Indiana MIECHV Statewide Needs Assessment 2020 Update

October 1, 2020

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Introduction

Indiana has a rich history of early childhood initiatives that are locally focused, incorporate collaborative efforts across state agencies, address population priorities, and include local, regional, and state administration voice. This report – the Indiana MIECHV Statewide Needs Assessment 2020 Update (2020 Update) – has utilized existing data and survey response to review the current landscape of home visiting in Indiana. Home visiting – for the purpose of this report – is defined as a primary service delivery strategy in which services are offered on a voluntary basis to at-risk pregnant women and parents with young children, targeting participant outcomes which include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports.

Purpose of the Needs Assessment

The Bipartisan Budget Act of 2018 requires Maternal Infant Early Childhood Home Visiting (MIECHV) awardees to review and conduct an updated needs assessment by October 1, 2020. The 2020 Update assesses the needs of young children, pregnant women, families and communities in Indiana as well as collaboration and partnerships with Indiana state agencies administering home visiting or related services. As a MIECHV awardee, Indiana must identify counties with concentrations of risk, determine quality and capacity of existing home visiting programs, and discuss the state's capacity for providing substance abuse treatment and counseling services for this 2020 Update.

The 2020 Update[1] includes data from state and local agencies in order to illustrate the circumstances of services available for young children and families. The analysis and summation of this data is used to identify service gaps and inform stakeholders of opportunities to build upon and strengthen existing services and partnerships.

The purpose of this 2020 Update is to meet the statutory requirements of MIECHV funding, but more importantly, the purpose is to create a document that will inform implementing agencies, collaborating partners and stakeholders as well as guide implementation, expansion and future use of resources in the Hoosier state.

Overview of Families and Home Visiting in Indiana

According to U.S. Census estimates, as of 2018, 303,685 families resided in Indiana with 504,278 total children under age 6 (Puzzanchera, Sladky & Kang, 2019). A third of families (33%) were single-parent families and 22% of children under the age of 6 were living in poverty (U.S. Census Bureau, 2019). According to the Heath Resources and Services Administration (HRSA)'s analysis[2] of families with young children under age 6 living in poverty who also exhibited at least one "at-risk" factor (such as no high school diploma), 41,815 families were in need of home visiting services across the state in 2017. (See Table 1.)

Table 1

Indiana Children and Families				
Infants 80,539	1-2 Years of Age 166,762	3-5 Years of Age 256,977	Total Young Children 504,278	Young Children in Poverty 109,392
Families with Young Children 303,685		Single-Parent Families 99,631		Families in Need of Home Visiting Services 41,815

Indiana's MIECHV vision is to improve health and development outcomes for children and families who are at risk through achievement of the following goals: 1) Provide appropriate home visiting services to women, their infants and families who are low-income and high-risk; 2) Develop a system of statewide coordinated home visiting services that provide appropriate, targeted, and unduplicated services and locally coordinated referrals; 3) Coordinate necessary services outside of home visiting programs to address needs of participants.

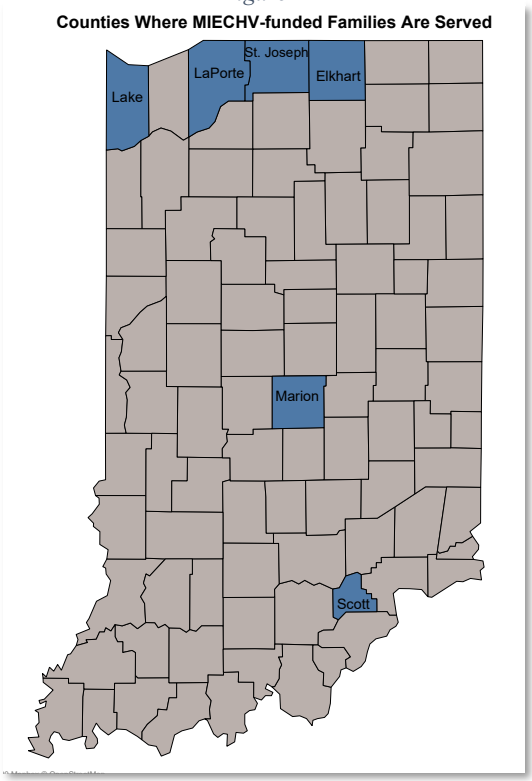
Indiana has an outstanding history of implementing a comprehensive, high-quality early childhood system characterized by multiple collaborative efforts and leaders committed to the health and well-being of mothers and children. This is evidenced by the fact that Indiana's Governor designated co-lead agencies for MIECHV[3]. Both co-lead agencies, the Indiana State Department of Health (ISDH) and Department of Child Services (DCS), have long-standing histories of addressing needs of women and children through home visiting[4], as well as other programs and initiatives that contribute to a comprehensive, high-quality early childhood system throughout the state. The collaborative relationship between ISDH and DCS

[1] The Indiana MIECHV Team contracted with Transform Consulting Group to conduct the needs assessment update.
[2] A Guide to Conducting the Maternal, Infant, and Early Childhood Home Visiting Program Statewide Needs Assessment Update, February 2019
[3] The MIECHV State Team is comprised of ISDH Home Visiting Program Manager, DCS Prevention Services Manager, DCS MIECHV Coordinator, and ISDH MIECHV Coordinator. The MIECHV State Team is responsible for oversight and management of all MIECHV activities, including the Indiana MIECHV Needs Assessment 2020 Update.
[4]DCS has administered HFI since 1992. ISDH has administered NFP since 2011.

mirrors the relationship between MCH Bureau (MCHB) Health Resources Services Administration (HRSA) and Administration for Children and Families (ACF) who are the national co-lead administrators of the MIECHV funds. The partnership between ISDH and DCS as well as collective efforts with other state collaborators has contributed to the successful home visiting initiatives in the Hoosier state.

MIECHV-funded families in Indiana receive home visiting services from either Nurse Family Partnership (NFP) or Healthy Families Indiana (HFI) implementations in 6 Indiana counties: Elkhart, Lake, LaPorte, Marion, Scott, and St. Joseph. (See Figure 1.)

Figure 1



As of June 30, 2020, Indiana has served 10,694 families through 253,541 home visits with MIECHV funding since its inception.

NFP is an evidence-based, community health program with over 40 years of evidence showing significant improvements in the health and lives of first-time moms and their children living in poverty. NFP pairs a first-time mom with a specially trained nurse who regularly conducts home visits starting early in pregnancy, continuing through the child's second birthday. To qualify for the program, a woman must be fewer than 28 weeks pregnant with her first child, be Medicaid eligible, and live in a county where services are currently offered.

HFI is a voluntary evidence-based home visitation program that is designed to promote healthy families and healthy children through a variety of services including child development, access to health care, and parent education. HFI has been in partnership with Healthy Families America (HFA), the national home visitation model, since 1994. In order for a family to be entered into HFI, the family must screen positive on an Eight Item Screen that measures risks based on: Single marital status, Inadequate income/no information/income from disability, Unstable housing, Education under 12 years, History of/ current substance abuse, History of/current psychiatric care, Martial or family problems, History of/current depression. The family must be within an income eligibility of 250% of federal poverty line or less and at least one family member must have a social security number. The family must score 40 and above on Parent Survey Process Assessment that measures risk based on the following:

• Parent beaten or deprived as child • Parent with criminal/mental illness/substance abuse • Parent suspected of abuse in the past • Low self-esteem/social isolation/depression/no lifelines • Violent temper outburst • Rigid and unrealistic expectations of child	• Multiple crises/stresses • Harsh punishment of child • Child difficult and/or provocative as perceived by parents • Child unwanted • Child at risk for poor bonding

Priority will also be given to families that score at least 25 on the Parent Survey Process but have any of the following:

• Safety concerns expressed by hospital staff • Mother or father low functioning • Teen parent with no support system • Active untreated mental illness • Active alcohol/drug abuse • Active interpersonal violence reported	• Target child born at 36 weeks of gestation or less • Target child diagnosed with significant developmental delays at birth • Family assessment worker witnesses physical punishment of child(ren) at visit • Scores of 10 or above or 3 on question#10 on the Early Postpartum Depression Scale

Through multiple funding sources, HFI is available statewide in all 92 counties, and NFP is available in 39 counties. A variety of additional evidence-based programs, including Parents as Teachers (PAT), Healthy Start, Early Head Start (EHS), and Head Start (HS), as well as locally developed programs, are available in Indiana. See Appendix A for a geographical illustration of these programs. Funding sources in addition to MIECHV may include federal funding such as Temporary Assistance for Needy Families (TANF), HRSA, ACF, Title V), state funding, local funding, private funding, or a combination.

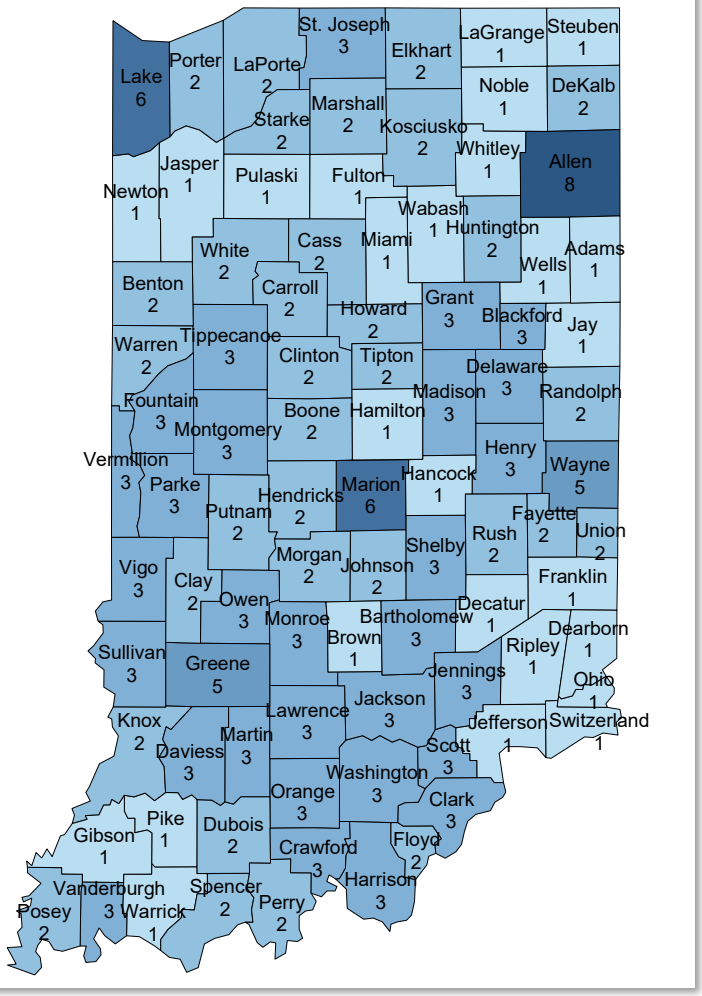
Eligibility requirements for home visiting programs across the state include being a resident of the county where the program is being offered. Additionally eligibility requirements vary by location and program, but may include: teen pregnancy, lack of high school diploma, pregnant or parenting child less than 3 months old, history of miscarriage, hospital specific delivery, enrollment during pregnancy, Medicaid eligibility, and pregnant or infant less than 1 year old, limited income.

Figure 2 illustrates that home visiting services are present throughout Indiana, and that most (73% or 67/92) counties have more than one program available to serve families.

Figure 2

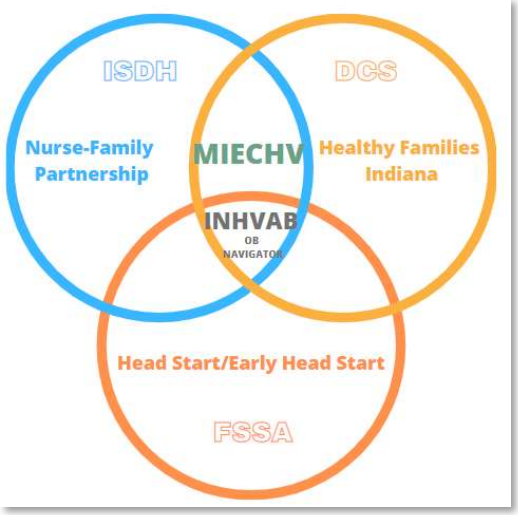
Number of Known Home Visiting Programs in Indiana

Home visiting programs are available in every Indiana county.



The OB Navigator initiative is a collaboration between the Indiana State Department of Health (ISDH), the Indiana Family and Social Services Administration (FSSA) and the Indiana Department of Child Services (DCS). This initiative is building a network of services and support to wrap around moms and babies to create healthier outcomes for both. It was established by House Enrolled Act 1007, which was signed into law by Governor Eric Holcomb in 2019. The initiative is working to connect pregnant women who are covered by Medicaid in Indiana's highest-risk areas to home visiting services in their communities. Twenty-two (22) counties are part of the OB Navigator 2020 rollout with plans to expand to additional counties in 2021. Five counties serving MIECHV-funded families are part of Indiana's OB Navigator initiative. Figure 3 illustrates state agency collaboration to support home visiting specific initiatives.

Figure 3



Families that participate in home visiting services have needs that are sometimes better addressed through other community resources. Education regarding available resources requires an ongoing commitment to

regular communication with local communities and staying informed regarding state-level initiatives. In Indiana, several collaborative initiatives and advisory boards demonstrate meaningful support and partnership vital for system integration that lead to family success have been established. More information on these collaborative efforts can be found in Appendix B.

Summary of Indiana Home Visiting Overview

- Home visiting services are available in every county in Indiana.
- A variety of home visiting programs exist throughout the state.
- 73% (67/92) of counties have more than one home visiting program model available to serve families.
- Home visiting models are both publicly and privately funded and administered.
- Indiana hosts several collaborative initiatives and advisory boards that are specific to or support home visiting.

Identifying Communities with Concentrations of Risk

Methodology

Indiana selected the HRSA simplified method[5] with modifications for identifying communities with concentrations of risk. This method used HRSA-provided, relevant county-level data that aligned with the statutorily defined risk factors, consisting of 13 indicators across five domains. The modified method included additional Indiana-provided data as described below.

The utilization of additional data to reflect Indiana context, as provided for in the HRSA guidance[6], incorporated two additional domains and six additional indicators. Specifically, Indiana expanded the Adverse Perinatal Outcomes domain by adding infant mortality rates and created two additional domains to capture domestic violence and maternal health indicators. While domestic violence was excluded from the HRSA-provided data and considered a limitation due to lack of national sources of county-level data, Indiana was able to include state-sourced indicators of victims and fatalities. Data for infant mortality, domestic violence, and maternal health were included in previous Indiana needs assessments, and represent indicators that focus on populations receiving home visiting services and align with the Indiana culture of reducing infant mortality. In total, Indiana analyzed seven domains consisting of 19 indicators.[7] (See Table 2.)

Domains and Indicators *Table 2*

Socioeconomic Status	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Maternal Health*	Domestic Violence*
• Poverty • Unemployment • High School Dropout • Income Inequality	• Preterm Birth • Infant Mortality Rate* • Low Birth Weight	• Alcohol • Marijuana • Illicit Drugs • Pain Relievers	• Crime Reports • Juvenile Arrests	• Child Maltreatment	• Smoking During Pregnancy* • Not Breastfeeding* • No Early Prenatal Care*	• Victims* • Fatalities*

**Indicating additional domains and indicators added by Indiana as part of the modified HRSA simplified method*

When comparing the 2020 Update to previous Indiana MIECHV needs assessments, it is important to note the change in methodology of county rank. In earlier needs assessments, counties were prioritized by ranking each 1 to 92 (total number of counties in Indiana) for every indicator (40 indicators in 2010, 34 indicators in 2017). Next, all scores were combined and averaged to determine an overall ranking from 1

[5] For the full description of the HRSA simplified methodology, refer to Appendix C
[6] A Guide to Conducting the Maternal, Infant, and Early Childhood Home Visiting Program Statewide Needs Assessment Update, February 2019
[7] Detailed information on the domains and indicators can be found in Appendix D.

to 92, giving each indicator the same weight in the analysis. The HRSA simplified method assigns indicators to a domain, and it is the domains (not the indicators) that are given equal weight.

Another distinction to note of this 2020 Update, is that the particular indicators Indiana historically used focused on populations directly impacted by home visiting services, in alignment with Indiana state priorities and included locally (state) sourced data. HRSA included data generally reflective of the overall county population (not specifically home-visiting populations) and was limited by nationally-sourced available data.

Determining At-Risk Counties

As outlined in the HRSA guidance, the simplified methodology used to determine at-risk counties included several steps as summarized in this section. First, the raw county-level data was used to compute the mean and standard deviation for each indicator. The data was then standardized for each county by computing a z-score. A z-score greater than one (1) indicated that the data value for that county is among the worst 16% of all counties for that indicator in the state. If at least half of the indicators within a domain have z-scores at or above one, then that domain is considered at risk. A county is considered at risk if two or more of the seven domains were designated as at risk.

Solely based on the modified HRSA simplified methodology[8], Indiana identified 27 counties where two or more of the seven domains were calculated as most at-risk[9] (See Table 3.):

Table 3

Indiana Counties with 2 or more at-risk domains based on modified HRSA simplified methodology with 7 domains			
County	At-Risk Domains	County	At-Risk Domains
Blackford County	4	Fayette County	2
Vermillion County	4	Greene County	2
Vigo County	4	Jackson County	2
Crawford County	3	Lake County	2
Grant County	3	Madison County	2
Marion County	3	Martin County	2
Monroe County	3	Owen County	2
Scott County	3	Perry County	2
Tippecanoe County	3	Putnam County	2
Tipton County	3	Rush County	2
Vanderburgh County	3	St. Joseph County	2
Benton County	2	Sullivan County	2
Clinton County	2	Wayne County	2
Delaware County	2		

In comparing at-risk rankings across time, Indiana counties fluctuate in ranking of "highest risk". Figure 4 illustrates the difference in the highest at-risk counties identified in each of the 2010, 2017 and 2020 needs assessments. While the methodology for the 2020 Update analysis does not produce an individual county ranking, the counties listed in Figure 5 have the highest number of (three or four) at-risk domains. The 2010 and 2017 needs assessments had 5 of the top 10 counties in common, whereas the 2020 Update only has three counties in common with the 2017 needs assessment and three with the 2010 needs assessment.

It is important to note that during the process of determining methodology, Indiana spent appreciable time considering how the assignment of indicators to domains impacted the at-risk calculation. Through exploration of a variety of assignments – including adding indicators to HRSA defined domains, as well as the creation of additional domains – Indiana noted that while a few counties consistently fell in the "highest-risk" rankings, many counties fell into higher- or lower-risk ranking depending on the indicator assignment and the number of domains. While it is clear "higher risk" counties exist, no county could be

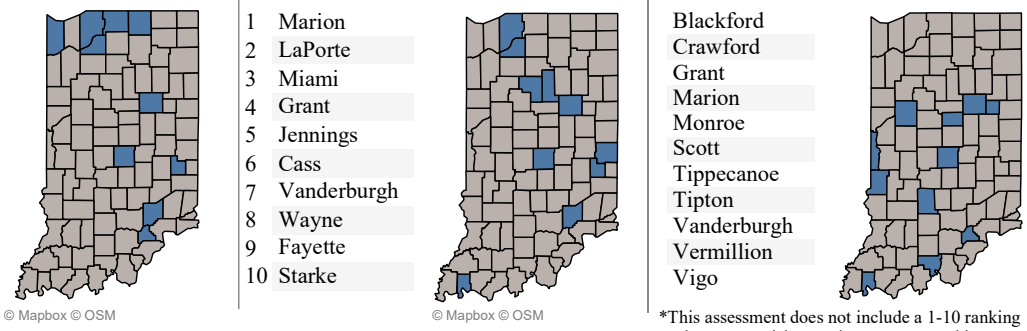
[8] 7 domains and 19 indicators
[9] These counties had a z-score of 2 or higher

consistently determined to be “not at-risk”.

Figure 4

Most At-Risk Counties in Indiana

	2010 Needs Assessment	2017 Needs Assessment	2020 Needs Assessment*
1	Marion	Marion	Blackford
2	Lake	LaPorte	Crawford
3	Scott	Miami	Grant
4	Elkhart	Grant	Marion
5	St. Joseph	Jennings	Monroe
6	Fayette	Cass	Scott
7	Jennings	Vanderburgh	Tippecanoe
8	Starke	Wayne	Tipton
9	LaPorte	Fayette	Vanderburgh
10	Grant	Starke	Vermillion
			Vigo

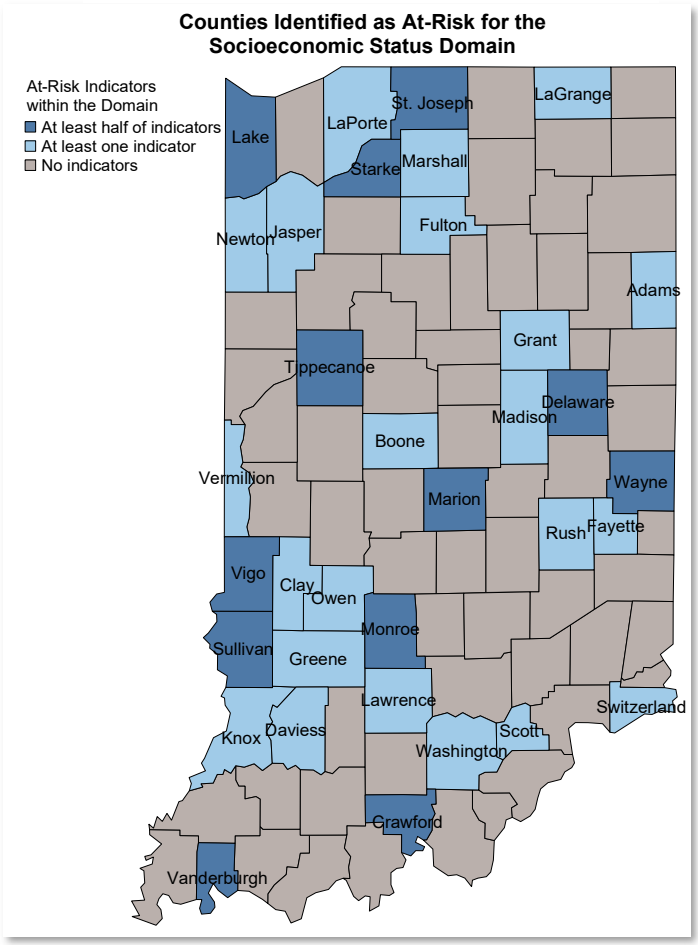


*This assessment does not include a 1-10 ranking so the most at-risk counties are presented in alphabetical order.

The appropriate data is not available to determine if the lack of consensus is due to the change in methodology, impact of MIECHV funds, or other positive or negative factors occurring during this 10 year period.

It may be noted that Indiana counties serving MIECHV-funded families as of June 30, 2020 (Elkhart, Lake, LaPorte, Marion, Scott, and St. Joseph) are not all included in the highest-risk listings. These counties have consistently provided MIECHV-funded home visiting since 2012 (the inception of MIECHV-funded home visiting in Indiana). As described further below, additional indicators were considered when defining “at-risk” for the purpose of determining “need”.

Figure 5



Additional Indicators Determining Counties Known to be At-Risk

Data that **is** available illustrates that the majority of Indiana counties experience risk factors at levels exceeding national benchmarks when considering priority populations and communities with concentrations of statutorily-defined risk, and that no Indiana county can illustrate a “0” Infant Mortality Rate. Indiana recognizes the importance of prioritizing counties by risk factors, however, as mentioned above, a consistent ranking could not be established. This led Indiana to consider if all counties should be considered “at-risk”.

Only 18 of the 92 counties had no significant indicator; this means that 74 counties had at least one indicator that ranked in the worst 16% of all counties in

the state.

Consider the following highlighted analysis of each domain:

The *socioeconomic status domain* includes four indicators: poverty, unemployment, percentage of recent high school dropouts, and income inequality. Each indicator for this domain considers data for the general population of the county. Twelve counties are at-risk in the socioeconomic status domain (at least half of indicators are in the worst 16% of values for Indiana), and 34 counties had at least one at-risk indicator. (See Figure 5.)

The *adverse perinatal outcomes domain* includes three indicators: preterm birth, infant mortality rate, and low birth weight. Each indicator for this domain looks at births over a 5-year period. Twelve counties are at-risk in the adverse perinatal outcomes domain, and 25 counties had at least one at-risk indicator. (See Figure 6.)

Figure 6

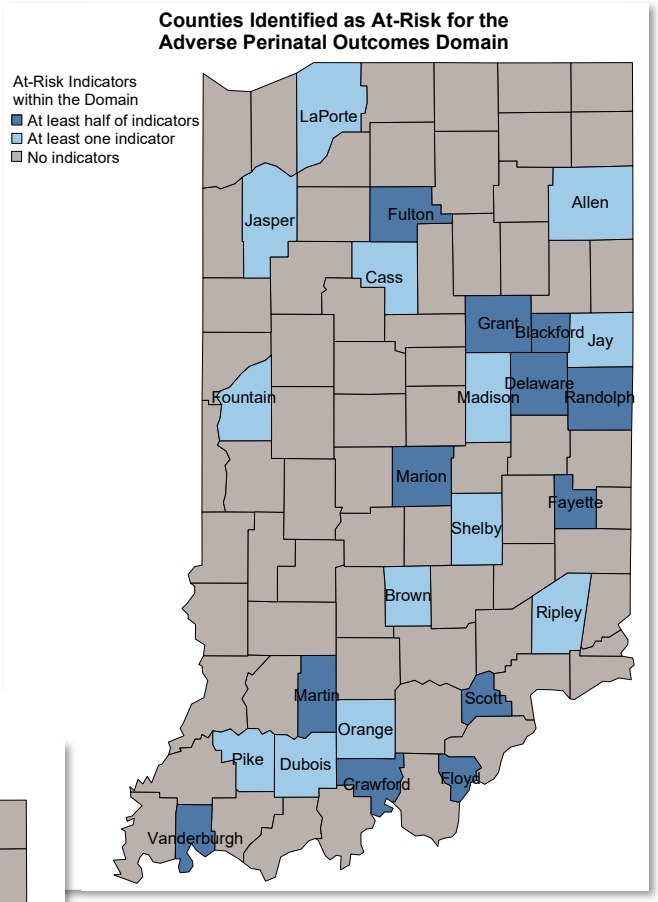
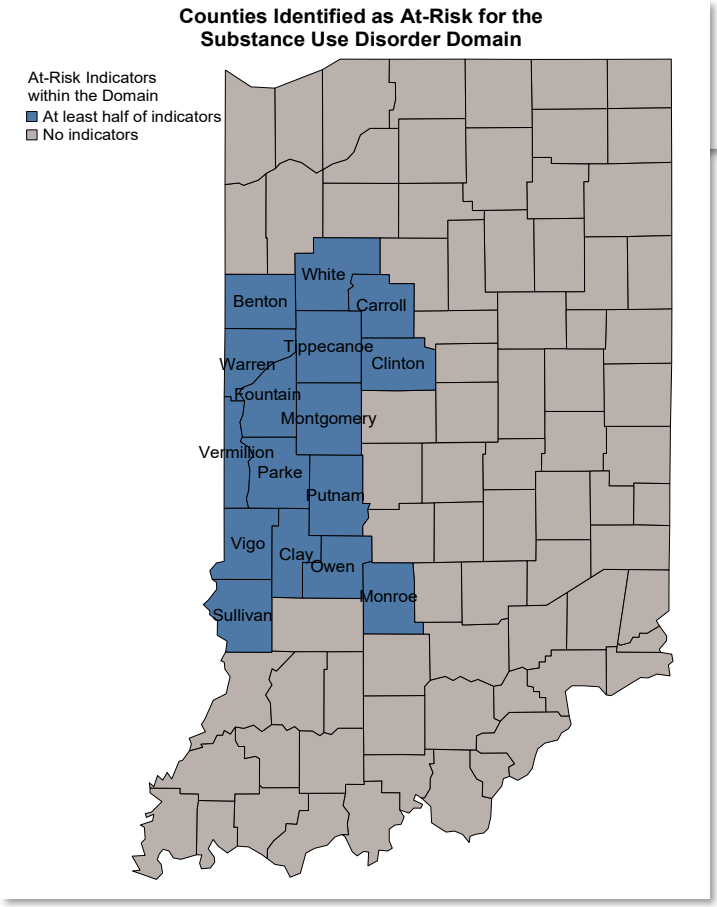
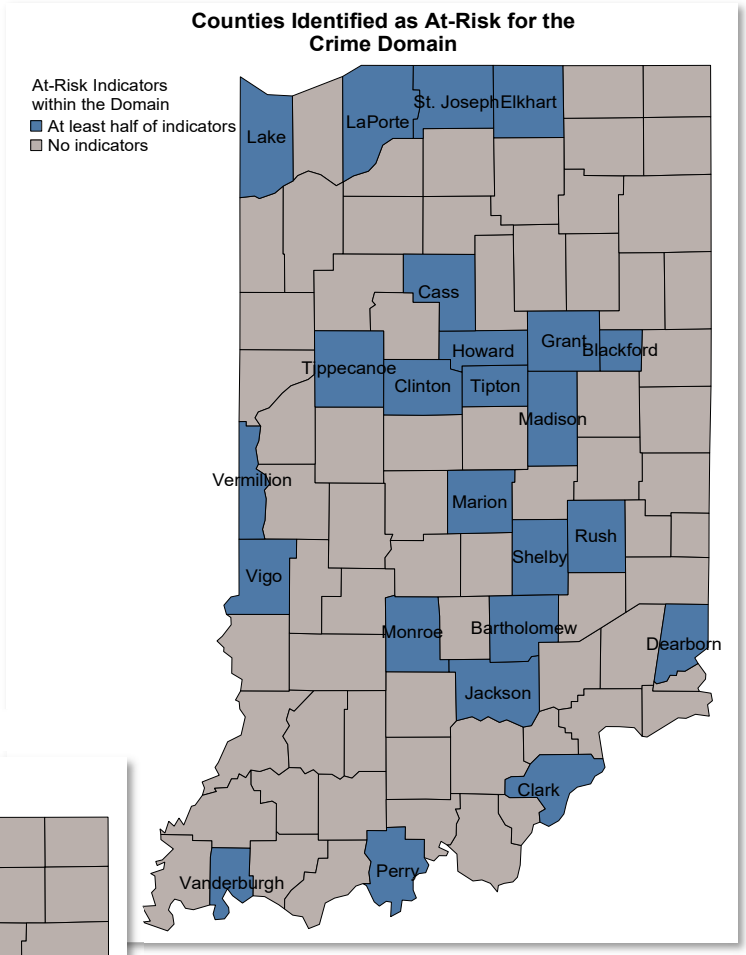


Figure 7



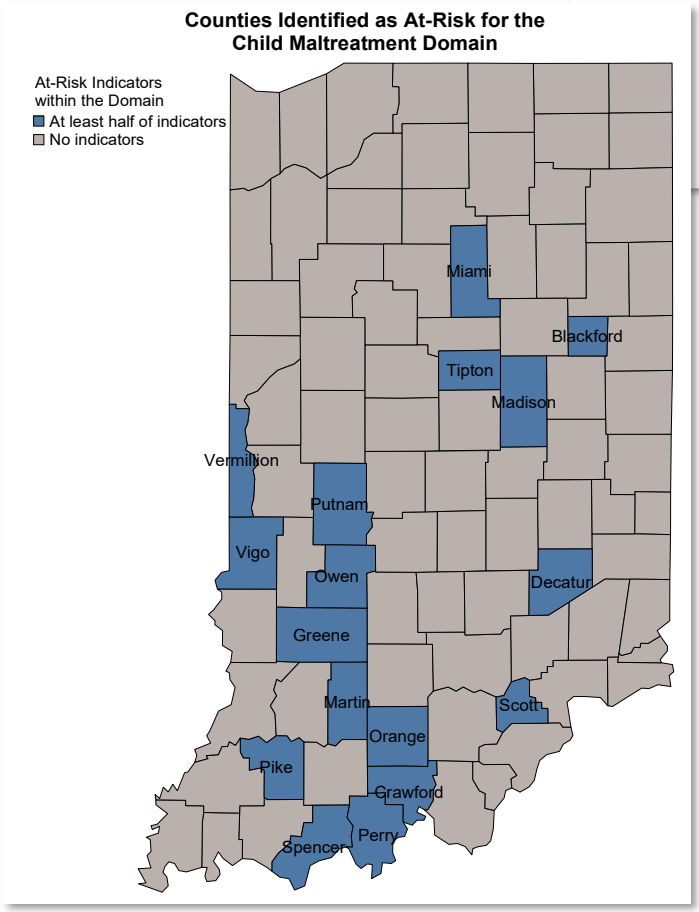
The *substance use disorder domain* includes four indicators: alcohol, marijuana, illicit drugs, and pain reliever use prevalence rate. Each indicator for this domain is reported on a regional level, as a member of a Substance Abuse Treatment Planning Region. (The county estimate is actually the regional data point.) Thus 16 counties (one region) are at-risk in the substance use disorder domain, and no additional counties had at least one at-risk indicator due to the regional calculation. (See Figure 7.)

