

2017

Building Healthy Futures



THE INDIANA MATERNAL, INFANT & EARLY CHILDHOOD
HOME VISITING PROGRAM
NEEDS ASSESSMENT
2017

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Importance of Home Visiting

As cited in a publication of the American Academy of Pediatrics, “Home-visitation programs began in the United States in the late 19th century. Public health nurses and social workers provided in-home education and health care to women and children, primarily in poor urban environments. At the beginning of the 20th century, the New York City Health Department implemented a home visitor program, using student nurses to instruct mothers about breastfeeding and hygiene. This program reduced the high mortality rate of inner-city infants from summer diarrhea when previous efforts of private agencies had failed. In the late 20th century, as funding for public health nurses has declined relative to the need, home-visitation programs have focused on families with special problems such as premature or low-birth-weight infants, children with developmental delay, teenage parents, and families at risk for child abuse or neglect.”¹



“Home visiting is a prevention strategy used to support pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent child abuse and neglect. Across the country, high-quality home visiting programs offer vital support to parents as they deal with the challenges of raising babies and young children. Participation in these programs is voluntary and families may choose to opt out whenever they want. Home visitors may be trained nurses, social workers or child development specialists. Their visits focus on linking pregnant women with prenatal care, promoting strong parent-child attachment, and coaching parents on learning activities that foster their child’s development and supporting parents’ role as their child’s first and most important teacher. Home visitors

¹ <http://pediatrics.aappublications.org/content/101/3/486>

also conduct regular screenings to help parents identify possible health and developmental issues.”²

Maternal, Infant and Early Childhood Home Visiting Program

The 2010 legislation that established the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) requires that grantees demonstrate measurable improvement in at least four of the following six benchmark domains:

- Improvement in maternal and newborn health
- Reduction in child injuries, abuse, and neglect
- Improved school readiness and achievement
- Reduction in crime or domestic violence
- Improved family economic self-sufficiency
- Improved coordination and referral for other community resources and supports.

The number of children and parents served by the MIECHV program nationally has increased nearly five-fold since 2012, and the number of home visits provided has increased more than five-fold, with more than 3.3 million home visits provided over the past five years.³ In FY2016, states served approximately 160,000 parents and children in 893 counties in all 50 states, DC, and five territories through home visiting programs. Nearly 43% of those were new enrollees.

The purpose of Indiana’s Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program is to support the delivery of coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families. The project aims to sustain the MIECHV funded services provided by two existing, evidence-based home

² <http://www.ncsl.org/research/human-services/home-visiting-improving-outcomes-for-children635399078.aspx>

³ <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>

visiting programs, Healthy Families Indiana (HFI) and Nurse-Family Partnership (NFP). Indiana has served 6,962 MIECHV-funded families through 146,338 home visits since the inception of MIECHV through 9/30/2016⁴. MIECHV-funded services are currently provided in Delaware, Elkhart, Grant, Lake, LaPorte, Madison, Marion, Scott, and St. Joseph Counties. A data profile of the MIECHV participants is included in the Home Visiting Capacity section of the report.

Needs Assessment

It has been seven years since the original required MIECHV needs assessment was conducted. While Indiana data on critical issues/factors are examined on an annual basis, the need was identified for a more current and comprehensive environmental scan on the status of high risk families and the issues that impact the six benchmark domains established by MIECHV. The Indiana Home Visiting Advisory Board (INHVAB) provided oversight of the needs assessment by utilizing the 2010 needs assessment as a guiding document and identifying the data elements and components to be included in this iteration, representing community partner input for home visiting as an important component in a comprehensive early childhood system.

While home visiting has expanded in Indiana over the last seven years, the need for home visiting programs is escalating at a much faster rate due to continued increases in risk factors for families with young children. Indiana's infant mortality rate remains above the national rate and significantly above the Healthy People 2020 goal. Black infants are 2.5 times more likely to die than white infants in Indiana. The smoking rates among Indiana pregnant women, especially white women, are always among the nation's worst.

⁴ Enrollment and home visit data from DMCN (data collection system for NFP services provided by Goodwill Industries, verified by Indiana State Department for Health) and FamilyWise provided by Datatude, Inc.; gathered over time from Oct 1, 2011 – September 30, 2016; compiled by MIECHV grant coordinators 19 January 2017

Additionally, 32.5% of pregnant women in Indiana do not enter prenatal care in the first trimester. That percentage is higher (44.1%) for black women in Indiana.⁵

Like many states, Indiana has been significantly impacted by the opioid crisis. In 2014 Indiana ranked 15th nationally for drug overdose deaths. The Indiana State Department of Health established a pilot project with 27 hospitals to establish the prevalence of substance exposed newborns. The opioid crisis has also resulted in increasing caseloads for the Department of Child Services staff and the need for increased supportive services for both the baby and his/her family. According to data contained in the 2017 Indiana Kids Count, in SFY 2016, 52.2% of children removed from a home by the Indiana Department of Child Services were removed due to parental drug and/or alcohol abuse, up from 48.0% the previous year.⁶

There are significant challenges that Indiana's most vulnerable populations are facing which are addressed in the following sections. While there are several "needs assessments" targeting families in Indiana, this MIECHV needs assessment is focused on the risk factors believed to be most impacted by home visiting services and other community services that support home visiting. Expansion of home visiting is a significant tool that can be used to address many challenges Hoosier households face and to work collectively to support optimal health and development of infants and toddlers and their families.

This needs assessment document has six sections:

- 1) An overview of Indiana;
- 2) A Data Portrait that incorporates:
 - a. Maternal and Child Health;
 - b. Family Economic Self-Sufficiency;
 - c. School Readiness and Achievement;
 - d. Child Maltreatment; and
 - e. Crime and Domestic Violence;

⁵ <http://www.in.gov/isdh/files/IM%20Disparities%202014.pdf>

⁶ https://s3.amazonaws.com/iyi-website/data-book/2017_Data-Book.pdf?mtime=20170227080137

- 3) Indiana’s Home Visiting Advisory Board;
- 4) Home Visiting Capacity in Indiana;
- 5) Substance Abuse Counseling and Treatment; and
- 6) County rankings based on identified risk factors.

The information contained in this needs assessment will be utilized to guide implementation of the MIECHV programming to better serve the highest risk population in Indiana.

1.0: State Overview

Often referred to as the “Crossroads of America”, Indiana has a population of 6,619,680 (2015 est.) which represents a 2.1% growth since the 2010 census. Its rank was 16th in the United States. Indiana has a total of 35,867 square miles with a population density of 182/square mile. Indiana is the smallest state in the continental United States west of the Appalachian Mountains. Only six of Indiana’s counties have a population base above 200,000 and only four cities have a population that exceeds 100,000. Its capital and largest city is Indianapolis which ranks as the 13th largest city and 30th largest metropolitan area in the United States. Seventy percent of the Indiana population live in a metropolitan statistical area while the remaining 30% live in rural areas.⁷



⁷ **Metropolitan Statistical Areas** are CBSAs associated with at least one urbanized area that has a population of at least 50,000. The metropolitan statistical area comprises the central county or counties or equivalent entities containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county or counties as measured through commuting. https://www.census.gov/geo/reference/gtc/gtc_cbsa.html#md

1.1 Demographics

In 2014 there were 83,927 resident live births which was a slight increase from 2013 but an overall decline over the previous ten years. In 2014 the preschool population represented 6.3% and the school age population represented 17.5% of the total population. Of the total population, 40.8% of the population is 45 years and older. The median age in Indiana based on 2015 population estimates is 37.5 years.

