When asked whether they had ever had at least one drink of alcohol, 69.2% indicated that they had. Thirty-eight percent (38.5%) indicated they had at least one drink of alcohol during the 30 days prior to the survey and 24.9% indicated they had five or more drinks of alcohol in a row within a couple of hours on at least one day. The percentage of students who reported they had used marijuana one or more times in the 30 days prior to the survey was 20.9%. The percentage of students reporting they had used any form of cocaine in the same time frame was much lower at 2.7%. When asked about sniffing glue, inhaling paints or sprays or breathing contents of aerosol spray, 16% of the students indicated they had engaged in that behavior at least once in their lives.

Finally, 25.5% of the students indicated that they had been offered, sold or given an illegal drug by someone on school property in the 12 months prior to completing the survey.

Early Childhood

As of 2008, there were 4,333 licensed child care facilities - 598 Licensed Centers, 3,067 Licensed Homes and 668 Registered Ministries. There are 99,327 slots available in these facilities. There were 19,159 families and 36,321 children authorized to receive child care vouchers in July 2010. There were 8,885 families and 14,864 children on wait lists.

In 2007, the Indiana Bureau of Child Care initiated a statewide quality rating system titled *Paths to QUALITY*. This initiative is designed to improve the quality of early childcare and education and to aid parents in selecting a high-quality early care and education provider. As of July 2010, there were 1,916 providers participating in *Paths to QUALITY*. There were 468 Licensed Centers, 1,420 Licensed Homes and 28 Regulated Ministries. The total capacity of the providers is 70,527. Of the children receiving child care vouchers in Indiana, 52.25% of them are participating in a program enrolled in *Paths to QUALITY*.

Young children with disabilities participate in either the First Steps (Part C of IDEA) system or in preschool special education (Part B of IDEA, Section 619). In 2008, First Steps served 9,756 children from birth to three (3.64% of the population). There were 18,834 children served in preschool education which represents 7.2% of the population.

Indiana currently has 2,636 funded Early Head Start slots and 13,690 funded slots for Head Start. The cumulative waitlist for both the Early Head Start and Head Start programs in the spring of 2010 was an estimated 7,000 families statewide.

Part 2: Alignment of State Home Visiting Needs Assessment with Head Start, CAPTA and Title V

The Affordable Care Act identified six desired outcomes for the Maternal, Infant and Early Childhood Home Visiting Program:

a. Improved maternal and newborn health;
b. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
c. Improvement in school readiness and achievement;
d. Reduction in crime or domestic violence;
e. Improvements in family economic self-sufficiency; and
f. Improvements in coordination and referrals for other community resources and supports.

As a function of conducting the needs assessment required for home visiting, Indiana's collaborating agencies reviewed and analyzed the strategic plans and needs assessments of the agencies identified in the *Supplemental Information Reques*t. The overall findings are that the identified outcomes for home visiting are in alignment with state agencies and programs that serve young children and families in Indiana. A description of these plans and needs assessments follows.

Indiana Head Start State Collaboration Office

Source Document: Needs Assessment Survey 2009

Established in 1965, Head Start is a program of the United States Department of Health and Human Services that is charged to provide comprehensive education, health, nutrition, and parent involvement services to low-income (100% of the federal poverty level) children, age three to five and their families. Other enrollment priorities include children with disabilities and children who are homeless. In 1994, the program was expanded to serve the birth to three population and entitled Early Head Start.

The Head Start philosophy is based on three key points. These are:

- Comprehensive child development services;
- Parent involvement; and
- Community partnerships and community-based services.

In late 2008, the Indiana State Collaboration Office contracted with the Indiana Head Start Association to "conduct the required assessment that addresses the needs of Head Start agencies

in the State with respect to collaboration, coordination and alignment." A comprehensive survey was distributed to all Head Start and Early Head Start agencies in Indiana. The survey focused on nine priority areas:

- Early Childhood Education and Transition;
- Professional Development;
- Child Care;
- Health Care;
- Family Literacy;
- Welfare and Child Welfare;
- Services to Children with Disabilities;
- Services to Children Experiencing Homelessness; and
- Community Services.

The needs assessment examined critical findings related to relationships and difficulties for each priority area, and established goals and objectives. The following table aligns the intended outcomes for home visiting with the Head Start goals and objectives based on the needs assessment.

Home Visiting Intended Outcomes	Head Start Goal	Head Start Objective
Improvement in school readiness and achievement	Through focus on quality, quantity and professionalism, improve and increase education services for young children	Continue building linkages at the state and local levels between early education programs, the Indiana Head Start Association, Department of Child Services, Division of Family Resources, Indiana Department of Education, and other state and local early childhood education organizations. Promote and support state and local efforts to set in place professional standards for persons in the early child education professions. Continue building linkages at the state and local levels between the
	Through focus on quality, quantity and professionalism, improve and increase early childhood education services for young children.	
	Through focus on quality, quantity and professionalism, improve	

Home Visiting Intended Outcomes	Head Start Goal	Head Start Objective
	and increase high quality child care services for young children.	Department of Child Services, Division of Family Resources, Indiana Association for Child Care Resource &Referral, the Indiana Head Start Association and other state and local early care and education organizations.
Improved maternal and newborn health	Expand and increase availability of needed health care services for low- income children and families.	Increase program ability to assist families to secure health care services for pregnant women and children birth to five.
Improvements in family economic self-sufficiency	Build a systemic approach for statewide awareness of and access to family literacy.	To encourage full implementation of family literacy including child development, adult education, parent education and interactive opportunities for parents and children together.
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	Establish sustainable early education linkages with the state's public assistance services and welfare reform.	The Collaboration Office continues to promote and build linkages between Early Head Start/Head Start programs and state public assistance agencies.
Improvement in school readiness and achievement	Continue and sustain efforts to ensure that children with disabilities will have opportunities to develop to their potential.	Promote inclusive programming for children with disabilities.
Improvement in school readiness and achievement	Strengthen and improve conditions for homeless families through coalition building.	Ensure homeless children receive needed services as a result of coalitions.
Improvements in the coordination and referrals	Head Start programs continue to increase their involvement with community service activities.	Support and promote Head Start programs utilization and involvement with local, state, and federal community service resources and activities.

Strategies have been established in the Head Start strategic plan to achieve each of the identified goals.

Department of Child Services/CAPTA

Source Document: Five Year Strategic Plan 2010-2014

The Department of Child Services (DCS) was established in 2005 as a separate cabinet-level Agency with responsibility for overseeing both child welfare services and child support enforcement. The Department of Child Services protects children and strengthens families through services that focus on family support and preservation. DCS administers child support, child protection, adoption and foster care throughout the state of Indiana.

Mission: The Indiana Division of Child Services (DCS) protects children from abuse and neglect. DCS does this by partnering with families and communities to provide safe, nurturing, and stable homes.

Vision: Children thrive in safe, caring, supportive families and communities.

Values:

- We believe every child has the right to be free from abuse and neglect.
- We believe every child has the right to appropriate care and a permanent home.
- We believe parents have the primary responsibility for the care and safety of their children.
- We believe the most desirable place for children to grow up is with their own families, when these families are able to provide safe, nurturing and stable homes.
- We believe in personal accountability for outcomes, including one's growth and development.
- We believe every person has value, worth and dignity.

In its strategic plan for 2010-2014, DCS established four overarching goals for the programs it administers including:

- Developing staff to have assessment skills and competencies that determine the risks and needs of children and their families;
- Ensuring that individualized programs and services are delivered to families and children in order to achieve safety, permanency and well-being outcomes;
- Ensuring that services are developed and planned in partnership with families and communities to protect children in their community through cooperation and communication; and
- Creating an infrastructure that will support and sustain all components of delivery within the child welfare system.

To address the requirements for the Child Abuse Prevention and Treatment Act (CAPTA) State Plan, DCS identified a series of activities from the fourteen prescribed in the legislation. The following activities will be the focus of CAPTA during the next five years:

- The intake, assessment, screening, and investigation of reports of abuse and neglect;
- Creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations;
- Improving legal preparation and representation, including—
    a. Procedures for appealing and responding to appeals of substantiated reports of abuse and neglect; and
    b. Provisions for the appointment of an individual appointed to represent a child in judicial proceedings;
- Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;
- Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols;
- Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange;
- Developing, strengthening, and facilitating training including—

    a. Training regarding research-based strategies to promote collaboration with the families;
    b. Training regarding the legal duties of such individuals; and
    c. Personal safety training for case workers.
- Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers;
- Developing and facilitating research-based strategies for training individuals mandated to report child abuse or neglect;
- Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect;
- Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level;
- Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;
- Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.

The following table aligns the DCS goals and CAPTA activities with the intended outcomes of home visiting.

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits Reduction in crime or domestic violence	• Development of staff to have assessment skills and competencies that determine the risks and needs of children and their families. • Ensure that individualized programs and services are delivered to families and children in order to achieve safety, permanency and well-being outcomes.	• The intake, assessment, screening, and investigation of reports of abuse and neglect • Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers; • Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols; • Developing, strengthening, and facilitating training including— o Training regarding research-based strategies to promote collaboration with the families; o Training regarding the legal duties of such individuals; and o Personal safety training for case workers.

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
Improvements in coordination and referrals for other community resources and supports.	• Ensure that services are developed and planned in partnership with families and communities to protect children in their community through cooperation and communication.	• Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families • Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems; • Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
		substantiated child maltreatment reports

Title V Maternal Child Health Services

Source Document: Title V Needs Assessment 2010

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

Vision / Purpose: To improve the health status of families in the State of Indiana and to ensure that all children within the context of their family and culture will achieve and maintain the highest level of physical, mental, and emotional health in order to realize their human potential to the fullest. The goal of MCH is to make services available to all residents of Indiana. Emphasis is placed on ensuring services to childbearing women, infants, children, and adolescents (including children with special health care needs, low income populations, those with poor nutritional status and those who do not have access to health care). This vision is carried out in collaboration with local communities, other state agencies, organizations and

individuals concerned with the health and well-being of families, women, infants, children, and adolescents.