Figure 8



The *crime domain* includes two indicators: crime reports and juvenile arrests. Each indicator is reported on at the county level. The crime reports indicator was missing values for 22% of counties, but all counties had data for juvenile arrests. Twenty-four counties are at-risk in the substance use disorder domain, and no additional counties had at least one at-risk indicator. (See Figure 8.)

Figure 9



The *child maltreatment domain* has one indicator: rate of child maltreatment. This indicator looks at the rate of maltreatment victims under the age of 17 for each county. Seventeen counties are at-risk in the child maltreatment domain. (See Figure 9.)

The *maternal health domain* includes three indicators: percentage smoking during pregnancy, not breastfeeding at discharge, and not receiving early prenatal care. Each indicator for this domain reports on women who have given birth in the previous 12 months. Eight counties are at-risk in the maternal health domain, and 31 counties had at least one at-risk indicator. (See Figure 10.)

The *domestic violence domain* includes two indicators: rate of victims who received services, and rate of domestic violence fatalities. Each indicator for this domain is calculated as a rate based on the county's adult population. The fatalities indicator was missing values for 79% of counties, but all counties had data for victims. Ten counties are at-risk in the domestic violence domain, and no additional counties had at least one at-risk indicator. (See Figure 11.)

Figure 10

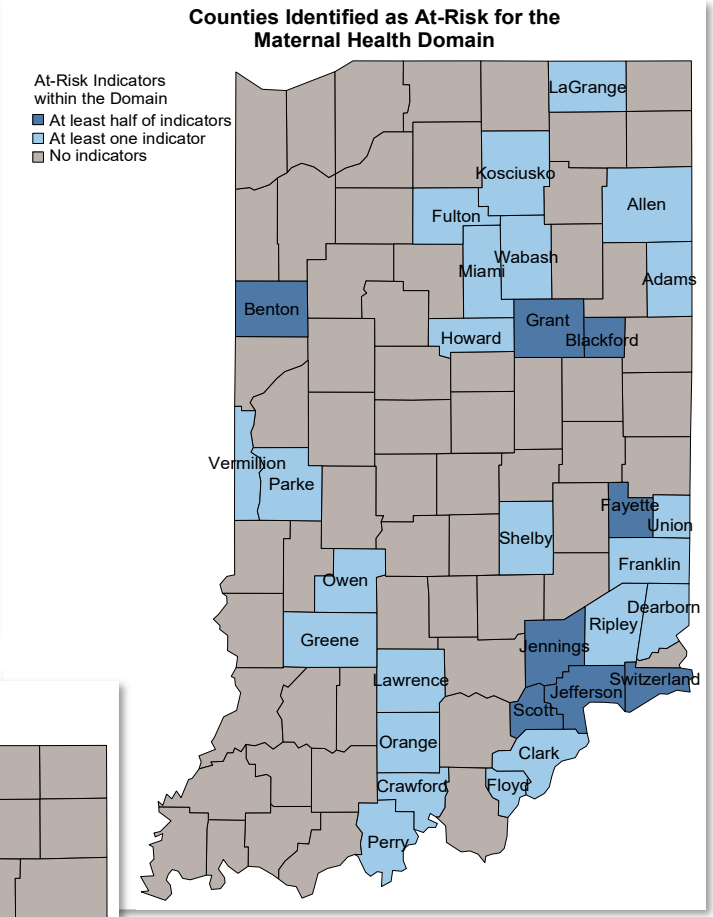
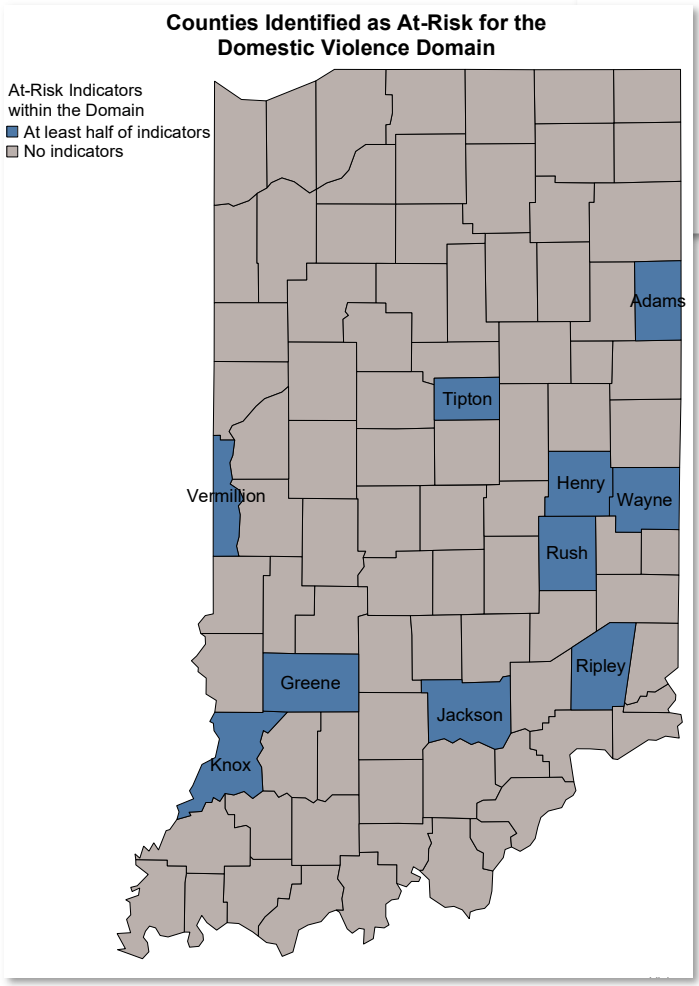


Figure 11



While HRSA's simplified method focused on prioritizing counties *most* at-risk within the state, national benchmarks show that many more counties in Indiana that should not be discounted as "not at-risk". When compared to the national benchmark for each indicator (for which a national data point was available), there are four indicators for which more than 65% of Indiana counties sit above the national benchmark. (See Table 4.) These four indicators are within the domains of Adverse Perinatal Outcomes and Maternal Health, added by Indiana as part of the modified simplified method to represent priority focus areas for the Hoosier state. In his 2018 State of the State address, Governor Holcomb set a goal for Indiana to have the lowest infant mortality rate in the Midwest by 2024. The death of an infant is not only devastating for families, but infant mortality is also an important indicator of a

geographical area's community health status, poverty and socioeconomic levels, and availability and quality of healthcare services[10]. In addition to adding the IMR indicator, smoking during pregnancy and no early prenatal care are also included as infant mortality risk factors[11]. The child maltreatment indicator was added not only because it is a state priority, but also due to the potential impact home visiting can have on child maltreatment reduction and prevention[12].

Within these indicators, even counties ranking as better performing in Indiana, are in need of improvement. Less than ten Indiana counties are performing better than the national benchmark[13] in rate of child maltreatment, percentage of women smoking during pregnancy, and percentage of women who received no early prenatal care.

Table 4

Indiana Priority Indicator	Indicator Definition	National Benchmark	Indiana Counties Above the National Benchmark
Infant Mortality	Infant deaths per 1,000 live births	5.7	63
Child Maltreatment	Rate of maltreatment victims ages <1-17 per 1,000 child residents under 18	9.1	87
Smoking During Pregnancy	Percentage of women who smoked during the last 3 months of pregnancy[14]	8.1	83
No Early Prenatal Care	Percentage of women who did not receive prenatal care during the first trimester	13.1	91

Every single county has at least one at-risk indicator as defined by HRSA[15] or one indicator that is worse than the national benchmarks. Specifically, please note the following for counties where MIECHV-funded families receive home visiting services (See Table 5.):

Table 5

County where MIECHV-funded families are served	Number of At-risk Domains[16]	Number of At-risk Indicators	Number of IN Priority Indicators Above National Benchmark (Out of 4)
Elkhart	1	1	4
Lake	2	3	4
LaPorte	1	3	3
Marion	3	5	4
Scott	3	7	4
St. Joseph	2	4	4

All Indiana counties rank above the national benchmark for priority areas or have at least one at-risk indicator as defined by HRSA. Therefore, **Indiana recognizes all 92 counties to be at risk.**

Key Findings and Takeaways of Communities with Concentrations of Risk

- The methodology determining at-risk counties changed from Indiana's previous needs assessments. Indiana added indicators and domains to reflect state priorities and populations served by home visiting.
- Counties identified as "highest-risk" in the 2020 update are notably different from counties considered most at risk in previous needs assessments. Appropriate data is not available to

[10] http://www.amchp.org/programsandtopics/data-assessment/InfantMortalityToolkit/Documents/Why%20Focus%20on%20IM.pdf
[11] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm
[12] https://journals.sagepub.com/doi/full/10.1177/1077559517701230
[13] Sources for specific national benchmarks can be found in Appedix E
[14] This definition is different from the data from Indiana counties which included pregnant women who smoked at any point during their pregnancy.
[15] A full listing of counties and at-risk indicators is located in Appendix G.
[16] Elkhart – Crime, Lake – Socioeconomic Status, Crime, LaPorte – Crime, Marion – Socioeconomic Status, Adverse Perinatal Outcomes, Crime, Scott – Child Maltreatment, Maternal Health, St. Joseph – Socioeconomic Status, Crime

determine if the distinction is due to change in needs assessment methodology, impact of MIECHV funds, or other factors.

- All Indiana counties are considered "at risk." All Indiana counties exhibit at least one HRSA-defined risk indicator or fall above the national benchmark for one or more priority focus area.

Quality and Capacity of Existing Programs

Indiana has a combination of evidence-based and locally developed home visiting programs serving pregnant women, young children, and families. Every county has at least one evidence-based home visiting program. In order to understand the current capacity and quality of existing programs across the state, the Indiana MIECHV Team reached out to known programs providing home visiting services, as well as community partners who fund or in other ways engage with these programs.

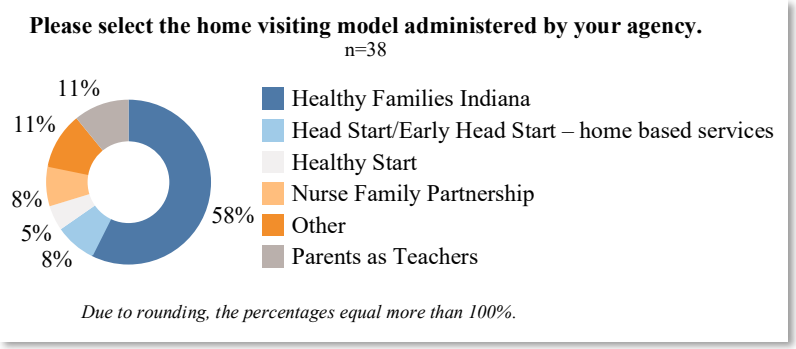
Data Collection

Home Visiting Program Survey

An online survey, referred to as the 'program survey' was sent to home visiting programs across the state to gather data on the quality, capacity, and resources in their community. The survey was in the field from March 11-April 15, 2020. The survey was sent to the inventory of existing home visiting programs (located in Appendix F) consisting of 77 organizations. A total of 33 organizations took the survey for a response rate of 43%, which is large enough to apply any survey findings and recommendations to the overall sample population (programs throughout the state). It is also important to note that this survey was in the field while state and local communities were responding to the COVID-19 pandemic. The 33 organizations who responded to the survey serve all but 13 of the 92 counties in Indiana. The counties with no survey responses are Cass, Dubois, Fulton, Gibson, Hamilton, Hancock, Jay, Miami, Perry, Pike, Posey, Spencer, and Warrick.

The first half of the survey asked questions of the specific home visiting programs while the second half of the survey asked more general questions relevant to their whole organization. If an organization implements more than one home visiting program model, it responded to the first set of questions for each model. In total, 33 organizations took the survey and provided answers for 38 programs.

Figure 12



The majority of agencies (22/38, 58%) who answered the survey were implementing HFI programs, which make up almost half (34/77, 44%) of the state's inventory of agencies administering home visiting. Other agencies that responded to the survey were implementing Head Start/Early Head Start, Healthy Start, NFP, Parents as Teachers, and locally developed models who selected "other". (See Figure 12.)

Community Survey

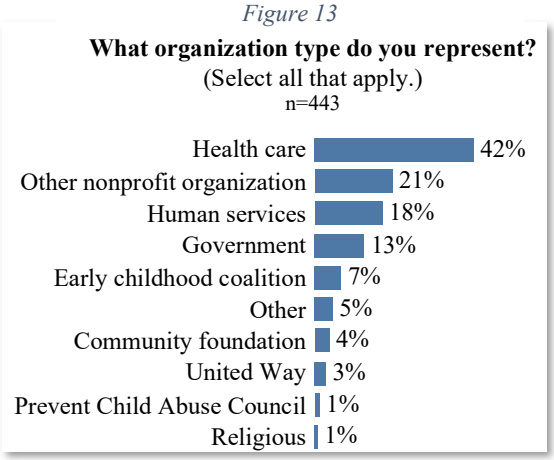
An additional online survey, referred to as 'community survey' was provided to known contacts who were believed to have relevant feedback. These were MIECHV partners and other organizations that would be familiar with the needs of MIECHV priority populations and interests of the community at-large. The survey was in the field from April 20-May 6, 2020 and received 444 responses[17] representing

[17] Many survey respondents did not provide answers for all questions in the survey, creating variance in the denominator for each question. The number of respondents is noted as "n" in each chart.

every county in the state.

The survey was conducted during the Indiana stay-at-home period with state and local communities responding to the COVID-19 pandemic, Indiana had originally intended to follow the survey with local focus groups, but in-person gatherings were not possible during this period and many agencies were still adjusting to virtual meeting platforms.

Figure 13



Marion County, the most populous county in Indiana, is the location of 21% (94/444) of community survey respondents. Nearly one in 10 (41/444, 9%) respondents work for organizations that serve the entire state. The largest percentage of organizations that responded to the survey were health care providers at 42% (188/443), followed by other nonprofits at 21% (95/443). Some organizations selected "other" as their answer choice or in addition to another selected choice. These organizations were often for-profit service providers, education organizations (e.g., K-12, university), child cares, or home visiting programs. (See Figure 13.)

Title V

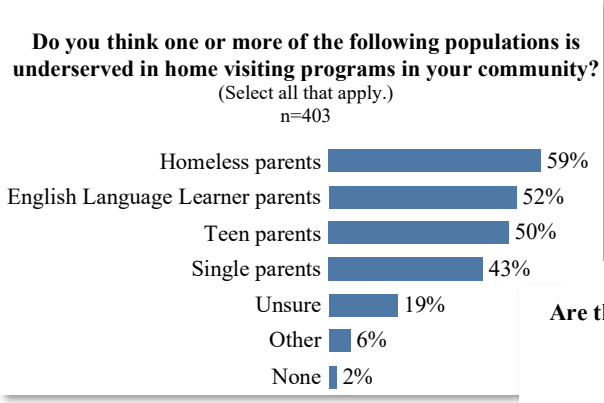
The Indiana Title V Needs Assessment surveyed health care partners across the state, as well as adult Hoosier citizens to gather information around their health and the health of their children. Findings from these surveys align with survey results from the MIECHV home visiting program and community surveys. More information is included in the Title V section below.

Gaps in the Service Delivery of Early Childhood Home Visiting

As derived from the program and community survey, identified gaps are described impacting delivery of home visiting services.

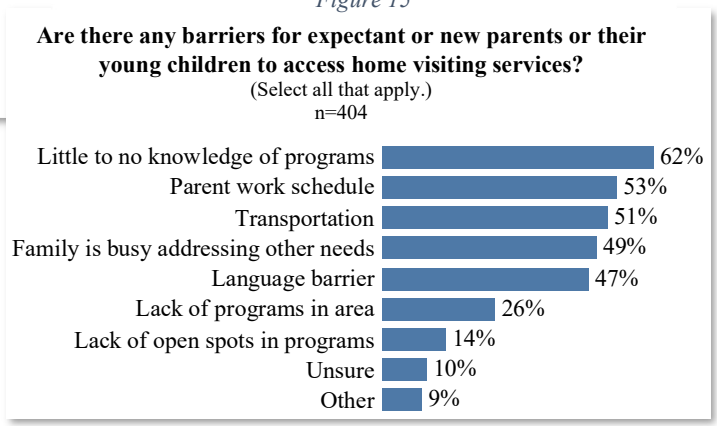
Populations Served – Question from Community Survey

Figure 14



Community survey respondents were asked which if any populations may be underserved by home visiting programs if their community. While homeless parents ranked highest, selected by 59% (237/403) of respondents, English Language Learner parents (210/403, 52%), teen parents (201/403, 50%), and single parents (172/403, 43%) were also selected by a large percentage of respondents. Additional populations mentioned in "other" included minorities, immigrants, low-income families, and LGBTQ. (See Figure 14.)

Figure 15



Some populations may be underserved due to the barriers facing expectant parents and young families when accessing home visiting services. However, the top barrier selected by more

than half of community survey respondents (251/404, 62%) would impact all populations, that is having little knowledge of programs. Other barriers affecting many families include finding time within a parent's work schedule (216/404, 53%), lack of transportation (208/404, 51%), a family that is busy addressing other urgent needs (197/404, 49%), and language barriers (191/404, 47%). Barriers mentioned under "other" include a fear of the Department of Child Services, a stigma around accepting services, issues concerning privacy and trust, and not meeting eligibility requirements. (See Figure 15.)

Comments on Barriers to expectant or new parents from Community Survey Respondents:

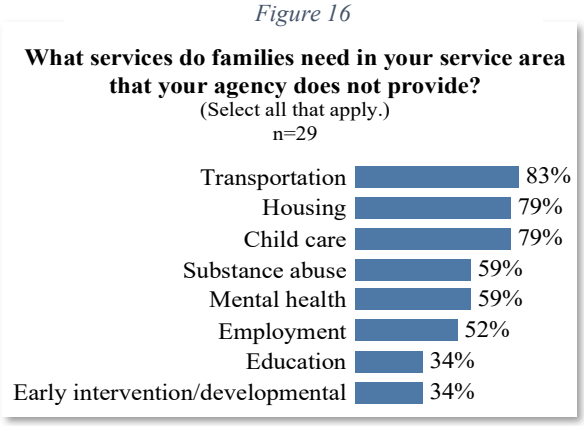
> *"Expectant and new parents often don't realize how difficult parenting is until after the child is 3 months old, and several programs don't accept families once the child is over age 3 months."*

> *"Fear of allowing a stranger access to your home and the potential of DCS involvement. Many in the community associate home visits with negative interventions."*

Barriers for Children and Families – Question from Program Survey

Home visiting programs were asked what they perceive to be barriers to serving children and/or families in their community. While programs feel they are fairly well equipped to assist families with their needs, a third of respondents see gaps in availability for health services, social services, or other additional services they do not offer. Similar to the top barriers discussed by community survey respondents, home visiting programs find that the top two barriers to providing adequate services were difficulty coordinating parent schedules and that families are busy addressing other needs. Prominent barriers for Title V perinatal/infant health focus group participants included accessing healthcare resources during and after pregnancy. These barriers included not having local providers, challenges accessing local providers (e.g., not accepting new patients, appointment hours not convenient), and challenges accessing resources for their baby or for themselves post-partum.

Figure 16

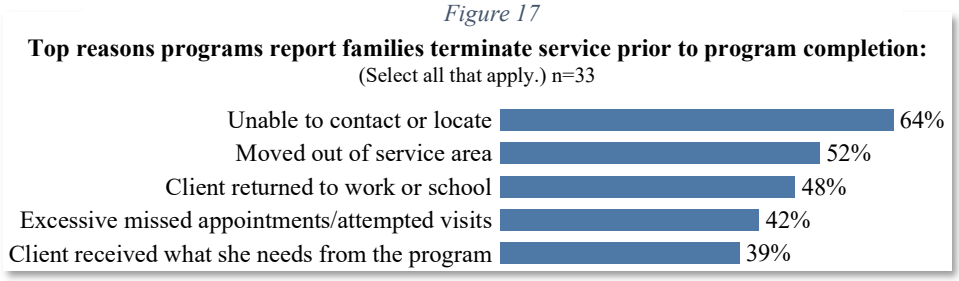


The top service that families often need which programs rarely provide is transportation. Close behind transportation is the client's need for housing and child care. (See Figure 16.)

Client Attrition – Question from Program Survey

When asked about client attrition, only half of program respondents (19/38) provided an answer to how many families leave a program before completion. The attrition rates of the 15 programs who provided a numerical value for the question reported attrition rates ranging from 10%-75% with an average around 33%.

Figure 17

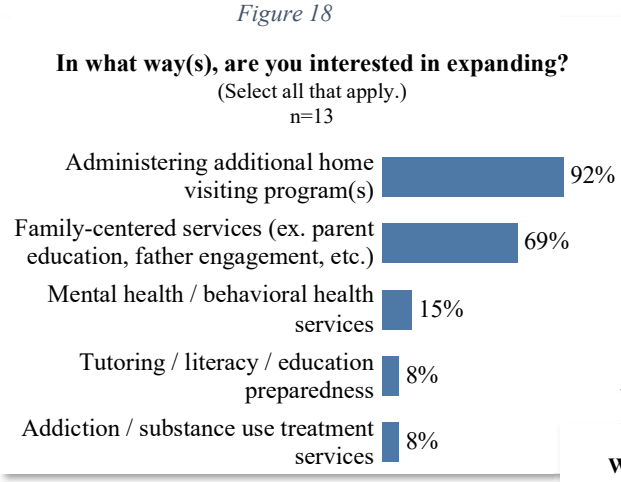


Nearly all programs provided responses as to the top reasons (program survey respondents could select up to 3 choices) families terminate service prior to program completion. The top two reasons are that the program is no longer able to locate the client or that the client has moved out of the service area. (See Figure 17.)

Home Visiting Expansion – Questions from Program and Community Surveys

Almost three out of every four home visiting organizations (24/33, 73%) are interested in expanding beyond their current capacity or enrollment. Eight organizations selected either not interested or unsure, and one organization selected other.

Figure 18



Less than half of program survey respondents indicated interest in expanding to provide additional home visiting or community-based services. Only 42% (14 of 33 respondents) answered yes, 30% (10/33) answered no, 24% (8/33) are unsure, and one program selected other. Of those interested in providing additional services, 12 of the 13 programs would like to administer additional home visiting programs and nine of 13 want to expand family-centered services. (See Figure 18.)

When community survey respondents were asked what services expectant and new parents and their young children need, they selected mental health/behavioral health services (336/404, 83%) as the most needed service in their community. Mental health was also indicated as a top need for Title V statewide survey respondents. More than half of respondents also feel that expectant parents and young families need family-centered services (309/404, 76%), economic self-sufficiency services (287/404, 71%), and addiction/substance use treatment services (283/404, 70%). Community survey respondents identified additional home visiting services as one of the least needed services in their community, selected by 42% (169/404) of respondents. (See Figure 19.)

Figure 19

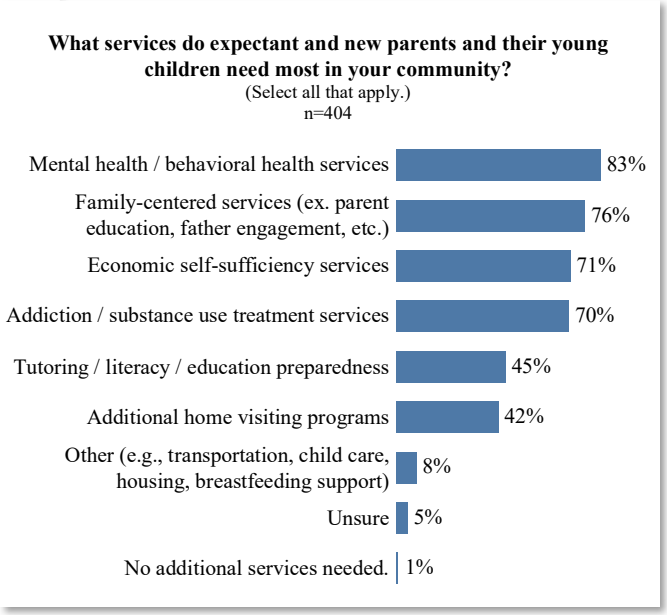
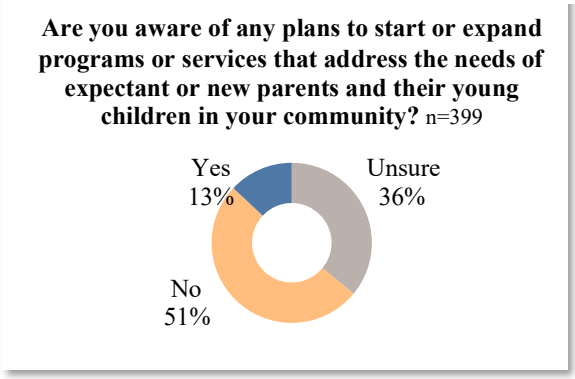


Figure 20

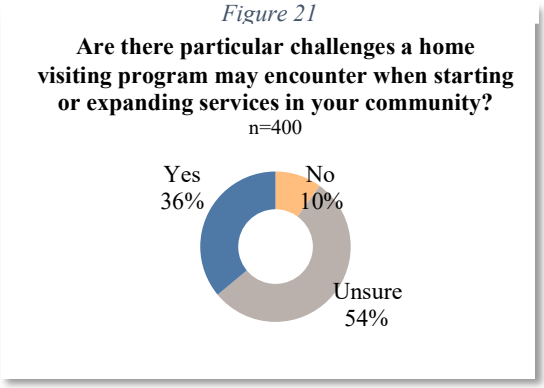


All home visiting programs were asked to identify the barriers to expanding, and the number one answer was funding, selected by 91% (29/32) of respondents. The second most cited barrier by 40% (13/32) of respondents was number of staff, and 19% (6/32) of respondents indicated that space is a barrier.

Community survey respondents were asked if they were aware of any plans for additional programs or services and if they perceive any barriers to expansion of services for expectant or new parents and their young children. It is important for the MIECHV team to gather information on the dynamics of a community before attempting to start or expand services in that area. Only

13% (53/399) of community survey respondents are aware of any plans to start or expand programs or services for expectant or new parents and their young children in the community. (See Figure 20.) Some of the 53 respondents who are aware of plans, work for organizations that serve the entire state and may know of initiatives that would serve a large portion of the state. New or expanding programs that were mentioned include NFP, OB navigator the OB Navigator initiative, a parent group at a community center, and additional Pre to 3 programs.

Figure 21



A third of community survey respondents (142/400, 36%) believe there are challenges a home visiting program may encounter when starting or expanding services and 54% (217/400) were unsure. (See Figure 21.) Nearly 150 respondents provided explanations of challenges, such as finances, lack of trust in the community when not already connected, and families being hard to reach. Additional challenges faced within communities include being slow to adopt new programs, community (and community members) having distrust of government programs, and providers not always willing or able to go into high crime areas where services are needed. Community survey respondents also discussed reasons community members may not be supportive of new services such as barriers with language, transportation, communication, and having staff that reflect the families being served.

Comments from Community Survey Respondents regarding challenges a home visiting program may encounter when starting or expanding in a community:

"1. Identifying families who would benefit 2. Participation from families 3. Language barriers 4. Some families just don't want people in their homes but have transportation problems to access other programs 5. Concern from the home visiting providers regarding their safety"

"You need to gain the medical community's trust that you are reliable and helpful. Same goes for earning trust from the families."

"Having the upfront capital to hire and sustain new staff until a full caseload is obtained."

"Competing with the existing programs BUT these programs are full and not accessible to everyone. They are just well established and known by community partners."