	B-4	5-17	18-44	45+
IN	6.3%	17.5%	35.4%	40.8%
US	6.2%	16.7%	36.1%	41%

Figure 1: Population by age

Indiana has limited cultural diversity outside of its metropolitan areas with over 76% of its counties reporting non-Hispanic populations of 95% or higher. Indiana's overall Hispanic population is 6.7% with a range across counties of 1% to 18.3%. Marion County, Indiana's largest county, has the most diverse population with a white population of 65.8%, a black population of 28%, an Asian population of 2.8% and 2.8% of the population identify with two or more races. Statewide, the white population in counties ranges from 65.8% to 99%. The black population ranges from 0.3% to 28%. People identifying with two or more races ranges from 0.7% to 2.9%.

	IN	US
White Only	85.8%	77.1%
Black Only	9.6%	13.3%
Asian Only	2.1%	5.6%
American Indian Alaska Native Native Hawaiian Pacific Islander	0.4%	1.2%
Two or More Races	1.9%	2.6%
Hispanic	6.7%	17.6%
Non-Hispanic	93.3%	82.4%

Figure 2: Population by race and ethnicity

In 2014, 64% of children ages 0-17 lived in married couple households, 8% lived in fathers only household and 26% lived in mothers only households.⁸ The percentage of children living with their grandparents has remained stable at 4%⁹.

1.2 Economy

In December 2016, there were 3,329,000 in the Indiana workforce.¹⁰ According to the Bureau of Labor Statistics, Indiana's unemployment rate declined from a high of 10.9 in January 2009 to 4.0 in December 2016.

Indiana is primarily considered a manufacturing state with a growth rate of 17.6% since 2010. However, the largest job gains (21.8%) are in professional and business services. While there is a significant agricultural component to Indiana's economy, farm related employment represents only 8% of the workforce. Indiana is located within the U.S. corn and grain belts with corn and soybeans as major cash crops. Indiana is also home to the international headquarters of Eli Lilly, a major pharmaceutical company which is the state's largest corporation. Tourism is another major economic factor in Indiana and is the sixth largest industry in the state. According to the Indiana Tourism Association¹¹, over 74 million visitors spent \$10.7 billion in 2014. Direct employment in the tourism industry exceeds 144,200 and supports over 192,000 jobs.



Figure 3: Indiana Unemployment Rate

Indiana's economy is one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union

⁸ <http://datacenter.kidscount.org/data/tables/105-child-population-by-household-type?loc=16&loct=2#detailed/2/16/false/573,869,36,868,867/4290,4291,4292/427,428>

⁹ <http://datacenter.kidscount.org/data/tables/108-children-in-the-care-of-grandparents?loc=16&loct=2#detailed/2/16/false/573,869,36,868,867/any/433,434>

¹⁰ US Bureau of Labor Statistics, Indiana Economy at a Glance

¹¹ <http://www.indianatourismassociation.com/indiana-tourism-facts>

membership, and labor laws. The doctrine of “at will” employment, whereby an employer can terminate an employee for any or no reason, is in force. Indiana is also home to many insurance home offices and has a high rate of self-insured policies.

1.3 Education

Education is a major factor in economic well-being. In 2015, 87.8% of Indiana adults have graduated from high school. This percentage is higher than the US percentage of 83.2%.¹² The percentage of Indiana adults with a bachelor’s degree is 15.4% and with a graduate degree is 8.7%.¹³ According to the United States Census Bureau, nationally 32.5% of adults have a bachelor’s degree and 12% have a graduate degree.

2.0 A Data Portrait of Indiana

This section of the needs assessment is organized by MIECHV benchmark areas that impact the developmental status and well-being of young children and their families:

- Maternal and Newborn Health;
- Family Economic Self-Sufficiency;
- School Readiness and Achievement;
- Prevention of Child Maltreatment; and
- Reduction in Crime and Domestic Violence.

These benchmark areas provide a portrait of the well-being of families in Indiana and provides an understanding of the challenges that families of young children face. Unless specifically noted, all data used in these components are from 2014. All data sources are identified in Appendix C.

¹² <http://www.governing.com/gov-data/high-school-graduation-rates-by-state.html>

¹³ http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=302&output_mode=1

2.1 Maternal and Child Health

Infant mortality and morbidity remain the number one priority of the Indiana State Department of Health. This section will focus on data elements that have a high probability of influencing the health of young children and their families.

2.1.1 Infant Mortality

Infant mortality is often used as a measure of the health of the population. In 2014 the infant mortality rate in Indiana was 7.1 per 1000 births. This compares to 5.8 per 1,000 births for the United States. Indiana has a significant disparity between black and white populations for infant mortality. While the overall rate for 2014 was 7.1, the rate for births to white women in Indiana was 5.9 while the rate for births to black women was 14.7 – more than double of the white rate. Infant mortality rates in Indiana counties range from a rate of 4.4 to 10.5 per 1000 births excluding those counties where the rate was unstable.

2.1.2 Low Birthweight

Low birthweight and very low birthweight infants have a higher risk of poor outcomes and long-term challenges. The 2014 low birthweight (<2,500 grams) percentage for Indiana matched the federal percentage at 8%. Again, the disparity between white and black infants was significant. The percentage of white low birthweight (<1,500 grams) babies was 7.3% compared to 13.3% for black low birthweight babies. The percentage of very low birthweight births matched the federal percentage at 1.4%. However, the disparity still exists with 1.2% for white births compared to 2.7% for black births. The percentage of low birthweight births in Indiana counties ranged from a low of 3.2% to 14.1%.

"The problem of infant mortality is one of the great social and economic problems of our day. A nation may waste its forest, its water power, its mines and to some degree even its land, but if it is to hold its own...its children must be conserved at any cost. On the physical, intellectual and moral strength of the children of today, the future depends."

-Julia Lathrop, MD, Director, Federal Children's Bureau, 1913

2.1.3 Preterm Births

Preterm births (<37 weeks gestation) are calculated in two ways: by the date of the last menstrual period (LMP) and by obstetric estimate. Using the LMP methodology, 11% of Indiana births were preterm compared to 11.3% of the births in the United States. When using obstetric estimates, preterm births accounted for 9.7% of 2014 births in Indiana. Disparity remains an issue for preterm births with 9.2% of white births and 13.4% of black births using the obstetric estimate methodology. The percent of preterm births in Indiana counties ranged from a low of 5.6% to a high of 19.1%.