Mission Statement: In order to accomplish its mission, the Indiana Maternal & Child Health Services will:

1. Promote the delivery of high quality, comprehensive, family-centered health services for women, infants, children, and adolescents.
2. Identify and assess the health factors and conditions of families that adversely affect their social, economic, and health status.
3. Monitor relevant health status indicators to identify, assess, and proactively plan for current and future areas of need, including proposals for regulatory change.
4. Promote early prenatal care, treatment for substance abuse, breastfeeding, provision of nutritious food, health education and referrals in preventative and primary health care services to improve pregnancy outcome and child health.
5. Develop and promote effective outreach and identification, including the provision of culturally sensitive and competent care coordination and management.
6. Establish policy and standards of care, and promote quality preventative health care services that emphasize early evaluation, prevention of regression of health status and promotion of maximum function.
7. Strengthen outreach, educational and marketing efforts including communications to target high-risk populations, local agencies, and community organizations.
8. Provide technical assistance to local communities to assure the development of systems of health, nutrition education and special health care services.
9. Develop standards for health and nutrition services to evaluate the quality and outcomes of initiatives and to evaluate local project operations and management.
10. Procure and appropriately utilize funds and other resources to improve the health of families, with emphasis on women, infants, children, adolescents and children with special health care needs.

Values: The underlying values of Maternal & Child Health Services are:

1. MCH is committed to comprehensive Family Centered Health Care that is culturally sensitive.
2. Preventive Health Care Services; and Early Identification, Diagnosis, & Treatment are the most effective and efficient methods to safeguard the public's health.
3. MCH operates in collaboration with local communities, other state agencies, organizations and individuals concerned with the health and well-being of families, women, infants, and children.

In July of 2010, Indiana MCH submitted the required five-year needs assessment for FY 2011-2015. The goals of the Indiana Title V Needs Assessment process were to (1) identify health needs for the maternal, infant, child, adolescent and children with special healthcare needs (CSHCN) populations in Indiana; (2) improve working relationships with collaborative partners; and (3) provide a roadmap for improving health outcomes for the same populations.

Ten priority areas were identified for the populations served by MCH. For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding.

For infants, two areas were identified that require a special focus: prematurity rates and accidental suffocation under one year of age.

Concerns involving children and adolescents centered on lead poisoning, STIs, obesity, and social-emotional heath of very young children.

Based on the findings of the needs assessment, ten performance measures were identified for action in the next five years. The table below aligns the priorities with outcomes established for home visiting.

Home Visiting Intended Outcomes	Indiana Title V Performance Measures
Improved maternal and newborn health	1. Decrease the percentage of pregnant women on Medicaid who smoke (SPM 3)

Home Visiting Intended Outcomes	Indiana Title V Performance Measures
	2. Increase the percentage of black women (15-44) with a live birth whose prenatal visits were adequate (SPM 4) 3. Increase the percentage of women who initiate exclusive breastfeeding (SPM 2) 4. Decrease the percentage of preterm births (SPM 7) 5. Decrease the percentage of births occurring within 18 months of a previous birth to the same birth mother (SPM 6) 6. Decrease the rate of suffocation deaths of infants (SPM 1)
Improvement in school readiness and achievement	1. Decrease the percentage of children age 0-72 months with blood levels greater than or equal to 10 micrograms per deciliter (SPM 5) related to lead poisoning. 2. Decrease the percentage of high school students who are obese (SPM 8) 3. Decrease the percentage of high school students who become infected with an STI (SPM 9) 4. Increase capacity for promoting social-emotional health in children 0 to 5 (SPM 10)

Conclusion

In reviewing the needs assessments and strategic plans, Indiana's collaborating agencies identified a clearly documented effort to comprehensively address the needs of high risk pregnant women, families and children. The goals and strategies of each agency are in alignment with the outcomes identified in statute for the home visiting initiative. Alignment of goals is critical to the long term sustainability of efforts to improve outcomes for this vulnerable population. Each agency specifically discussed the importance of communication and collaboration across agencies and programs to achieve the desired outcomes. This degree of cooperation and collaboration will enhance the ability of Indiana to achieve the desired outcomes for home visiting.

Part 3: Indiana Home Visiting Capacity

A variety of home visiting programs have emerged in recent years to serve Indiana communities with the growing awareness of the value that home visiting interventions bring to addressing health, safety and literacy needs. The Indiana Department of Child Services has more than a decade long commitment to home visiting in the form of Healthy Families Indiana (HFI). HFI serves families in all 92 Indiana counties. In addition to HFI, additional programs have emerged including Even Start, Early Head Start, and Parents as Teachers (PAT). Diverse funding streams and outcome objectives, expanding eligibility criteria and targeted population have driven the growth of programs. Existing Indiana home visiting programs offer ongoing services to individuals primarily in a home setting, although many offer group services as well. Services are delivered by trained home visiting professionals or paraprofessionals with the goal of addressing specific issues based upon the individual family's eligibility for the program.

For the purposes of this needs assessment, the following overview of Indiana's home visiting programs will include those programs meeting the aforementioned criteria. Programs not included are those delivering services as part of federal IDEA Part C requirements, programs providing one-time home visits and programs that do not provide routine and sustained home visits.

The discussion below summarizes home visiting programs in Indiana and describes in detail each individual home visiting program in the state. To the extent possible, program descriptions include the program components, scope of service, number and type of individuals and families served, ability of the programs to meet the needs of eligible families, and the individual program gaps and concerns.

Early Head Start

Early Head Start (EHS) is a national evidence-based multi-service early childhood, community-based program for low-income families with infants and toddlers and pregnant women. Early Head Start strives to:

- Promote healthy prenatal outcomes for pregnant women;

- Enhance the development of children ages birth to three; and
- Support healthy family functioning.

EHS is administered by the Office of Head Start (OHS), Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (DHHS). EHS's home visiting component provides – through the use of home visitors – comprehensive services to promote school readiness and enhance children's physical, dental, nutritional, social/emotional, and cognitive development.

In FY09, Indiana had 15 Early Head Start program sites. ARRA funding provided a significant expansion to the capacity of Early Head Start in Indiana with the creation of 1,037 new slots. Eleven additional sites were funded with some existing sites expanding enrollment. Indiana currently has 2,636 EHS slots in 26 programs. Program design and service delivery models vary from home visitation, social groups and classroom services to a combination of these models. Many sites designate slots from various program models to best meet the needs of the families served. The estimated cost of the Early Head Start home visiting program differs significantly from site to site ranging from approximately $7,000 to $14,000 per child. While the current waitlist for the EHS home visiting component is unknown, the cumulative waitlist for both the EHS and HS programs in the spring of 2010 was an estimated 7,000 families statewide. Program administrators feel that demand exceeds enrollment capacity for EHS and similar programs, and that more resources need to be dedicated to programs serving at-risk populations.

Healthy Families Indiana

Healthy Families Indiana (HFI) is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. HFI awards grants from the Indiana Department of Child Services (DCS) to single county and cluster site grantees that provide assessment and home visiting services in all 92 Indiana counties. HFI serves eligible families of children prenatally to age three. Currently to qualify for services, a family's income must be at or below 250% of the federal poverty line and the family must score 40 or higher on the Kempe Family Stress Checklist. At the onset of services, each enrolled family is visited a minimum of once a week for a minimum of six months. Thereafter, based on well-defined criteria regarding family

need, progress, and engagement in the program the required number of visits per family per month may be increased or decreased. The maximum cost per family per year is $4,500.

The HFI program uses a variety of curricula based on the needs of the families and their personal learning styles. Curricula and educational materials used are PCI activity-based, sequential and include an instruction manual for home visitors. Curricula currently approved for use in HFI programs include:

- Great Beginnings- Prenatal;
- Healthy Start;
- MELD New Middle of the Night;
- MELD - Nueva Familia;
- MELD - Young Families at Home;
- Mom Project Prenatal Curriculum;
- Nurturing Program for Prenatal Families;
- Nurturing Program for Families with Special Needs;
- Nurturing Program for Teen Parents;
- Nurturing Program - Birth to Five;
- Nurturing Program - 4 to 12;
- PAT, 0-3;
- PAT, 3-K;
- Partners for a Healthy Baby – Prenatal;
- PIPE;
- Resource Mother's Handbook;
- Ezparenting; and
- Partners for a Healthy Baby-Birth to 3.

From July 1, 2009 to June 30, 2010, HFI served 22,739 families, providing home visiting to 14,475 families statewide with a total budget of $34,436,323. HFI programs are not permitted to develop waitlists for services, yet there are capacity limitations which require that families who are eligible but not enrolled in HFI be referred to other services to meet their needs. Significant

reductions of funding are now limiting enrollment to families with a score 40 or higher on the Kempe Family Stress Checklist rather than the previously required minimum score of 25.

Healthy Families E-Parenting Project (EPP)

The E-Parenting Project is an ongoing, multi-state research project funded by the Centers for Disease Control and Prevention involving 420 Indiana families. One third of the families are in a control group and are not receiving any services. The other two-thirds are enrolled in two Healthy Family Indiana programs: HFI Allen County (SCAN) and the MOM Project in Marion County. The EPP curriculum is eight 20-30 minute sessions provided on a laptop touch screen computer as part of a regularly scheduled HFI home visit. These evidence-based interventions are designed to reduce risk factors for child maltreatment. The components include:

1) Motivational interviewing related to:
    a. Participation in home visiting;
    b. Domestic (interpersonal) violence;
    c. Substance Use (drugs and alcohol); and
    d. Mental Health – primarily depression.
2) Cognitive retraining that focuses on changing inappropriate maternal attributions for infant behaviors to appropriate attributions; and
3) Project Safe Care (health & safety behaviors to prevent neglect).