Many community survey respondents offered advice to individuals implementing home visiting services in the community. From the 200 responses, the following themes emerged:

- Communicate or build relationships with partners who make referrals (e.g., community organizations, doctors, etc.) *"Build relationships with community resources and families served."*
- Collaborate (do not duplicate or compete) with other organizations *"Collaborate with others already providing home visiting services to maximize resources."*
- Learn the needs of the community and develop buy-in *"Get out and get to know the community that you are trying to service. Different communities in Indiana have different needs. If a new provider doesn't take the time to get to know the community some communities might not be receptive to someone new coming in if they don't understand the intentions of the new program." "Meet with parents and have parent advisors to ensure the services are truly addressing needs"*
- Advertise/market the program *"Network with local agencies so they understand what your program offers. Then network some more!"*
- Build relationship/trust with client *"Relationship building and trust are important. People need to be the right ones implementing programs. Dedication, follow-through are very important."*
- Be nonjudgmental/respectful of families *"Listen to what the client wants- not what you think they need. Be flexible and give it time. Meet them where they are and be non-judgmental."*

- Develop cultural competency (as well as have a diverse workforce) *"Be sure to provide information in Spanish AND English. Reach out to community groups to assist in areas where program falls short." "Hire a diverse staff."*
- Educate/advocate for programs (with clients and communities) *"Present at neighborhood community meetings to let people learn more and understand how to enroll. They need a face/person to associate with the program - not just a website."*
- Meet clients where they are (literally and figuratively) *"First meet people where they are--Walmart, laundromat, child and Family Services, library, park.."*
- Be flexible/creative with families *"Try to be flexible to accommodate varying schedules."*

Availability of Programs – Question from Community Survey

While almost half of community survey respondents (178/403, 44%) are unsure of how widely programs serving expectant and new parents and their children are utilized, nearly two thirds (259/404, 64%) believe there is a need for additional home visiting services in the community. (See Figures 22 and 23.)

Figure 22

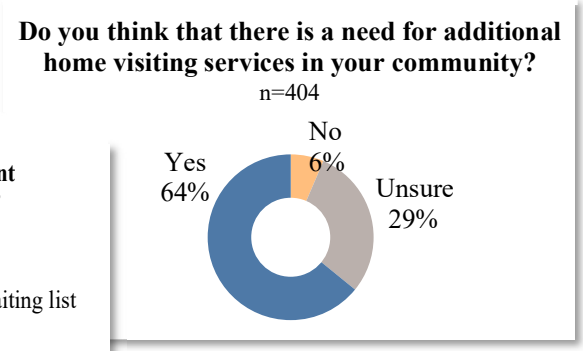
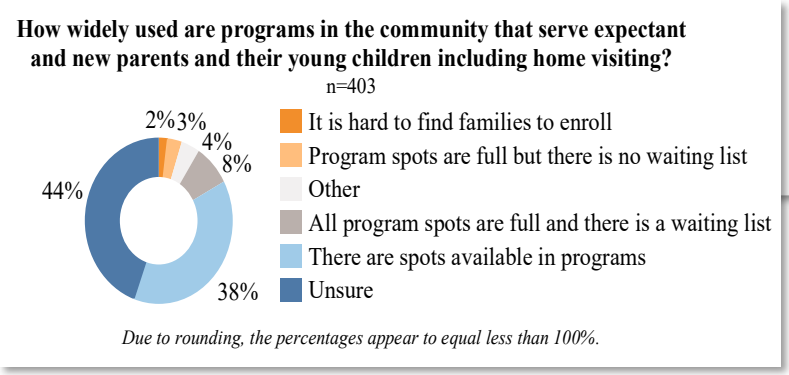


Figure 23



Due to rounding, the percentages appear to equal less than 100%.

Key Findings and Takeaways of Gaps in Delivery of Home Visiting Services

- Top three services home visiting program survey respondents reported that families need in their service area that are not provided within their agency were Transportation (83%), Housing (79%) and Childcare (79%)
- 73% of home visiting program survey respondents indicated interest in expanding beyond current capacity.
- Community survey respondents offered advice for implementing home visiting services: Learn the needs of the community and develop buy-in, Develop cultural competency, Communicate or build relationships with partners who make referrals, Meet clients where they are (literally and figuratively).
- Community survey respondents indicated a belief that a need for additional home visiting services exist (64%)

The Extent to which Home Visiting Services Meet the Needs of Families in Indiana

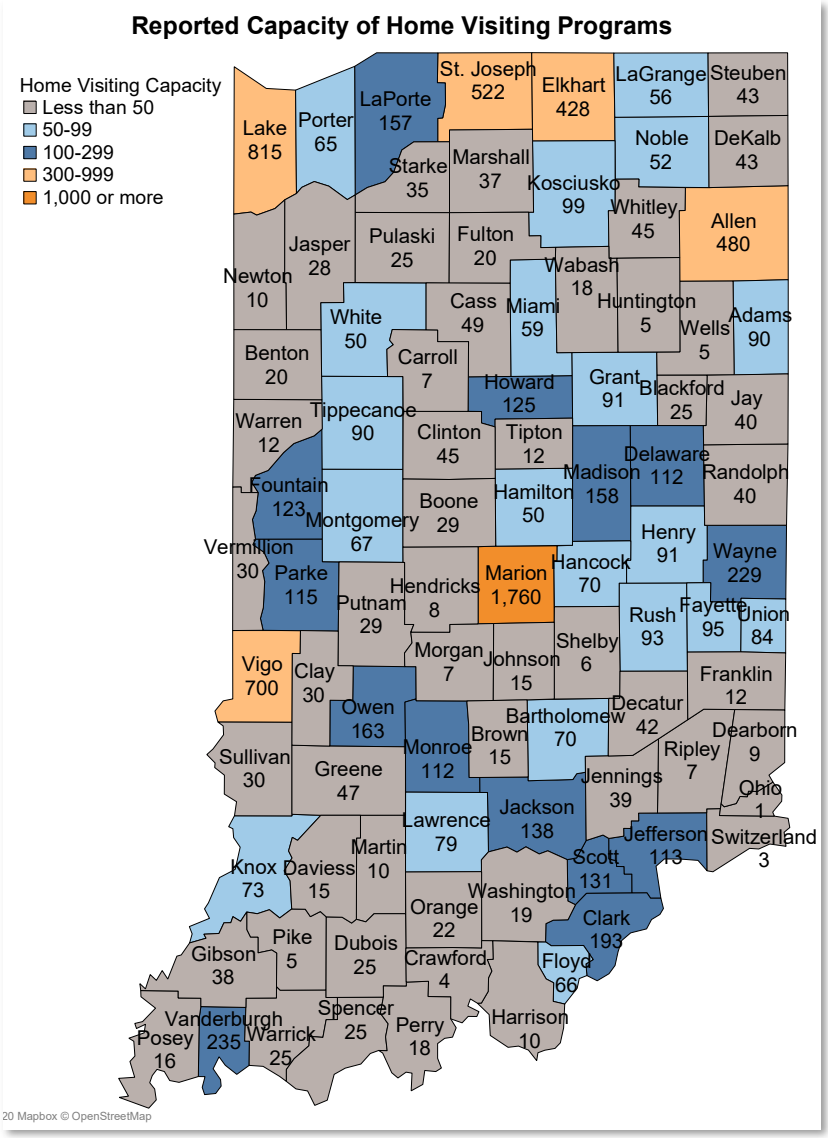
Capacity and Enrollment – Questions from Program Survey

Home visiting program survey respondents reported a capacity to serve 8,777 clients.[18] Members of the Indiana MIECHV Team followed up with programs that did not take the survey to request capacity numbers. An additional 21 programs responded, bringing the self-reported home visiting capacity in Indiana to 9,454 clients. Capacity by county ranged from 1 client to 1,760. (See Figure 24.) A full list of

[18] Capacity was defined for survey takers as "*the maximum number of families/clients your program can serve with current resources including funding and staffing in a typical month*".

counties with reported capacity can be found in Appendix H.

Figure 24



While program survey data provided capacity, HRSA determined the number of families in need as the number of families who are in poverty and meet one additional risk factor. Families with children under the age of six who live below 100% of the poverty line, were examined for the following risk factors: mothers with low education – a proxy for poor education outcomes, young mothers under the age of 21, and families with an infant. These risk factors were chosen because they are linked with negative maternal and child health outcomes such as low birth weight, child injury, child maltreatment, school readiness disparities, etc.

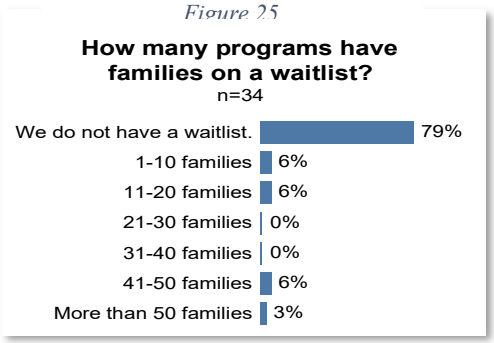
Indiana considered an alternate estimated need of potentially eligible families totaling 66,716 families. Indiana's alternate estimated need of eligible families only looks at one eligibility factor – the number of families with a child under the age of 5 who live below the poverty level.

Considering the two estimates of need, counties have the capacity to serve anywhere from 1% to over 100% of families identified as potentially in need and eligible for home visiting services. The number of families in need can vary greatly between the two estimates for each county. As seen in the at-risk county analysis, different factors are impacting communities. The variance in need shows that counties may require different program models with different supports.

A caveat to determining home visiting capacity to meet need is that no one eligibility factor or dataset that encompasses all families in need of services is present. Home visiting programs vary in their eligibility requirements and even the same program model may adapt its requirements to the specific locations it is serving. However, reviewing this data can inform discussions to prioritize counties where the need for home visiting services is being met or where the data shows a county may best be served by other initiatives and funds outside of MIECHV.

Home visiting programs were also asked about how many unique (unduplicated) families they served in the most recently completed service year. Not all home visiting program survey respondents provided an answer to that question. Twenty-six organizations provided the number of unique unduplicated families served, totaling 8,576 clients. Indiana is currently limited to this survey response, however, it is likely a

Figure 25



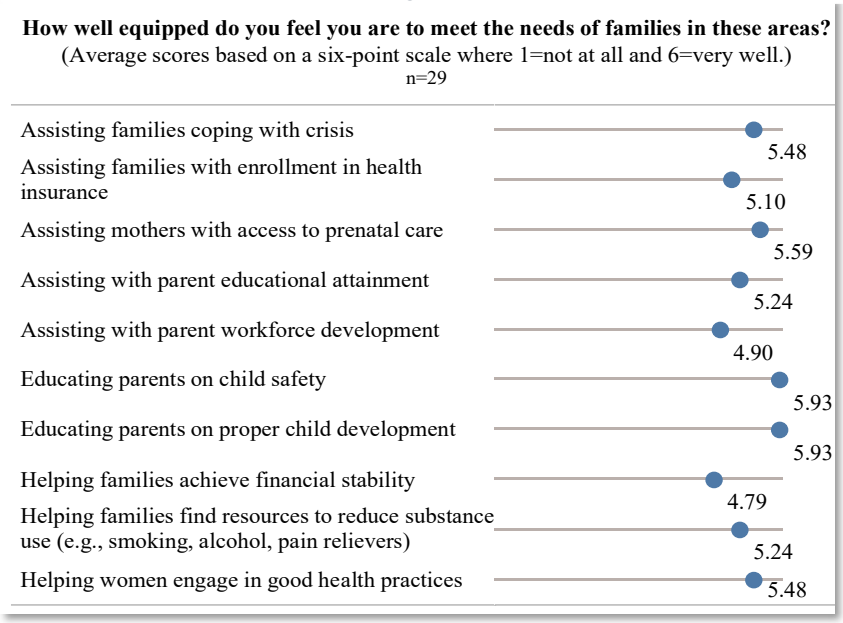
conservative number, as administrative data from the HFI system alone indicates that 11,124 families[19] were served from 10/1/2018 – 9/30/2019. Administrative data is not available for all home visiting programs in Indiana.

In general, home visiting programs are not operating with a waitlist; however, three home visiting programs indicated waitlists with 40+ potential clients on it. (See Figure 25.) Only two home visiting programs indicated that the waitlist has changed over the past 3-5 years with one saying it has been larger and the other saying it has been smaller in the past.

Community Needs According to Home Visiting Providers – Question from Program Survey

Program survey respondents were asked to rate how well equipped they feel they are to meet the needs of families in their communities on a scale from 1-6 (1=not at all equipped, 6=very well equipped). Programs feel most well equipped to educate parents on proper child development and safety, assist families coping with crisis, and help families find resources to reduce substance use. Programs feel least equipped to help families achieve financial stability and assist with parent workforce development. However, the average score in these areas is still relatively high indicating they are "fairly equipped" to "well-equipped." (See Figure 26.)

Figure 26



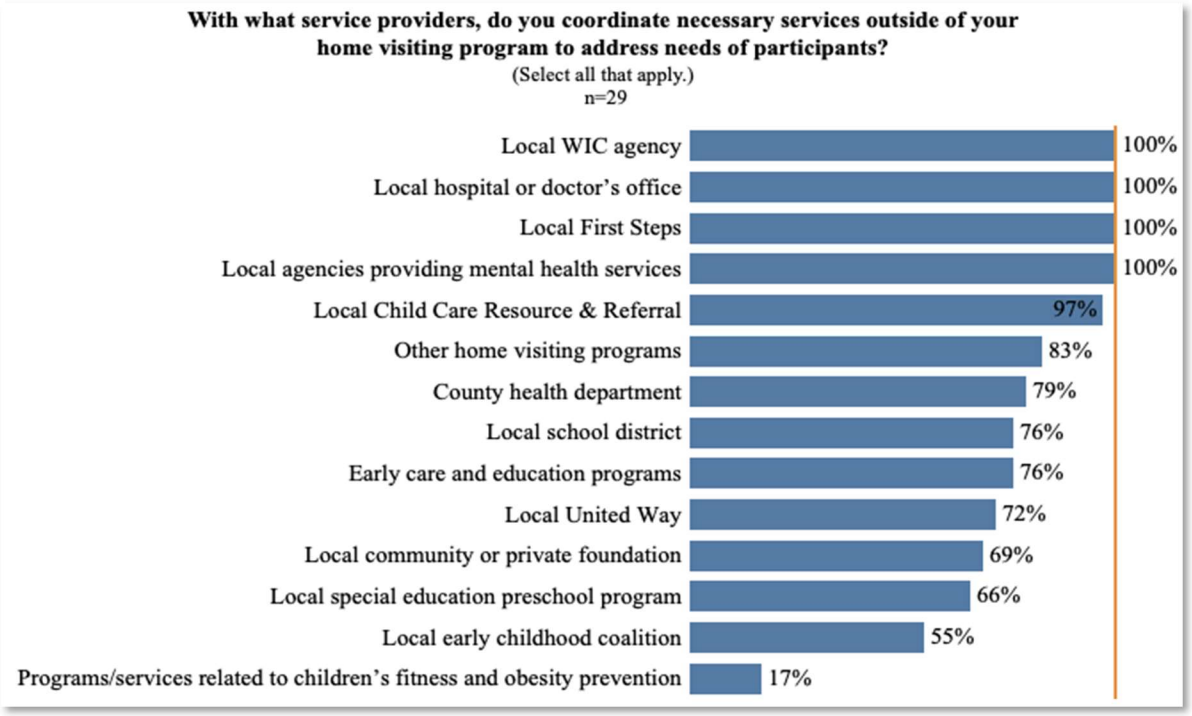
Community Collaboration – Question from Program Survey

To address the needs of clients, home visiting programs indicated partnering with many other local service providers. (See Figure 27.)

The majority of organizations (25/29, 86%) share data with partners, and often share multiple types of data. Three quarters of organizations (22/29) share referral data, and two thirds (18/29) share enrollment information, such as capacity and waitlist numbers. Less than half of organizations share data on family or child outcomes. Only 14% (4/29) indicate that they do not share data at all with their partners. (See Figure 28.)

[19] National Child Abuse and Neglect Data System (NCANDS) 2019

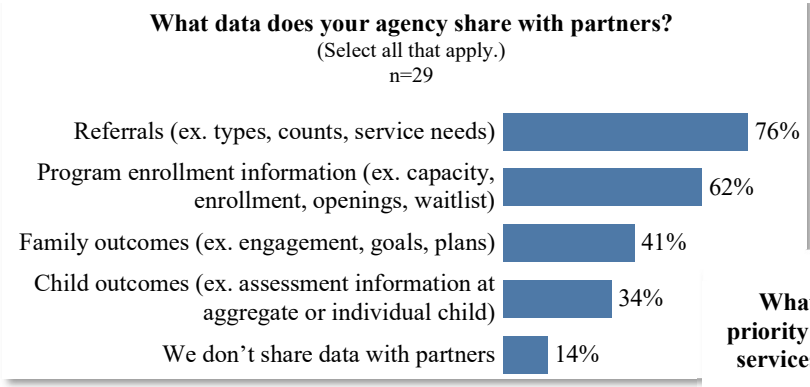
Figure 27



Community Support of Home Visiting Services – Questions from Program (Home Visiting Survey)

A measure to consider when determining community readiness for new or expanded services is community support. Organizations that responded to the program survey were asked about the level of support they receive from the community and how the community prioritizes the needs of expectant and new parents and their young children.

Figure 28



A great majority of home visiting programs (25/29, 86%) believe community members see the needs of the MIECHV population to be of moderate to highest priority. No program believes that providing services for expectant and new parents and their young children is not a priority in their community. (See Figure 29.)

Figure 29

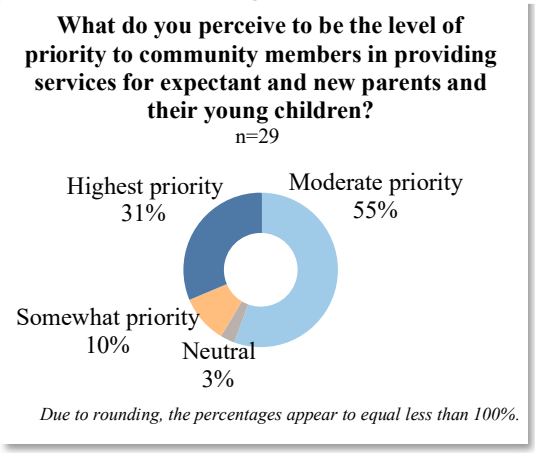


Figure 30

How supportive do you perceive your community to be for providing home visiting services?
n=29

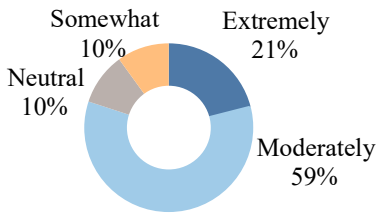


Figure 31

How do community members support your home visiting program(s)?
(Select all that apply.) n=29

The perception of community support for providing home visiting services drops below that of the perceived level of priority for expectant and new parents and their young children, but just slightly. More than three quarters (23/29, 80%) of organizations providing home visiting services perceive their community to be moderately or extremely supportive of providing home visiting services. Again, no organization rated their community as being not at all supportive. (See Figure 30.)

Support for home visiting programs is shown in many different ways by community members. Program survey respondents said community members most often show support by providing professional development opportunities. Community members also support home visiting programs by assisting with planning programs and advocating for additional resources. Only one program said that community members do not support their programs. (See Figure 31.)

Key Findings and Takeaways of Extent Home Visiting Services Meet Needs of Families

- The self-reported[20] capacity for home visiting in Indiana is 9,454 families.
- Home visiting program respondents indicated they felt equipped to meet the needs of families, specifically most well equipped to educate parents on proper child development and safety, assist families coping with crisis, and help families find resources to reduce substance use.
- The majority of organizations (25/29, 86%) indicated data sharing with partners, and often share multiple types of data.

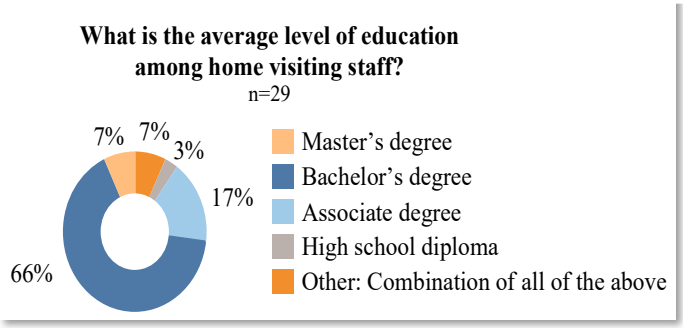
Gaps in Staffing, Community Resource, and Other Requirements for Delivering Evidence-Based Home Visiting Services

Staffing – Question from Program Survey

Less than half of home visiting programs (15/33, 45%) indicated a sufficient labor pool in their community from which to draw potential candidates with the requisite education, skills, and experience to fill staff positions for their home visiting program. Additionally 42% (14/33) said the labor pool is somewhat sufficient while four organizations (4/33, 12%) said there is not a sufficient labor pool in their community.

Figure 32

What is the average level of education among home visiting staff?
n=29



The average level of education among home visiting staff of participating programs is typically a bachelor's degree. Five programs

[20] as indicated by respondents to the home visiting program survey

said the average education level is an associate degree and two programs selected master's degree. (See Figure 32.)

Home visiting program survey respondents indicated the majority (16/27, 57%) of their home visiting staff are social workers. A third of organizations have a majority of staff with a Child Development Associate (CDA) credential, and a little less than a quarter said the majority of staff are registered nurses or community health workers. Seven organizations selected other with general responses of staff having a specialty in education or human services. (See Figure 33.)

Figure 33

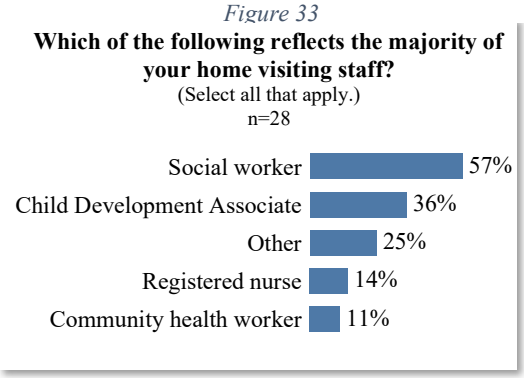
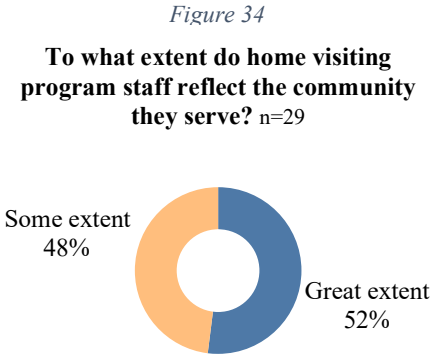


Figure 34

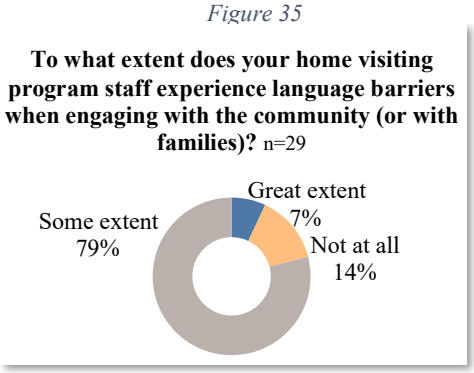


Community Representation – Questions from Program Survey

Overall, home visiting programs indicated that staff reflect the community they serve, and no programs indicated that staff do not reflect their community at all. (See Figure 34.)

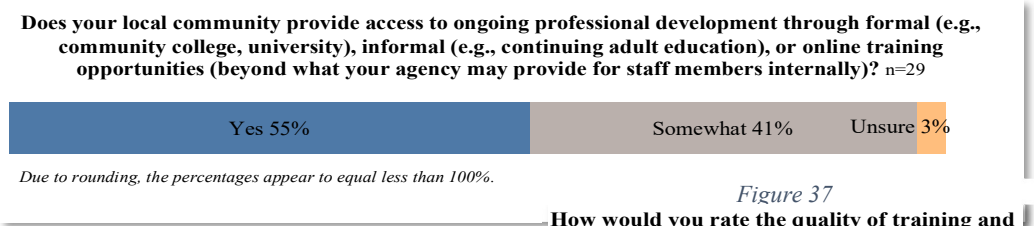
In a previous survey question, a third of programs indicated that language can be a barrier to families receiving services. The number of programs who experience these barriers though is even larger. Nearly 90% (25/29) of programs deal with language barriers to some extent with 7% (2/29) of the 90% saying it is to a great extent. (See Figure 35.)

Figure 35



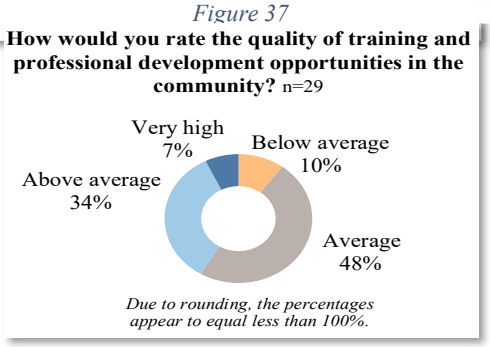
Program survey respondents were also asked to discuss opportunities for professional development in their communities and the quality of the opportunities available. Less than half of program survey respondents (12/29, 41%) feel that their community "somewhat" provides access to formal, informal, or online training opportunities for their organization; program survey respondents did not reported lack of access to ongoing professional development. (See Figure 36.) These responses about access to opportunity are comparable to reports about the quality of the professional development.

Figure 36



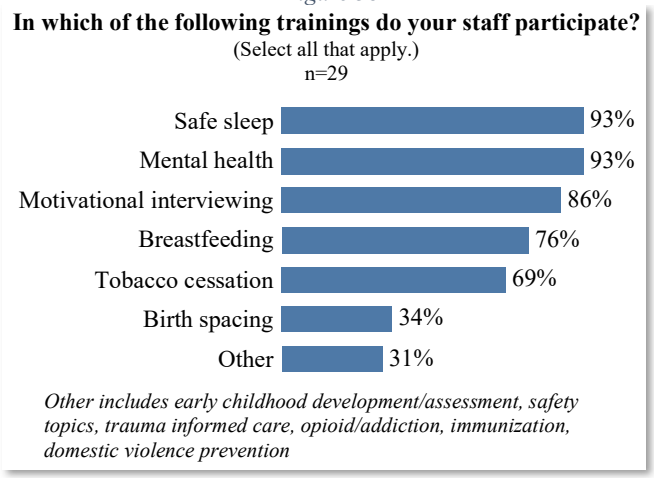
Half of program survey respondents (14/29, 48%) rate training and professional development opportunities available in their community as average. A third (10/29, 34%) rate their opportunities as above average while the remaining 17% (5/29) is split between very high quality and below average quality. No very low ratings were indicated by program survey respondents regarding the quality of professional development opportunities in the community. (See Figure 37.)

Figure 37



Training on topics such as mental health and safe sleep are occurring at most organizations participating in the home visiting survey. Motivational interviewing was not far behind at 86% (25/29). More than half of the organizations utilize training on breastfeeding and tobacco cessation. (See Figure 38.)

Figure 38



Key Findings and Takeaways – Gaps in Staffing, Community Resource and Other

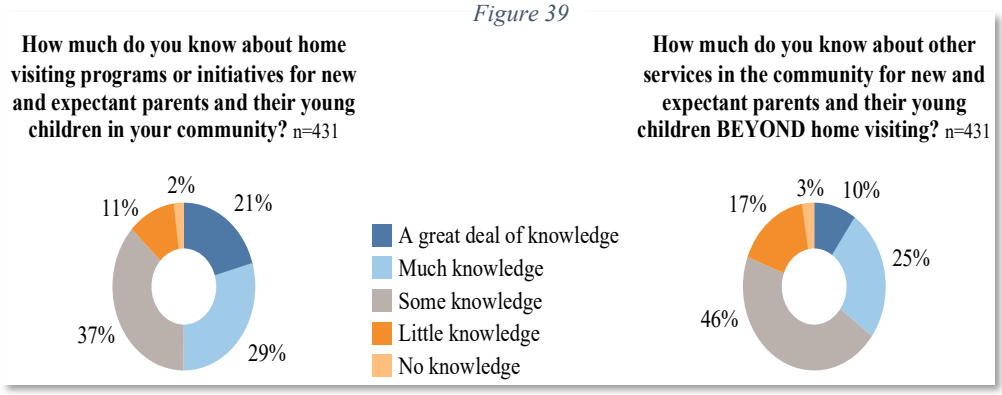
- Less than half of home visiting programs (15/33, 45%) indicated a sufficient labor pool in their community from which to draw potential candidates with the requisite education, skills, and experience to fill staff positions for their home visiting program.
- Home visiting program survey respondents indicated the majority (16/27, 57%) of their home visiting staff are social workers.
- Training on topics such as mental health and safe sleep are occurring at most organizations participating in the home visiting survey.

Determining Community Readiness

In addition to reviewing the need of communities of Indiana and capacity of existing home visiting programs, the Indiana MIECHV Team also assessed the ability of communities to support home visiting programs. While home visiting programs were surveyed about their community's support for their work, it was also beneficial to reach out directly to community stakeholders to learn more about their perception of the community's needs and the level of support available when addressing these needs. If a community is identified as one in need of additional services, it is important to know whether that community is ready for new or expanded services. Responses from home visiting programs and community partner surveys helps to gauge a community's readiness and ability to serve more families.

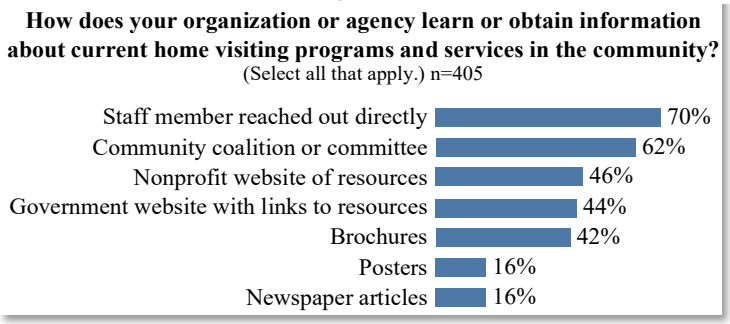
The majority of respondents to the community survey (357/442, 81%) work for organizations that provide programming to expectant parents and/or families with young children. This led to the vast majority of respondents (375/431, 87%) having at least some knowledge of home visiting programs or initiatives. Slightly fewer respondents (348/431, 81%) had at least some knowledge of services beyond home visiting. (See Figure 39.) A large number of community survey respondents work with potential MIECHV families and have at least some knowledge of home visiting programs. Therefore, it is not surprising that 70% (284/405) learn of home visiting programs in the community by talking directly with their staff. Nearly two thirds of respondents (253/405, 62%) learn about home visiting programs in the community through a community coalition or committee. Resource websites hosted by nonprofits or government agencies as well as a traditional brochure are also fairly successful at reaching community stakeholders and informing them of home visiting programs. Respondents that

Figure 39



selected "other" mentioned learning of programs through grant proposals, referrals, families in the community, and at health or community fairs. (See Figure 40.)