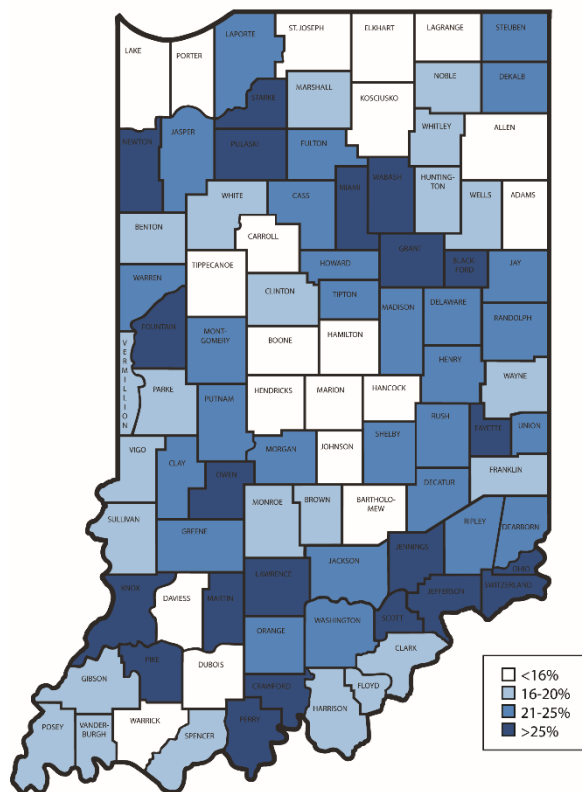
2.1.4 Smoking during pregnancy

Smoking during pregnancy remains a significant problem for Indiana as 15.1% of all pregnant women smoke during their pregnancy. This compares to 8.4% of women nationally. The disparity is reversed for this factor as 16.4% of white women smoke during pregnancy compared to 12.1% of black women. The percentage of pregnant women who smoke ranges from a low of 2.7% to a high of 38.5% across Indiana's 92 counties.

2.1.5 Breastfeeding at Hospital Discharge

Breastfeeding is recognized by health care professionals as the optimal method for providing nutrition to infants. The percentage of Indiana women breastfeeding their infant at hospital discharge is 79.3% compared to the national average of 81%. The percentage of women breastfeeding at discharge across Indiana ranged from a low of 57% to a high of 94%.

Figure 4: Smoking During Pregnancy



degree. Obesity is another priority of ISDH and increases risk factors for pregnant women. Indiana’s percentage of obese adults is 31% compared to 37.9% at the national level. The range for obese adults across Indiana counties is 21% to 39%.

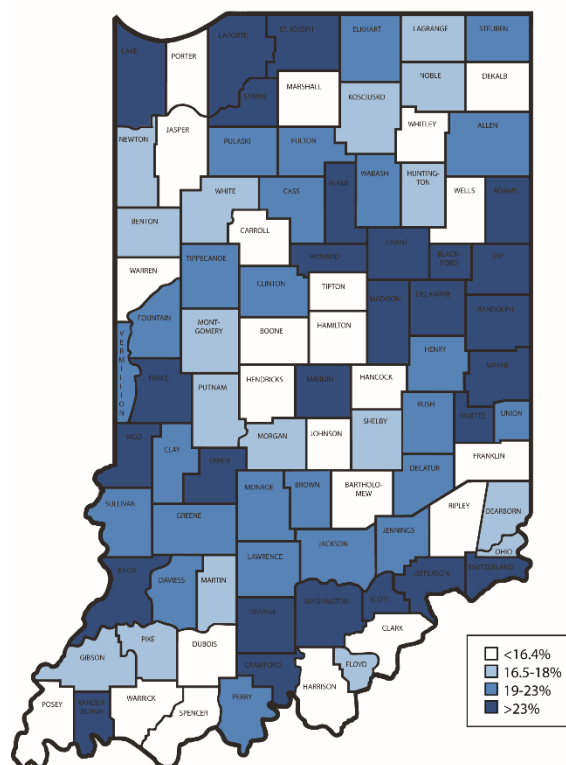
2.2 Family Economic Self-Sufficiency

The economic well-being of Indiana families can be defined by the family’s ability to secure sufficient income to support the basic needs of their family, which includes food and housing. Young children are the most vulnerable and are at higher risk for poor outcomes that can change their developmental trajectory and their long-term capacity to be meaningful contributors to their communities. While Indiana has not experienced as severe an economic crisis as other states, the challenges faced by Indiana families is significant. In 2015 the median household income in Indiana was \$49,255 with a range from \$38,190 in Blackford County to \$86,222 in Hamilton County.¹⁴ In 2015, 20.4% of Indiana’s children lived in poverty with a range of 5.2% in Hamilton County to 31.2% in Delaware County. Uninsured Indiana children account for 7.5% of children at all income levels with 9.8% for children at or below 200% of the Federal Poverty Level.

2.2.1 Children in Poverty

Poverty is defined as 100% of the federal poverty level (FPL) guidelines which was \$23,850 for a family of four in 2014. In Indiana, 21.2% of children under the age of 18 live in poverty compared to 22% nationally. For children under the age of five in Indiana, that percentage increases to 25% compared to the

Figure 6: Children Under 18 in Poverty



¹⁴ <http://www.census.gov/did/www/saipe/index.html>

national percentage of 24% In 2014, 45% of children in Indiana lived below 200% of the FPL which equated to \$47,700 for a family of four. The percentage of children living in poverty across Indiana counties range from a low of 5.7% to a high of 35.2%.

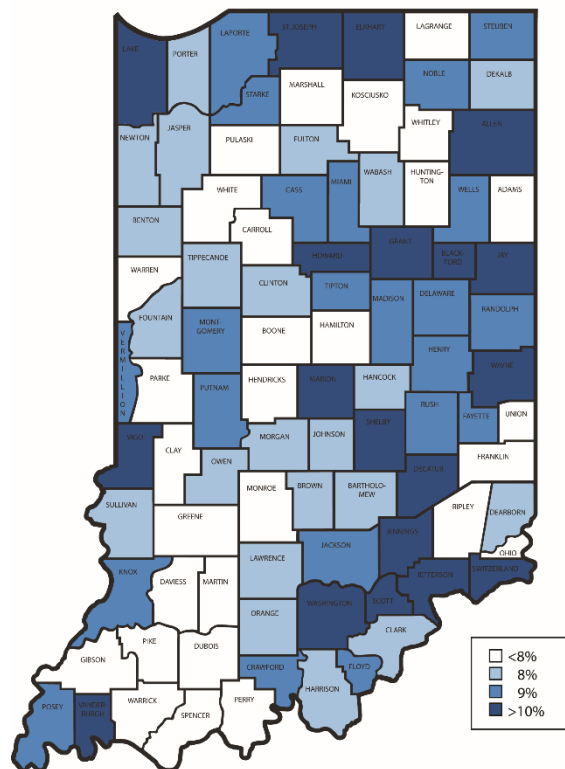
2.2.2 Children with Free/Reduced Lunch

The National School Lunch Program¹⁵ is a federally assisted meal program operating in over 100,000 public and non-profit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to low income children each school day. Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals. In Indiana, 49.1% of school age children participate in this program. The percentage of participation across Indiana counties ranges from 16.2% to 68.9%.