Families in this study who are receiving services are provided either regular HFI home visiting (using curriculum selected by HFI) or regular HFI home visiting augmented with E-Parenting on eight of the home visits that occur between birth and six months. The intent of the study is to determine if a computer-based program that incorporates evidence-based interventions can improve outcomes of families who participate in Healthy Families America home visiting. If E-Parenting is more effective than traditional home visiting there are several advantages to this technology including: 1) consistent implementation, 2) ease of dissemination, and 3) negligible additional cost. Moreover, E-Parenting can be continually monitored and evaluated in order to improve implementation, acceptance and effectiveness. For example, E-parenting can be enhanced by incorporating new evidence-based interventions as they become available.

EPP study participants are limited to English-speaking mothers age 18 and older. Mothers in the study include Non-Hispanic White, Hispanic, Black, Asian and Mixed/Other populations.

Parents as Teachers (PAT)

Parents as Teachers (PAT), a national evidence- based home visiting model, provides family-centered services that help to increase parent knowledge, promote optimal child development, and increase school readiness. Grounded in research, PAT developed the *Born to Learn* evidence-based curriculum that supports and encourages school readiness and the improvement of child health. The *Born to Learn* curriculum includes a health assessment, annual developmental screen, and referrals to support parents in their role as their child's first and best teachers. Supporting parents using the BTL curriculum can help to improve parenting practices, provide early detection of developmental delays and health issues including nutrition and wellness, prevent child abuse and neglect, and ensure children are ready to learn.

PAT's funding sources vary significantly across Indiana. The most current published data for July 2008 through June 2009 reports on the outcomes and progress of the 44 Indiana Parents as Teachers programs. Several communities have stand-alone Parents as Teachers programs that are funded by a combination of foundation dollars, local public resources and donations. Other Indiana programs that use PAT as part of home visiting programs and that are funded with federal or state dollars include Healthy Families Indiana (26 of the programs), Early Head Start (3), and Even Start (1). In total, 5,688 Indiana families received at least one PAT home visit during the 2008-09 program year.

The Newborn Individualized Developmental Care and Assessment Program

The Newborn Individualized Developmental Care and Assessment Program (NIDCAP) offers an individualized and nurturing approach to the care of infants in neonatal intensive care units (NICU) and special care nurseries (SCN). NIDCAP is a relationship-based, family-centered approach that promotes the idea that infants and their families are collaborators in developing an individualized program of support to maximize physical, mental, and emotional growth and health and to improve long-term outcomes for pre-term and high medical risk newborns.

The NIDCAP approach uses methods of detailed documentation of an infant's ongoing communication to teach parents and caregivers skills in observing an individual infant's

behavioral signals. These sometimes subtle signals provide the basis for interpreting what the infant is trying to communicate and can be used to guide parents and caregivers to adapt all interaction and care to be supportive of the infant's behavior. Suggestions for care are made in support of the infant's self-regulation, calmness, well-being and strengths, and the infant's sense of competence and effectiveness. Such suggestions begin with support, nurturance and respect for the infant's parents and family, who are the primary co-regulators of the infant's development. These suggestions should extend to the atmosphere and ambiance of nursery space, the organization and layout of the infant's care space, and the structuring and delivery of specific medical and nursing care procedures and specialty care. These practices ensure that a developmental perspective and the infant's environment are incorporated into the infant's care.

The St. Vincent NICU in Indianapolis previously utilized the NIDCAP program. The staffing and training requirements of the program lead the hospital to translate the key concepts of the approach to a more global staffing and environment effort, ensuring that all bedside caregivers are trained to support healthy, positive infant development.

Even Start

The purpose of the William F. Goodling Even Start Family Literacy Program (Even Start) is to provide intensive family literacy services to help break the cycle of poverty and illiteracy by improving the educational opportunities of low-income families. The Indiana Department of Education administers federal Even Start funding, making competitive grants available to local applicants. In program year 2009-10, $1,048,648 in funding supported six program sites. Indiana Even Start programs provide a year-round unified family literacy program which integrates child and adult literacy or basic education, parenting, and parent/child literacy activities. While program formats vary by site, each program is required to include a home visitation component to ensure parenting and family literacy is extended beyond the classroom and into the natural home environment. In addition to monthly home visits conducted by program staff, it is expected that families will carry out literacy activities and parenting strategies discussed. Curriculum is chosen by the local program but must be a scientifically based. The Creative Curriculum, those offered by Steck-Vaughn and the High Scope curriculum have all been used at sites in Indiana. Funded sites are required to ensure that the families selected for Even Start are those most in need of the full range of services offered. To be eligible for Even Start parents

must be 16 years of age or older, not be enrolled or required to be enrolled in secondary school, and lack sufficient mastery of basic educational skills to function effectively in society. To participate in an Even Start program, a family must have at least one eligible parent and one eligible child participating together in the full scope of the project. Enrolled children range from birth to eight years of age. During the 2009/2010 reporting year 204 families were served at six sites in six Indiana Counties.

Indiana Even Start sites do not maintain a waiting list. When space is no longer available to serve all eligible applicants, programs refer families to other community resources that may address some of the family needs until space opens. The IDOE identifies that there is considerable unmet need for Even Start as the state currently only operates six programs and many other communities likely have literacy needs that could be met effectively by this program. The IDOE continues to receive requests for additional programs however no additional funds are currently available.

Healthy Start

Indiana hosts two of the 104 Health Resources and Services Administration (HRSA) funded Healthy Start projects. Healthy Start provides community-based, culturally competent, family-centered, and comprehensive perinatal health services to women, infants, and their families in communities with very high rates of infant mortality. The target population is pregnant or parenting women who reside in communities with infant mortality rates 1.5 - 2.5 times the national average. The majority of population served is Medicaid eligible. Services provided include outreach, health education, case management, depression screening and referral, and interconception care.

Health and Hospital Corporation of Marion County is the grantee for the Indianapolis Healthy Start Project grant, while Northwest Indiana Health Department Cooperative is the grantee for Northwest Indiana Healthy Start Project. Both Indiana Healthy Start projects provide case management (which includes risk assessment), coordination services, home visitation, health education, counseling, and guidance.

Healthy Start receives 100% of its funding from HRSA. In FY09, case-managed home visiting services were provided to 568 families in Marion County and 554 in Lake County. The projects

provided outreach to 32,916 families in Marion County and 58,211 families in Lake County. Community Education reached 19,883 families in Lake County and 21,664 families in Marion County. Families receiving case management are served at a cost of $1,125 in Marion County and $1,040 in Lake County per family annually. HRSA flat funding of Healthy Start for the past thirteen years has limited the opportunity to expand this program.

First Steps

First Steps, Indiana's program for infants and young children with disabilities or who are developmentally vulnerable (Part C of IDEA), is a comprehensive statewide program of early intervention services for infants and toddlers with disabilities and their families. Families who are eligible to participate in the Indiana First Steps system have children under the age of three who: are experiencing developmental delays of 25% or -2 standard deviations from the mean in one or more developmental domains; are experiencing developmental delays of 20% or -1.5 standard deviations from the mean in two or more developmental domains; or have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. First Steps services are provided at no cost to eligible families whose income is under 250% of the federal poverty line; families with income greater than 250% pay cost participation fees on a sliding scale. Indiana's Family and Social Services Admiration (FSSA) serves as the lead agency and administrator of the program, and is advised and assisted by an Interagency Coordinating Council (ICC). Ten regional contractors provide intake, eligibility determination and service coordination for families. Individual Family Services Plans (IFSPs) outline services which may include Assistive Technology, Occupational Therapy, Audiology, Developmental Therapy, Physical Therapy, Health Services, Psychology, Interpreter Services, Social Work, Medical, Speech Therapy, Nursing, Vision, Nutrition and other services and are provided to the extent possible in the children's natural environment, often their homes.

Between April 1, 2009, and March 31, 2010, 20,997 children were served by First Steps statewide at a total cost of $51,231,737.62.

Part 4: Substance Abuse Counseling and Treatment Capacity

Indiana has made significant efforts to prevent substance abuse as well as provide treatment options to support individuals who wish to address abuse issues. Indiana's Strategic Prevention Framework State Incentive Grant (SPF-SIG) is a five-year project awarded to the Office of the Governor and has an overall goal to reduce substance abuse and use over the lifespan of Hoosiers. Funding for this project comes from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP). As a part of this project the Governor has appointed a Governor's Advisory Council (GAC) whose role is to collect and analyze data to help direct the strategic efforts of the state. The state plan summarizes Indiana's epidemiological profile regarding alcohol as follows:

"Alcohol is the most frequently used drug in both Indiana and the United States. According to estimates from the 2004 National Survey on Drug Use and Health, NSDUH (Substance Abuse and Mental Health Services Administration, SAMHSA, 2006), 47.37% of Indiana residents 12 years and older currently consume alcohol (U.S.: 50.71%). Risky consumption patterns, such as binge and heavy drinking, as well as underage drinking, are of particular interest. The most recent 2004 NSDUH estimates report, 21.70% of Hoosiers 12 years and older engaged in binge drinking in the past month, i.e., they had five or more drinks on the same occasion (U.S.: 22.69%); and 40.60% reported heavy use, or consumption of five or more drinks on the same occasion on at least 5 different days in the past 30 days (U.S.: 41.30%). Especially, young adults between the ages of 18 and 25 seemed to be at risk, with 43.47% stating to have engaged in binge drinking within the last 30 days (U.S.: 41.39%). The Behavioral Risk Factor Surveillance System, BRFSS (Centers for Disease Control and Prevention, CDC, 2005), shows that in 2005, 30.30% of all adults (18 years and older) reported binge drinking in the past month (U.S.: 23.50%)." According to the Youth Risk Behavior Surveillance System, YRBSS (CDC, 2006a), 41.4% of Indiana high school students had consumed at least one alcoholic beverage in the past 30 days.

Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents Survey, ATOD (Indiana Prevention Resource Center, IPRC, 2006) and Monitoring the Future Survey, MTF (National Institute on Drug Abuse, 2006a) report that in 2005, alcohol consumption in Indiana

for 8th, 10th, and 12th grade students combined was as follows: lifetime use 49.0% (U.S.: 41.0%), annual use 39.0% (U.S.: 33.9%), monthly use 21.1% (U.S.: 17.1%), daily use 1.8% (U.S.: 0.5%), and binge drinking 11.6% (U.S.: 10.5%).

Heavy alcohol use can lead to alcohol abuse and dependence and is associated with unsafe behaviors, such as smoking cigarettes, illicit drug use, and risky sex. According to the Treatment Episode Data System, TEDS (Substance Abuse and Mental Health Data Archive, SAMHDA, n.d.), 7.6% of Indiana residents were diagnosed with alcohol abuse and/or dependence in 2004 (U.S.: 7.5%). Another serious, long-term consequence of chronic alcohol use is liver disease. The Alcohol-Related Disease Impact (ARDI) database (CDC, 2004) estimated that in 2001, 8.0% of all deaths in Indiana were alcohol-related (U.S.: 8.0%). Furthermore, alcohol seems to be a contributing factor in fatal motor vehicle accidents, certain types of crime (e.g., aggravated assaults, sexual assaults, robberies, driving under the influence, liquor law violations, and public intoxication), and even homicides and suicides.

Further, the Indiana Perinatal Network *(Source: www.indianaperinatal. org/)* contends that nearly 20 percent of women in Indiana use tobacco, while 10 percent use alcohol and 5 percent use other drugs during pregnancy. A critical step to prevent poor outcomes associated with substance use during pregnancy is to verbally screen all pregnant women for alcohol, tobacco and other drug use. The 2007 White House Office of National Drug Control Policy estimates that savings from verbal screening and brief interventions are $2.50 for every $1 spent. The estimated lifetime costs of caring for a baby exposed to alcohol, tobacco and other drugs range from $750,000 to $1.4 million.

The SPF-SIG planning grant has provided Indiana with an opportunity to assess, coordinate and plan efforts to identify and address substance abuse issues in the state. The Division of Mental Health and Addiction (DMHA) oversees Indiana's efforts in addressing substance abuse. DMHA closely works with the Criminal Justice Institute (ICJI) to coordinate efforts with the criminal justice system in Indiana. The ICJI seeks to create a healthier and safer environment in Indiana by linking resources to communities. Indiana also enjoys the Indiana Resource Prevention Center (IPRC) located in Bloomington which serves as a clearinghouse for information and resources regarding alcohol, tobacco and drugs. The IPRC coordinates Indiana's annual survey of Children and Adolescents for Alcohol, Tobacco and Other Drug Use. At the county level Indiana has 92

Local Community Councils (LCC's) that are charged with developing a strategic plan at the local level to address substance abuse issues.

The result of the SPF-SIG planning efforts identified target areas for recommending allocation of funding to the highest need communities. The top needs identified indicate resources should be allocated to reducing the use/abuse of alcohol. These recommendations were based on a ranking of counties using six indicators. Twenty counties are identified as "high need" for alcohol-related SPF-SIG funding. These include (with highest need listed first) Lake, Tippecanoe, Marion, Allen, La Porte, St. Joseph, Vanderburgh, Floyd , Vigo, Madison, Porter, Elkhart, Shelby, Wayne, Delaware, Jasper, Kosciusko, Marshall, Monroe, and Newton. Nine counties are identified as "high need" for cocaine-related SPF-SIG funding. These include (with highest need listed first) Marion, Wayne, St. Joseph, Howard, Allen, Grant, Elkhart, Lake, and Tippecanoe. Ten counties are identified as "high need" for methamphetamine-related SPF-SIG funding. These include (with highest need list first) Gibson, Bartholomew, Vigo, Daviess, Warrick, Greene, Vanderburgh, Tippecanoe, Elkhart, and Hamilton.

High need counties for prevention funding as identified by Indiana's SPF-SIG project

** signifies counties in more than one category*
***signifies counties in all three categories*

Alcohol	Cocaine	Methamphetamine
Lake*	Marion	Gibson
Tippecanoe**	Wayne	Bartholomew
Marion*	St. Joseph	Vigo
Allen*	Howard	Daviess
La Porte	Allen	Warrick
St. Joseph*	Grant	Greene
Vanderburgh*	Elkhart	Vanderburgh
Floyd	Lake	Tippecanoe
Vigo*	Tippecanoe	Elkhart
Madison		Hamilton
Porter		
Elkhart*		
Shelby		
Wayne*		
Delaware		
Jasper		
Kosciusko		
Marshall		
Monroe		
Newton		

In Indiana there is a long-term, focused approach on substance abuse prevention. The Indiana Prevention Resource Center (IPRC) was established in 1987 to assist Indiana based alcohol, tobacco and other drug (ATOD) prevention practitioners improve the quality of their services. In

recent years IPRC's purview has expanded to include problem gambling prevention and ATOD treatment. The IPRC, located in Bloomington, is part of the Department of Applied Health Science at Indiana University. The primary target audience is the community of prevention professionals and volunteers, and government officials who are providing or monitoring delivery of ATOD and problem gambling prevention and treatment services to Indiana residents. The IPRC enables prevention and treatment professionals to deliver evidence based programs, policies and practices to the general public.

The IPRC mission is to strengthen prevention and treatment efforts through education, resources and research. The center works to bring together research and practice and thereby better ensure that Indiana's residents receive state of the art prevention technology. The project website offers a host of useful search tools to gather information about specific counties and the prevalence of substance abuse, admission to a variety of treatment modalities as well as multiple demographic variables. The center is available to support local/county efforts to assess current statistics and how to use the data to support prevention and intervention efforts. These resources are available at www.drugs.indiana.edu.

Treatment Resources

Indiana has a great number of substance abuse counseling and treatment resources throughout the state. While there are more resources located around larger metropolitan communities, there is some level of resource available in most Indiana counties. It is noted that substance abuse can affect anyone, anywhere; it is a condition that does not discriminate for age, sex, gender, educational level, economic status or geographic location.

The Family Social Service Administration, Division of Mental Health and Addictions oversees substance abuse services. A variety of certifications/licenses is available. These include 1) Addiction Services Certification, Residential Care Provider Certification, 3) Supervised Group Living and Sub Acute Licenses, 4) Community Mental Health Center Certification, 5) Managed Care Provider Certification, and 6) Private Mental Health Institution (Hospital) Certification. To receive various funding to support treatment services and be included in the state and national listing of treatment resources, programs must hold the appropriate certification or licensure. More information about FSSA/DMHA certification and licensure is available at

http://www.in.gov/fssa/dmha/4560.htm. The DMHA statewide treatment resource locator is available at http://www.in.gov/fssa/dmha/2578.htm.

According to the Indiana State Department of Health's 2007 report of substance report treatment facilities, there are treatment service facilities located in all but 5 Indiana counties. Metropolitan areas tend to house multiple programs although most programs will serve clients from any county. A listing of substance abuse programs in Indiana complied by SAMHSA indicates at least 150 different programs in the state. A 2007 report compiled by the Indiana State Department of Health Geographic Information Systems provides a useful, interactive map of Indiana with a representation of substance abuse treatment services by type and payment source. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a national database of substance abuse and mental health services. This listing is generally considered the best and most convenient, accurate source of information regarding available services. The SAMHSA listing is updated regularly for current, up-to-date information about specific resources. The SAMHSA national treatment resource locator is available at http://dasis3.samhsa.gov/Default.aspx.

Of particular interest to the home visiting perspective are programs serving adolescents, women and pregnant women. Fifty-three (53) programs provide services to adolescents with eleven programs having multiple sites. Eight offer inpatient services, three offer residential services, 13 offer partial hospitalization/day services, and 49 offer outpatient services. It should be noted that some programs provide more than one type of service and may therefore be represented more than once in these statistics.

Twenty (20) programs provide services to pregnant women with four programs having multiple sites. Of these programs four offer residential services, three offer partial hospitalization/day treatment, and 15 offer outpatient services. It should be noted that some programs provide more than one type of service and may therefore be represented more than once in these statistics.

Fifty-eight (58) programs provide services to women with nine programs having multiple sites. Of these programs two offer inpatient services, two offer partial hospitalization/day services, six offer residential services and 48 offer outpatient services. It should be noted that some programs

provide more than one type of service and may therefore be represented more than once in these statistics.

Description of Services Provided

Indiana facilities providing substance abuse treatment services offer a variety of services. These facilities offer services such as inpatient, detoxification, residential, outpatient, and programs for special populations. Some programs cater to special populations such as adolescents and women. Others offer services for people who speak Spanish and American Sign Language. Services are paid for by a variety of payment sources including Medicaid, Medicare, state financing, private health insurance, military insurance, self-payment, and sliding fee schedules.

Projects of special interest for special populations

a) The Indiana Access to Recovery (ATR) is a SAMHSA Center for Substance Abuse Treatment discretionary grant aimed at expanding the chemical dependency recovery infrastructure in the state to include both faith-based and community organizations that have traditionally not been involved in chemical dependency recovery. Indiana ATR funds are available for adults at or below 200% of the federal poverty level, residing in **Allen, Elkhart, Lake, Marion, St. Joseph, Vanderburgh, and Vigo** counties. The program is designed to eliminate barriers to treatment and recovery services for adults dealing with substance abuse and addiction issues. The three target populations are: adults transitioning into the community after incarceration, ***women who are pregnant or who have dependent children*** and adults with a history of Methamphetamine use.