Figure 40



The majority of community survey respondents (212/393, 54%) believe providing services for expectant and new parents and their young children is a moderate or high priority in their community. (See Figure 41.)

Community survey respondents see community leaders demonstrating support in a variety of ways. Not one single action was chosen by more than half of respondents. Of the 385 respondents, only eight individuals do not believe community leaders support home visiting programs. (See Figure 42.)

Figure 41

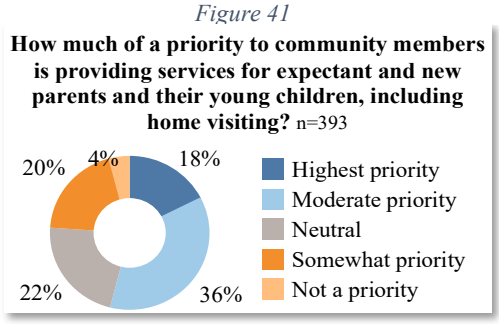
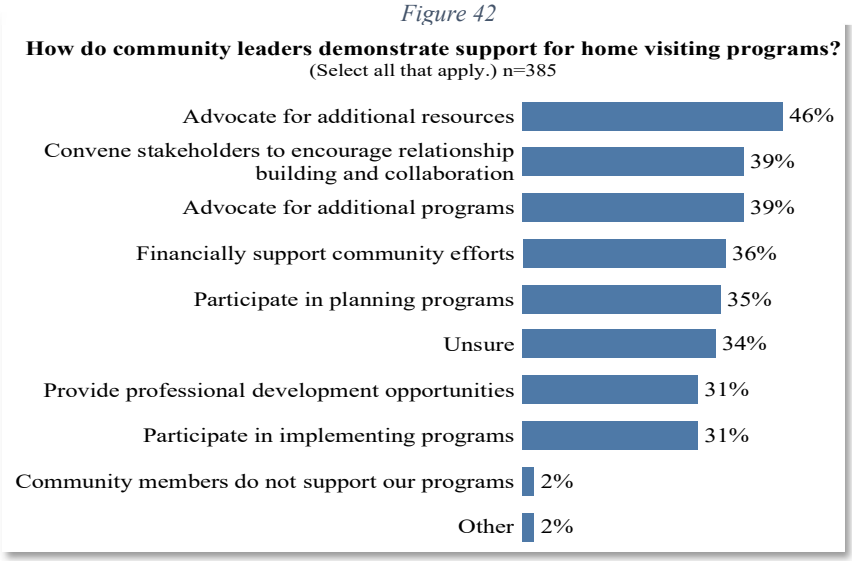


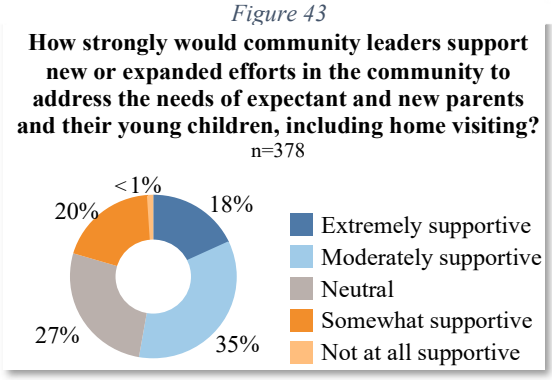
Figure 42



The majority of community survey respondents (201/378, 53%) believe community leaders would be moderately or extremely supportive of new or expanded community efforts to serve expectant parents and young families. (See Figure 43.) These responses are similar to those regarding how much of a priority community leaders see those programs to be.

Community survey respondents were given the option to explain why they answered the previous question the way they did. Some respondents believe community leaders would be "somewhat supportive" or "neutral" to new or expanded efforts think and more education on the issue (the needs of expectant and new parents and their young children) would result in more community support. The communities where community leaders are "moderately supportive" or "extremely supportive" already see infant mortality as a local priority issue and/or leaders are invested in the community and supportive of current efforts.

Figure 43



Comments from Community Survey Respondents regarding support from community leaders:

"A majority of the families that I serve are happy to receive home-based services. It is very helpful and convenient for them. Members of the community (doctors, case workers, educators) support our program and we work together to serve children and families in need of developmental services."

"I've seen support for these programs increase over the last few years, particularly related to evidence-based programs that address well publicized needs (DCS population)."

"I feel that the need for expanded efforts is widely known and community leaders are looking for creative ways to engage and connect with expectant parents."

"Shockingly wide health disparities in the county and growing awareness of racial inequality has piqued interest."

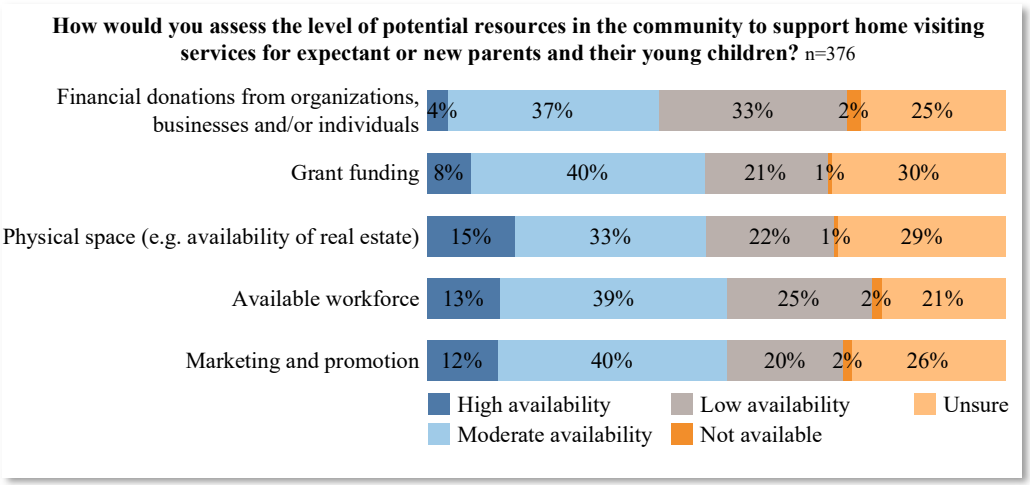
"Having one the highest number of infant mortality rates in the state has caught the attention of leaders in community. Showing the need and advocating for nurses to be one to one with these at-risk populations has shown to reduce mortality in infants and in pregnancy. "

"I think if community leaders were educated or informed about the need, they would become supportive."

Availability of Resources – Questions from Community Survey

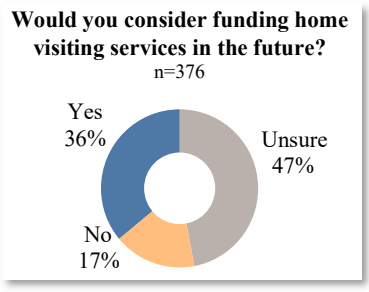
Beyond community support, it is important to determine the amount of resources available to enable home visiting programs and services to expand or enter a new location. Community survey respondents were asked about five resources in particular, and each was rated to have generally low to moderate availability. Also, each resource had between 21% (79/376) and 30% (111/376) of respondents select "unsure" as to its availability. Available workforce and marketing & promotion were ranked highest at 52% (194/376) moderate to high availability. (See Figure 44.)

Figure 44



Since many of the community survey respondents were from organizations that may provide grant funding, as well as other support to home visiting services, they were asked if they had ever funded home visiting services before. About a third (132/377, 35%) said they had funded home visiting services and a similar amount (136/376, 36%) said they would consider doing so in the future. (See Figure 45.) Of the organizations that said they do not fund home visiting services, many mentioned that they simply do not have the means to fund additional programs. Still some respondents indicated interest in partnering to help advocate for the services or even be a service provider if funding were available.

Figure 45



Comments from Community Survey Respondents regarding consideration of funding home visiting:

"The one home visiting service has only applied once. They seem to receive enough state funding"

"We would support in some way but likely not funding. We could partner in collaboration but would need to cover cost."

"As a foundation, we are interested in preventative programming to keep children out of the DCS system."

Early Childhood Education Coalitions

In addition to surveying community partners to assess their capacity and support for prenatal and children's services, the Indiana MIECHV Team also gathered data on the development of local community coalitions with a focus on supporting young children (ages 0-5) in their community. Over the last six years, Indiana has seen a growth in the development of these local coalitions. While some states used federal or state funding from Race to the Top or Preschool Development Grants to support local community coalitions with a focus on supporting the first five years, Indiana did not receive or use public funding in this way.

The Indiana early childhood coalitions have been locally grown and developed, often started by a combination of philanthropic partners like United Way agencies or Community Foundations, business leaders and other non-profit organizations. The development and expansion of Indiana's state-funded pre-kindergarten program, On My Way Pre-K, had an initial requirement that the pilot communities have a coalition in place. This state funding that started in 2014 helped to incentivize local community leaders to organize a coalition to be eligible to receive state pre-k funding in their community. Even as the state regulations for the pre-k program have changed, more communities have come together to collaborate on addressing the issues for their youngest citizens.

Indiana has approximately 39 local community coalitions that support 55 counties (over half of the state) with a focus on supporting the first five years. (Refer to Appendix I for map of these coalitions.) Some of the coalitions are county-focused while others are regionally focused, and they are all at various stages of development and capacity from having dedicated full-time staff and funding to being a volunteer-run organization. Just over half (16/29, 55%) of home visiting organizations indicated in the survey that they currently coordinate necessary services with early childhood education coalitions.

Key Findings and Takeaways – Determining Community Readiness

- Four out of every five community survey respondents are familiar with home visiting programs and other services serving a similar population.
- More than half of home visiting program survey respondents believe community leaders are supportive of services for expectant women and families with young children, and that they would also be supportive of initiatives to expand such services.
- More than half of the state has a local community coalition that is focused on supporting young children ages 0-5.

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

The 2020 Update is tasked with identifying the state's capacity to serve pregnant women and women with young children who are in need of substance use disorder treatment and/or counseling services. The Indiana MIECHV Team reached out to Indiana's Division of Mental Health and Addiction (DMHA), which manages Indiana's Substance Abuse Prevention and Treatment Block Grant (SABG) program funds.[21] Funds administered by Indiana's Division of Mental Health and Addiction are used for individuals with a serious mental illness and/or a substance use disorder who are at or below 200% of the federal poverty line (FSSA DMHA, 2018, p. 30).

Indiana has a statewide mental health and addiction recovery system that serves all 92 counties through contracts with 24[22] community mental health centers (CMHCs) and other specialty providers (Family and

[21] Information for this section is from the Indiana Fiscal Year 18/19 State Behavioral Health Assessment and Plan, Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant. (Newer data was available at the time of this report, but due to changes in reporting/data systems, Indiana's Division of Mental Health and Addiction felt more confident in the accuracy of the numbers in their 2018-2019 Substance Abuse Prevention and Treatment Block Grant application.)

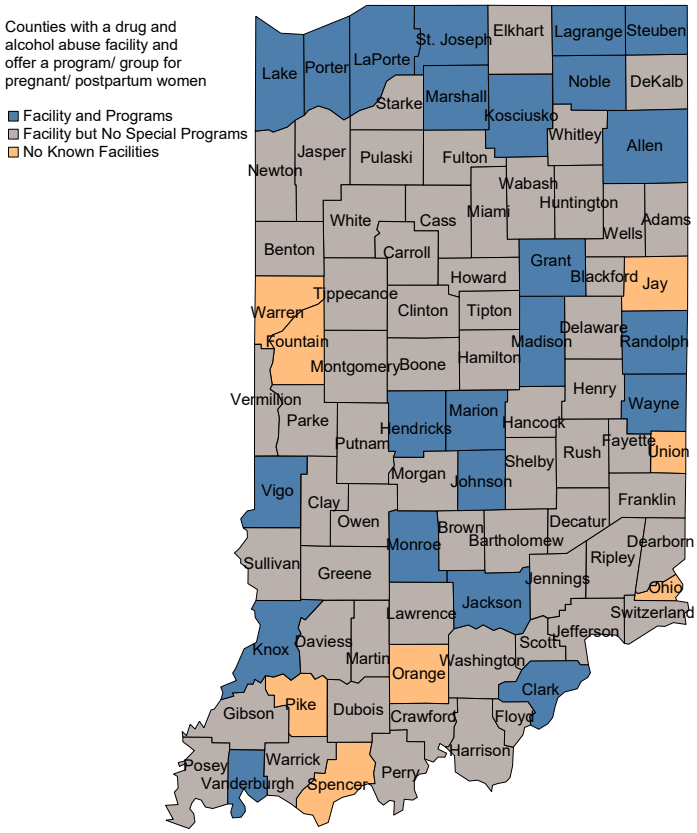
[22] The application reported 25 CMHCs, but one has closed since the submission of the 2018-2019 Substance Abuse Prevention and Treatment Block Grant application.

Social Services Administration Division of Mental Health and Addiction [FSSA DMHA], 2018, p. 30). Satellite offices for CMHCs are available in all but two counties where outreach and transportation services assist those counties in accessing the nearest CMHC. Indiana's measure of accessibility is that outpatient services are available in the county, an adjacent county or within a 60-minute drive (p.30).

The 2018 National Directory of Drug and Alcohol Abuse Treatment Facilities (Substance Abuse and Mental Health Services Administration, 2018) shows a facility located in all but eight counties in Indiana (Fountain, Jay, Ohio, Orange, Pike, Spencer, Union, Warren). **Of the 356 facilities located across the state, 144 offer special programs and/or groups for adult women and 54 offer special programs and/or groups for pregnant and postpartum women.** (See Figure 46.) These 54 programs are only available in 23 counties.

Figure 46

2018 Drug and Alcohol Abuse Treatment Facility Locations that Offer Special Programs and/or Groups for Pregnant or Postpartum Women



Source: Substance Abuse and Mental Health Services Administration (SAMHSA). *2018 National Directory Of Drug And Alcohol Abuse Treatment Facilities.*

Substance Use Disorder – including Opioid Misuse – is addressed during the HFI Assessment process as well as throughout HFI home visiting services, following expectations of Healthy Families America (HFA). In addition to these activities, referrals are provided to mental health professionals or substance abuse services when necessary, though it is important to note that voluntary home visiting services do not include compelled treatment for participating families. Similarly, NFP addresses substance disorder, including opioid misuse, throughout the program as appropriate. NFP Nurses have the following additional modules available:

- Opioid Use Disorder: Definitions and Trends
- Opioid Use Disorder: Brain Pathophysiology
- Opioid Use Disorder: Symptoms and Care for the Mother
- Opioid Use Disorder: Symptoms and Care for the Baby
- Opioid Use Disorder: Legal Aspects and Resources

Nurses with training in Opioid Use Disorder/Substance Use Disorder prevention, following the NFP model, can provide primary, secondary, and tertiary prevention to enrolled mothers. Nurse home visitors utilize data collection tools to understand a woman's experience with substance use disorder, including opioid misuse. This supports utilizing clinical judgement and assessment skills to assist with decision making about the client's care. As part of the discussion between nurse home visitor and client, referrals to additional services are offered when the family may benefit from the additional support.

Range of Treatment and Counseling Services

Substance use disorder treatment services focus on priority populations including pregnant women and women with dependent children. Priority populations receive preferred admission within 48 hours of outpatient treatment and prioritized admission for residential treatment (FSSA DMHA, 2018, p. 39). Residential treatment is available at 24 CMHCs and six women's residential treatment providers across

the state (p. 39). Alternate treatment facilities are utilized if residential treatment centers are unable to admit these populations within 14 days (p. 39). Access to services for pregnant women and women with dependent children include medical care; including prenatal care, childcare, pediatric care and gender-specific treatment and other therapeutic interventions for women.

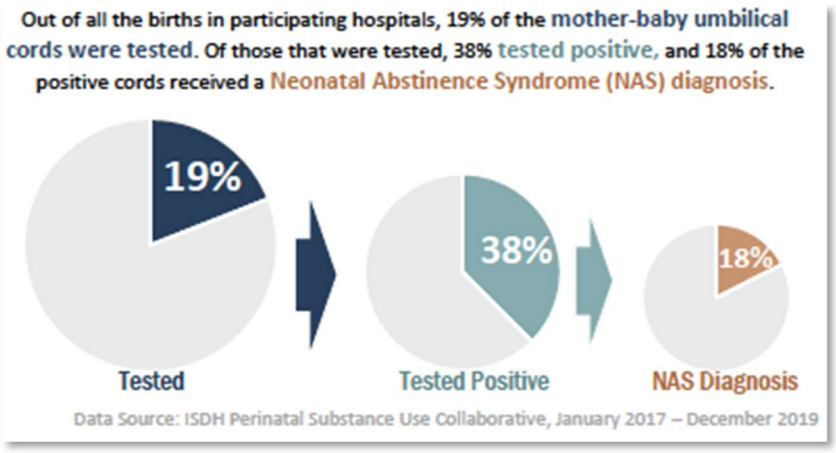
A pilot project, MOMentum (FSSA DMHA, 2018, p. 734), has been implemented to help pregnant women suffering from substance use disorder. Support services given to the women include education, medication assisted treatment (MAT), group support and case management. The goals of the program are to expand access to MAT, shorten NICU stays, improve health outcomes and build effective relationships between medical providers, hospitals and addiction treatment providers. This program involved insurance companies/Medicaid, medical providers, hospitals and treatment providers which raised awareness of MAT.

Gaps in the Current Level of Treatment and Counseling Services Available to Home Visiting Service Populations

SABG and other state data on characteristics of pregnant women and birth outcomes show that additional treatment and prevention for substance abuse among pregnant women and women with dependent children is needed. SABG-funded initiatives serve individuals under 200% federal poverty level which may include populations eligible for home visiting services.

According to the Indiana State Department of Health (ISDH), 116 children were born with fetal alcohol syndrome, the most severe form of fetal alcohol spectrum disorder from 2008-2012 (FSSA DMHA, 2018, p. 84). The Perinatal Substance Use Collaborative at ISDH found that of the umbilical cords tested, 38% tested positive for drugs. The most commonly found substances were cannabinoids and opiates. Of the positive cords, 18% received a Neonatal Abstinence Syndrome (NAS) diagnosis. (See Figure 47.)

Figure 47



From 2007 to 2015, ISDH found that the percentage of births to mothers who smoked during pregnancy declined from 18.5% to 14.3% (FSSA DMHA, 208, p. 110). It is a state strategic behavioral health priority to reduce smoking in pregnant women from 14.3% to 8.0% by 2021 (FSSA DMHA, 2018, p. 270).

According to the National Survey on Drug Use and Health (NSDUH) in 2016, Indiana had an estimated 4,489 women who were pregnant or had dependent children in need of substance abuse treatment (FSSA DMHA, 2018, p. 620). The Data Assessment Registry Mental Health and Addiction (DARMHA) system used by community mental health centers and addiction facilities showed 343 pregnant women or women with dependent children admitted for substance use disorder treatment during the state fiscal year 2016 (p. 620). A year later, the number admitted was 434, surpassing the goal of increasing admittance of pregnant women or women with dependent children by 5% (p. 620). The goal for state fiscal year 2018 is to admit 456 women, again increasing the number of admissions by 5% (p. 620).

In 2016, an estimated 2,250 pregnant women and 13,000 women with dependent children in need of substance use disorder treatment who would be eligible for SABG-funded treatment from October

1, 2016 – June 30, 2017 based on national and state data (FSSA DMHA, 2018, p. 630).[23] **Less than 25% of pregnant women (548) and just over 50% of women with dependent children (6,865) are in treatment for substance use disorder** (p. 630).

Barriers to Receipt of Substance Use Disorder Treatment and Counseling Services

A barrier to more women being admitted to substance use disorder treatment could be attributed to funding levels, specifically decreases in actual dollars and available services[24] (FSSA DMHA, 2018, p. 621). In the Title V statewide survey, women indicated income/employment, stigma, and affordable healthcare as top barriers in addressing needs related to addiction and drug use.

Opportunities for Collaboration with State and Local Partners

In the SABG application, Indiana DMHA indicated having an established collaboration plan with child welfare agencies, juvenile justice, and education organizations. DMHA is also a member of Indiana's System of Care and Indiana's System of Care Governance Board, a collaboration of child-serving agencies and stakeholders with a shared vision to promote system collaboration for meeting the needs of youth and families (FSSA DMHA, 2018, p. 743). Voting members of the Governance Board include representatives from areas such as the Department of Child Services, Department of Education, Juvenile Detention Alternative Initiative, Community Mental Health, Child Advocacy, Residential Services, and Hospital-based Care (FSSA DMHA, 2018, p. 744).

According to the Maternal and Child Health Services Title V Block Grant application, ISDH supported 22 Baby & Me Tobacco Free sites in 2018. Of the 22 ISDH sites, 8 locations were supported with Title V funding and 11 were supported in partnership with the DMHA using Substance Abuse and Mental Health Services Administration (SAMHSA) Prevention funding. This close collaboration has strengthened both agencies work on primary prevention, in that the Baby and Me Tobacco Free Program emphasizes keeping new mothers and their families smoke free after baby is born so that children can be raised in a healthy, smoke-free environment. In an effort to better serve rural communities, some site facilitators have partnered with NFP home visitors and paramedicine professionals. ISDH's Maternal and Child Health (MCH) Division also collaborates with the ISDH Tobacco Prevention and Cessation Division's quit line to ensure families are referred to the program that best meets their needs and to maximize the efforts of the agency. ISDH is in the process of evaluating program outcomes to determine if funding should remain invested in this program or if alternative national programming options should be pursued. (Indiana State Department of Health [ISDH], 2019, p. 6)

The Indiana Department of Child Services (DCS) provides an Annual Progress and Services Report (APSR) where it reports on goals and the progress that has been made on specific objectives. The APSR has one specific objective under Goal 3 that focuses on ensuring the delivery of appropriate substance use/abuse treatment services for families where substance use is identified. (DCS, 2019b, pgs. 106-107)

DCS will assess statewide need for substance use treatment and work with local providers to build capacity in underserved areas. The first activity (i) identify scalable Sobriety and Recovery Teams (START) practices that can be implemented in communities outside of Monroe County (where START has been in use) has already been completed. The Second activity (ii) applying lessons learned from START locations by expanding principles of the START Model across Indiana, is also well under way. The principles of the START model are being trained all across the state as they can be implemented without having a formal START site. START principles include the following (DCS, 2019b, pgs. 155-156):

- Quick Access to Treatment
- Engagements of Families
- Utilizing Peer Recovery Support to increase parent engagement
- Shared Decision Model between DCS and treatment provider(s)
- Treatment is based on level of need for the client & provided for all applicable family members
- Increased face-to-face contacts between family and FCM during crisis points and critical case junctures
- Increasing Recovery Capital/informal supports

[23] The totals in this paragraph include the estimates and numbers served according to NSDUH and DARMHA data described in the previous paragraph.
[24] Data on additional barriers to the receipt of substance use disorder treatment and counseling services has not been collected by DMHA.

Additional activities to meet this objective include (iii) DCS will partner with the Indiana Office of Court Services (IOCS) to discuss the expansion of Family Recovery Courts in strategic locations throughout the State; (iv) DCS will partner with other state agencies and local providers to enhance substance use treatment by providing more timely access to services; and (v) DCS is working to expand treatment and placement options for mothers and children in an effort to keep mothers and babies together during substance use treatment. (DCS, 2019b, pgs. 106-107)

Current Activities to Strengthen the System of Care for Addressing Substance Use Disorder

The Indiana DMHA has a goal to prioritize admission of substance abusing pregnant women and women with dependent children. They plan to achieve this by increasing funding to DMHA providers.

Four objectives are listed for this priority area and goal (FSSA DMHA, 2018, p. 620):

1. Regular quality improvement checks to ensure the prioritization admission of pregnant women and women with dependent children as well as pregnant women who inject drugs within 48 hours for outpatient treatment, as well as prioritizing admission as soon as possible for women with dependent children at a community mental health center, at an addiction specialty provider for outpatient treatment including interim services to protect the baby and children, or a women's residential treatment provider.
2. Educate providers about neonatal abstinence syndrome and need for medical oversight for pregnant women who inject drugs.
3. Educate providers of the necessity of treating the family as a whole when treating women with dependent children.
4. Educate providers of treating the priority populations with a sense of urgency.

The strategies included to obtain the above objectives include (FSSA DMHA, 2018, p. 620):[25]

1. DMHA currently funds Community Mental Health Centers (CMHCs) which serve each of Indiana's 92 counties and provide assessment, crisis services, case management, outpatient (OP) services, intensive outpatient treatment (IOT), and sub-acute stabilization. DMHA also funds 10 Addiction Specialty providers around Indiana. Out of these agencies, six (6) are Women's Residential Services providers, and **all are required by contract to provide priority treatment for women during pregnancy and for women with dependent children.**
2. Through DMHA funding, providers will be able to treat people with substance use disorder despite the person not having a form of reimbursement, increasing admissions to treatment.
3. Quality visits, technical assistance, evaluation tools and training the impetus of increasing services to priority populations will be reinforced on many levels changing treatment availability and culture which will increase admissions.
4. Informing the public, DMHA advises Indiana residents that treatment is a priority for women during pregnancy and with dependent children which will increase admissions.
5. **DMHA requires all 35 funded addiction treatment providers to serve a woman having a child immediately, or in the case of insufficient capacity, to establish and utilize a referral system to do so.** DMHA is to be notified if immediate access to services cannot be arranged. Through training and site visits, DMHA will assure admission or interim services immediately or within 48 hours. In the rare case where a woman is not admitted to services the same day, the provider is contractually required to assure provision of interim services within 48 hours.
6. Create and provide needed tools for SABG recipients to conduct self-verification in compliance for increased knowledge of expectations and accountability.
7. Quality improvement checks for SABG recipients will identify gaps to create goals for recipients to better serve the priority populations, increasing service quality and quantity.

Key Findings and Takeaways for Capacity for Providing Substance Use Disorder Treatment and Counseling Services

- Community Mental Health Center satellite offices are present in all but two counties in Indiana. All but eight counties have a drug and alcohol abuse treatment facility.
- Only 23 counties have a drug and alcohol abuse facility with programs and/or groups specifically for pregnant and postpartum women.
- HFI and NFP can provide substance abuse support and referrals to families; however it is up to the families to participate in these services.

[25] Emphasis added for the Indiana MIECHV Needs Assessment 2020 Update.

- Even with priority admittance, less than 25% of pregnant women in need of substance abuse treatment were enrolled. This calls into question whether Indiana has enough facilities available for pregnant women to meet its own measure of accessibility (outpatient services are available in the county, an adjacent county, or within a 60-minute drive).
- Multiple program goals and objectives indicate that pregnant women and women with dependent children are a priority population that should receive priority admission. These goals are backed up with measurable outcomes, and data is being collected and analyzed to track progress.

Coordination with Additional Indiana Needs Assessments

In the Overview of Families and Home Visiting section above, many cross-agency collaborative efforts within the early childhood system in Indiana are illustrated, including the INHVAB and cross-agency MOU addressing home visiting and early childhood system coordination. As required, this 2020 Update includes summary and highlight of pertinent sections of Indiana's Title V MCH Block Grant Five-Year Needs Assessment which includes the Title V maternal and child health priority needs, Indiana's Head Start community-wide strategic planning and needs assessments, and Title II of the CAPTA -- the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect. In addition, information from Indiana's Family and Social Services Administration Preschool Development Grant (PDG) has been included. Internal and cross-agency partners were contacted with explanation of the purpose of the 2020 Update and worked the Indiana MIECHV Team and contracted vendor to determine appropriate information to be included in the 2020 Update. Data was shared in the format of annual progress reports, grant applications, and needs assessments that contained relevant information for the MIECHV population.

ISDH Title V Needs Assessment

The Title V Maternal and Child Health Block Grant Program in Indiana was also required to conduct an updated needs assessment for submission in September 2020. The Title V MCH Services Block Grant legislation (section 505[a][1]) requires the state, as part of its application, to prepare and transmit a comprehensive statewide needs assessment that identifies (consistent with the health status goals and national health objectives) the need for the following:

- Preventive and primary care services for pregnant women, mothers, and infants up to age one
- Preventive and primary care services for children
- Services for children with special health care needs

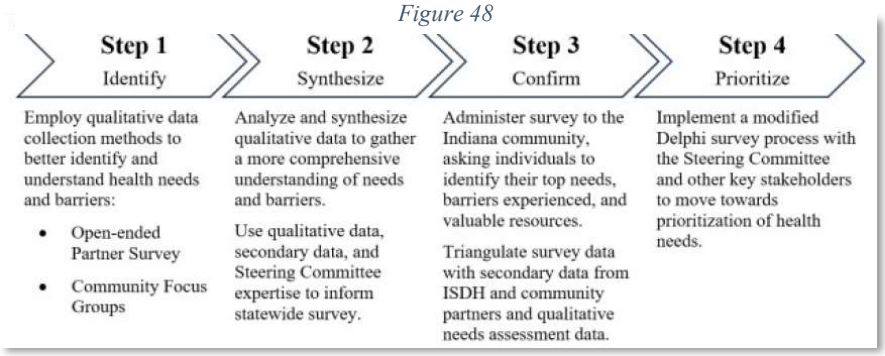
Process Description

The Title V Needs Assessment for FY 2021-2025 was a collaborative effort with divisions across ISDH, community and health partners, and Hoosier community members. The Title V

Needs Assessment is led by ISDH's Maternal and Child Health (MCH) and Children's Special Health Care Services (CSHCS) divisions in collaboration with Diehl Consulting Group (DCG).

The primary goal of the needs assessment was to better understand the health needs and challenges facing Indiana's communities, the barriers that were preventing them from addressing their needs, and the types of resources that have been valuable to them. Overall methodology for the needs assessment was guided by best practices for needs assessments, including using existing research to support identified problems and solutions, triangulating quantitative and qualitative data sources, and including a wide range of stakeholders to offer diverse views (Finifter, Jensen, Wilson,

Figure 48



& Koenig, 2005a).

The methodology for this assessment included four steps: (1) identifying needs and barriers through qualitative data collection, (2) analyzing and synthesizing data findings, (3) confirming top health needs (e.g., statewide survey, data triangulation), and (4) prioritizing areas of need through a modified Delphi process. An overview of each step is provided in Figure 48.