2.2.3 Single Parent Households

“Children growing up in single-parent families typically do not have the same economic or human resources available as those growing up in two-parent families. Compared with children in married-couple families, children raised in single-parent households are more likely to drop out of school, to have or cause a teen pregnancy and to experience a divorce in adulthood.”¹⁶ Nationally, 35% of children live in a single-parent household. In Indiana that percentage is 36% with a range across Indiana counties of 13% to 46%.

Figure 7: Single Parent Households



¹⁵ <https://www.fns.usda.gov/sites/default/files/NSLPFactSheet.pdf>

¹⁶ <http://datacenter.kidscount.org/data/tables/106-children-in-single-parent-families#detailed/2/2-52/false/573,869,36,868,867/any/429,430>

2.2.4 Children with Food Insecurity

“Sixteen million US children (21%) live in households without consistent access to adequate food. After multiple risk factors are considered, children who live in households that are food insecure, even at the lowest levels, are likely to be sick more often, recover from illness more slowly, and be hospitalized more frequently. Lack of adequate healthy food can impair a child’s ability to concentrate and perform well in school and is linked to higher levels of behavioral and emotional problems from preschool through adolescence.”¹⁷ In Indiana, 21.2% of children live in households with food insecurity. The range across Indiana counties was 13.5% to 26.1%.

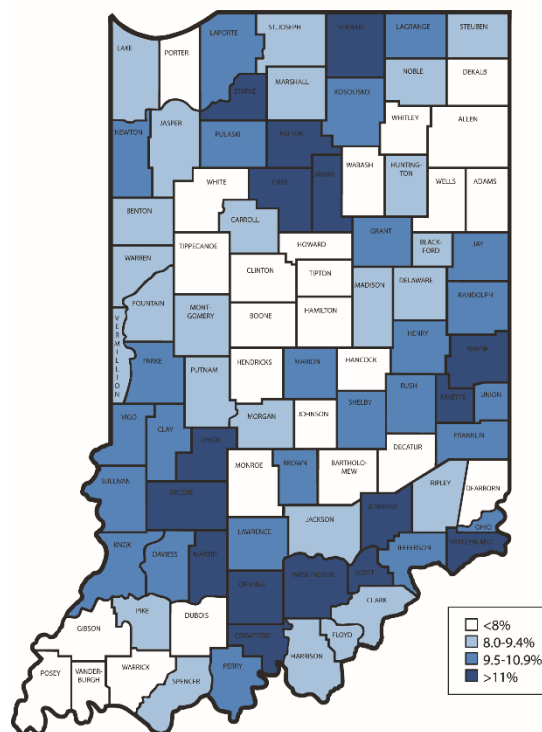
2.2.5 Unemployment

Indiana negotiated the economic turndown better than many other states. In 2009, the Indiana unemployment rate peaked at 10.9% and dropped to 6.0% in 2014. That compared to 6.2% at the national level. Unemployment rates across Indiana counties range from 4.1% to 8.7%.

2.2.6 High School Dropouts

Every year, over 1.2 million students drop out of high school in the United States alone. That equates to one student every 26 seconds – or 7,000 a day. The U.S., which in the past had some of the highest graduation rates of any developed country, now ranks 22nd out of 27 developed countries. A high school dropout will earn \$200,000 less than a high school graduate over his/her lifetime and almost a million dollars less than a college graduate. In the United States, high

Figure 8: High School Dropouts



¹⁷ www.pediatrics.org/cgi/doi/10.1542/peds.2015-3301

school dropouts commit about 75% of crimes.¹⁸ In Indiana, 8.3% of the population are high school dropouts. The range of high school dropouts across Indiana counties is 2.6% to 13.5%.

2.2.7 Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program is designed to help needy families achieve self-sufficiency through financial assistance to help pay for food, shelter, utilities, and expenses except for medical expenses. Statewide, the monthly average number of families receiving direct TANF benefits is 10,680. Monthly, TANF participation across Indiana counties ranges from 8 families to 2,664 families.

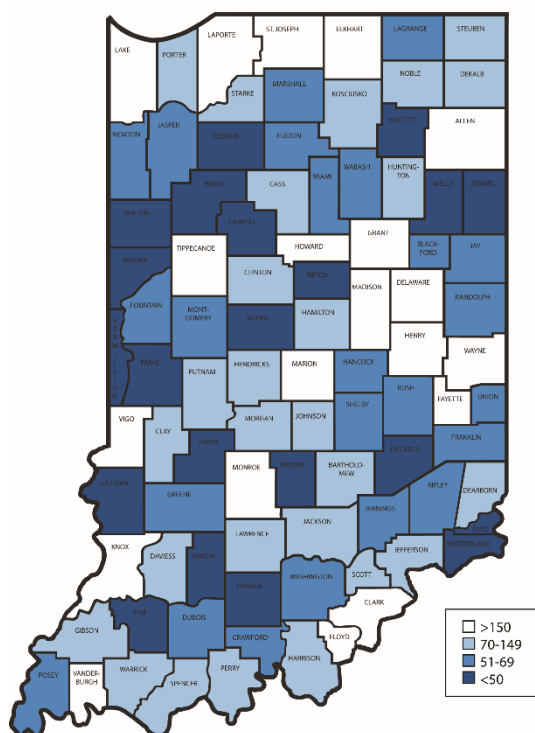
2.3 School Readiness and Achievement

Indiana’s ability to assure children are ready for school, can read at grade level by third grade, graduate from high school, pursue a post-secondary education and contribute to the economy is influenced by the healthy development of our youngest children.¹⁹

2.3.1 Early Head Start and Head Start Slots

Head Start is a federal program that promotes the school readiness of children under five from low-income families by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children's growth in many areas such as language, literacy and social and emotional development. Head Start emphasizes the role of parents as their child's first and most important teacher. These programs help build relationships

Figure 9: Head Start Slots



¹⁸ <https://www.dosomething.org/us/facts/11-facts-about-high-school-dropout-rates>

¹⁹ http://www.elacindiana.org/elacindiana/wp-content/uploads/2016/01/Indiana-Infant-Toddler_PolicyBrief-1.pdf

with families that support family well-being and many other important areas. Early Head Start programs serve infants, toddlers and pregnant women and their families who have incomes below the federal poverty level. Early Head Start programs were established in recognition of the mounting evidence that the earliest years matter a great deal to a child's growth and development.²⁰

The Head Start and Early Head Start programs are administered by the Office of Head Start, within the Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS). The Office of Head Start (OHS) administers grant funding and oversight to the 1,700 public and private nonprofit and for-profit agencies that provide Head Start services.²¹ In 2014, there were 927,275 slots for Early Head Start/Head Start across states. In Indiana, there were 1,945 Early Head Start slots and 13,598 Head Start slots. Forty-three counties had no slots for Early Head Start. The number of slots in Early Head Start ranged from 10 to 1,898 in the remaining forty-nine counties that had slots for Early Head Start.

2.3.2 Students in Grade 3 Passing IREAD

The purpose of the *Indiana Reading Evaluation and Determination (IREAD-3)* assessment is to measure foundational reading standards through grade three. Based on the Indiana Academic Standards, *IREAD-3* is a summative assessment that was developed in accordance with House Enrolled Act 1367 (also known as Public Law 109 in 2010), which "requires the evaluation of reading skills for students who are in grade three beginning in the Spring of 2012 to ensure that all students can read proficiently before moving on to grade four."²² In 2014, 90.3% of children in 3rd grade in Indiana passed their IREAD exam. The range across counties was 81.7% to 97.3%.