   Each client enrolled in ATR works with a Recovery Consultant who helps them assess their recovery needs and guides them in the development of their Individualized Recovery Plan. The Recovery Consultant authorizes vouchers allowing the client to access ATR funded services and also helps the client to connect with any non-ATR services they may require. ATR approved providers are be both secular and faith-based, giving the client the option of selecting the provider they are most comfortable with. When a client accesses services at an ATR provider organization, that organization will then be reimbursed by the state. Adults enrolled in ATR must be residents of one of the seven designated counties. However, ATR

clients may access services at any certified ATR Provider, which could be located in a non-ATR county. *Source: http://www.in.gov/fssa/dmha/6942.htm*

b) Project HOME (Midtown Community Mental Health Center, Indianapolis) provides specialized services for pregnant women with infant up to age 6 months. The program is offered through Midtown Addictions Clinic and available to Marion county residents. Services are paid for primarily through Medicaid and Wishard Health Advantage funds. Women are referred to Project HOME when receiving addictions services. The program offers a wide variety of supports in an effort to assure these pregnant women/mothers are successfully treated. Services include case management with weekly or biweekly home visits. The focus of the home visit depends upon the specific needs of the client. The provider may offer counseling as needed using the Motivational Interviewing model. Clients may also receive services such as transportation and child care in order to maximize success. Source: Interview with Project HOME staff. More information is available at http://www.wishard.edu/Midtown.

c) Tara Treatment Center is located in Franklin. The program offers detoxification, residential, transitional residential, intensive outpatient, outpatient, aftercare, education, and family programming. Tara is licensed for a 13 bed residential/transitional residential program especially designed for women. These beds are available for a residential program (typical length of stay is 30 to 42 days) and for a transitional residential program (typical length of stay is three to six months). Tara receives referrals by telephone and does an initial screening to be sure the center is an appropriate source for treatment. If admission is suggested, women make an appointment to visit the center for a full psycho-social evaluation. Pregnant women are also referred to an OBGYN for a physical and to coordinate care. Many women are referred to other local community and state resources. For women who have children, they are allowed to visit weekly. Tara also offers a monthly parenting class offering tools and strategies to support positive parenting techniques. Source: Interview with Tara Center staff. More information is available at www.taracenter.com.

d) Fairbanks is located in Indianapolis, IN and has over 60 years experience in treatment substance abuse issues. The program offers inpatient/detox, partial hospitalization,

intensive outpatient services, and a Supported Living Program (SLP). Fairbanks offers services to adolescents and adult men and women. Currently women and men participate in educational programming together for the inpatient/detox and the partial hospitalization programs. There is a specialized Intensive Outpatient Program (IOP) for women. The IOP is 3 hours a day for 3 days a week for a total of 6 six weeks. This program is offered both during day and evening hours. The SLP or halfway house program is housed at an apartment complex near the Fairbanks facility and offered at $130 per week. Fairbanks is currently considering some targeted programming to meet the specific needs of women in need of substance abuse treatment and intervention. *Source: Interview with Fairbanks staff. Additional information available at www.fairbankscd.org.*

e) Amethyst House is a Bloomington, IN based not-for-profit United Way agency that provides residential and outpatient services for people with drug and alcohol addiction with an additional outpatient office in Evansville, Indiana. The Women's halfway program serves up to 10 women. This halfway house expects residents to have been clean and sober for at least 2 weeks prior to admission. Applicants must prove they are homeless and are asked to make a commitment to stay for a minimum of six months and to maintain work in order to pay for their stay. While in the program women participate in weekly meetings with a case manager to monitor progress and make appropriate referrals. Residents participate in a 12 week outpatient treatment program (weekly) and attend self help/support group meetings. Applications can be accessed online and the average wait to get into the program is 3 to 4 weeks. *Source: Interview with staff. More information is available at www.amethysthouse.org.*

f) The John P. Craine House is an alternative sentencing program for non-violent female offenders and their pre-school age children. This facility is one of six in existence in the country and the only one in the Midwest. The Craine House Residential program allows women from within Marion and surrounding counties to serve out their executed sentence with their children, in lieu of jail or prison. The program offers structure and guidance with individualized goals for the women. Craine House offers an array of programs to better serve each woman's needs; parenting, GED classes,

tutoring, health and nutrition, substance abuse programs, employment resources, and faith-based opportunities. *Source: http://www.crainehouse.org/*

g) Stepping Stones - Southwest IN Mental Health Center is located in Evansville. The program offers 26 residential treatment beds for individuals 18 and older. The program offers detoxification, residential (typical length of stay 21 – 28 days), intensive outpatient, outpatient, groups, and individual counseling. Stepping Stones has two dedicated beds for women transitional residential (or halfway house) services with a length of stay up to six months. This program has a strong connection with local community services for long term/halfway house services needs such as the YWCA and Ruth House (a faith based program). Stepping Stones considers pregnant women or women using IV and/or meth as high priority admissions. *Source: Interview with Stepping Stones staff; www.southwestern.org*

Substance Abuse Screening – Home visiting programs may be particularly interested in evidence based screening tools to support home visitors in identifying potential substance abuse issues and making appropriate referrals. Several resources have been identified including an Indiana project current being funded to research a specific screening tool's validity.

a) Screening, Brief Intervention, and Referral to Treatment (SBIRT) – This project is a collaborative effort between the IU School of Medicine, Wishard Health Services, and Midtown Community Mental Health Center funded by SAMHSA. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. It uses a screening tool that attempts to identify those with "hazardous" substance abuse and provides an effective intervention prior to the need for more targeted, in-depth treatment. The model is currently being evaluated for its effectiveness. It is possible this tool could be adapted for use by home visitors. *Source: Dean Babcock, ACSW, LCSW, Associate Vice President, Midtown Community Mental Health Center.*

b) Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) – This is a model for helping staff of public and private agencies respond to families affected by substance use disorders. It was developed by the National Center on

Substance Abuse and Child Welfare (NCSACW), a training and technical assistance resource center established jointly by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration and the Office on Child Abuse and Neglect of the Administration for Children and Families. Both agencies are part of the U.S. Department of Health and Human Services. The tool and model were developed to help caseworkers screen parents for potential substance abuse disorders in order to make decisions about children's safety. The authors admit that no single tool can provide all of the information caseworkers need to make important decisions around the safety of children, however they support the idea of a collaborative approach among professionals in using a variety of tools such as those discussed in this model. The 300+ publication describing this model and how to implement it can be accessed electronically through http://www.ncsacw.samhsa.gov.

c) Substance Abuse Subtle Screening Inventory (SASSI) The SASSI Institute was formed in 1998 when it published its first screening/inventory tool. The institute has become a leading publisher in tools that specialize in screening instruments for substance abuse. The current adult screening tool (SASSI-3) is targeted for individuals aged 18 and higher, with a reading grade level of 3.2, an accuracy score of 94%, and can be administered and scored in 15 minutes. The adolescent screening tool (SASSI-A2) is targeted for youth age 12 to 18, with a minimum reading grade level of 4.4, an accuracy score of 94% and administered and scored in 15 minutes. There is an adult Spanish version with a reading grade level of 5 and a lower accuracy rate of 84% with a similar administration/scoring time of 15 minutes. More information about the tools and research efforts to validate these tools can be found at www.sassi.com.

d) The Indiana Perinatal Network offer s for sale a provider training video titled "Integrating Screening and Treatment of Substance Use into General Prenatal Care". The DVD training is designed specifically for health care professionals including home visitors. It features James Nocon, MD, a physician with Wishard Hospital and the IU School of Medicine. The training video includes practical role-play scenarios with clinical and research-based material and interventions. More information about this video presentation is available at http://www.indianaperinatal.org/sections/substance_use.php.

e) The National Resource Center for Permanency and Family Connection lists a variety of resources regarding substance abuse and child welfare. The web listing includes a variety of resources, curricula and presentations. This listing is available at http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/substance-abuse-and-child-welfare.html.

f) Addictions Licensure – In 2010 the Indiana Legislature passed SB 0096 which requires individuals providing substance abuse treatment services to acquire a license. The management of the licensure process has been placed in the newly named Behavioral Health and Human Services Licensing Board. The licensure provides for a two-tier system including a Licensed Clinical Addiction Counselor (LCAC) and a Licensed Addiction Counselor (LAC). The intent of this legislation is to assure a high quality of substance abuse treatment services to Indiana residents. The LCAC will be required to have master or doctorate degree with specific coursework as outlined in the law as well as supervision and experience. Passage of an exam is also required. The LAC requires at least a bachelor degree including specific coursework and a supervised practicum along with supervised experience and passage of an exam. There are provisions to grandfather in current providers who meet minimum established criteria with an application deadline of July 1, 2011. More information is available at www.in.gov/pla/3050.htm.

Part 5: Methodology Used to Identify High Risk Communities

Indiana's growing population of 6,423,113 (2009 est.) is spread unevenly among its 92 counties. Population patterns reflect the distinct rural and urban communities within the state with 70% of the population living in metropolitan areas and 30% in rural areas. These population patterns require that communities of risk be identified using a variety of variables. For the purpose of this needs assessment, the term community will refer to specific geographic area. In some areas of the state an entire county is a community, while in other counties the community will be defined as a city – which is both a population hub and an area of need – and still in other counties, communities will be defined at the neighborhood level within a city. Marion County, in central Indiana, hosts the largest city in Indiana, Indianapolis. Lake County, which is the furthest northwest county, just outside Chicago, consists of multiple large cities in Indiana, including

East Chicago and Gary. Because a few counties within Indiana hold so much of the population, crude numbers per county do not give an accurate account of the situation in these counties. In order to consider all communities of Indiana for inclusion in the identification of need, data that reflects rates of need were used rather than merely incidence calculations. As the first step in identifying the highest risk communities, Indiana's collaborating agencies identified sixty-five indicators that were linked to the established home visiting outcomes. As the data were gathered and analyzed, the list of indicators was narrowed to forty which were then utilized to determine the high risk status of counties in Indiana. The list of final indicators used for establishing risk can be found in Figure 1.

In deciding which counties were at the highest risk, the forty indicators with established rates and percentages were used to rank the 92 counties. Indiana ranked all 92 counties in the 40 different measures, individually. For example, for the infant mortality rate, all the counties were ranked from 1 through 92, with 92 representing the county with the worst rate. The same process was repeated for each of the indicators. A ranking was identified for each county regarding each indicator. All the measures were given equal weight. Once all the measures were completed, the overall scores for each county were combined, then divided by the overall measures to give a score ranking the counties overall for all the measures, with the possibility of being 1 through 92. Through this process the county with the highest risk score across all indicators, is Marion County with the score of 70.35. To see the overall scores, please refer to Figure 2.