Title V Health Care Partners Survey[26]

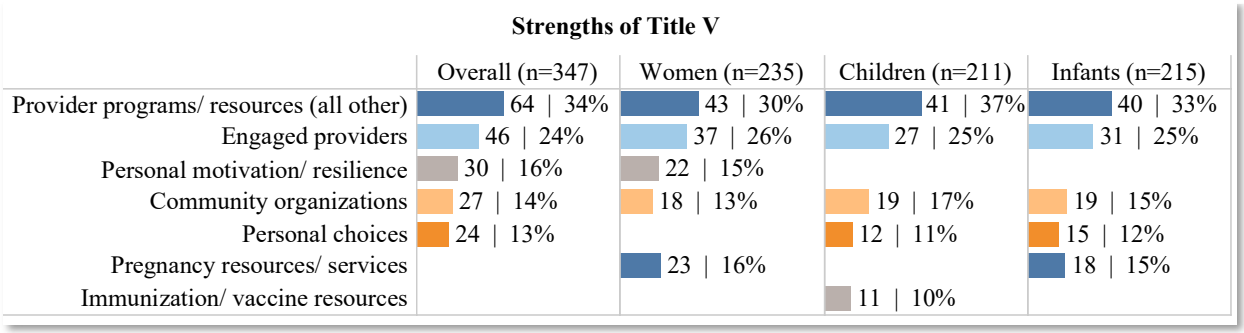
In Fall 2019, a qualitative survey was distributed electronically to Title V health care partners across the state as part of the updated needs assessment. This survey asked respondents to identify and describe up to five health-related needs, barriers to meeting those needs, and health-related strengths of the population(s) they serve. A total of 347 health care partners from across the state responded. Researchers analyzed the open-ended responses and identified main themes for each question.

Many of the populations served by Title V are also primary populations for MIECHV, including women/maternal, perinatal/infant, and children. For the purposes of the survey, children were defined as ages 1-9. Two thirds (68%) of respondents selected women/maternal as a primary population their organization serves. Nearly two thirds (62%) selected perinatal/infant as a primary population served and 61% said they serve children.

The top six needs of the populations they serve according to all respondents were physical health, mental health, drug addiction/dependency, reproductive & maternity care, dental/oral health, and breastfeeding. The top five barriers overall were access to care, transportation, other priorities/personal choices, income/employment, and education. While the order may change, the top needs and barriers were the same when analyzed by Title V population – women/maternal, perinatal/infant, and children.

There was slightly more variation in the top five strengths overall and by population. The top strengths overall were provider programs/resources (all other),[27] engaged providers, community organizations, personal choices, and immunization/vaccine resources. The top two strengths remained the same across all populations but the remaining three varied in frequency. (See Figure 49.)

Figure 49



Title V Statewide Survey[28]

In Spring 2020, an online survey was shared across the state to gather feedback from adults (ages 18 and older) about their health and the health of their children. Survey respondents were grouped into the following population categories: Women/Maternal, Perinatal/Infant, Child, Adolescent, Children with Special Health Care Needs, and Cross-Cutting. This survey asked respondents to identify health-related needs, barriers to meeting those needs, and resources used. A total of 4,934 responses were collected from

[26] Preliminary data was provided to the MIECHV Team in April 2020. The full Indiana Title V Needs Assessment will be published in late 2020.
[27] Provider programs/resources (all other) are resources from local partners and/or government programs, not including pregnancy, breastfeeding, or immunization resources.
[28] Preliminary data was provided to the MIECHV Team in June and September 2020. The full Indiana Title V Needs Assessment will be published in late 2020.

Indiana residents from across the state.

To further understand the needs of particular subgroups, children were separated into three groups: baby or young child (ages 0-5), child (ages 6-12), and teen or young adult (ages 13-15). A subgroup was also created for pregnant women to see how their needs differed from all women. (Results for women presented below does include answers from pregnant women; however, pregnant women were also asked additional questions.)

Figure 50

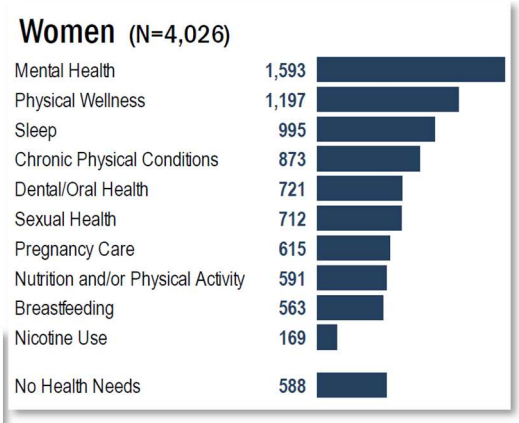
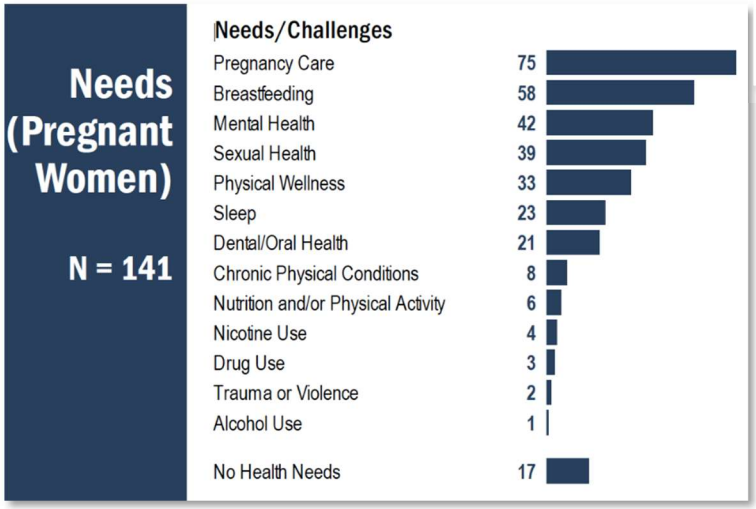


Figure 51



For the MIECHV 2020 Update, only the needs/challenges, barriers, and resources of all women, pregnant women, and baby or young children (with and without special health care needs) are included in this analysis.

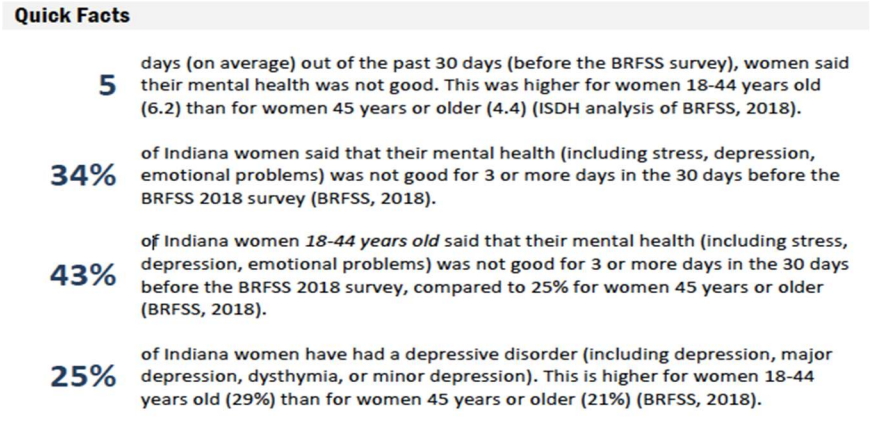
The Needs, Barriers, and Resources for Women

Women's (n=4,026) top needs were mental health, physical wellness, sleep, chronic physical conditions and dental/oral health. (See Figure 50.) Only 141 of the women who completed the survey were pregnant at the time, and their health needs are slightly different starting with pregnancy care followed by breastfeeding (needs), mental health, sexual health, and physical wellness. (See Figure 51.)

Mental Health Needs

Mental health was selected as the top health need of women in Indiana. The Behavior Risk Factor Surveillance Survey shows that this need is greater for women ages 18-44 than women 45 and older. (See Figure 52.)

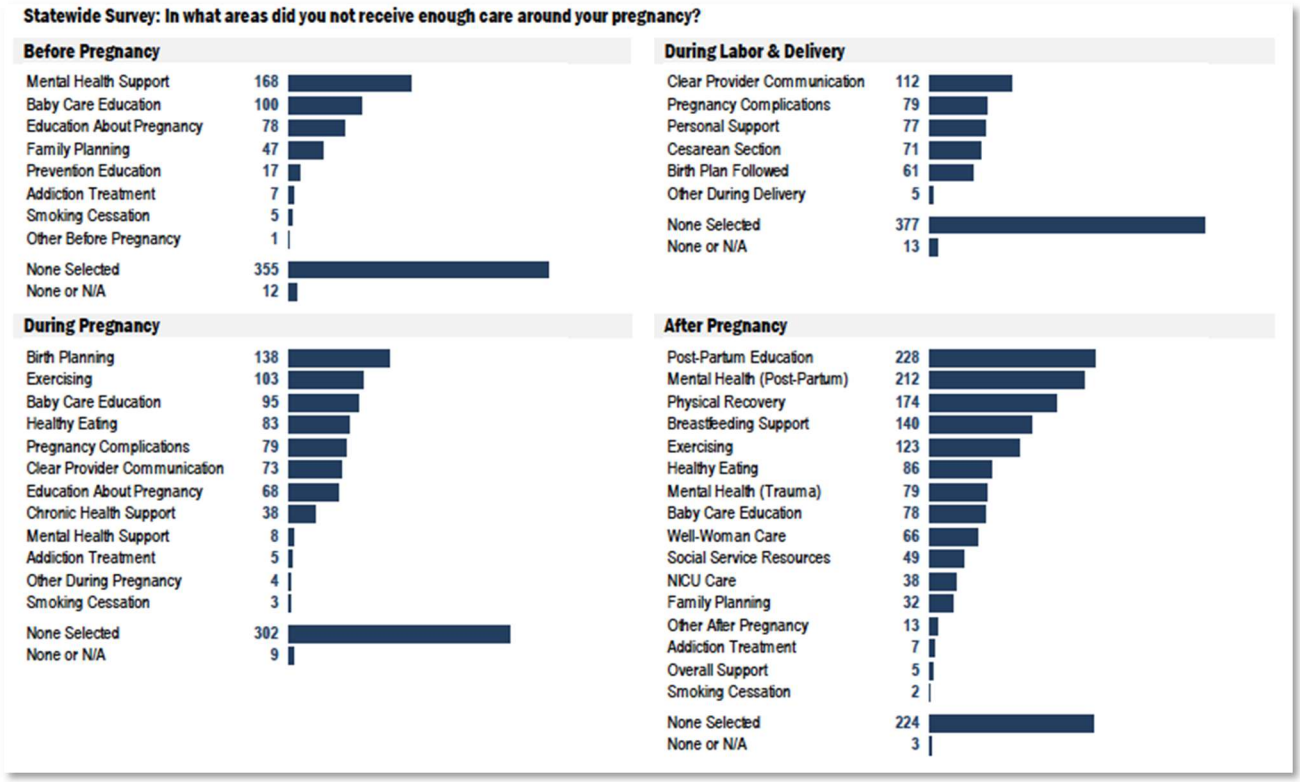
Figure 52



Pregnancy-Related Care Needs

Pregnancy care is the top need of pregnant women and a top need (past or present) of over 600 women who took the survey. Asked about their experiences before, during, and after pregnancy, women provided information on the areas in which they feel they did not receive enough care. (See Figure 53.)

Figure 53



The top five health barriers selected by women (n=3,002) were (needing to focus on) other priorities, income/employment, (lack of) affordable healthcare, health insurance coverage, and provider interactions. (See Figure 54.) Pregnant women (n=93) had much the same barriers but instead of provider interactions they find a greater barrier in using the healthcare system. (See Figure 55.)

Figure 54

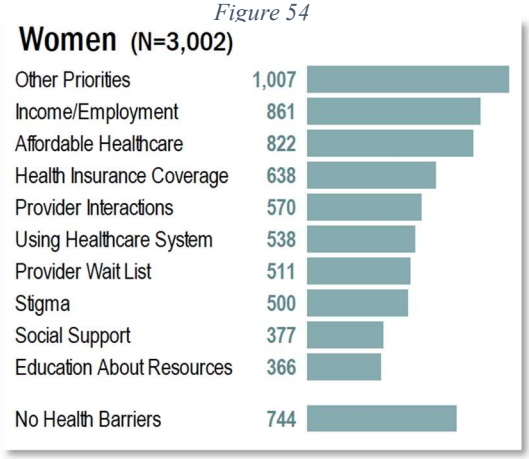
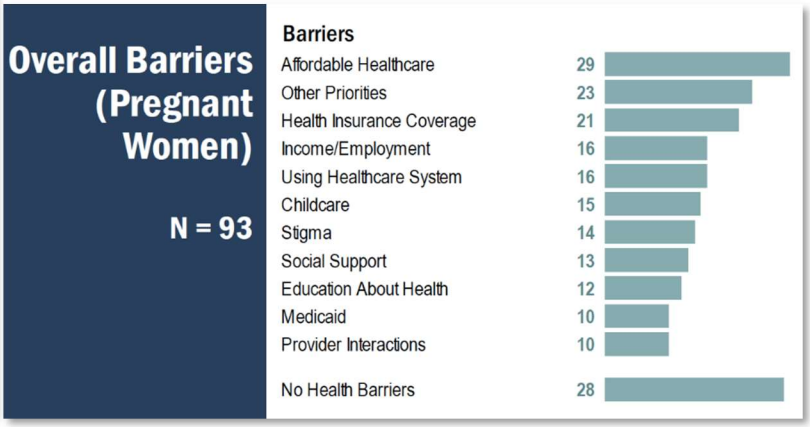


Figure 55



Pregnancy-Related Care and Breastfeeding Barriers

About half of the women who selected pregnancy-related care as a health need (past or present) answered the follow up question on what the barriers were to meeting this need. (See Figure 56.)

Figure 56

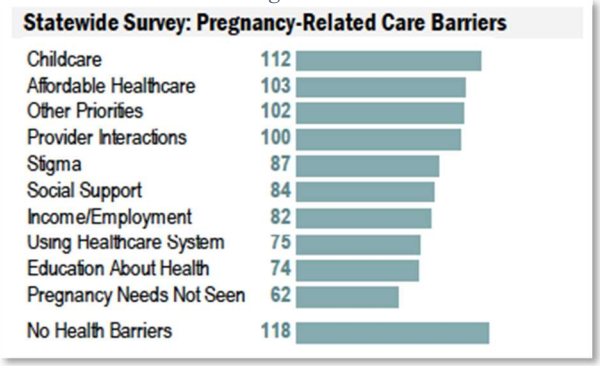
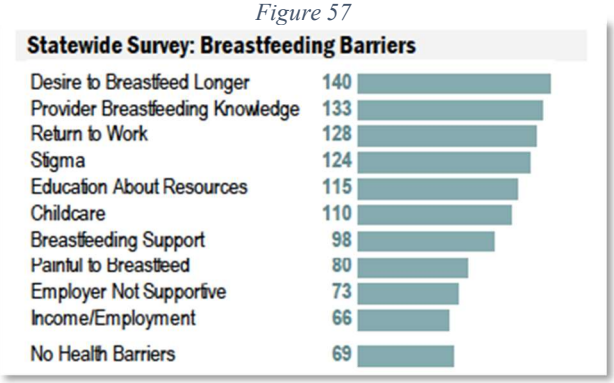


Figure 57



Breastfeeding was selected as a health need (past or present) by over 500 women, and many indicated that they experienced one or more of the following barriers to breastfeeding. (See Figure 57.)
The top resources selected by women (n=2,636) were family and/or friends, doctors, internet, community organizations, and other health workers. (See Figure 58.) Again, pregnant women (n=79) selected much the same resources except instead of community organizations; one of their top resources is parenting classes/groups. (See Figure 59.)

Figure 58

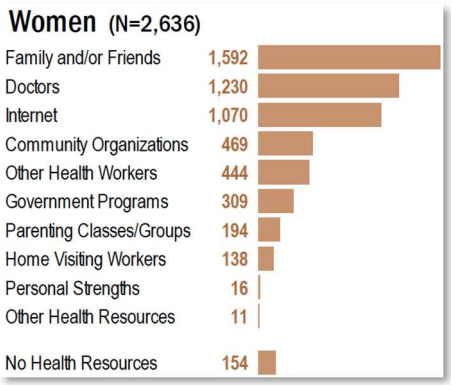


Figure 59

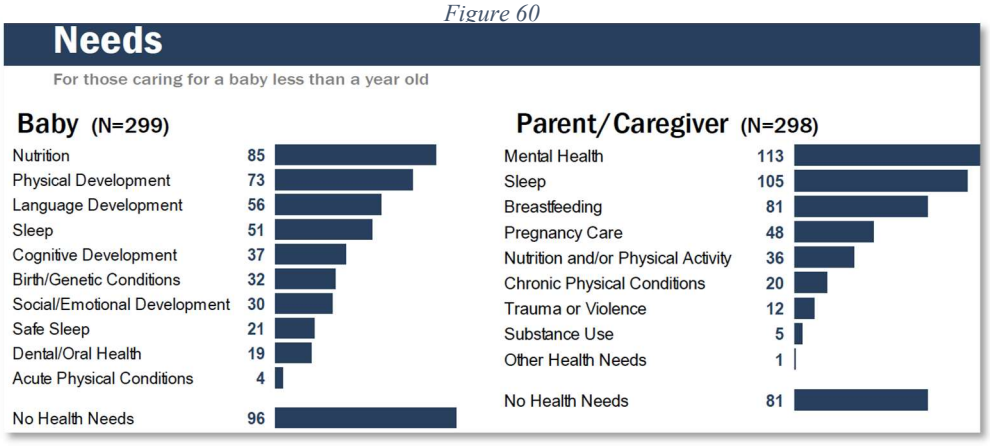
The Needs, Barriers, and Resources for Caregivers and Babies

Of the nearly 5,000 survey respondents, 299 individuals are caring for a baby less than a year old. The top health needs for these individuals are mental health, sleep, breastfeeding, pregnancy care, and nutrition and/or physical activity. The top health barriers are other priorities, baby not sleeping, affordable healthcare, (not having access to affordable) childcare, and income/employment. Caregivers of babies selected family and/or friends, doctors, internet, government programs, and other health workers as their top resources.

The top needs of babies less than a year old (n=299) were nutrition, physical development, language development, sleep, and cognitive development. The top barriers and top resources for babies were the

same as their caregivers. (See Figure 60.)

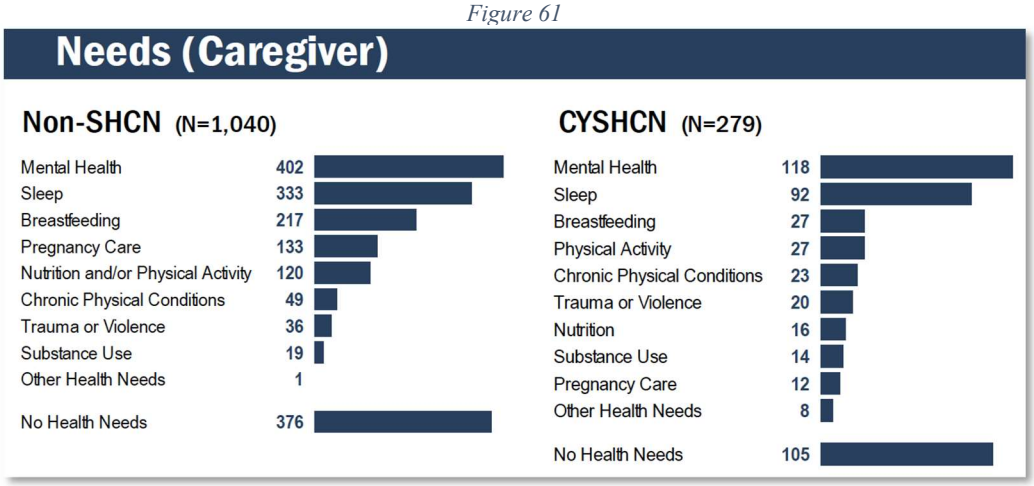
Figure 60



The Needs, Barriers, and Resources for Caregivers and Young Children

Caregivers of babies or young children (ages 0-5) were split into two groups: parents of children with special needs (n=279) and parents of children who do not have special needs (n=1,040).

Figure 61



The needs of these groups of caregivers are almost the same with both selecting mental health, sleep, breastfeeding, and physical activity. Caregivers of children without special needs also selected pregnancy care as a top need while caregivers of children with special needs selected chronic physical conditions. (See Figure 61.)

The top barriers of the two groups were also very similar, but caregivers of children with special needs selected health insurance coverage while caregivers of children without special needs selected affordable healthcare. (See Figure 62.) Resources selected by each group of caregivers were the same: family and/or friends, doctors, internet, government programs, and other health workers.

Figure 62

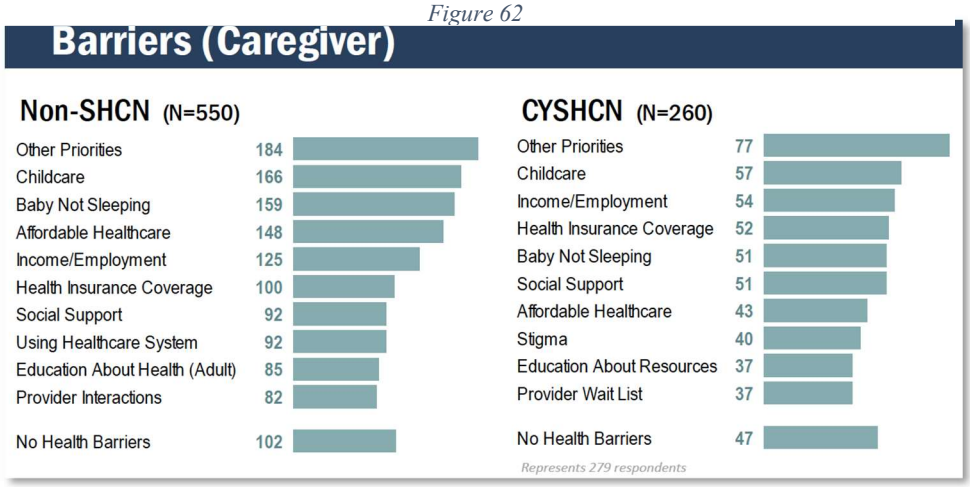
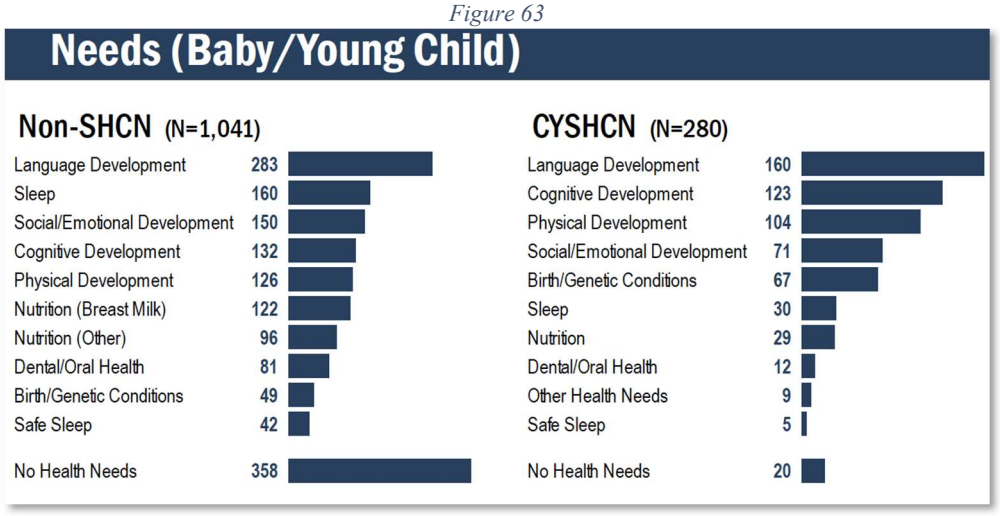


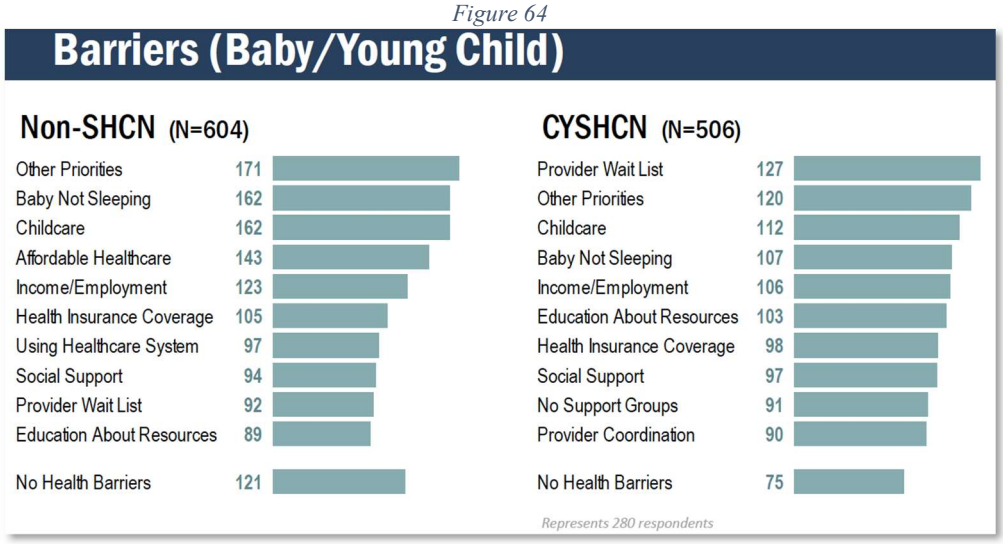
Figure 63



Four of the five top needs of babies or young children (ages 0-5) were the same between those children with special needs (n=280) and those children without special needs (n=1,041): language development, social/emotional development, cognitive development, and physical development. Children without special needs included sleep in their top five needs while children with special needs selected birth/genetic conditions. (See Figure 63.)

The top barriers followed the same pattern with other priorities, baby not sleeping, childcare, and income/employment being selected for both groups of children. Children with special needs had a top barrier of a provider waitlist while children without special needs had a top barrier of affordable healthcare. (See Figure 64.)

Figure 64



Home visiting workers were selected as a top resource for children with special needs while children without special needs selected other health workers instead. The remaining four top resources were the same: family and/or friends, doctors, government programs, and internet

Additional Needs of Pregnant Women and Children

The Title V fact sheets identified three additional needs of pregnant women and children based on data from state agencies: more prenatal care, increased rate of infants breastfed at discharge, and an increased rate of developmental screenings for young children.

- 32% of pregnant women in Indiana did not receive prenatal care in their first trimester (Indiana State Department of Health Maternal & Child Health [MCH] analysis of Vital Records, 2018)
- 82% of Indiana's infants were breastfed at hospital discharge (MCH analysis of Vital Records, 2018)
- 27% of Indiana children 9-35 months received a developmental screening using a parent-completed screening tool in the past year, compared to 34% of children nationally (National Survey of Children's Health, 2017-2018)

Priorities

Based on its findings, Title V Steering Committee and Leadership team has chosen the following Priorities:

Indiana's Priorities
1. **Reduce Preventable Deaths** in the MCH population with a focus on reduction and elimination of inequities in mortality rates. 2. **Reduce Health Disparities and Inequities** in internal programs, policies, and practices to improve maternal and child health. 3. **Prevent Substance Use** including alcohol, tobacco and other drugs among pregnant women and youth. 4. **Strengthen Mental, Social, and Emotional Wellbeing** through partnerships and programs that build capacity and reduce stigma. 5. **Promote Physical Activity** through policy improvements and changes to the built environment. 6. **Access to high-quality, family-centered, trusted care** is available to all Hoosiers. 7. **Engage Families and Youth** with diverse life experiences to inform and improve MCH services. 8. **Ensure Frequent Surveillance, Assessment and Evaluation** of data drives funding, programming, and system change.

To meet the identified priorities, a total of 18 National and State Performance Measures[29] were selected as a focus for 2021 -2025. The following NPMs and SPMs are a select sub-set demonstrating alignment with MIECHV.

Population Health Domain	Related Performance Measures
Women/Maternal Health	**NPM 1: Well-Woman Visits:** Percent of women, ages 18 through 44, with a preventive medical visit in the past year. **SPM:** Prevent substance Use - including alcohol, tobacco, and other drugs - among pregnant women. **SPM:** Reduce Maternal Mortality Rates and Disparities by promoting best practices in clinical care
Perinatal/Infant Health	**SPM:** Reduce disparities in Infant Mortality
Child/CSHCN Health	**NPM 7.1: Injury Hospitalization - Ages 0 through 9:** Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9. **NPM 11: Medical Home-** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. **SPM:** Promotion of optimal health development and well-being
Cross-Cutting/Life Course	**SPM:** Strengthen mental, social, and emotional wellbeing through partnerships and programs that build capacity and reduce stigma. **SPM:** Reduce health disparities and inequities in internal programs, policies, and practices to improve maternal and child health. **SPM:** Engage families and youth with diverse life experiences to improve MCH services.

Department of Child Services Child Abuse Prevention and Treatment Act (CAPTA)

The Indiana MIECHV Team reviewed the most recent Child Abuse Prevention and Treatment Act (CAPTA) plan to understand how the state is responding to child abuse. CAPTA was enacted in 1974 to address child abuse and neglect. It provides "funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations."[30] The Indiana Department of Child Services (DCS) manages CAPTA funding and services for the state.

Child Maltreatment

In 2016, the prevalence of children in Indiana experiencing maltreatment was nearly twice the national average. According to the federal Children's Bureau's Child Maltreatment report, Indiana had the third highest rate in the nation. Indiana's rate has steadily increased since 2013 (U.S. Department of Health & Human Services [HHS], 2018, p. 33). Nearly half (48%) of children who were victims of child

[29] Indiana selected 9 NPMs and 9 SPMs
[30] https://www.childwelfare.gov/pubPDFs/about.pdf

maltreatment in Indiana in 2016 were under the age of 6, and 16% of all children were under the age of 1 (HHS, 2018, p. 36).

Current Prevention Services in Indiana

Indiana receives CAPTA funding with the Child Abuse and Neglect State Grant and the Community-Based Child Abuse Prevention (CBCAP) Grants serving over 35,000 children (HHS, 2018, p. 84). Including additional funding, Indiana provided prevention services to more than 48,000 children in 2016. The following list includes publicly funded prevention efforts that are administered or overseen by DCS to prevent child abuse.

Community Partners for Child Safety

Community Partners for Child Safety (CPCS) is a statewide secondary prevention initiative and is the main recipient of the CBCAP funds. CPCS is a service continuum that builds community support for families. The purpose of CPCS is to develop a child abuse prevention service array that can be delivered in every region of the state. The goal is to intervene with at-risk families to preserve the family structure so that a referral to DCS will not be necessary.