2.3.3 4th Graders Passing ISTEP

The purpose of the Indiana Statewide Testing for Educational Progress-Plus (ISTEP+) Indiana Statewide Testing for Educational Progress Plus (ISTEP+) program is to measure

²⁰ <http://www.in.gov/fssa/carefinder/2679.htm>

²¹ <https://www.acf.hhs.gov/ohs/about/what-we-do>

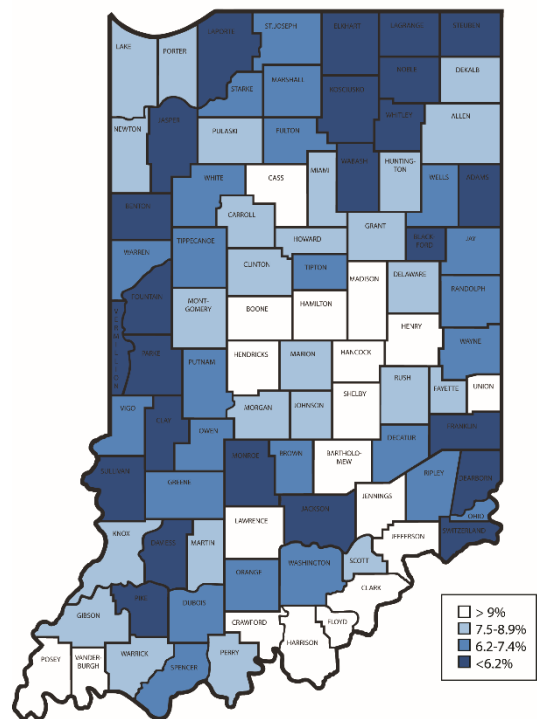
²² <http://www.doe.in.gov/assessment/iread-3>

student achievement in the subject areas of English/Language Arts, Mathematics, Science (Grades 4 and 6), and Social Studies (Grades 5 and 7). In particular, ISTEP+ reports student achievement levels according to the Indiana Academic Standards that were adopted by the Indiana State Board of Education. The assessments are administered in two parts: Part 1 consists of applied skills (open-ended) items, and Part 2 includes multiple-choice and technology-enhanced items. Both Part 1 and Part 2 are required components of the ISTEP+ program and are used to measure student mastery of the Indiana Academic Standards.²³ In 2014, 77.5% of students in 4th grade passed their ISTEP testing. The range across Indiana counties was 61.5% to 90.3% for students in 4th grad who passed their ISTEP testing.

2.3.4 First Steps Enrollment

First Steps is Indiana’s response to Part C of the federal Individuals with Disabilities Education Act (IDEA). Part C was designed by Congress to be a family-centered, interagency, community-based, coordinated system of supports and services for infants and toddlers (birth to age 3) with disabilities and their families. In accordance with IDEA, each state and jurisdiction selects a lead agency to administer the program and establish eligibility criteria. In Indiana, the lead agency is the Family and Social Services Administration. In 2014, Indiana ranked 13 on the percentage of infants and toddlers served at 3.79%. The range across all states was 1% to 8.89% with a national average of 2.95%. The percentage served across Indiana counties ranged from 2.7% to 12.4%.

Figure 10: Birth to Three Population Enrolled in First Steps



²³ <http://www.doe.in.gov/assessment/istep-grades-3-8>

2.3.5 Children with Limited English Proficiency

“In 2013, approximately 61.6 million individuals, foreign and U.S. born, spoke a language other than English at home. While most of these individuals also spoke English with native fluency or very well, about 41 percent (25.1 million) were considered Limited English Proficient (LEP). Limited English proficiency refers to anyone above the age of 5 who reported speaking English less than “very well,” as classified by the U.S. Census Bureau. Though most LEP individuals are immigrants, nearly 19 percent (4.7 million) were born in the United States, most to immigrant parents. Overall, the LEP population represented 8 percent of the total U.S. population ages 5 and older.”²⁴ In Indiana, 5.3% of children in public school meet the definition of limited English proficiency. This compares to the national figure of 4%. Four counties in Indiana report 0% of children with limited English proficiency while the highest percentage in an Indiana county was 16.5%.

2.3.6 Adults with a High School Diploma or Equivalent

In Indiana, 34.3% of adults 25 years and older had a high school diploma or equivalency. This compares to 27.6% of adults nationally. The total receiving a high school diploma or more is 88.2%, with 24.9% completing a bachelor’s degree or higher level of education. Across Indiana counties, the percentage of adults with a high school diploma ranged from 16.1% to 49.9%.

2.4 Child Maltreatment

Research over the last two decades has consistently confirmed that providing education and support services to parents around the time of a child’s birth, and continuing for months or years afterwards, significantly reduces the risk of child maltreatment and contributes to positive, healthy child rearing practices. Families receiving this type of intensive home visitor service also show other positive changes such as consistent use of preventive health services, increased high school completion rates for teen parents, higher employment rates, lower welfare use and fewer pregnancies.²⁵ Healthy Families Indiana was established in 1994 as a tool to reduce the incidence of child maltreatment which

²⁴ <http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>

²⁵ <http://www.in.gov/dcs/2459.htm>

includes child abuse and neglect. Indiana captures two main categories of child maltreatment: abuse and neglect. Within the category of abuse, both physical and sexual abuse are documented. There is a hierarchy of maltreatment as defined at the federal level: sexual abuse, physical abuse and then neglect²⁶. The data that follow reflect those cases that were investigated and the charges were substantiated in 2014. There were approximately 198,000 reports made to the Department of Child Services hotline in 2014. This figure represents the number of reports and does not represent the number of children or families investigated since there can be multiple reports regarding a single family. Thus, each of the percentages below reflects the proportion of reports, by allegation type, that DCS substantiated using the preponderance of evidence standard and do not reflect the proportion of children experiencing maltreatment in the state of Indiana.

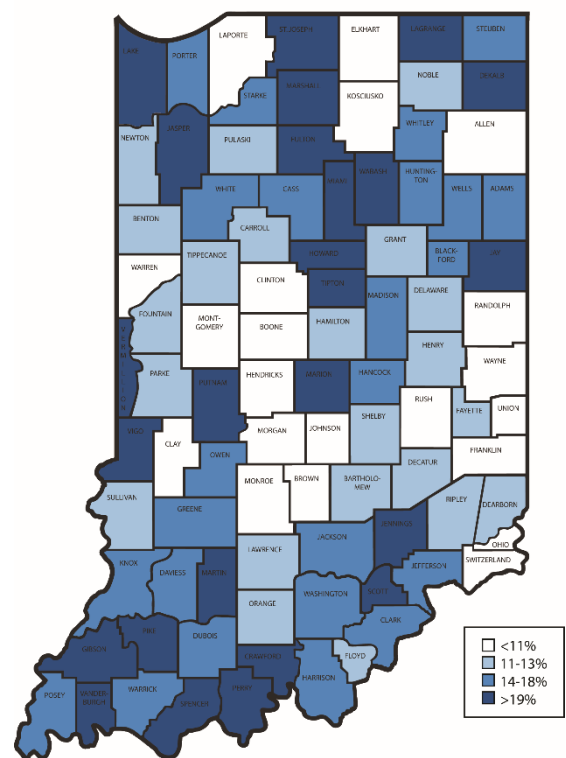
2.4.1 Substantiated Neglect

In Indiana, 16.7% of the reported neglect cases that were investigated by the Department of Child Services were substantiated. The range across Indiana counties was 5.8% to 36%.