To see how the rankings separate the counties, the scores are divided into quartiles. Eleven counties in the highest quartile are targeted as the highest risk counties, all with a score above 60. To see the map of Indiana divided into quartiles, please refer to Figure 3. There were a few surprises in the final results. Owen County, Fayette County, Jennings County and Scott County are all small rural counties, but have very high risk scores. Not surprising high risk scores along with Marion County were Lake County, La Porte County, St. Joseph County, and Elkhart County, which are all located in the northern part of Indiana and have large, diverse populations much like Marion County. The final two counties at the highest risk are Starke County, which is also in northern Indiana, and Grant County, which is home to the city of Marion.

The next step for the final home visiting application process is to drill down within these eleven high risk counties to find the cities and towns that have the highest risk. The rural counties, such as Scott, Fayette, Jennings, Starke and Owen, cannot be analyzed any further than the county level. In Grant County, the city of Marion represents the majority of the county's population, so Marion will be analyzed to identify whether the city as a whole or a specific neighborhood will be identified as high risk. This can also be said for Elkhart, which is the largest city in Elkhart County, and South Bend, which is the largest city in St. Joseph County. When looking at Lake County, the two cities furthest north, and just outside Chicago are also the highest risk cities, East Chicago and Gary. Even though they have very similar rates in negative outcomes, more resources are available to Gary. This will play a role when looking into the communities of East Chicago and Gary. Much like Lake County, La Porte County has two large cities that both have high risk areas in Michigan City and La Porte. The negative outcome rates are higher in Michigan City than La Porte, so when looking at the community level, this will be taken into account. The final county is of course Marion, which is represented by Indianapolis, the largest city and capital of Indiana. Because of the size and number of high risk areas in Indianapolis, the city will be analyzed in different segments, then communities. To see a chart of the counties and cities of the highest risk, please refer to Figure 4.

While analyzing the scores, the fear of all the major populated cities being at the highest risk was not realized. In fact, of the 35 largest cities in Indiana, only eight made the list of highest risk areas. Indiana's second and third largest cities, Evansville and Fort Wayne, (located in Vanderburgh and Allen Counties) did not rank in the top 15. This shows that Indiana does have a need in many rural counties, along with urban, high populated counties. The next step will be to work with the local area health departments and partners in these rural counties and large cities, to determine which communities are at the highest risk.

Indiana's collaborating agencies are committed to connecting with communities as a part of future analysis as the target communities of need are identified. The next step will be to work with local area health departments and partners in these rural counties and large cities to determine which specific communities are at the highest risk.

Figure 1: Indicators Used to Assess Risk

Indicators
% Low Birth weight
% Very Low Birth weight
% Preterm Birth
Rate of Infant Deaths
Rate of Neonatal Deaths
Rate of Post Neonatal Deaths
% of Women with Late of No Prenatal Care
% of Women Smoking during Pregnancy
% of Adult Smokers
% of Births to First Time Mothers
Birth Rates (15-19)
% of Pregnant Women on WIC
% of Women Breastfeeding at Discharge
% of Births to Unmarried Parents
% of Births to Mothers w/o High School Degree
% of substantiated child abuse
% of substantiated child neglect
% of Immunizations
% of Adult obesity
% of binge drinking
% of uninsured children
% of children with confirmed EBL>10
% of schools meeting Annual Yearly Progress (AYP)
Number of slots available in licensed child care per 100 Age 0-4
% of children in public schools with limited English proficiency
% of public school dropouts
% of 4th graders passing their ISTEP tests
% of unemployment
% of unemployment annual average
% of children in poverty
% of children receiving free or reduced lunch
% of households on food stamps
% of households on TANF
% of high school graduates
% of adults with a college education
% single parent households
% of children birth to 6 receiving Medicaid
Helpline Calls

Figure 2: Overall County Scores

High Risk Counties	Score	Rank	Average
Marion	2814	92	70.35
Lake	2626	91	65.65
Scott	2538	90	63.45
Elkhart	2533	89	63.325
St Joseph	2512	88	62.8
Fayette	2477	87	61.925
Jennings	2466	86	61.65
Starke	2444	85	61.1
LaPorte	2434	84	60.85
Grant	2422	83	60.55
Owen	2409	82	60.225
Madison	2365	81	59.125
Cass	2354	80	58.85
Switzerland	2333	79	58.325
Wayne	2225	78	55.625
Randolph	2220	77	55.5
Vanderburgh	2199	76	54.975
Clark	2183	75	54.575
Jefferson	2178	74	54.45
Vigo	2170	73	54.25
Wabash	2169	72	54.225
Noble	2161	71	54.025
Blackford	2158	70	53.95
Allen	2156	69	53.9
Washington	2132	68	53.3
Crawford	2116	67	52.9

High Risk Counties	Score	Rank	Average
Clinton	2112	66	52.8
White	2102	65	52.55
Orange	2074	64	51.85
Rush	2071	63	51.775
Vermillion	2061	62	51.525
Sullivan	2059	61	51.475
Fulton	2044	60	51.1
Miami	2037	59	50.925
Fountain	2036	58	50.9
Steuben	2026	57	50.65
Henry	2013	56	50.325
Montgomery	2012	55	50.3
Jackson	2006	54	50.15
Howard	1979	53	49.475
Jay	1969	52	49.225
Clay	1960	51	49
Delaware	1956	50	48.9
Newton	1942	49	48.55
Pulaski	1904	48	47.6
Lawrence	1903	47	47.575
Greene	1892	46	47.3
Shelby	1874	45	46.85
Marshall	1865	44	46.625
Decatur	1865	43	46.625
Kosciusko	1858	42	46.45
Daviess	1835	41	45.875
Morgan	1834	40	45.85
Union	1820	39	45.5

High Risk Counties	Score	Rank	Average
Parke	1819	38	45.475
Knox	1810	37	45.25
Perry	1809	36	45.225
Floyd	1802	35	45.05
Putnam	1798	34	44.95
Tippecanoe	1793	33	44.825
Adams	1788	32	44.7
Martin	1786	31	44.65
Harrison	1767	30	44.175
Bartholomew	1756	29	43.9
Huntington	1725	28	43.125
Ohio	1717	27	42.925
Jasper	1712	26	42.8
Ripley	1707	25	42.675
Pike	1683	24	42.075
Warren	1657	23	41.425
LaGrange	1642	22	41.05
Whitley	1614	21	40.35
DeKalb	1549	20	38.725
Wells	1528	19	38.2
Porter	1484	18	37.1
Monroe	1483	17	37.075
Franklin	1471	16	36.775
Benton	1460	15	36.5
Dearborn	1455	14	36.375
Tipton	1445	13	36.125
Brown	1441	12	36.025
Posey	1410	11	35.25

High Risk Counties	Score	Rank	Average
Spencer	1371	10	34.275
Johnson	1371	9	34.275
Carroll	1262	8	31.55
Warrick	1248	7	31.2
Gibson	1234	6	30.85
Dubois	1185	5	29.625
Hancock	1177	4	29.425
Hendricks	1113	3	27.825
Hamilton	948	2	23.7
Boone	940	1	23.5

Figure 3: Indiana County Score Map by Quartiles

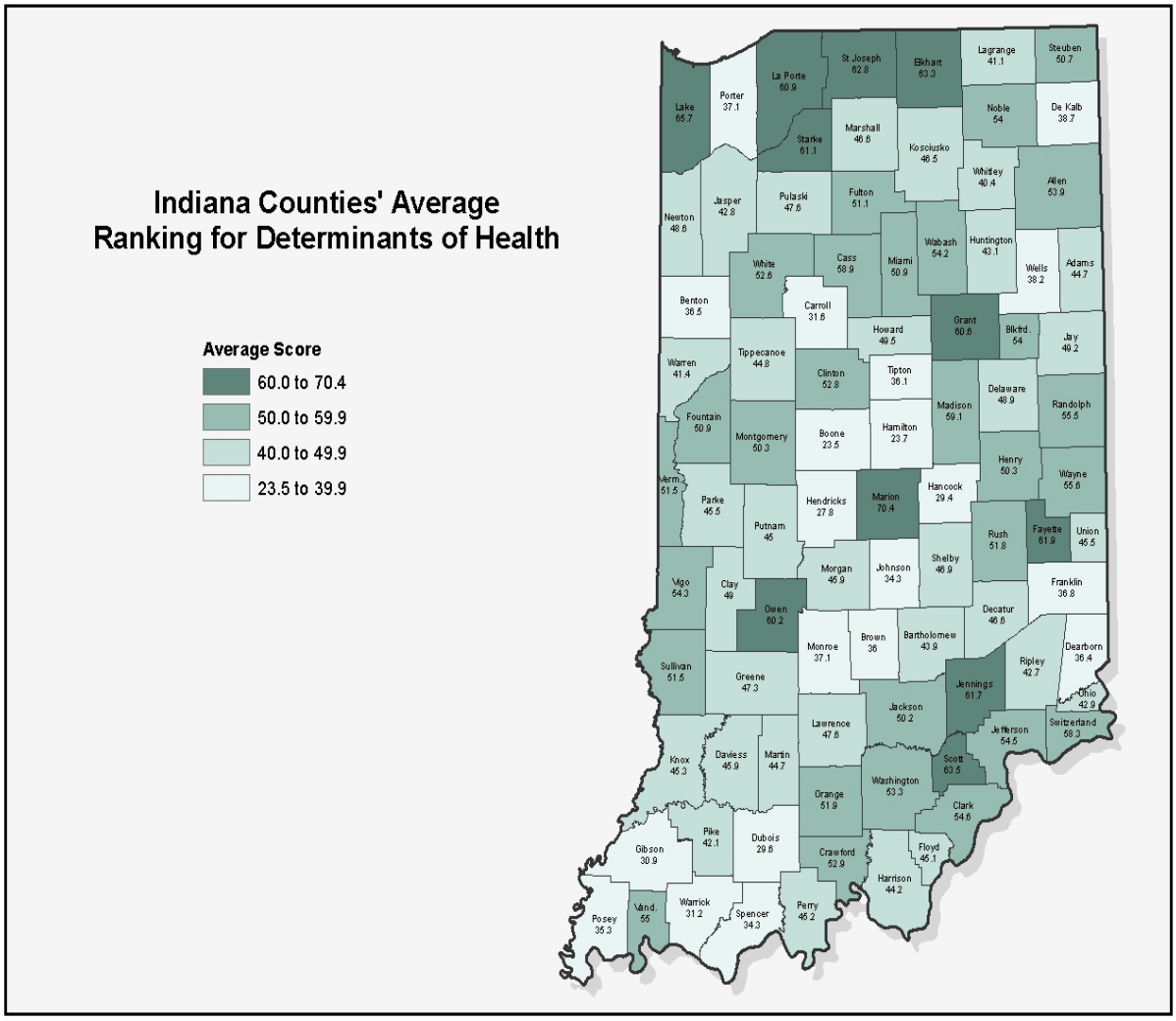
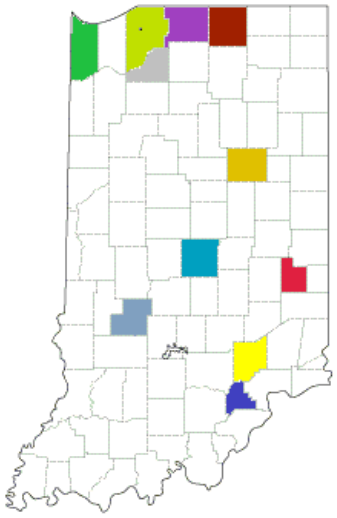