This initiative provides home-based case management services to connect families to resources to strengthen the family and prevent child abuse and neglect. Supports may include assistance with family needs (transportation, rent, child care, etc.) in addition to services to enhance parenting skills, promote healthy child development, and build and maintain social support networks.

Families refer themselves or are referred by other community agencies. Services are provided statewide by five regional service providers. DCS works closely with the 18 Regional Service Councils across the state to identify primary and secondary prevention needs and services. (Indiana Department of Child Services [DCS], 2019a2019, p. 4)

The Indiana CBCAP Report for Federal Fiscal Year 2019 (October 2018-September 2019) showed that Community Partners provided 145,473 direct services including 32,086 home visits and 8,284 attempted home visits during that year (DCS, 2019a2019, p. 15). Of the newly referred families, 9,046 (of 18,815) completed a needs assessment form indicating that their greatest needs were the following (DCS, 2019a2019, p. 16):

- 41% Need rent/utilities
- 30% Subsidized housing
- 29% Child behavior
- 29% Job training/employment
- 25% Child care assistance
- 25% Counseling
- 26% Information on budgeting

Community Partners for Childhood Safety (CPCS) programs work with HFI to coordinate support and services in each county. They coordinate outreach efforts to reach underserved populations (e.g., parents with newborns, parents of children with disabilities, fathers) and work cooperatively to make sure families are receiving the appropriate services while avoiding duplication of efforts.

Prevent Child Abuse Indiana

Prevent Child Abuse Indiana (PCAI) serves as a crucial prevention resource and aims to be the voice in Indiana for preventing child abuse in all forms. Their activities include increasing awareness of child maltreatment and informing communities about solutions, serving as a resource for families and organizations, advocating for expanded and improved programs and policies to prevent child maltreatment, and fostering a statewide network committed to child abuse prevention.

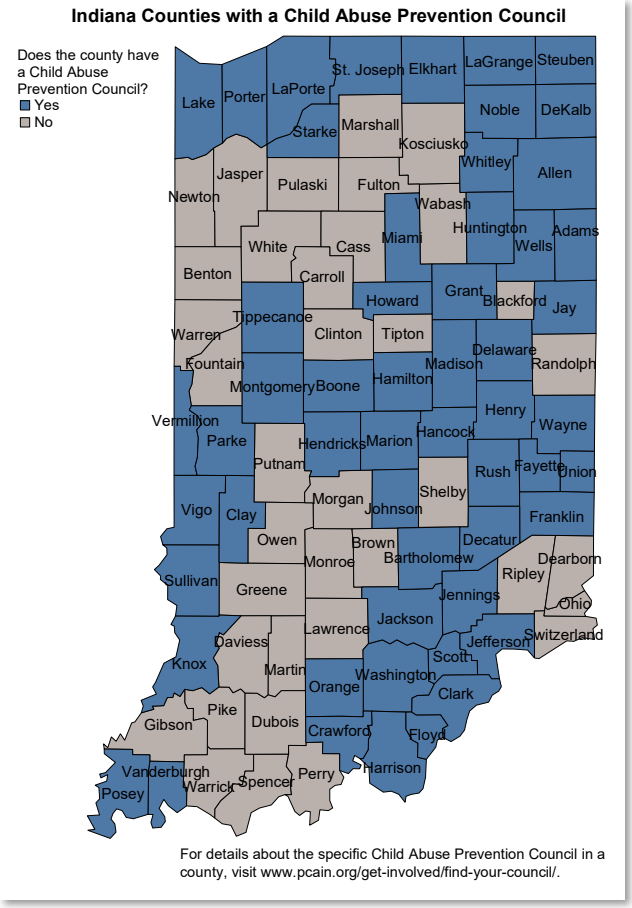
PCAI promotes primary prevention by raising awareness, distributing information about parenting, creating educational programs that support families, and building support for community-based prevention programs. PCAI also provides primary prevention services through Local Child Abuse Prevention Councils. These Councils represent 58 of 92 counties throughout Indiana (DCS, 2019a2019, p. 32). (See Figure 65.)

Healthy Families Indiana (HFI)

HFI is a secondary prevention initiative that provides an evidence-based home visiting program, Healthy Families America (HFA), in every county in Indiana since 1994. The program is funded through a combination of federal[31], state, and local funding.

One of the primary outcomes of HFI is the prevention of child maltreatment. Indiana tracks whether families served by an HFI program have a substantiated report of child abuse or neglect in the 12-month period after home visiting services end. **Ninety-eight percent of families served by HFI do not receive a substantiated report of abuse or neglect in the year following services** (Indiana Department of Child Services, 2019, p. 3).)

Figure 65



Institute for Strengthening Families

DCS provides prevention training and skill development for professionals through the Institute for Strengthening Families each year. The Institute provides an opportunity to bring together a wide array of service providers who serve families through prevention and early intervention services. DCS Prevention collaborates with a number of agencies and programs and has formed a formal planning committee to plan each Institute. The Institute provides high-quality, affordable training and promotion of the vast array of services available to assist service providers in their efforts to improve the lives of the children and families they serve. (Indiana Department of Child Services, 2019, p. 12)

DCS Biennial Regional Services Strategic Plans and Annual Progress and Services Report (APSR)

The Indiana MIECHV Team reviewed data relevant to CAPTA and the MIECHV population included in the biennial regional services strategic plans submitted to DCS from each of 18 regions across Indiana. Information in this section reflects primarily on the data provided in the appendices of the regional strategic plans: most frequently utilized services, needs assessment survey, and prevention data. The full service array can be found in Appendix J.

Most Frequently Utilized Services

Home-based family-centered therapy services were provided to 10,574 cases, and home-based family-centered casework services were provided to 13,680 cases from July 2016 to July 2017. However, within a specific region, these services were received by anywhere from 21% to 76% of cases. In all but Regions 5 and 6, home-based family-centered therapy services and home-based family-centered casework services were two of the five most utilized services for DCS cases (not including probation cases).[32] Throughout the state, nearly 4,700 cases received substance use outpatient treatment services, 3,590 received homemaker or parent aid, and 1,731 cases received domestic violence services to round out the five most utilized services in the state.

[31] Temporary Assistance for Needy Families (TANF) and Maternal Infant Early Childhood Home Visiting (MIECHV)
[32] The full list of most commonly utilized services by DCS Region are available in Appendix K.

Needs Assessment Survey

DCS issued surveys to family case managers, service providers and other community members to measure their perceptions of the array of services (26 in total), specifically how much each one is needed, available, utilized, and effective. Each rated on five-point scales with high scores indicating greater need, availability, utilization, and effectiveness.

Need – The service rated with the highest need was substance use/abuse with a mean score of 4.28 out of 5, and Region 5 indicated the highest need with a score of 4.48. Home-based case management came in a close second with a mean score of 4.27. Regions 6 and 10 tied for highest need with a mean score of 4.51.
Availability – Housing was rated as the least available service with a mean score of 3.11. Region 17 rated it lowest with a mean availability score of 2.63 out of 5.
Utilization – Other was rated as the service with the highest utilization with a mean score of 4.39. Home-based case management came in second with a mean utilization score of 4.23. Region 5 had the highest utilization score at 4.47.
Effectiveness – Other was rated as the service with the highest effectiveness with a mean score of 4.47. Dental services came in second with a mean effectiveness score of 4.29. Region 3 reported the highest effectiveness score at 4.66. Region 15 had the lowest effectiveness score of 3.85, but they also had the lowest availability score of all the regions.

Two of the top five services most often provided to families across all regions are assistance with rent/utilities and job training/employment. Either child care assistance or child behavior is also found in the top five services provided in each region.[33] By utilizing these extra resources, the families will be strengthened which may in turn prevent child abuse and neglect.

Annual Progress and Services Report 2019-2020

The (DCS) Annual Progress and Services Report (APSR) including the CAPTA state plan requirements and update, was also reviewed. The annual report provides an update to the Indiana DCS plan for improvement along with progress made to improve outcomes. The report defines services, discusses services for children under the age of 5, and provides a look at programming potentially available to expectant parents and families with young children.

Service Coordination

Indiana State Department of Health (ISDH) is a frequent collaborator with DCS in an effort to better coordinate federal and state resources. The statewide Safe Sleep Program, Maternal and Child Health, Early Childhood Comprehensive Systems (ECCS), Help Me Grow Indiana, MIECHV, and Indiana Home Visiting Advisory Board (INHVAB) are all collaborative initiatives or programs between DCS and ISDH (Indiana Department of Child Services, 2018, pgs. 69-74).

DCS also collaborates with the Family and Social Services Administration (FSSA) where they also support expectant women and families with young children. Agencies within FSSA that DCS interacts with the following (Indiana Department of Child Services, 2018, pgs. 74-77):

- Division of Mental Health and Addiction
- Department of Family Resources which administers TANF
- Office of Early Childhood and Out-of-School Learning which administers Child Care and Development Fund vouchers and houses the Indiana Head Start State Collaboration Office (IHSSCO)
- Bureau of Child Developmental Services which administers First Steps, Indiana's early intervention program

Additionally, DCS collaborates with the Indiana Coalition Against Domestic Violence who provides technical assistance, data, resources, information, and training to those serving victims of domestic violence.

Additional Services

- DCS implemented a pilot program where one case manager managed both the older youth's open DCS case, as well as the open DCS case for the child of the older youth. Before leaving care, the parenting youth and their team will make sure the youth have established sustainable resources.

[33] A full list of the top services most often provided to families by DCS Region is available in Appendix L.

The effectiveness of this pilot is being evaluated by comparing outcomes of youth in the pilot with a control group of youth in similar situations who had a different case worker than their child. Depending upon the results of the evaluation, DCS may expand the program to other areas across the state (Indiana Department of Child Services, 2018, p. 132).

- Family Preservation Services[34] are designed for families (with a substantiated case of abuse or neglect) that DCS believes could safely care for the children in their home with the assistance of appropriate services. Family Preservation Services are home-based and monitor and address any safety concerns for the child. Any interventions are strength-based and family-driven with the family actively participating in identifying the focus of services. Providers will deliver services to families using at least one evidence-based practice and will provide concrete assistance to support preservation.
- The Kinship Navigator Program[35] piloted in May 2019 in northeast Indiana and is now being implemented statewide. The program focuses on developing a network of resources for formal and informal kinship families and assuring those services are easily accessible. The Kinship Navigator Program supports efforts to place children going into foster care with relatives.

Family and Social Services Administration Preschool Development Grant (PDG)

Indiana's Birth to Age Five Mixed Delivery System Needs Assessment

Birth to Age 5 Mixed Delivery System Needs Assessment and Strategic Plan 2020-2022 Goals were completed in 2019 via the Preschool Development Grant (PDG). 114,781 children were enrolled in known early childhood education programming as of April 2019 (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 14), while nearly 70% of children under the age of 6 are in need of care because all parents are in the labor force (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 30) . The types of care in Indiana include Head Start programs, ministries, child care centers, family child cares, and preschool programs. The majority of children enrolled in early childhood education programming are preschool age (ages 3-5) with 30% (75,845/254,961) of children enrolled versus just 10% (8,416/82,498) of infants and 18% (30,520/168,798) of toddlers. The map in Figure 66[36] shows the number of children enrolled in a licensed or registered program by county.

The availability of early childhood education programming varies by county with some counties having seats available for as few as 4% of their birth to age 5 population and the top county with availability for 42%[37] of its young children (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 16). Available spots may not be open to all age groups, infants through preschoolers.

Indiana has a few publicly funded programs to support young children in need access early childhood education. This includes Title 1 funding, Child Care and Development Fund (CCDF vouchers), early intervention (Individuals with Disabilities Education Act "IDEA", Part C) and preschool special education (IDEA, Part B), and state pre-k (On My Way Pre-K).

Title I Preschools

Title I Part A funds provide assistance to school districts with a high percentage of students from low-income families. Some districts choose to use these funds to operate a preschool program. During the 2016-2017 school year, 6,742 students were served in Title I preschools (Indiana Early Learning Advisory Committee [ELAC] Funding Streams Workgroup, 2018, p. 4).

[34] Family Preservation Services began in June 2020, after the publication of the latest annual progress and services report. Source: https://www.in.gov/dcs/4102.htm

[35] The Kinship Navigator Program statewide implementation began after the publication of the latest annual progress and services report. Source: https://www.in.gov/dcs/files/11.25.2019%20Karen%20Hayden%20Sturgis%20Kinship%20Navigator.pdf

[36] The analysis of percent of population enrolled in early childhood education programming has been updated with the latest available Census figures. Percentages in this map may differ slightly from the map provided in the PDG report.

[37] Wayne County's percentage of 62.71% in the PDG report has been corrected to 42%.

CCDF Vouchers

	Number of CCDF Vouchers
Infants	1,040
Toddlers	6,740
Preschool-age	12,407

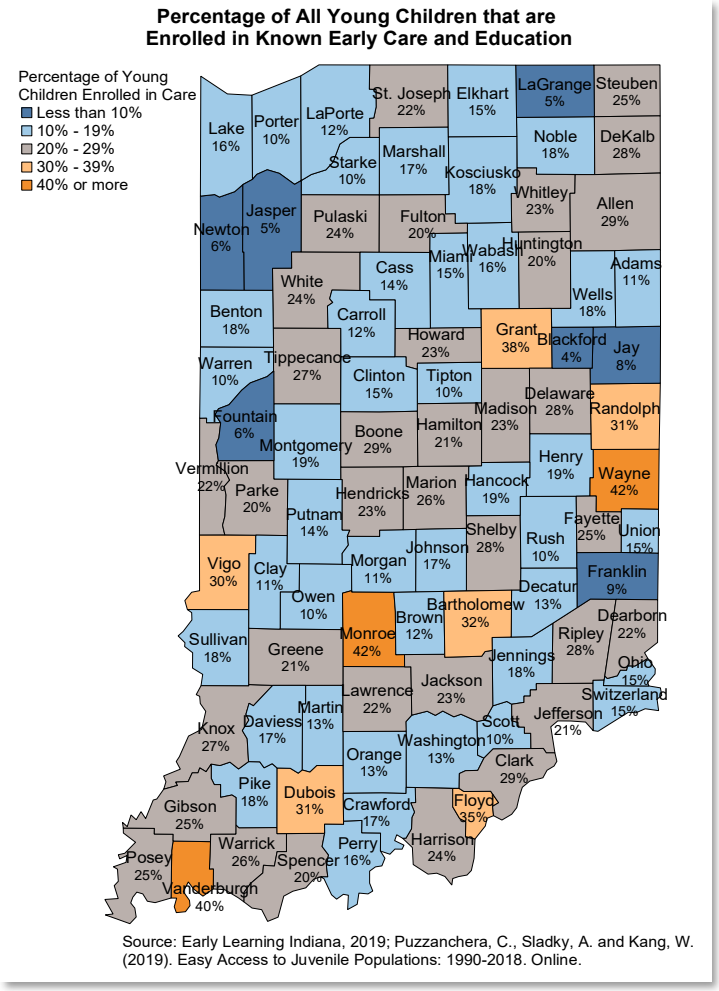
Indiana FSSA administers the Child Care and Development Fund (CCDF) through the Office of Early Childhood and Out-of-School Learning (OECOSL). Families with an income below 127% FPL and at least one parent working or enrolled in school are eligible for CCDF vouchers to subsidize child care (Indiana ELAC Funding Streams Workgroup, 2018, pgs. 2-5). As of February 2019, 20,187 children ages 0-5 had an active CCDF voucher (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 51). Similar to the number of children enrolled in programs by age, the majority of CCDF vouchers are with preschoolers. A large number of known early childhood programs accept the CCDF voucher, 3,638 as of June 30th, 2020[38].

Children with Disabilities

Indiana's Individuals with Disabilities Education Act (IDEA), Part C early intervention program is First Steps. First Steps providers serve all 92 Indiana counties, working with children birth to age 3 who have developmental delays and disabilities. As of December 2018, First Steps was serving approximately 11,500 children; almost half (41%) of these children were from families with a household income below the poverty line (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 55).

Indiana's IDEA, Part B special education for preschoolers is administered by Indiana Department of Education (IDOE) and local school districts. During the 2018-2019 school year, IDOE served 19,350 children with developmental delays or disabilities through the developmental preschool or special education programs (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 57).

Figure 66



Source: Early Learning Indiana, 2019; Puzzanchera, C., Sladky, A. and Kang, W. (2019). Easy Access to Juvenile Populations: 1990-2018. Online.

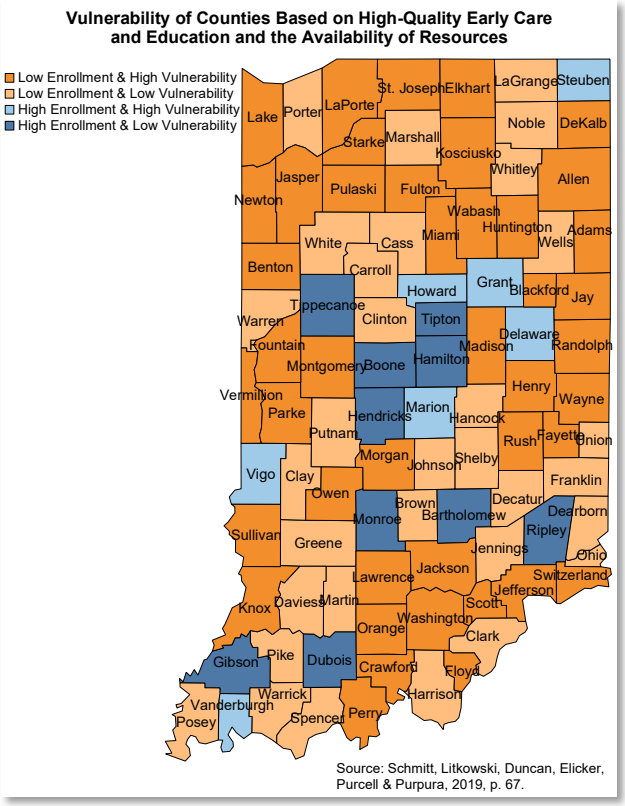
Vulnerable Populations

According to the PDG Needs Assessment, no comprehensive data on vulnerable populations and their access to and participation in early childhood education is available. Participation in programs for low-income families, children with disabilities, and other programs serving specifically vulnerable populations are reported on in the report by program (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 39). To determine the availability of early childhood education to vulnerable populations, vulnerability was calculated for each county based on the following eight indicators (of equal weight) from the Indiana State Department of Health (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 66):

[38] Information provided by Indiana's OECOSL.

- Percentage of families on Medicaid
- Child immunization rates (ages 19-35 months)
- Maternal smoking during pregnancy
- Low birthweight infants
- Prenatal care in the first trimester
- Deaths from drug poisoning involving opioids
- Number of substantiated abuse/neglect cases
- Percentage of children living in poverty

Figure 67



Based on this assessment, the research team identified Starke County with the greatest vulnerability, and Spencer County with the lowest vulnerability score (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 66). This vulnerability score was combined with data on access to high-quality early childhood education to determine the level of enrollment in child care in relation to their calculated vulnerability. Starke County, which was determined to be the most vulnerable county, has low enrollment in high-quality early childhood education, while Spencer County has low enrollment in early childhood education along with low vulnerability. Forty-two counties have low enrollment in high-quality child care and high vulnerability based on health, child maltreatment, and poverty indicators above (Schmitt, Litkowski, Duncan, Elicker, Purcell & Purpura, 2019, p. 67). (See Figure 67.)

Indiana Birth-5 Strategic Plan 2020-2022 Goals

Based on the PDG needs assessment, Indiana created a strategic plan containing 12 goals across four federally defined focus areas. Five of the 12 goals are relevant to the MIECHV population or possibly impactful to MIECHV's work and can be found in Appendix M.

Head Start

The Indiana Head Start State Collaboration Office (IHSSCO) completes an annual needs assessment to determine the needs of Head Start grantees across the state. The information in this section comes from the 2020 Indiana Head Start and Early Head Start Needs Assessment published in Summer 2020.

According to Indiana's program information report (PIR), 14,847 spots in Indiana Head Start and Early Head Start programs were funded in 2018-2019 - 12,219 for Head Start children, 2,530 for Early Head Start children, and 98 for pregnant women (IHSSCO, 2020, p. 7).

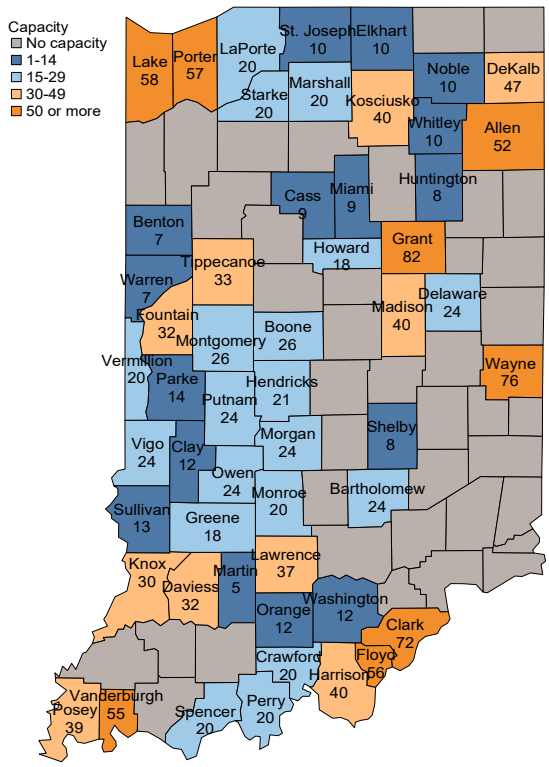
Indiana has 39 Head Start and Early Head Start grantees (Indiana Head Start State Collaboration Office [IHSSCO], 2020, p. 15) that operate 336 programs at 278 centers across the state (p. 12). The majority of programs (74%) are Head Start programs serving children ages 3 to 5 years old, and a quarter of centers (24%) are Early Head Start programs serving children birth through 2 years and pregnant women. The remaining two percent of centers provide migrant and seasonal Head Start programs (p. 12).

Head Start serves 11,983 children ages 3-5 in center-based programs, and Early Head Start serves 1,274

children ages 0-2[39]. Head Start centers are located in all but two counties in the state (90 of 92), while Early Head Start centers are located in 47 counties (IHSSCO, 2020, p. 13).

Figure 68

Head Start/ Early Head Start Home-Based Service Capacity for Children Under 6 Years and Pregnant Women



While the majority of children are provided programming at a center, 1,370 slots were for home-based services (IHSSCO, 2019a; IHSSCO, 2019b)). Data from the Office of Head Start is not provided at the county level since some grantees have a service area that may include more than one county. In the 2020 IHSSCO Needs Assessment, grantees were asked, via an online survey, how many home-based services slots they have by county. This identified the location of 1,082 slots, placing them in 49 of Indiana's 92 counties as shown in Figure 68 (IHSSCO, 2020, pgs. 11-12).

One way children become eligible for Head Start is by having a family income below the poverty level. Taking into account the number of children under the age of 6 living in a particular county, along with the number of Head Start and Early Head Start slots, only six counties have the capacity to serve more than 50% of potentially eligible children (based on income). In the remaining 86 counties, rural counties have a slightly higher capacity to serve children in poverty than urban counties.

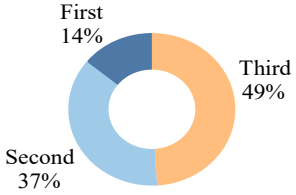
Pregnant women do not typically enroll in Early Head Start until their third trimester, but they could enroll as early as their first trimester and receive services. (See Figure 69.) Once the baby is born, the child takes the mother's slot in Early Head Start.

Almost a quarter of pregnant women (22%) enrolled in 2018-2019 had a high-risk pregnancy according to a physician or other health care provider (IHSSCO, 2020, p. 10).

Head Start grantees were asked about the level of collaboration and/or support they have with various entities including home visiting programs. Only four of the 38 grantees said they do not collaborate with home visiting programs. For the 89% (34/38) that do, they rate their level of collaboration and/or support as a 4.1 out of 5, indicating that it is good to very good (IHSSCO, 2020, p. 22).

Figure 69

Trimester of Pregnancy in which the Pregnant Women Served were Enrolled in Head Start Services



Source: Indiana Head Start State Collaboration Office, *Indiana Head Start and Early Head Start 2020 Needs Assessment*.

Efforts to Convene Stakeholders to Review and Contextualize Results from Various Needs Assessments in Indiana

The INHVAB/ECCS quarterly meeting has been a standing opportunity to share information and collaborate across state agencies for various needs assessments and funding opportunities. The INHVAB has been involved in reviewing and discussing prior Indiana MIECHV Needs Assessments, and the

[39] This data may not be in alignment with or reflected by the self-report capacity or unduplicated families served in the home visiting program survey administered for the purpose of this 2020 Update.

combined INHVAB/ECCS state advisory board structure[40] lends itself to communication and feedback from multiple state agency partners.

Prior to MIECHV needs assessment activities commencing, the Indiana MIECHV Team shared information at the INHVAB/ECCS meeting in September 2019 regarding required elements, selected vendor, and potential need for local data. Setting this expectation for partners to participate in data collection very likely contributed to the high rate of return in survey results.

In February 2020, a more detailed overview of the needs assessment process and forthcoming surveys were shared at the INHVAB/ECCS quarterly meeting. Indiana had originally planned to utilize both surveys and focus groups to collect and refine information from stakeholders related to home visiting need in the Hoosier state. Surveys were able to be completed and Indiana experienced an overwhelming response to the community stakeholders survey, however, the COVID-19 public health crisis created a barrier to conducting anticipated in-person focus groups to refine and add qualitative data and context to the 2020 Update.

Preliminary Title V Needs Assessment results were presented to the INHVAB/ECCS during the August 18, 2020 virtual meeting. These results, also presented in the Title V section of this 2020 Update, indicate need as reported by families representing the target populations of early childhood home visiting programs in Indiana.

Upon final submission and approval, the Indiana MIECHV Team will present an overview of this 2020 Update to the INHVAB/ECCS membership and make the final report available to interested parties. The Indiana MIECHV team may also present findings within the 2020 Update to Indiana Early Learning Advisory Committee, HFI Think Tank, and other relevant early childhood convenings.

Informing the Indiana MIECHV Needs Assessment 2020 Update

After gathering and reviewing data collected for this 2020 Update and the other relative Indiana needs assessments related to early childhood services, several findings and recommendations were identified.

Gaps in Services and Supports

The program and community survey questions on home visiting capacity, SABG grant application, IHSSCO Needs Assessment, and the PDG Needs Assessment show that there are still pregnant women, young children, and families in need of services, who are not able to access or for some reason participate in these programs. Many home visiting programs are interested in expanding their capacity of their current program, *a*s well as adding an additional home visiting program, or family-centered services. Funding is the number one barrier to expansion according to home visiting programs.

Lack of services for infants and toddlers: Community survey respondents are not sure how widely home visiting programs are used, yet they feel a need for more home visiting services is present. The IHSSCO Needs Assessment shows that Early Head Start (the program that serves similar ages to Indiana MIECHV, ages 0-3) and home-based services are currently available in only half of Indiana counties. The PDG Needs Assessment shows a similar lack of access to early childhood education, particularly for children ages birth to 2 years. Most spots in early childhood education programs are for preschool programs serving ages 3-5 years.

Lack of mental health services: The community survey of stakeholders and partners serving MIECHV populations indicated that mental health/behavioral health services are most needed in their community (selected by 83% of respondents). Following mental health/behavioral health services in most needed services were family-centered services, economic self-sufficiency services, and addiction/substance use treatment. All areas in need were selected by more than 70% of community survey respondents. Home visiting programs see similar needs in their clients selecting transportation (83%), housing (79%), child

[40] INHVAB membership includes: ISDH, DCS, Department of Workforce Development (DWD), Department of Education (DOE) and multiple divisions of the Family and Social Services Administration (FSSA) – including the Office of Early Childhood and Out of School Learning (OECOSL), First Steps/Bureau of Child Development Services, Indiana Head Start Collaboration, Office of Youth Services/Division of Mental Health and Addiction (DMHA), Policy/Temporary Assistance for Needy Families (TANF), and Office of Medicaid Policy and Planning.

care (79%), mental health services (59%), and employment services (52%). Home visiting programs feel they are least well equipped to help with workforce development and helping families achieve financial stability. The Title V statewide survey showed that women across Indiana see mental health as their top health need and income/employment as the second most selected barrier to meeting their health needs.

Lack of substance abuse treatment services for pregnant women: The SABG grant application and facilities directory illustrated 24 community mental health centers with a physical presence in 90 counties. Drug and alcohol abuse treatment facilities are in 84 counties, but only 23 counties have facilities that have programs and/or groups specifically for pregnant and postpartum women. Pregnant women are a priority population with preferred admission to any facility across the state. However, less than 25% of pregnant women in need of substance abuse treatment were enrolled in 2016.

While there is a gap present in substance abuse treatment services for pregnant women, home visiting can potentially narrow that gap by connecting women to services. HFI has an assessment process built into their program which will make referrals to mental health and substance abuse services when necessary. NFP nurses can provide opioid use disorder/substance use disorder prevention and will make referrals when appropriate.

Barriers and Challenges to Services

Families have barriers to access services: Home visiting program staff and community stakeholders selected similar barriers to home visiting services. Half of respondents in both groups indicated that parent work schedule and the family being busy addressing other needs as two top barriers to using home visiting services. Respondents to the community survey selected "little knowledge of programs" as the top barrier to using home visiting services (selected by 62% of respondents). Transportation was also mentioned as a barrier by half of community survey respondents, and home visiting programs selected it as the top need of families that they do not provide (selected by 83% of home visiting programs).

The 2020 Title V grant application lists needing to focus on other priorities, not having enough money or income, and unaffordable healthcare as health barriers for women. Additionally, the SABG grant application indicated that not every county in Indiana has health resources such as specialized doctors or hospitals.

Duplication of Services

Implement a coordinated data system: So far little evidence has pointed to duplication of services occurring in Indiana. However, the PDG Needs Assessment and Goals highlight the need for a coordinated data system. Since programs are administered across different state agencies and even different departments within agencies, siloes and additional barriers for families can occur. Currently, data is not routinely being collected to show whether vulnerable populations are accessing services, and if it is, the data is not connected to other programs to show if families are utilizing more than one service (which might result in a duplication of efforts). In addition, it is unclear how well vulnerable children are being served across multiple programs like the example shared above of the transition of a children enrolled in HFI and transition to Head Start.

Opportunities to Strengthen Coordination of Services

Coordinate service transitions: HFI has programs serving every county in Indiana. Head Start has a physical location in 90 counties, Early Head Start in 47 counties, and home-based services are currently available to 49 counties. First Steps serves children ages 0-3 across the state, and in 2018, 41% of the children were from families with incomes below the poverty line. These programs have similar population demographics in age and income. Each program has indicated some level of collaboration with others, but the potential opportunity to improve collaboration and alignment to create better transitions among services for children and families is present.