2.4.2 Substantiated Physical Abuse

In Indiana, 7.9% of the reported physical abuse cases that were investigated by the Department of Child Services were substantiated. The range across Indiana counties was 0.0% to 25.6%.

Figure 11: Substantiated Neglect



²⁶ <https://www.childwelfare.gov/pubPDFs/define.pdf>

2.4.3 Substantiated Sexual Abuse

In Indiana, 16.4% of the reported sexual abuse cases that were investigated by the Department of Child Services were substantiated. The range across Indiana counties was 6.3% to 35.7%.

2.5 Crime and Domestic Violence

Most home visiting models focused on young children do not have an explicit, primary goal of reducing juvenile delinquency, family violence, and crime. However, home visiting models do seek to reduce risky parental behaviors that are related to criminal behavior by the parent and future behavior of their children. Provision of services and linkages to community resources such as domestic violence shelters may affect families' long-term well-being and reduce the likelihood of adult criminal behavior and family violence. Many home visiting program models provide parenting education and parent-child interaction activities, which may improve parents' capacity to manage their children's behaviors and set children on a trajectory in which they are less likely to engage in later risky behaviors such as juvenile delinquency. It is not unreasonable to suggest that evidence based home visiting programs, through secondary outcomes, may help communities in reducing their crime and family violence rates over time. However, the strength of the relationship between home visiting programs and future criminal behavior has not been well measured.

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²⁷ <https://homvee.acf.hhs.gov/Outcome/2/Reductions-Juvenile-Delinquency-Family-Violence-Crime/5/1>

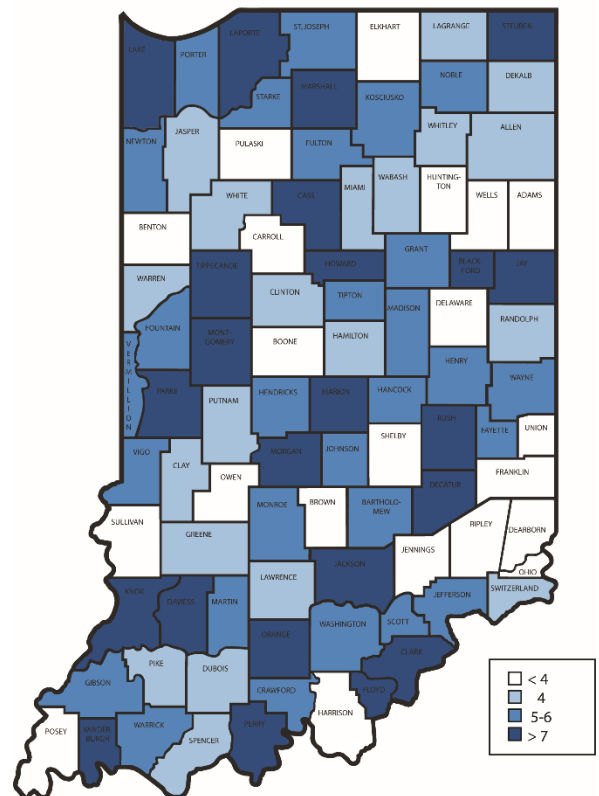
2.5.1 Drug Related Arrests per 1,000

The Uniform Crime Reporting System is a national database for law enforcement programs to report arrests. The data represent reported crimes in the vicinity where the arrest occurred, rather than the area of residence of the arrestee. The reporting uses only four drug categories: 1) Opium, cocaine and their derivatives, 2) marijuana, 3) other dangerous non-narcotic drugs such as barbiturates and Bensedrine and 4) synthetic narcotics such as Demerol and methadone.²⁸ In 2012, the arrest rate in Indiana was 6 per 1,000 with a range of 1 to 14 arrests per 1,000 across Indiana counties.

2.5.2 Domestic Violence Residential/Non-Residential Slots

On September 16, 2015, 45 out of 45 (100%) identified domestic violence programs in Indiana participated in the 2015 National Census of Domestic Violence Services. The following figures represent the information provided by 45 participating programs about services provided during the 24-hour survey period. 1,231 domestic violence victims (619 children and 612 adults) found refuge in emergency shelters or transitional housing provided by local domestic violence programs. 632 adults and children received non-residential assistance and services, including counseling, legal advocacy, and children’s support groups.

Figure 12: Drug-Related Arrests per 1,000



²⁸ http://www.drugs.indiana.edu/main/GIS_table.php?page_group=21&tablename=Intro2.2

Living in shelter may be stressful in and of itself, given the fact that the family has been uprooted in a situation of crisis and danger. The combination of experiencing trauma and being in shelter may be especially challenging for both children and their caregivers. Research has shown that trauma can impact children’s brain function and structure, altering their cognitive, emotional, and behavioral development. In young children who have experienced early, chronic violence, particularly at the hands of their caregivers, their brains end up focusing their energy on survival instead of higher reasoning and learning. Having a parent provide emotionally responsive caregiving, including mother’s warmth and emotional stability, are some predictors for a child’s healthy recovery from domestic violence exposure.²⁹ As mentioned earlier in this document, home visiting services promote strong parent-child attachment and support parents to foster their child’s development.

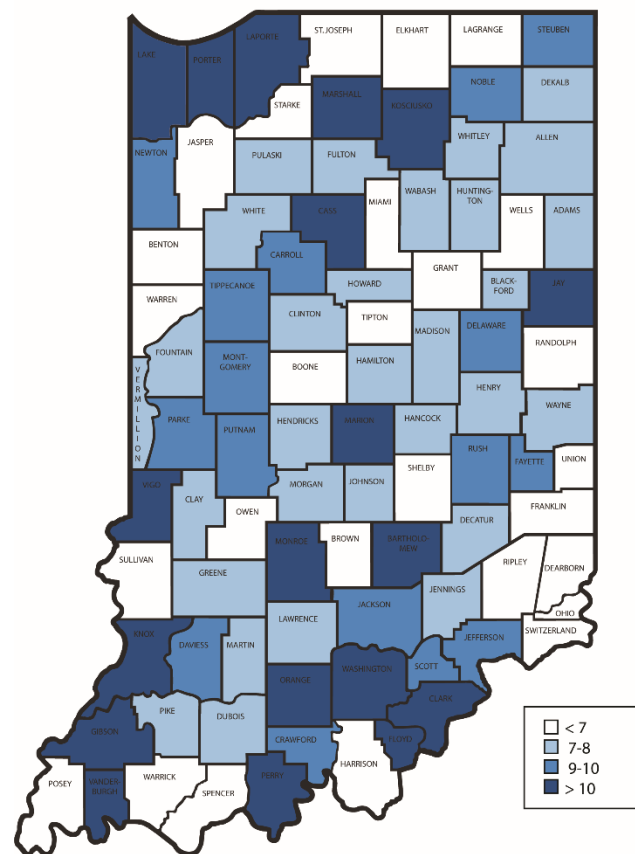
2.5.3 Alcohol Related Arrests per 1,000

Alcohol related arrests include operating a vehicle while intoxicated, public intoxication, and liquor law violations. In 2012, the Indiana rate was 9 arrests per 1,000 with a range from 3 to 15 per 1,000 for Indiana counties.