Figure 4: Community Selection Plan

County	**City**	**Community**
Marion	Indianapolis	
Lake	East Chicago	
	Gary	
Scott		
Elkhart	Elkhart	
St. Joseph	South Bend	
Fayette		
Jennings		
Starke		
La Porte	Michigan City	
	La Porte	
Grant	Marion	
Owen		

Figure 5: Capacity in High Risk Communities for Home Visiting and Substance Abuse Treatment Resources



	Healthy Families	Healthy Families with E-Parent	Early Head Start	Even Start	Parents as Teachers	Healthy Start	NIDCAP
Elkhart	X		X		X		
Fayette	X						
Grant	X		X				
Jennings	X						
La Porte	X		X		X		
Lake	X		X		X	X	
Marion	X	X	X	X	X	X	
Owen	X		X		X		
Scott	X				X		
St. Joseph	X		X		X		
Starke	X		X				

County	Substance Abuse	Detoxification	Halfway House	Outpatient	Partial Hosp/ Day Tx	Residential	Hospital	Adolescents	Pregnant Women	Women
Elkhart	X	X		X	X		X		X	X
Fayette	X			X				X		
Grant	X	X		X	X	X	X	X	X	X
Jennings	X			X						
La Porte	X			X				X		
Lake	X	X	X	X	X	X	X	X	X	X
Marion	X	X	X	X	X	X	X	X	X	X
Owen		X			X					X
Scott	X			X						
St. Joseph	X	X	X	X		X	X		X	X
Starke	X			X				X		

Part 6: Statewide Gaps in Maternal, Infant and Early Childhood Home Visiting Programs

Indiana has an array of home visiting programs across the state designed to address high risk populations and high risk issues such as family literacy, school readiness, economic self-sufficiency, maternal depression, abuse and child development. Despite this foundation, there are significant gaps in maternal, infant and early childhood home visiting in Indiana.

Identified Themes through the Needs Assessment Process

Funding Stability:

Indiana home visiting programs currently draw from a variety of funding streams. The current economic environment has created strains on all funding sources, while at the same time programs report increases in numbers and needs of eligible families. Programs specifically noted the following areas of concern:

- Need to utilize Medicaid billing effectively when appropriate; and
- Lack of mental health clinicians/Long waiting lists.

Maternal Mental Health:

Indiana home visiting programs consistently noted the need to increase services for women in the postpartum period. Programs specifically noted the following areas of concern:

- Postpartum/Maternal depression; and
- Lack of mental health clinicians/Long waiting lists.

Family Economic Self-Sufficiency:

Indiana home visiting programs consistently noted the need to increase services for homeless families and to bolster economic self-sufficiency programming. Specifically:

- Transportation resources to support families' access to services, employment opportunities and community resources;

- Housing resources to include financial assistance with deposits and arrearages (increasing rent and foreclosure rates have impacted target populations that consistently relocate);
- Career and workforce development support; and
- Food security.

Comprehensive System of Care:

Indiana home visiting programs voiced concern about the need to increase collaborations within home visiting programs and with other family support programs into a seamless structure of family services. Programs also noted the increased need for:

- A comprehensive approach to data collection and data sharing in order to avoid duplication of services, and to provide clear and consistent information;
- Improved awareness of potential partnering programs to ease referrals and meet needs beyond an individual program's capacity;
- Increased need for fiscal resources in order to provide on-going training opportunities for home visitors;
- Continuity of care for families transitioning into and out of home; and
- Coordination of program evaluation.

Non-Traditional Populations:

Indiana home visiting programs consistently noted the need to increase services to non-traditional populations who typically are not targeted for services in the parent, infant and early childhood spectrum. Among the population groups identified as underserved were:

- Fathers;
- Immigrant populations including Hispanic and Burmese ;
- Amish;
- Grandparents who are parenting; and
- Teen parents.

Part 7: Indiana's Plan to Address the Gaps

The collaborating agencies have developed preliminary responses to the identified gaps as a result of the needs assessment. As the high risk communities are further delineated, the responses will be adjusted to reflect the specific needs of each community.

Funding Stability:

The *overarching mission* of the Indiana Office of Medicaid Policy and Planning (OMPP) is to improve the quality and quantity of Hoosier lives in an outcome and value driven health care system. This mission is in alignment with the established outcomes for home visiting. The collaborating agencies will seek to partner with OMPP to ensure sustainability of Indiana's home visiting system in order to achieve shared outcomes for pregnant women, young children and their families. The presumptive eligibility policies of OMPP have supported timely entry into prenatal care for pregnant women in Indiana. A focus on evidence based programming that meets the requirements of OMPP for reimbursement will support programmatic sustainability and expansion of home visiting to other high risk counties.

Maternal Mental Health:

Research confirms the critical importance of the mental health and well-being of pregnant women and mothers. As indicated in the position paper developed by the Indiana Perinatal Network "*Women need to be screened for signs and symptoms of depression during and after pregnancy so early identification and prompt intervention can be offered. Postpartum depression can occur within days to one year after giving birth—but usually occurs within the first three months. Women with a previous history of depression have up to a 50% risk of developing postpartum depression and should be counseled before conception that they are at risk for recurrent depression during pregnancy and the postpartum period.*" The collaborating agencies are committed to continue programming that focuses on training for health care and social services providers.

Addressing the social-emotional development of young children has been a priority outcome for Sunny Start, the Indiana response to the Early Childhood Comprehensive System (ECCS)

initiative. Recognizing the importance of the mother child dyad is critical to positive child and family outcomes. Sunny Start has focused its efforts on workforce development to ensure there is provider capacity to meet the mental health needs of the pediatric population. In the coming year, Indiana will implement the Michigan Infant Toddler Mental Health Credential. This voluntary credential will be part of continuing education efforts for personnel in Early Head Start, Head Start, Child Care, mental health center providers and early childhood providers. This initiative is being funded and supported by the collaborating agencies for this home visiting effort.

Family Economic Self-Sufficiency:

The Indiana Commission on Childhood Poverty is charged with presenting an implementation plan that includes procedures and priorities for implementing strategies and biennial benchmarks to achieve the reduction of childhood poverty by 50% in Indiana by 2020. The plan must include provisions for improving the following for parents and children living in poverty:

- Workforce training and placement to promote career progression;
- Education opportunities, including higher education opportunities and literacy programs;
- Affordable housing;
- Child care and early education programs;
- After school programs and mentoring programs;
- Access to affordable health care, including access to mental health services and substance abuse programs; and
- Streamlining services through public and private agencies providing human services to low income children and families.

These provisions are aligned with the outcomes for home visiting.

An additional resource available for incorporation into the home visiting initiative is the Goodwill Guides initiative, an innovative approach to wrap-around services and supports to ensure all those who influence the child's growth are effectively empowered in a family strengthening process. This resource builds a platform that provides a holistic, whole family continuum of health, education, employment and social services within the community, using existing services as much as possible.

Sunny Start has also provided resources to support family self-sufficiency through the Early Childhood Meeting Place Family Page. This internet resource covers all 92 Indiana Counties and provides information related to Community resources, Child Care and Early Education, Health and Safety, Parenting and Families and Financial Resources. There are a series of 20 fact sheets related to public programs and resources that help families access resources that they may be eligible for. The fact sheets have been developed in both English and Spanish.

Comprehensive System of Care:

Across the identified statewide gaps speak to the need for a statewide system of home visiting. While Healthy Families Indiana has a well developed statewide programmatic system of home visiting and collaborates with other programs, there is no statewide consortium that brings together all providers of home visiting to comprehensively address infrastructure and service delivery needs for high risk pregnant women, fathers, and young children.

The development of a consortium would increase the ability of Indiana home visiting programs to:

- Establish shared outcomes for home visiting;
- Share training resources;
- Maximize the limited available state and local resources;
- Identify a common set of data elements across programs;
- Create common evaluation criteria; and
- Improve communication across programs.

Operating as a consortium does not require that any program change its model. The shared opportunities and activities can strengthen and enhance each program's existing model. The ability to share, learn from each other and work with common purpose can only improve the outcomes for children and families.