Target services to high-need areas: DCS provides a continuum of services to all counties including prevention services through community partners including HFI. DCS also provides home-based family centered casework and therapy services as part of its preservation and reunification services. Indiana's child maltreatment rate was third highest in the country in 2016, and nearly half of the victims of child maltreatment in Indiana are under the age of 6 (HHS, 2018, pgs. 33-36). More community partners,

especially those mentioned above that focus on children under the age of 6, could be brought in to help address child maltreatment in their county.

Key Findings and Takeaways – Coordination with other Needs Assessments

- The Title V application discusses geographical barriers to the receipt of services. All other agencies discussed in this section provide services in every county. Further evaluation of gaps in services and potential for strengthening collaboration can be reviewed by county by layering these assessments along with program and community stakeholder results.
- As counties are reviewed for potential new or expanded services and funding, review community needs assessments related to the MIECHV population, particularly assessments from organizations that serve a similar or overlapping population. DCS offers a continuum of prevention services to prevent child abuse.
- The Indiana Preschool Development Grant reports illustrate that a higher percentage preschool children (ages 3-5) are enrolled in early childhood education programming than children under 3 (infants and toddlers). Fewer CCDF Vouchers are available for infants and toddlers than for preschool children. While no comprehensive data on vulnerable populations and their access to early childhood education is available, these findings suggest significant gap for services available to working families.

Limitations

A discussion of limitations to this report – specifically the impact of COVID 19 is in Appendix N

Conclusion

The Indiana MIECHV Needs Assessment 2020 Update is rich with qualitative and quantitative data that can assist in informing Indiana MIECHV implementation moving forward. The responses from 38 home visiting programs and 444 community stakeholders provide valuable perspective and input from those providing services to the community. The coordination with other divisions and state agencies provides further context and support through information on maternal and child health populations and initiatives, programs assisting families with substance use issues, efforts to prevent child abuse, and early education programs.

The 2020 Update created opportunities for discussion with other agencies and entities in Indiana as to what determines need for at-risk pregnant women and parents with young children and how need is used to direct service development and collaborative efforts. As data collection gets stronger and the interest in sharing data grows, many state agencies are now working toward creating an inventory of programs and services, determining need in the community, and quantifying the work that is being done to meet the need.

Major Findings

The 2020 Update utilized an analysis methodology to determine at-risk counties that differed from Indiana's 2010 and 2017 needs assessments. The HRSA methodology with added indicators and domains by the Indiana MIECHV Team found 27 counties to be at-risk and 74 out of 92 counties had at least one indicator that fell in the worst 16% of all counties in the state. Further research into four maternal and infant health indicators (infant mortality rate, child maltreatment rate, smoking during pregnancy, and lack of early prenatal care) highlighted the fact that even though some counties are performing better than others, compared to the national benchmark for each indicator, many counties are doing worse than the nation. In fact, 91 of 92 counties are worse than the nation in the number of mothers receiving early prenatal care. Thus, **the assessment found that all 92 Indiana counties should be considered "at risk"** and are in need of improvement in at least one indicator that impacts the outcomes of women and young children.

Survey data from both programs and community stakeholders provided information on potential barriers, challenges, and overall readiness to bringing in more resources. Self-reported home visiting capacity showed that many communities may have more families in need than receive services. Home visiting

services are voluntary, and the program and community surveys provided information on why families may not start services such as not meeting eligibility requirements, not knowing about the services early enough, or a fear of being involved with government agencies that provide family and child services. Additionally, both surveys feel that many families are in need of additional services including mental health, transportation, and assistance with basic needs. While there are challenges and barriers to meeting the needs of families, community members feel they are important and supported, and programs feel that from their communities as well.

The data gathered from Head Start, DCS, and PDG provides further context as to what is already happening in a county or region. The SABG application and Title V resources provide a state-level summary of needs, supports, and gaps to potential MIECHV families. Most of these needs assessments showed gaps in services, particularly in rural areas. Head Start and Early Head Start is able to serve a similar percentage of children in urban and rural areas, but currently Early Head Start and home-based services are only available in about half of Indiana's counties. The assessments along with program survey data discussed partnerships and collaboration but also highlighted an opportunity for further coordination of services beyond referrals.

As the Indiana MIECHV Team looks to identify counties in which to expand or bring new services, the 2020 Update provides the means to make data-informed decisions. All data collected and analyzed for the 2020 Update provides the Indiana MIECHV Team with a comprehensive look at gaps in services and supports, barriers and challenges to services, opportunities for collaboration, and opportunities to strengthen.

Beyond consideration for at-risk counties and allotment of MIECHV funds, the 2020 Update identified the following recommendations for the Indiana MIECHV Team to consider for the improvement of home visiting programs in Indiana:

- Indiana programs and initiatives are looking to develop an inventory of services and determine the ability of those services to meet community needs. MIECHV should be at the table as agencies share those results and promote collaboration over segregation to address community needs.
- Create a resource to help determine potential for overlap or gaps among programs and state agencies before determining need in a community.
- Families have additional needs for services beyond home visiting. Determine ways home visiting programs can have stronger referral connections to meet the needs of families .
- Home visiting programs can move beyond building awareness of program availability with community stakeholders and advocate for additional resources to support home visiting services.
- Additional data sharing at the state and local level would strengthen collaboration and create efficiencies to further impact for families.
- As some home visiting programs provide services to children up to age 3, opportunity is present for facilitating the transition to early childhood education providers.

Dissemination

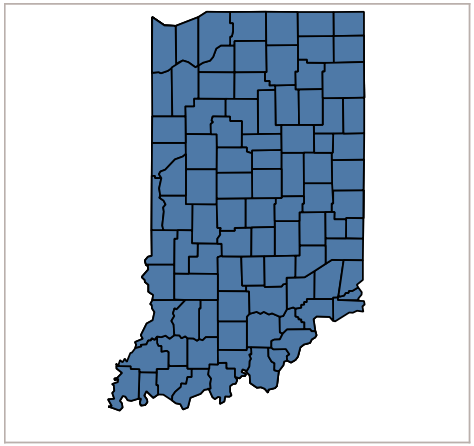
After submission approval, Indiana will include a copy of the 2020 Update report on the Indiana MIECHV website, and share with LIAs, state partners, and community stakeholders. An executive summary will also be drafted for ease of sharing. The MIECHV State Team intends to discuss findings from the 2020 Update with the Indiana Home Visiting Advisory Board and with other state agency coalitions. Indiana will continue to use the data and lessons learned to inform practice and implementation within home visiting and collaborative early childhood efforts.

Please refer to Appendix O for a full list of references.

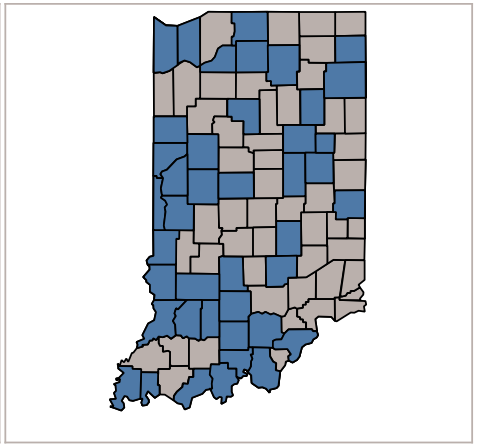
Appendices

Appendix A: Home Visiting Programs Available by County

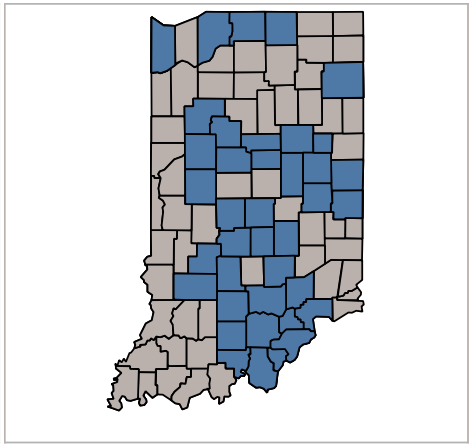
Healthy Families Indiana
92 Counties



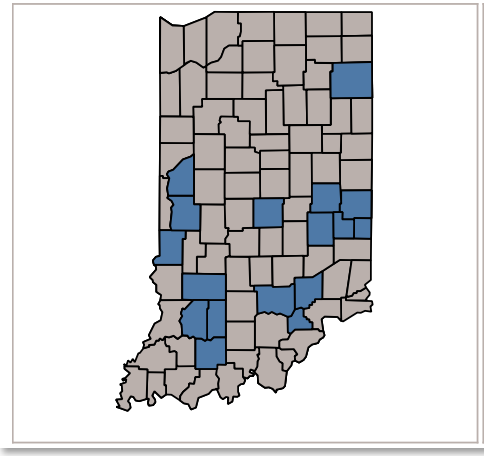
Home-Based Head Start/ Early Head Start
42 Counties



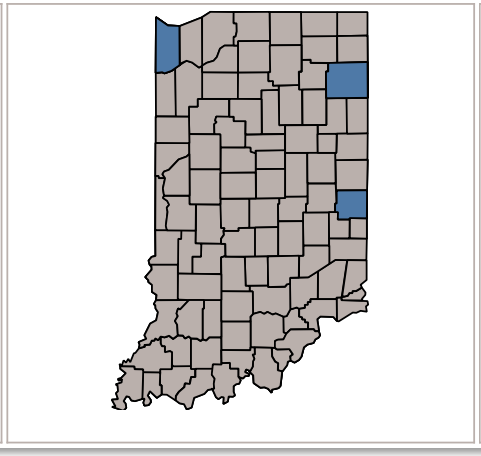
Nurse Family Partnership
39 Counties



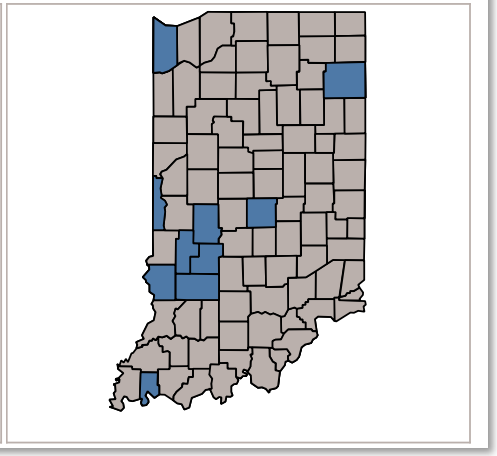
Healthy Start
17 Counties



Parents as Teachers
3 Counties



Locally Developed Models
10 Counties



Appendix B: Early Childhood Collaborative Efforts

Indiana Home Visiting Advisory Board (INHVAB): The goal of INHVAB is to coordinate, promote and define Home Visiting efforts in Indiana and to utilize data to assess need, identify service gaps, maximize resources and inform policy to improve health and developmental outcomes for Hoosier families and children. INHVAB membership includes: ISDH, DCS, Department of Workforce Development (DWD), Department of Education (DOE) and multiple divisions of the Family and Social Services Administration (FSSA) – including the Office of Early Childhood and Out of School Learning (OECOSL), First Steps/Bureau of Child Development Services, Indiana Head Start Collaboration, Office of Youth Services/Division of Mental Health and Addiction (DMHA), Policy/Temporary Assistance for Needy Families (TANF), and Office of Medicaid Policy and Planning.
Memorandum of Understanding (MOU) – A multi-agency MOU has been in place since 6/1/2017 for the purpose or coordinating the INHVAB, sharing professional development opportunities, designating staff to share information about home visiting and early childhood services, and providing data as feasible and permitted. Parties to the MOU include ISDH, DCS, DOE, FSSA Division of Disability and Rehabilitative Services (DDRS), and OECOSL.
Early Childhood Comprehensive System (ECCS): Since 2003, Indiana's ECCS grant has been awarded to ISDH/MCH and provided impetus for much needed collaboration of statewide early childhood organizations. In 2016, Indiana was awarded the competitive ECCS Impact grant, which supports enhancement of early childhood systems building and demonstration of improved outcomes in population-based children's developmental health and family well-being indicators through a Collaborative Innovation and Improvement Network (CoIIN) approach. Indiana partners with IndyEast Promise Zone, within the service area of MIECHV LIAs, to 1) develop collective impact expertise, implementation and sustainability of efforts at the state, county and community levels; 2) increase by 25% from baseline in age appropriate developmental skills among 3 year old children; 3) increase access to child developmental & maternal depression screenings as well as improved coordination of Indiana Early Childhood Systems.
Early Learning Advisory Committee (ELAC): ELAC was established in 2013 by the Indiana General Assembly to assess availability, affordability, and quality of early childhood programs statewide and to make best practice recommendations for interventions to improve and expand early childhood education. ELAC works to ensure children ages birth to 8 years and their families have access to affordable, high quality early education programs that keep children healthy, safe and learning. Members of the MIECHV team actively participate in the various workgroups of ELAC. From 2017 - 2019, the child development and well-being work group served as the leadership team for the implementation of Help Me Grow. The data workgroup also served as a guiding team for Help Me Grow, in understanding what data needed to be collected the Help Me Grow National, MIECHV Innovations and ECCS.
Project LAUNCH (Linking Actions for Unmet Needs in Children's Health): In 2012, ISDH MCH with co-lead DMHA, was awarded Project LAUNCH bringing together key stakeholders including State and Local child-serving agencies and parents to create the **State Young Child Wellness Council (YCWC**). The YCWC developed a vision that states: Indiana Project LAUNCH envisioned a State where all individuals responsible for the care and development of children before birth to age 8 years are supported to promote optimal social and emotional wellness in all children leading to healthier families and safer communities. Indiana Project LAUNCH was tasked with piloting initiatives that focus on family strengthening and parent skills training, screening and assessment, integration of behavioral health into primary care settings, mental health consultation, and enhancing home visiting. Trainings in Motivational Interviewing, Trauma-Informed Care Approaches, Mental Health First Aid, and the Georgetown Model of Mental Health Consultation have been provided to a variety of home visitors in the Southeastern region including HFI, First Steps, and Head Start. A mental health consultation initiative (distinct from the model used within MIECHV) served as a support to home visitors, children and their families. In 2016, Parent Café's (an evidence-based parenting model from Be Strong Families out of Illinois) began statewide expansion to increase parent skills and promote family strengthening. Project LAUNCH convenings transitioned to support HMG implementation.

Parent Café's continue to support families in Indiana by teaching protective factors and creating peer sharing opportunities such as grandparent and father café's
Help Me Grow (HMG): a system approach to designing a comprehensive, integrated process for ensuring developmental promotion, early identification, referral and linkage. The system model of HMG reflects a set of best practices for designing and implementing a system that can optimally meet the needs of young children and families. The Help Me Grow system is used to implement effective, universal, early surveillance and screening for all children and then link them to existing quality programs through organization and leverage of existing resources in order to be serve families with children at-risk. HMG implementation in Indiana has been funded as a collaboration across MIECHV Innovation and ECCS Impact Grants.
Indiana Commission on Improving the Status of Children (CISC): CISC was established under a law signed by Governor Pence on April 30, 2013. This 18-member Commission consists of leadership from all three branches of government including the Director of DCS and ISDH Commissioner. CISC is charged with studying and evaluating services for vulnerable youth, promoting information sharing and best practices, and reviewing and making recommendations concerning pending legislation. This broad-based state commission studies and evaluates state agency policy and practice as well as proposes legislation that affects the well-being and best interests of children in Indiana. The enhancement and expansion of our statewide home visiting programs aligns well with this multi-tiered, action-oriented, outcome-expected approach.
Indiana Children's Mental Health Initiative (CMHI): The CMHI is collaboration between DCS and DMHA and local Community Mental Health Centers (CMHCs) and other providers who serve as access sites to ensure children are served in the most appropriate system to meet their needs. The purpose of the children's mental health initiative (CMHI) is to allow families access to needed services so that children do not enter the child welfare system or probation system for the sole purpose of accessing services, to ensure that children are receiving services in the most appropriate system, and to build community collaborations.
DFR, TANF and Supplemental Nutrition Assistance Program (SNAP): DFR is responsible for establishing eligibility for Medicaid, SNAP, and TANF to support families by emphasizing self-sufficiency and personal responsibility. TANF provides a number of services to low income families. In addition, DCS and ISDH have MOUs with DFR to utilize a portion of the state's TANF allotment for the provision of HFI and NFP services, demonstrating one example of Indiana's collaborative approach to supporting home visiting efforts.
Indiana Head Start State Collaboration Office (IHSSCO): IHSSCO partners with Early Childhood stakeholders to provide coordination across early childhood programs. Representatives from ISDH MCH and DCS Prevention Programs are members of the Multi-Agency Advisory Council. The mission of this council is to build early childhood systems to enhance access to comprehensive services and support for children throughout the state. The IHSSCO provided annual financial support to DCS Prevention Programs for the bi-annual Institute for Strengthening Families conferences which provides high quality training opportunities at a low cost to providers serving families across the state. The financial support from the Collaboration Office allows for significant attendance from Head Start and Early Head Start Program staff and further demonstrates the state's priority to support the development of all high-quality home visiting programs available to Indiana families.
Healthy Start: The Indianapolis Healthy Start Program offers education, referral and support services to pregnant women and their families in an effort to eliminate the disparities in birth outcomes and improve infant mortality. In January 2016, the new ISDH/MCH Director and Director of Women, Children and Adolescent Health programs began meeting with the Indianapolis Healthy Start Program Director to enhance collaboration efforts moving forward. The MIECHV State team has subsequently been invited to join the **Indianapolis Healthy Babies Consortium** which is led by Healthy Start.
Indiana Perinatal Quality Improvement Collaborative (IPQIC): The mission of IPQIC is to improve maternal and perinatal outcomes in Indiana through a collaborative effort with the use of evidence-based methods. The Governing Council of IPQIC is co-chaired by the ISDH Commissioner and the President of the Indiana Hospital Association, and is comprised of members across various hospital, medical, state and community health departments and social services organizations from both

the state and community levels including key members of State MIECHV Team. The IPQIC serves as an advisory board to the ISDH with the primary goal of improving the health of women and children throughout Indiana.
First Steps[41] is advised by the **Interagency Coordinating Council (ICC),** a federally mandated group that assists and advises the state's program of early intervention services for infants and toddlers with disabilities and their families. ICC is a Governor-appointed council that includes membership of all pertinent state agencies/departments, service providers, and family consumers and includes the DCS Prevention Program Manager (CBCAP Lead). Many First Steps providers regularly participate in training opportunities available through The Institute for Strengthening Families. Referral coordination occurs at the state level through a data exchange between DCS for child welfare clients and First Steps. At the local level, many HFI and NFP providers have developed reciprocal referral relationships with their local First Steps offices as part of outreach efforts to support families of children with disabilities.
The Institute for Strengthening Families: The Institute for Strengthening Families, administered by DCS Prevention Team, offers a unique opportunity to bring together a wide array of providers serving families and parents across multiple systems for high quality, affordable training and promotion of services available to assist in efforts to improve the lives of children and families in Indiana. Many members of the Institute Planning Committee represent collaborative partners listed in this report.
Safety PIN: Protecting Indiana's Newborns (PIN) – State-appropriated funding to provide competitive grant funding to health departments, hospitals, other health care related entities, or nonprofit organizations. The goal is to develop and implement services focused on reducing infant mortality throughout Indiana. The 2018 awards provided the state the ability to support a Safety PIN program in each of the Indiana hospital districts. This funding also supported the creation of a state pregnancy mobile app with a focus on reducing infant mortality. The app launched in November 2017 including statewide resources to improve health and is promoted amongst home visiting programs.

Appendix C: HRSA Simplified Methodology

Simplified Method Overview

Indicators were selected in collaboration with HRSA/MCHB to match as closely as possible the statutorily-defined criteria for identifying target communities for home visiting programs. Issues such as data availability and reliability of indicators at the county level were considered when selecting the final indicator list. Selected indicators were grouped according to five domains (Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment). The algorithm for identifying at-risk counties is as follows:

1. Obtain raw, county-level data for each indicator from the listed data source as defined in Tab 2 - Description of Indicators.

2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.) (Tab 3. Descriptive Statistics).

3. Standardize indicator values (compute z-score) for each county so that all indicators have a mean of 0 and a SD of 1. Z-score = (county value - mean)/SD. (Tab 5. Standardized Indicators).

4. Using the resulting z-scores for each county, calculate the proportion of indicators within each domain for which that county's z-score was greater than 1, that is, the proportion of indicators for which a given county is in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains is identified as at-risk. (Tab 6. At-Risk Domains).

[41] administered by FSSA's Bureau of Child Developmental Services, Indiana's Early Intervention Program, Part C of the Individuals with Disabilities Education Act (IDEA)

Appendix D: Domain and Indicator Definitions and Sources

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source
Socioeconomic Status (SES)	Poverty	% population living below %100 FPL	Poverty	2017	Census Small Area Income and Poverty Estimates
	Unemployment	Unemployed percent of the civilian labor force	Unemployment	2017	Bureau of Labor Statistics
	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2017	American Community Survey
		% of 16-19 year olds not enrolled in school with no high school diploma		2013-2017	
		% of 16-19 year olds not enrolled in school with no high school diploma		2013-2017 OR 2017	
	Income Inequality	Gini Coefficient - 1 Yr Estimate	N/A	2017	American Community Survey
		Gini Coefficient - 5 Yr Estimate		2013-2017	
		Gini Coefficient - 1 Yr or 5 Yr Estimate		2013-2017 OR 2017	
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2013-2017	NVSS - Raw Natality File
	Infant Mortality Rate *	Infant deaths per 1,000 live births - 5 year estimate	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2014-2018	Indiana State Department of Health
	Low Birth Weight	% live births <2500 g	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2013-2017	NVSS - Raw Natality File
Substance Use Disorder	Alcohol	Prevalence rate: Binge alcohol use in past month	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health
	Marijuana	Prevalence rate: Marijuana use in past month		2014-2016	
	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month		2012-2014	
	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year		2012-2014	
Crime	Crime Reports	# reported crimes/1000 residents	Crime	2016	Institute for Social Research - National Archive of Criminal Justice Data
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17		2016	Institute for Social Research - National Archive of Criminal Justice Data
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	Child maltreatment	2016	ACF
Maternal Health *	Smoking *	% Smoked during pregnancy	Other indicators of at-risk prenatal, maternal, and newborn health	2018	Indiana State Department of Health
	Not Breastfeeding *	% Not breastfeeding at discharge		2018	
	No Early Prenatal Care *	% Did not receive prenatal care beginning in the first trimester		2018	
Domestic Violence *	Victims *	Rate of victims who received services per 1,000	Domestic violence	2018	Indiana Criminal Justice Institute
	Fatalities *	Rate of domestic violence fatalities per 1,000 residents		2018	

** Indicating additional domains and indicators added by Indiana as part of the modified HRSA simplified method*

Appendix E: National Benchmark Data Sources

Indicator	National Benchmark Sources
Infant Mortality	2018 CDC NCHS data
Child Maltreatment	Children's Bureau Child Maltreatment 2016 Report (ACF)
Smoking During Pregnancy	2017 PRAMS data
No Early Prenatal Care	2017 PRAMS data

Appendix F: Inventory of Home Visiting Programs

Program	County	Local Implementing Agencies
Healthy Families	Adams	North Adams Community Schools
Healthy Families	Allen	SCAN Inc.
Healthy Start	Allen	Healthier Moms and Babies
Nontraditional Model	Allen	ECHO Lutheran Social Services
Nontraditional Model	Allen	Catholic Charities
Nontraditional Model	Allen	Parkview Health
Nurse Family Partnership	Allen	Healthier Moms and Babies
Parents as Teachers	Allen	EC Alliance
Start Home-based Services	Allen	Brightpoint
Healthy Families	Bartholomew	New Hope Services Inc.
Nurse Family Partnership	Bartholomew	Indiana
Start Home-based Services	Bartholomew	Human Servcies, Inc.
Healthy Families	Benton	Families United Inc.
Start Home-based Services	Benton	Community Action Program of Western Indiana
Healthy Families	Blackford	Inc.
Nurse Family Partnership	Blackford	Indiana
Start Home-based Services	Blackford	Carey Services
Healthy Families	Boone	Putnam County Family Support Services Inc.
Start Home-based Services	Boone	Community Action Program of Western Indiana
Healthy Families	Brown	The Villages of Indiana Inc.
Healthy Families	Carroll	Family Services Inc.
Nurse Family Partnership	Carroll	Indiana
Healthy Families	Cass	Area Five Agency on Aging and Community Services Inc.
Start Home-based Services	Cass	Bona Vista
Healthy Families	Clark	New Hope Services Inc.
Nurse Family Partnership	Clark	Indiana
Start Home-based Services	Clark	CASI

Program	County	Local Implementing Agencies
Healthy Families	Clay	Child-Adult Resource Services Inc.
Nontraditional Model	Clay	Union Hospital/Lugar Center
Healthy Families	Clinton	Family Service Association of Howard County Inc.
Nurse Family Partnership	Clinton	Indiana
Healthy Families	Crawford	Blue River Services Inc
Nurse Family Partnership	Crawford	Indiana
Start Home-based Services	Crawford	Lincoln Hills Development Corporation
Healthy Families	Daviess	Child-Adult Resource Services Inc.
Healthy Start	Daviess	Daviess Community Hospital Healthy Start
Start Home-based Services	Daviess	PACE Community Action Agency Inc.
Healthy Families	Dearborn	New Hope Services Inc.
Healthy Families	Decatur	The Villages of Indiana Inc.
Healthy Families	Dekalb	Dekalb County Parent Group for Handicapped Children D/B/A Children First Center Inc.
Start Home-based Services	DeKalb	Garrett Keyser Butler Community Head Start and Early Head Start
Healthy Families	Delaware	The Villages of Indiana Inc.
Nurse Family Partnership	Delaware	Indiana
Start Home-based Services	Delaware	Transition Resource Center
Healthy Families	Dubois	Dubois-Pike-Warrick Economic Opportunity Committee
Healthy Start	Dubois	Memorial Hospital Healthy Start
Healthy Families	Elkhart	Child and Parent Services Inc.
Nurse Family Partnership	Elkhart	Goodwill of Michiana
Healthy Families	Fayette	New Hope Services Inc.
Healthy Start	Fayette	Centerstone Healthy Start

Program	County	Local Implementing Agencies
Healthy Families	Floyd	New Hope Services Inc.
Nurse Family Partnership	Floyd	Indiana
Healthy Families	Fountain	Families United Inc.
Healthy Start	Fountain	West Central Indiana Healthy Start
Start Home-based Services	Fountain	Community Action Program of Western Indiana
Healthy Families	Franklin	New Hope Services Inc.
Healthy Families	Fulton	Area Five Agency on Aging and Community Services Inc.
Healthy Families	Gibson	Lincoln Hills Development Corporation
Healthy Families	Grant	Family Service Society Inc.
Nurse Family Partnership	Grant	Indiana
Start Home-based Services	Grant	Carey Services
Healthy Families	Greene	Hamilton Center Inc.
Healthy Start	Greene	Greene County Hospital Healthy Start
Nontraditional Model	Greene	Union Hospital/Lugar Center
Nurse Family Partnership	Greene	IU Health Community Health
Start Home-based Services	Greene	PACE Community Action Agency Inc.
Healthy Families	Hamilton	The Villages of Indiana Inc.
Healthy Families	Hancock	The Villages of Indiana Inc.
Healthy Families	Harrison	Blue River Services Inc
Nurse Family Partnership	Harrison	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Harrison	Lincoln Hills Development Corporation
Healthy Families	Hendricks	Hendricks Board of Commisioners
Nurse Family Partnership	Hendricks	Goodwill of Central and Southern Indiana
Healthy Families	Henry	Family Services and Prevention Programs Inc.
Healthy Start	Henry	Centerstone Healthy Start
Nurse Family Partnership	Henry	Indiana

Program	County	Local Implementing Agencies
Healthy Families	Howard	Family Service Association of Howard County Inc.
Nurse Family Partnership	Howard	Indiana
Healthy Families	Huntington	Family Centered Services Inc
Start Home-based Services	Huntington	Pathfinder Services Inc.
Healthy Families	Jackson	New Hope Services Inc.
Healthy Start	Jackson	Centerstone Healthy Start
Nurse Family Partnership	Jackson	Goodwill of Central and Southern Indiana
Healthy Families	Jasper	Family Focus Inc.
Healthy Families	Jay	Inc.
Healthy Families	Jefferson	New Hope Services Inc.
Nurse Family Partnership	Jefferson	Goodwill of Central and Southern Indiana
Healthy Families	Jennings	New Hope Services Inc.
Healthy Start	Jennings	Centerstone Healthy Start
Nurse Family Partnership	Jennings	Indiana
Healthy Families	Johnson	Family Services and Prevention Programs Inc.
Nurse Family Partnership	Johnson	Goodwill of Central and Southern Indiana
Healthy Families	Knox	Lincoln Hills Development Corporation
Start Home-based Services	Knox	PACE Community Action Agency Inc.
Healthy Families	Kosciusko	Cardinal Services Inc. of Indiana
Start Home-based Services	Kosciusko	Cardinal Services Inc. of Indiana
Healthy Families	LaGrange	Dekalb County Parent Group for Handicapped Children D/B/A Children First Center Inc.
Healthy Families	Lake	Mental Health America of Northwest Indiana Inc.
Nontraditional Model	Lake	Mental Health America of Northwest Indiana
Nontraditional Model	Lake	Franciscan Crown Point
Nurse Family Partnership	Lake	Goodwill of Michiana
Parents as Teachers	Lake	Mental Health America
Start Home-based Services	Lake	Geminus

Program	County	Local Implementing Agencies
Healthy Families	LaPorte	Dunebrook Inc.
Nurse Family Partnership	LaPorte	Goodwill of Michiana
Healthy Families	Lawrence	The Villages of Indiana Inc.
Nurse Family Partnership	Lawrence	IU Health Community Health
Head Start/Early Head Start Home-based Services	Lawrence	Hoosier Uplands
Healthy Families	Madison	St. Vincent Anderson Regional Hospital
Nurse Family Partnership	Madison	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Madison	Transition Resource Center
Healthy Families	Marion	Health and Hospital Corporation of Marion County (Marion 4/HH Corp)
Healthy Families	Marion	HealthNet Inc (Marion 1)
Healthy Families	Marion	The Villages of Indiana Inc. (Marion 2/MOM Project)
Healthy Start	Marion	Indianapolis Healthy Start
Nontraditional Model	Marion	Regenstrief Institute
Nurse Family Partnership	Marion	Goodwill of Central and Southern Indiana
Healthy Families	Marshall	Family Focus Inc.
Head Start/Early Head Start Home-based Services	Marshall	Marshall-Starke Head Start Center
Healthy Families	Martin	Child-Adult Resource Services Inc.
Healthy Start	Martin	Memorial Hospital Healthy Start
Head Start/Early Head Start Home-based Services	Martin	Hoosier Uplands
Healthy Families	Miami	Area Five Agency on Aging and Community Services Inc.
Healthy Families	Monroe	The Villages of Indiana Inc.
Nurse Family Partnership	Monroe	IU Health Community Health
Head Start/Early Head Start Home-based Services	Monroe	South Central Community Action Program
Healthy Families	Montgomery	Putnam County Family Support Services Inc.
Nurse Family Partnership	Montgomery	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Montgomery	Community Action Program of Western Indiana