Evaluation

As the project evaluation design is developed, a key component will be the assessment of how well the project addresses the gaps that have been identified through the needs assessment. A comprehensive plan that includes formative and summative evaluation components with clearly defined objectives and instrumentation will be part of the next phase of the application process.

Appendix A: Data Charts

Geographic Area: Indiana

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	8.5%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	7.5%					
Poverty -# residents below 100% FPL/total # residents (Children)	17.2%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.8%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					1.3 per 1,000 Sheltered	Indiana Coalition Against Domestic Violence
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.55%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month16 -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month				Binge Alcohol 17.41% Marijuana Use 6.26% Illicit Drug 4.2% Non-Prescription Painkiller 6.04%	Binge Alcohol 14.1% (Indiana Youth Institute)	
Unemployment -Percent: # unemployed and seeking work/total workforce					19.1%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		20% (Neglect) 16% (Abuse)				
Percentage Prenatal Care 1st trimester	67.5%					

Geographic Area: Marion County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	12.0					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.4					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	9.1					
Poverty -# residents below 100% FPL/total # residents (children)	24%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					6.2%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					18.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		31% (Neglect) 9% (Abuse)				
Percentage Prenatal Care 1st trimester	60.6%					

Geographic Area: Lake County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.7					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	10.6					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	9.9					
Poverty -# residents below 100% FPL/total # residents (Children)	24.7%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					4.1%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.5%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					24.2%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		18% (Neglect) 6% (Abuse)				
Percentage Prenatal Care 1st trimester	59.6%					

Geographic Area: Scott County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.7%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	7.5%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	24.7%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					2.4%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					1.0%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					8%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.7%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		19% (Neglect) 14% (Abuse)				
Percentage Prenatal Care 1st trimester	57.8%					

Geographic Area: Elkhart County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	8.5%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	6.9%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	18%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					4.8%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.6%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					13%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					16.1%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		18% (Neglect) 23% (Abuse)				
Percentage Prenatal Care 1st trimester	51.8%					

Geographic Area: Fayette County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	12.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.9%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	21.3%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.9%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.8%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					26.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		12% (Neglect) 10% (Abuse)				
Percentage Prenatal Care 1st trimester	72.0%					

Geographic Area: Jennings County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	8.9%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	7.8%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	18.1%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					2.6%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.2%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					16%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					19.4%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		25% (Neglect) 14% (Abuse)				
Percentage Prenatal Care 1st trimester	66.0%					

Geographic Area: Starke County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	7.9%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	6.6%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	24.1%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.2%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					1.4%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					N/A	
Unemployment -Percent: # unemployed and seeking work/total workforce					28.5%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		23% (Neglect) 20% (Abuse)				
Percentage Prenatal Care 1st trimester	73.2%					

Geographic Area: La Porte County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.4%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	11.1%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	19%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					9.6%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					18%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.6%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		8% (Neglect) 8% (Abuse)				
Percentage Prenatal Care 1st trimester	67.1%					

Geographic Area: Grant County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.7%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.7%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	25.6%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					5.1%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					11%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		16% (Neglect) 16% (Abuse)				
Percentage Prenatal Care 1st trimester	65.7%					

Geographic Area: Owen County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.2%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	21.6%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					1.5%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					2.0%	DOE
Substance abuse -Prevalence rate: **Binge alcohol** use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					21%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					23.7%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		27% (Neglect) 8% (Abuse)				
Percentage Prenatal Care 1st trimester	70.3%					

Appendix B: Outcomes and Indicators Matrix

Intended Outcome	Data Indicators
Improved Maternal and Newborn Health	% low birthweight
	% preterm births
	% very low birthweight
	Rate of Infant Deaths
	Rate of Neonatal Deaths
	Rate of Post Neonatal Deaths
	% of women with late or no prenatal care
	% women smoking during pregnancy
	% women smoking during child bearing years
	% births to first time mothers
	Birth rates (10-14)/ Birth rates (15-19)
	% of pregnant women on WIC
	% of children on WIC
	% women using alcohol during pregnancy
	% women breastfeeding at discharge
	% of births to unmarried parents
	Child spacing
	% of births to first time mothers
	Rate of maternal Mortality
	% of children with special health care needs
	% of women receiving treatment for depression through Medicaid
Intended Outcome	Data Indicators
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	% of substantiated abuse
	% of substantiated neglect
	Infant Deaths due to neglect
	Rate of child fatalities due to abuse or neglect
	Asthma Hospitalizations Rate
	% of immunizations
	% of children receiving an EPSDT
	% of childhood obesity
	% of uninsured children
	Rate of unintentional injuries
	Lead Poisoning Rates
Intended Outcome	Data Indicators
Improvement in school readiness and achievement	% of B – 3 enrolled in Early Intervention
	% of 3-5 enrolled in Preschool Special Ed
	% of children enrolled in Early Head Start
	% of children enrolled in Head Start
	% of schools not meeting AYP

Intended Outcome	Data Indicators
	% of children in subsidized child care settings that participate in QRS
	Rate of high school dropouts
	% of children on wait lists for subsidized child care
	% of teens smoking (grades 9-12)
	% of teens report drinking alcohol(9-12)
	% of teens using marijuana (9-12)
	% of 4th graders passing their ISTEP test
	Truancy rate
Intended Outcome	Data Indicators
Reduction in crime or domestic violence	Rate of violent crime
	% of people arrested under 18
	Rate of property crime
	Rate of teens arrested for possession of drugs
	Rate of teens arrested for driving under the influence of alcohol
	Domestic violence
Intended Outcome	Data Indicators
Improvements in family economic self-sufficiency	% of children living in homes where head of household is unemployed
	% of children living in families with incomes under 100% of the poverty level
	% of children receiving free or reduced lunch
	% of families on food stamps
	% of high school dropouts
	% of women giving birth who are on public assistance
	% of children who are homeless
	% of adults with college education
	% of mothers without a high school degree
Intended Outcome	Data Indicators
Improvements in the coordination and referrals for other community resources and supports	% of children with primary care provider
	Medically underserved areas
	% women on Medicaid receiving prenatal care coordination
	% of families with ESL
	Health Professional Shortage
	Helpline calls
	Connect to help – United Way

Appendix C: Support Letters

Indiana State Department of Health
An Equal Opportunity Employer

Mitchell E. Daniels, Jr.
Governor

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

September 10, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Ms. Yowell:

As Indiana's state health commissioner, I continue to fully support Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. The Indiana State Department of Health, the state's Title V agency, is pleased to submit this Statewide Needs Assessment in collaboration with the Indiana Department of Child Services (DCS). Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the needs assessment methodology, and the identification of high risk communities.

The mission and vision statement of the Indiana State Department of Health includes achieving a healthier Indiana through focus on data-driven policy to determine appropriate evidence-based activities; evaluation activities to ensure measureable results, and collaboration with intra-agency program in policy-making and programming. I support the Statewide Needs Assessment and look forward to working with HRSA throughout this grant process.

Sincerely,

GREGORY N. LARKIN, M.D.
STATE HEALTH COMMISSIONER

Mitchell E. Daniels, Jr., Governor
James W. Payne, Director

Indiana Department of Child Services
Room W392 - MS03
402 W. Washington Street
Indianapolis, Indiana 46204-2739

317-232-4705
FAX: 317-232-4490

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

September 16, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Ms. Yowell:

The Indiana Department of Child Services (DCS) is writing this letter to represent our continued support for the Maternal, Infant, and Early Childhood Home Visiting program of the Indiana State Department of Health (ISDH). DCS has worked diligently and collaboratively with ISDH concerning the required statewide needs assessment.

Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

DCS has been a long term collaborator with ISDH and is committed to partnering with ISDH for the Maternal, Infant, and Early Childhood Home Visiting program.

Sincerely,

James W. Payne, Director

Protecting our children, families and future

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Mental Health and Addiction
402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

September 16, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

This letter is an expression of Indiana's Family and Social Service Administration Division of Mental Health and Addiction's (DMHA) continued support for the Maternal, Infant and Early Childhood Home Visiting program. DMHA has worked diligently and collaboratively on the required statewide needs assessment. Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

The Family and Social Services Administration Division of Mental Health and Addiction (DMHA), as the Single State Agency, supports the Indiana State Department of Health, Maternal and Child Health Division's (ISDH MCHD) partnership with the Indiana Department of Child Services (DCS) in their application submission for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. DMHA provides oversight to all mental health and addiction providers throughout the state of Indiana targeted by this application. We recognize the importance of collaboration among agencies to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The Department of Child Services has been a long term collaborator with DMHA. This initiative is another way in which we can work together to improve outcomes through the provision of home visiting services to at-risk children and families.

We are excited about working with DCS in this effort. Specifically, DMHA will be working with DCS to integrate/coordinate this initiative with the mental health and substance abuse providers in the state of Indiana.

Again, we are pleased to support DCS's application for the ACA Maternal, Infant and Early Childhood Home Visiting Program. If we can provide other input or comments, please do not hesitate to contact Gina Eckart, Director of the Division of Mental Health and Addiction at Gina.Eckart@fssa.in.gov.

Sincerely,

Gina Eckart

Gina Eckart
Director

Susan E. Lightle, Director
Indiana Head Start State Collaboration Office

Indiana Family and Social Services Administration
402 W. Washington Street, W361
Indianapolis, IN 46204

"People helping people help themselves"

September 13, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

This letter is an expression of the Indiana Head Start State Collaboration Office's continued support for the Maternal, Infant and Early Childhood Home Visiting program. IHSSCO has worked diligently and collaboratively on the required statewide needs assessment. Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

The Indiana Head Start State Collaboration Office is pleased to continue partnering with the Indiana Department of Health, Maternal and Children's Health and fully supports their application for the ACA Maternal, Infant and Early Childhood Home Visiting Program. If we can provide other input or comments, please do not hesitate to contact me at 317-233-6837, susan.lightle@fssa.in.gov.

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Best regards,

Susan Lightle, Director
Indiana Head Start State Collaboration Office