Program	County	Local Implementing Agencies
Healthy Families	Morgan	Child-Adult Resource Services Inc.
Nurse Family Partnership	Morgan	Goodwill of Central and Southern Indiana
Healthy Families	Newton	Family Focus Inc.
Healthy Families	Noble	Dekalb County Parent Group for Handicapped Children D/B/A Children First Center Inc.
Healthy Families	Ohio	New Hope Services Inc.
Healthy Families	Orange	Child-Adult Resource Services Inc
Nurse Family Partnership	Orange	IU Health Community Health
Head Start/Early Head Start Home-based Services	Orange	Hoosier Uplands
Healthy Families	Owen	Putnam County Family Support Services Inc.
Nontraditional Model	Owen	Union Hospital/Lugar Center
Nurse Family Partnership	Owen	IU Health Community Health
Healthy Families	Parke	Child-Adult Resource Services Inc.
Healthy Start	Parke	West Central Indiana Healthy Start
Head Start/Early Head Start Home-based Services	Parke	Community Action Program of Western Indiana
Healthy Families	Perry	Lincoln Hills Development Corporation
Head Start/Early Head Start Home-based Services	Perry	Lincoln Hills Development Corporation
Healthy Families	Pike	Lincoln Hills Development Corporation
Healthy Families	Porter	Youth Service Bureau of Porter County Inc
Head Start/Early Head Start Home-based Services	Porter	Geminus
Healthy Families	Posey	Lincoln Hills Development Corporation
Head Start/Early Head Start Home-based Services	Posey	Community Action Program of Evansville
Healthy Families	Pulaski	Family Focus Inc.
Healthy Families	Putnam	Putnam County Family Support Services Inc.
Nontraditional Model	Putnam	Union Hospital/Lugar Center
Healthy Families	Randolph	Youth Service Bureau of Jay County Inc.
Nurse Family Partnership	Randolph	Goodwill of Central and Southern Indiana

Program	County	Local Implementing Agencies
Healthy Families	Ripley	New Hope Services Inc.
Healthy Families	Rush	New Hope Services Inc.
Healthy Start	Rush	Centerstone Healthy Start
Healthy Families	Scott	New Hope Services Inc.
Healthy Start	Scott	Centerstone Healthy Start
Nurse Family Partnership	Scott	Goodwill of Central and Southern Indiana
Healthy Families	Shelby	Family Services and Prevention Programs Inc.
Nurse Family Partnership	Shelby	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Shelby	Human Servcies, Inc.
Healthy Families	Spencer	Dubois-Pike-Warrick Economic Opportunity Committee
Head Start/Early Head Start Home-based Services	Spencer	Lincoln Hills Development Corporation
Healthy Families	St. Joseph	Family & Children's Center Counseling and Development Services Inc.
Nurse Family Partnership	St. Joseph	Goodwill of Michiana
Head Start/Early Head Start Home-based Services	St. Joseph	Elkhart and St. Joseph Counties Head Start Consortium *Teen Program ONLY
Healthy Families	Starke	Family Focus Inc.
Head Start/Early Head Start Home-based Services	Starke	Marshall-Starke Head Start Center
Healthy Families	Steuben	Dekalb County Parent Group for Handicapped Children D/B/A Children First Center Inc.
Healthy Families	Sullivan	Hamilton Center Inc.
Nontraditional Model	Sullivan	Union Hospital/Lugar Center
Head Start/Early Head Start Home-based Services	Sullivan	PACE Community Action Agency Inc.
Healthy Families	Switzerland	New Hope Services Inc.
Healthy Families	Tippecanoe	Family Services Inc.
Nurse Family Partnership	Tippecanoe	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Tippecanoe	Bauer Family Resources
Healthy Families	Tipton	Family Service Association of Howard County Inc.
Nurse Family Partnership	Tipton	Goodwill of Central and Southern Indiana

Program	County	Local Implementing Agencies
Healthy Families	Union	New Hope Services Inc.
Healthy Start	Union	Centerstone Healthy Start
Healthy Families	Vanderburgh	Hillcrest Washington Youth Home, Inc Youth Service Bureau
Model	Vanderburgh	Vanderburgh County Health Department
Head Start/Early Head Start Home-based Services	Vanderburgh	Community Action Program of Evansville
Healthy Families	Vermillion	Hamilton Center Inc.
Nontraditional Model	Vermillion	Union Hospital/Lugar Center
Head Start/Early Head Start Home-based Services	Vermillion	Community Action Program of Western Indiana
Healthy Families	Vigo	Hamilton Center Inc.
Healthy Start	Vigo	West Central Indiana Healthy Start
Head Start/Early Head Start Home-based Services	Vigo	Hamiliton Center Early Head Start
Healthy Families	Wabash	Area Five Agency on Aging and Community Services Inc.
Healthy Families	Warren	Families United Inc.
Head Start/Early Head Start Home-based Services	Warren	Community Action Program of Western Indiana
Healthy Families	Warrick	Dubois-Pike-Warrick Economic Opportunity Committee
Healthy Families	Washington	Blue River Services Inc
Nurse Family Partnership	Washington	Goodwill of Central and Southern Indiana
Head Start/Early Head Start Home-based Services	Washington	Hoosier Uplands
Healthy Families	Wayne	Birth-to-Five Inc
Healthy Start	Wayne	Centerstone Healthy Start
Nurse Family Partnership	Wayne	Goodwill of Central and Southern Indiana
Parents as Teachers	Wayne	Birth to Five, Inc
Head Start/Early Head Start Home-based Services	Wayne	CAECI
Healthy Families	Wells	Family Centered Services Inc
Healthy Families	White	Families United Inc.
Nurse Family Partnership	White	Goodwill of Central and Southern Indiana
Healthy Families	Whitley	Dekalb County Parent Group for Handicapped Children D/B/A Children First Center Inc.

Appendix G: All Indicators by County

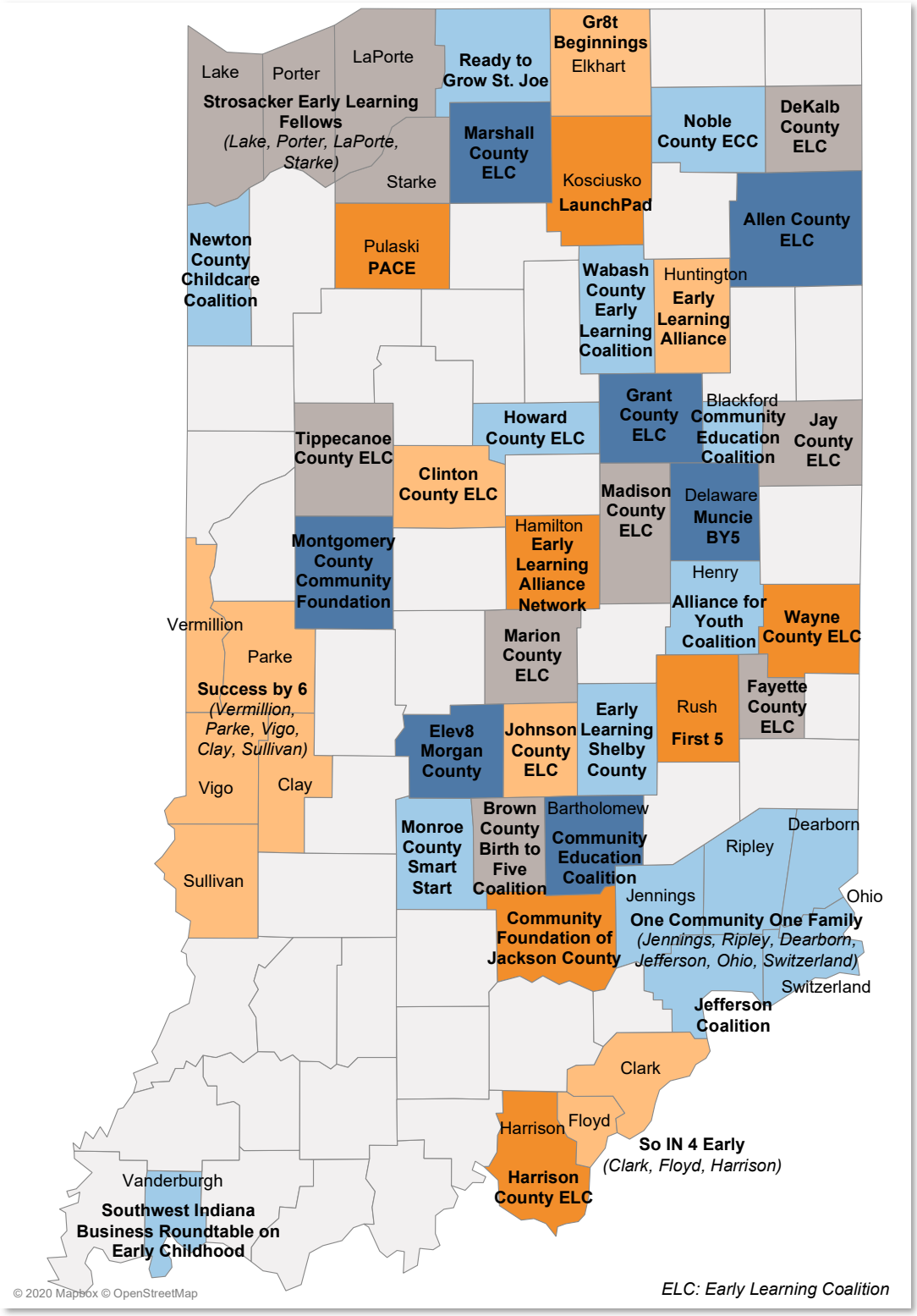
County	Poverty	Unemployment	HS dropout	Income Inequality	Preterm Birth	Infant Mortality Rate	Low Birth Rate	Alcohol	Marijuana 216	Illicit Drugs	Pain Relievers	Crime Reports	Juvenile Arrests	Child Maltreatment	Smoking	Not Breastfeeding	No Early Prenatal Care	DV Victims	DV Fatalities	Number of Significant Indicators	Above National Benchmark: Infant Mortality	Above National Benchmark: Child Maltreatment	Above National Benchmark: Smoking During Pregnancy	Above National Benchmark: No Early Prenatal Care	Total Number of Significant Indicators
Adams			X														X	X		3	X	X		X	6
Allen							X										X			2	X	X		X	5
Bartholomew													X							1	X	X	X	X	5
Benton								X	X	X	X				X	X				6		X	X	X	9
Blackford					X		X						X	X	X	X				6		X	X	X	9
Boone				X																1					1
Brown						X														1	X	X	X	X	5
Carroll								X	X	X	X									4		X	X	X	7
Cass						X							X							2	X	X	X	X	6
Clark													X				X			2	X	X	X	X	6
Clay			X					X	X	X	X									5	X	X	X	X	9
Clinton								X	X	X	X		X							5	X	X	X	X	9
Crawford	X	X			X		X							X		X				6	X	X	X	X	10
Daviess			X																	1	X	X	X	X	5
Dearborn												X					X			2		X	X	X	5
Decatur														X						1		X	X	X	4
DeKalb																				0		X	X	X	3
Delaware	X	X		X	X		X													5	X	X	X	X	9
Dubois					X															1	X	X	X	X	5
Elkhart												X								1	X	X	X	X	5
Fayette		X			X	X									X	X				5	X	X	X	X	9
Floyd					X		X										X			3		X	X	X	6
Fountain						X		X	X	X	X									5	X	X	X	X	9
Franklin																	X			1		X	X	X	4
Fulton			X			X	X									X				4	X	X	X	X	8
Gibson																				0	X	X	X	X	4
Grant	X				X	X	X						X		X	X				7	X	X	X	X	11
Greene		X												X	X				X	4		X	X	X	7
Hamilton																				0				X	1
Hancock																				0		X		X	2
Harrison																				0		X	X	X	3
Hendricks																				0				X	1
Henry																			X	1	X	X	X	X	5
Howard													X			X				2	X	X	X	X	6
Huntington																				0	X	X	X	X	4
Jackson													X						X	2	X	X	X	X	6
Jasper		X				X														2	X	X	X	X	6
Jay						X														1	X	X	X	X	5
Jefferson															X	X				2	X	X	X	X	6
Jennings															X	X				2		X	X	X	5
Johnson																				0			X	X	2
Knox	X																	X		2	X	X	X	X	6
Kosciusko																	X			1	X		X	X	4
LaGrange			X														X			2	X	X		X	5
Lake	X	X										X								3	X	X	X	X	7
LaPorte		X					X						X							3	X	X		X	6

County	Poverty	Unemployment	HS dropout	Income Inequality	Preterm Birth	Infant Mortality Rate	Low Birth Rate	Alcohol	Marijuana 216	Illicit Drugs	Pain Relievers	Crime Reports	Juvenile Arrests	Child Maltreatment	Smoking	Not Breastfeeding	No Early Prenatal Care	DV Victims	DV Fatalities	Number of Significant Indicators	Above National Benchmark: Infant Mortality	Above National Benchmark: Child Maltreatment	Above National Benchmark: Smoking During Pregnancy	Above National Benchmark: No Early Prenatal Care	Total Number of Significant Indicators
Lawrence		X													X					2	X	X	X	X	6
Madison	X						X						X	X						4	X	X	X	X	8
Marion	X			X	X		X					X								5	X	X	X	X	9
Marshall			X																	1	X	X	X	X	5
Martin					X		X							X						3		X	X	X	6
Miami														X		X				2	X	X	X	X	6
Monroe	X			X				X	X	X	X		X							7	X	X	X	X	11
Montgomery								X	X	X	X									4	X	X	X	X	8
Morgan																				0		X	X	X	3
Newton		X																		1	X	X	X	X	5
Noble																				0	X	X	X	X	4
Ohio																				0	X	X	X	X	4
Orange						X								X	X					3	X	X	X	X	7
Owen		X						X	X	X	X			X	X					7	X	X	X	X	11
Parke								X	X	X	X						X			5	X	X	X	X	9
Perry													X	X		X				3		X	X	X	6
Pike					X									X						2		X	X	X	5
Porter																				0		X	X	X	3
Posey																				0		X	X	X	3
Pulaski																				0	X	X	X	X	4
Putnam								X	X	X	X			X						5	X	X	X	X	9
Randolph					X	X	X													3	X	X	X	X	7
Ripley						X											X	X		3	X	X	X	X	7
Rush			X									X	X					X		4	X	X	X	X	8
St. Joseph	X			X								X	X							4	X	X	X	X	8
Scott	X					X	X							X	X	X	X			7	X	X	X	X	11
Shelby						X							X			X				3		X	X	X	6
Spencer														X						1	X	X	X	X	5
Starke	X	X																		2		X	X	X	5
Steuben																				0		X	X	X	3
Sullivan		X		X				X	X	X	X									6	X	X	X	X	10
Switzerland	X														X	X				3	X	X	X	X	7
Tippecanoe	X			X				X	X	X	X		X							7	X	X		X	10
Tipton													X	X				X		3		X	X	X	6
Union																	X			1		X	X	X	4
Vanderburgh	X			X	X		X					X	X							6	X	X	X	X	10
Vermillion		X						X	X	X	X	X		X	X			X		9	X	X	X	X	13
Vigo	X	X		X				X	X	X	X	X	X	X						10	X	X	X	X	14
Wabash																X				1	X	X	X	X	5
Warren								X	X	X	X									4	X	X	X	X	8
Warrick																				0	X	X	X	X	4
Washington			X																	1		X	X	X	4
Wayne	X			X														X		3	X	X	X	X	7
Wells																				0		X	X	X	3
White								X	X	X	X									4	X	X	X	X	8
Whitley																				0	X	X	X	X	4

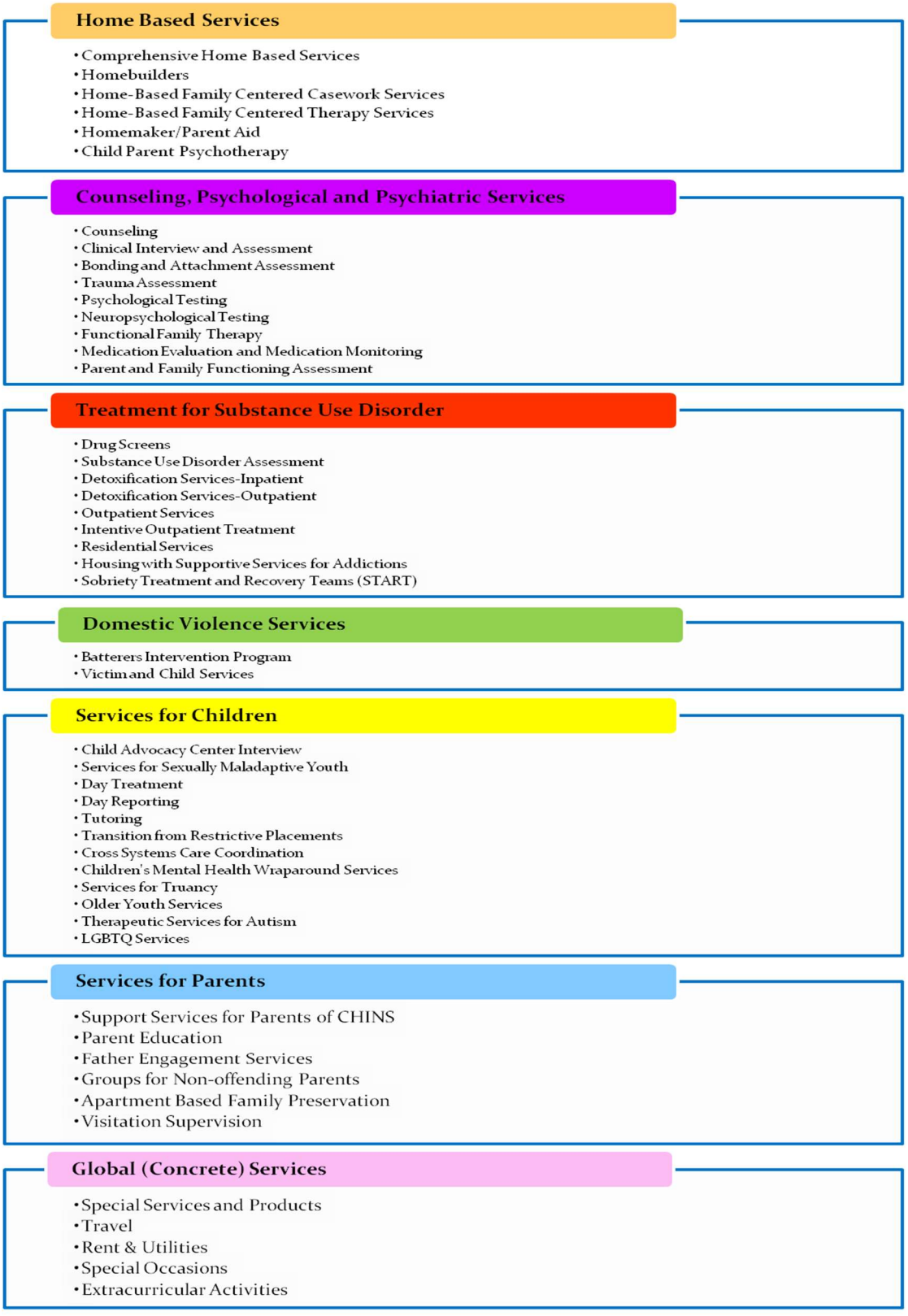
Appendix H: Reported Capacity of Home Visiting Programs

Total Capacity by County					
Adams	90	Hendricks	8	Pike	5
Allen	480	Henry	91	Porter	65
Bartholomew	70	Howard	125	Posey	16
Benton	20	Huntington	5	Pulaski	25
Blackford	25	Jackson	138	Putnam	29
Boone	29	Jasper	28	Randolph	40
Brown	15	Jay	40	Ripley	7
Carroll	7	Jefferson	113	Rush	93
Cass	49	Jennings	39	Scott	131
Clark	193	Johnson	15	Shelby	6
Clay	30	Knox	73	Spencer	25
Clinton	45	Kosciusko	99	St. Joseph	522
Crawford	4	Lagrange	56	Starke	35
Daviess	15	Lake	815	Steuben	43
Dearborn	9	La Porte	157	Sullivan	30
Decatur	42	Lawrence	79	Switzerland	3
De Kalb	43	Madison	158	Tippecanoe	90
Delaware	112	Marion	1760	Tipton	12
Dubois	25	Marshall	37	Union	84
Elkhart	428	Martin	10	Vanderburgh	235
Fayette	95	Miami	59	Vermillion	30
Floyd	66	Monroe	112	Vigo	700
Fountain	123	Montgomery	67	Wabash	18
Franklin	12	Morgan	7	Warren	12
Fulton	20	Newton	10	Warrick	25
Gibson	38	Noble	52	Washington	19
Grant	91	Ohio	1	Wayne	229
Greene	47	Orange	22	Wells	5
Hamilton	50	Owen	163	White	50
Hancock	70	Parke	115	Whitley	45
Harrison	10	Perry	18		

Appendix I: Early Childhood Education Coalitions



Appendix J: Department of Child Services Service Array



Appendix K: Most Utilized Services by DCS Region

Top Services									
DCS Cases (not including probation)	Region 1 (n=2,045)	Region 2 (n=841)	Region 3 (n=1,287)	Region 4 (n=1,867)	Region 5 (n=837)	Region 6 (n=729)	Region 7 (n=927)	Region 8 (n=1,012)	Region 9 (n=857)
1	65% Home-based family centered therapy services	61% home-based family centered therapy services	51% home-based family centered casework services	61% home-based family centered casework services	76% home-based family centered casework services	68% home-based family centered casework services	57% home-based family centered casework services	71% home-based family centered casework services	65% home-based family centered casework services
2	56% Home-based family centered casework services	58% home-based family centered casework services	33% home-based family centered therapy services	36% home-based family centered therapy services	43% random drug testing	33% substance use outpatient treatment	28% visittion facilitation - parent/child/sibling	43% home-based family centered therapy services	43% counseling
3	41% random drug testing	39% random drug testing	33% visitation facilitation - parent/child/sibling	35% visitation facilitation - parent/child/sibling	38% counseling	29% substance use disorder assessment	27% random drug testing	42% random drug testing	32% substance use outpatient treatment
4	30% parent education	26% substance use disorder assessment	28% counseling	32% substance use outpatient treatment	38% substance use disorder assessment	27% visitation facilitation - Parent/child/sibling	21% home-based family centered therapy services	24% substance use outpatient treatment	29% home-based family centered therapy services
5	29% parenting/family functioning assessment	25% visitation facilitation - parent/child/sibling	26% substance use disorder assessment	31% counseling	34% drug testing and supplies	24% counseling	18% counseling	21% substance use disorder assessment	27% substance use disorder assessment

Top Services									
DCS Cases (not including probation)	Region 10 (n=4,696)	Region11 (n=1,214)	Region 12 (n=729)	Region 13 (n=1,015)	Region 14 (n=1,030)	Region 15 (n=771)	Region 16 (n=1,564)	Region 17 (n=940)	Region 18 (n=1,025)
1	66% home-based family centered therapy services	60% home-based family centered casework services	59% home-based family centered casework services	64% home-based family centered casework services	61% home-based family centered casework services	65% home-based family centered casework services	56% random drug testing	50% home-based family centered therapy services	60% home-based family centered casework services
2	59% home-based family centered casework services	49% home-based family centered therapy services	36% substance use disorder assessment	46% home-based family centered therapy services	35% home-based family centered therapy services	36% counseling	46% visitation facilitation - parent/child/sibling	39% home-based family centered casework services	48% home-based family centered therapy services
3	43% random drug testing	36% random drug testing	36% substance use outpatient treatment	36% random drug testing	35% substance use outpatient treatment	35% random drug testing	39% homemaker/parent aid	39% homemaker/parent aid	27% substance use disorder assessment
4	37% drug testing and supplies	28% substance use disorder assessment	29% random drug testing	34% visitation facilitation - parent/child/sibling	32% substance use disorder assessment	30% home-based family centered therapy services	38% home-based family centered casework services	35% visitation facilitation - parent/child/sibling	23% diagnostic and evauatino services
5	19% visitation facilitation - parent/child/sibling	21% visitation facilitation - parent/child/sibling	28% home-based family centered therapy services	33% substance use outpatient treatment	24% visitation facilitation - parent/child/sibling	30% visitation facilitation - parent/child/sibling	35% home-based family centered therapy services	33% random drug testing	23% visitation facilitation - parent/child/sibling

Appendix L: Top Services Received by Families by DCS Region

Top Services Received by Families								
Region 1 (n=2,174)	Region 2 (n=230)	Region 3 (n=933)	Region 4 (n=1,026)	Region 5 (n=831)	Region 6 (n=329)	Region 7 (n=385)	Region 8 (n=356)	Region 9 (n=517)
28% Rent/Utilities	43% counseling	54% counseling	48% rent/utilities	56% rent/utilities	52% rent/utilities	56% rent/utilities	81% rent/utilities	62% rent/utilities
21% Job training/employment	34% school issues	53% subsidized housing	48% child behavior	41% job training/employment	47% child behavior	49% job training/employment	40% job training/employment	33% job training/employment
20% subsidized Housing	31% feeling hopeless	53% child behavior	43% information on budgeting	38% subsidized housing	43% counseling	41% subsidized housing	33% emergency food	29% emergencyfood
17% child behavior	28% child behavior	50% information on budgeting	39% job training/employment	38% child care assistance	41% job training/employment	33% counseling	28% subsidized housing	29% child care assistance
13% school issues	26% Rent/utilities	47% job training/employment	38% emergency food	33% counseling	40% information on budgeting	33% child care assistance	24% child care assistance	27% child behavior

Region 10 (n=1,150)	Region 11 (n=419)	Region 12 (n=360)	Region 13 (n=312)	Region 14 (n=517)	Region 15 (n=224)	Region 16 (n=615)	Region 17 (n=258)	Region 18 (n=283)
69% rent/utilities	45% rent/utilities	71% rent/utilities	40% child behavior	61% rent/utilities	36% subsidized housing	45% child behavior	41% child behavior	58% counseling
61% job training/employment	35% job training/employment	43% job training/employment	33% job training/employment	37% subsidized housing	35% job training/employment	34% school issues	28% school issues	49% child behavior
48% subsidized housing	33% counseling	34% subsidized housing	32% rent/utilities	37% job training/employment	30% rent/utilities	32% subsidized housing	23% job training/employment	41% subsidized housing
45% child care assistance	32% child behavior	34% information on budgeting	28% subsidized housing	33% child care assistance	24% child care assistance	31% job training/employment	22% rent/utilities	40% job training/employment
37% shelter	31% child care assistance	28% child care assistance	26% child care assistance	31% child behavior	23% information on Medicaid	28% rent/utilities	22% information on food	37% rent/utilities

Appendix M: Indiana Birth-5 Strategic Plan 2020-2022 Goals

(Family and Social Services Administration Office of Early Childhood and Out-of-School Learning, 2019, pgs. 12-29).

- System focus area 1: Grow high-quality birth-5 programs and supports
  - Goal 3: Implement family-centered practices (p. 17)
    - Desired Outcome: By the end of 2021, empower the full array of agencies who serve birth-5 families to better serve their clients by developing and implementing family-centered, evidence-based policies, practices, processes and structures.
- System focus area 3
  - Goal 9: Promote family engagement in Birth-5 programs
    - Desired outcome: Enable and support family engagement and advocacy for their children at each developmental stage.
  - Goal 10: Provide frameworks and tools for peer-to-peer networks
    - Desired outcome: Families connecting with peers and their communities for the well-being and growth of their child and the whole family unit.
  - Goal 11: Build local community partnerships
    - Desired outcome: New or expanded, sustainable local community partnerships that work to improve outcomes for underserved children birth-5 as determined by each volunteer community.
- System focus area 4
  - Goal 12: Establish inter-agency data-sharing for family-focused service delivery
    - Desired outcome: By 2022, an established ECIDS (Early Childhood Integrated Data System) and ECIDS Data Governance Committee that coordinates data sharing and integration for the benefit of birth-5 families. The establishment of an ECIDS and ECIDS committee will also lead to improved birth-5 data quality.

Appendix N: Limitations

While in the midst of completing the Indiana MIECHV Needs Assessment 2020 Update, Indiana – along with the rest of the nation – responded to the pandemic health crisis of COVID-19. Most of Indiana's data collection efforts were underway, but some elements of Indiana's initial plan were unable to be completed. For example, the community survey was conducted during the Indiana stay-at-home period. State-level offices down to local communities and staff members who are also individual citizens in responding to the COVID-19 pandemic, had to modify work routines, were challenged by access to data and resources, and suddenly lost many supports previously available. Indiana had originally intended to follow the survey with local focus groups, but in-person gatherings were not possible during this period as many agencies were still adjusting to virtual meeting platforms, connection security, and access.

The home visiting program survey did not have a 100% completion rate. Targeted efforts to reach out to home visiting programs that did not respond did glean additional data – specifically capacity estimates – however, this data cannot be considered complete as not all programs were reached. Some programs that responded to the survey did not provide figures for number of families served in a program year or family attrition rate. A limitation of this report and the home visiting landscape in general is centralized access to administrative data.

The COVID-19 pandemic and resulting impact on business practices and service provision created the most significant limitation to this 2020 Update. Mandates and restrictions resulting from the response to the COVID-19 pandemic disrupted plans to convene stakeholders to review and contextualize survey results as well as the results of relevant needs assessments from other state agencies and initiatives:

- The INHVAB quarterly meeting was postponed.
- The Indiana Early Learning Advisory Committee moved it's quarterly meeting to a virtual platform and changed its agenda to discuss the COVID-19 crisis.
- Other individuals and convening groups were no longer available due to travel restrictions and the addition of new duties to assist in addressing the COVID-19 crisis.

Appendix O: References

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