3.0 Indiana Home Visiting Advisory Board (INHVAB)

The impetus behind the Indiana Home Visiting Advisory Board (INHVAB) is to create a board with centralized knowledge that would provide a

Figure 13: Alcohol-Related Arrests per 1,000



²⁹ https://childandfamilypolicy.duke.edu/pdfs/projects/CCFH_Toolkit.pdf

framework for collaboration, inform home visiting practice and policy related to home visiting in the state of Indiana.

3.1 Vision, Mission and Goals

The goal of INHVAB is to coordinate, promote and define home visiting efforts in Indiana. The INHVAB will utilize data to assess need, identify service gaps, maximize resources and inform policy to improve health and development outcomes for Hoosier families and children.

The mission of INHVAB is to build partnerships among State agencies and Indiana home visiting programs, that optimize health outcomes for mother and child; support families in raising physically, socially and emotionally healthy children who are ready to learn; and build protective factors to prevent adverse experiences. Through these partnerships communities are strengthened and families have the resilience, skills and tools to thrive.

3.2 Member Organizations

State agencies that are members of INHVAB include Indiana State Department of Health (ISDH), Indiana Department of Child Services (DCS), Indiana Department of Corrections (DOC), Department of Workforce Development (DWD), and multiple divisions of the Family and Social Services Administration (FSSA) including the Office of Early Childhood and Out of School Learning (OECOSL), Division of Mental Health and Addiction (DMHA), and Department of Family Resources (DFR). A listing of members is included in Appendix B.

3.3 Definition of Home Visiting

INHVAB has been working with others to define home visiting in Indiana. In coordination with Indiana's Early Learning Advisory Council (ELAC), Family Engagement workgroup, INHVAB adopted a definition of Home Visiting Programs for Indiana in January 2017. In Indiana, Home Visiting Programs "describe evidence-based programs that partner with pregnant women and families with children age birth to five to provide voluntary, individualized services. Home visits can be part of many types of programs; however, this definition is limited to evidence-based programs that focus primarily on home visiting.

More specifically, this definition focused on home visiting programs that have research supporting their efficacy in achieving at least one of the following: optimizing health outcomes for mother and child; supporting families in raising physically, socially and emotionally healthy children; preventing child abuse; achieving school readiness; or helping families to build resiliency so that they can cope with adverse childhood experiences. Program models that meet the U.S. Department of Health and Human Services' "evidence-based" criteria are listed in the Home Visiting Evidence of Effectiveness (HomVEE) Review. Examples of such programs include NFP, HFI, Early Head Start (EHS), and Parents as Teachers (PAT). Home visiting services take place in a setting that is natural and comfortable for the family, such as the home, child care program, or library. Areas of support within home visiting may include: positive parenting, child development, maternal and child health, access to resources and social supports, and family economic self-sufficiency."

4.0 Home Visiting Capacity

Home visiting is a critical tool that Indiana has utilized to address child abuse and support improved outcomes for infants and toddlers and their families. While there has been substantial expansion of home visiting programs over the last several years, as demonstrated below, the need for expanded services remains a priority.

4.1 Healthy Families Indiana

In partnership with Healthy Families America, the national home visitation model, Healthy Families Indiana was launched in 1994. The underlying assumptions of this public/private partnership are:

- Parents are responsible for their children.
- Families have strengths which need to be recognized.
- When services are delivered, families should be actively involved in decisions which affect their lives.

- Service systems should be available to intervene early and be preventive in nature to avoid family crisis.
- Successful Healthy Families Programs are locally driven, collaborative in nature and build upon and strengthen existing and new partnerships.
- Program accountability is linked to results and continuous improvement.³⁰

Healthy Families Indiana (HFI), accredited by Healthy Families America, is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. The Indiana Department of Child Services (DCS) contracts for home visiting services with providers whose trained staff provide assessment and home visiting services in all 92 Indiana counties. HFI is funded by three different funding streams: Temporary Assistance for Needy Families (TANF); State; and MIECHV (9 sites around the state) through the Department of Child Services. HFI serves eligible families of children prenatally to age three. Currently to qualify for services, a family's income must be at or below 250% of the federal poverty line and the family must score 40 or higher on the Parent Stress Checklist. At the onset of services, each enrolled family is typically visited once a week for a minimum of six months. Thereafter, based on well-defined criteria regarding family need, progress, and engagement in the program the required number of visits per family per month may be increased or decreased. The HFI program uses a variety of curricula based on the needs of the families and their personal learning styles.

HFI has six primary program goals:

1. Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth;
2. Cultivate and strengthen nurturing parent-child relationships;
3. Promote healthy childhood growth and development;

³⁰ Healthy Families Indiana Strategic Plan January 1996.

4. Enhance family functioning by reducing risk and building protective factors;
5. Promote safe environments for children and families; and
6. Provide staff with the training and support needed for their professional well-being.

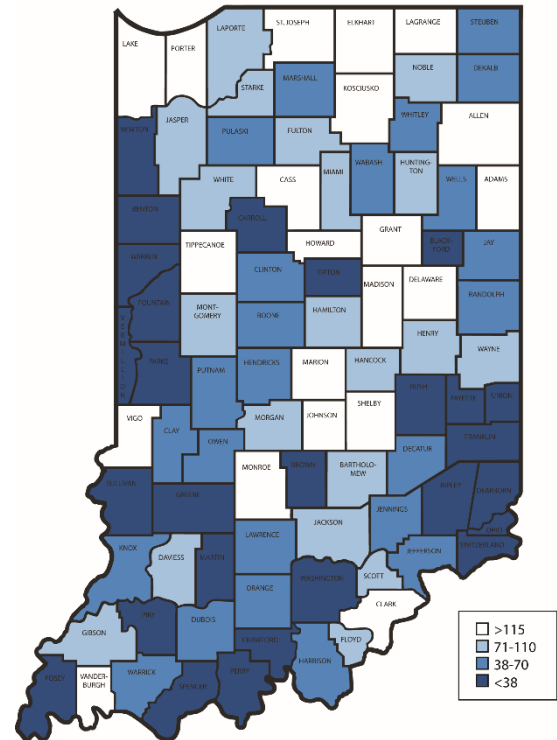
Each goal has several measurable objectives by which to be assessed. These objectives are operationalized and analyzed at least once a year.³¹

Enrollees

Data were reviewed for the five-year period of 2010-2014. During that time frame:

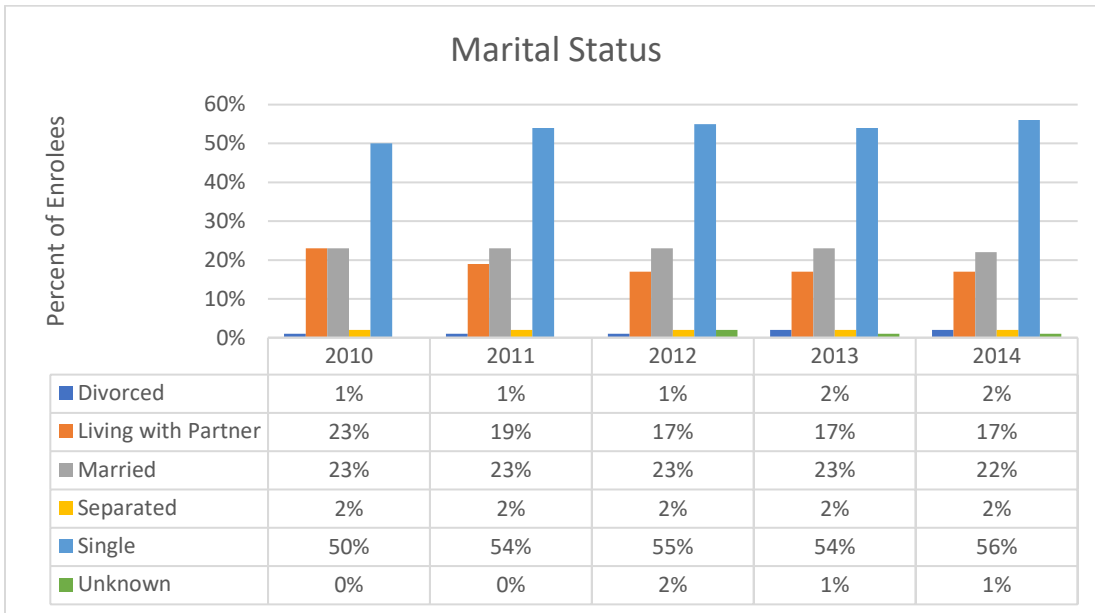
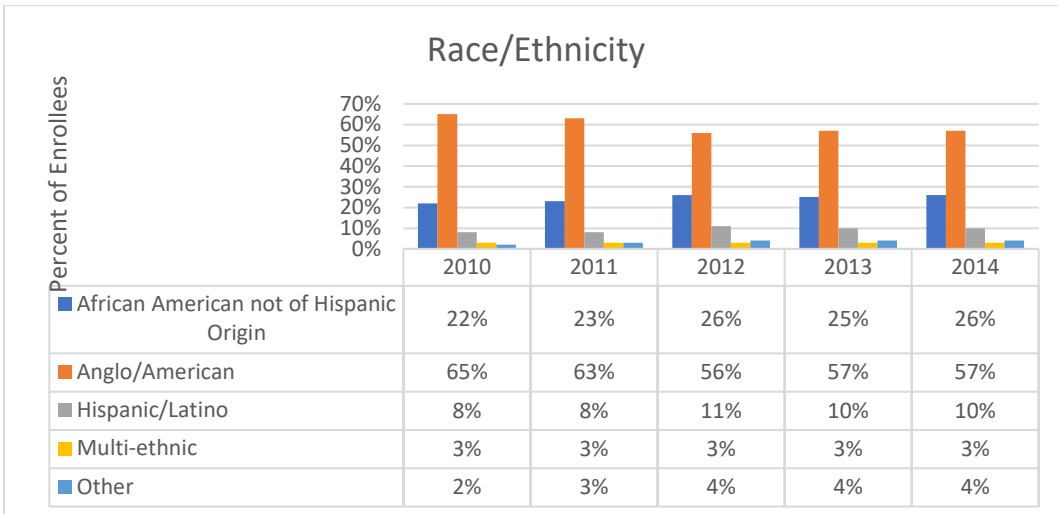
- There were 179,996 families referred to HFI Home Visiting Programs;
- Out of those 179,996 families, 120,709 families had a completed Screen (67%);
- 109,919 families screened positive (91%);
- Out of those that screened positive, 53,666 families agreed to an assessment using the Parent Survey Assessment Tool (45%);
- The Mother of the Baby (MOB) was the person assessed 99% of the time;
- Out of those families that were given the Parent Survey Assessment Tool, 46,242 were documented as Positive Assessments (86%);
- 39,143 families were offered home visiting services (85%); and
- 24,615 families accepted services and had a first home visit (63%).

Figure 14: Children Served by Healthy Families Indiana

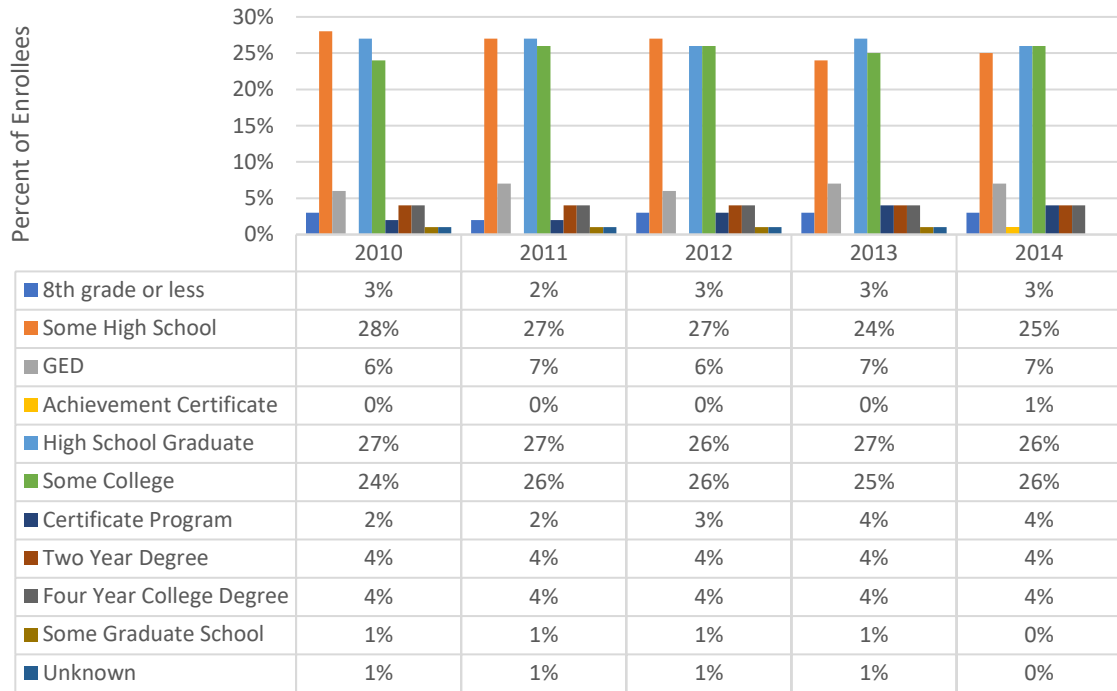


The following charts provide a demographic profile of the participants in the Healthy Families Indiana program.

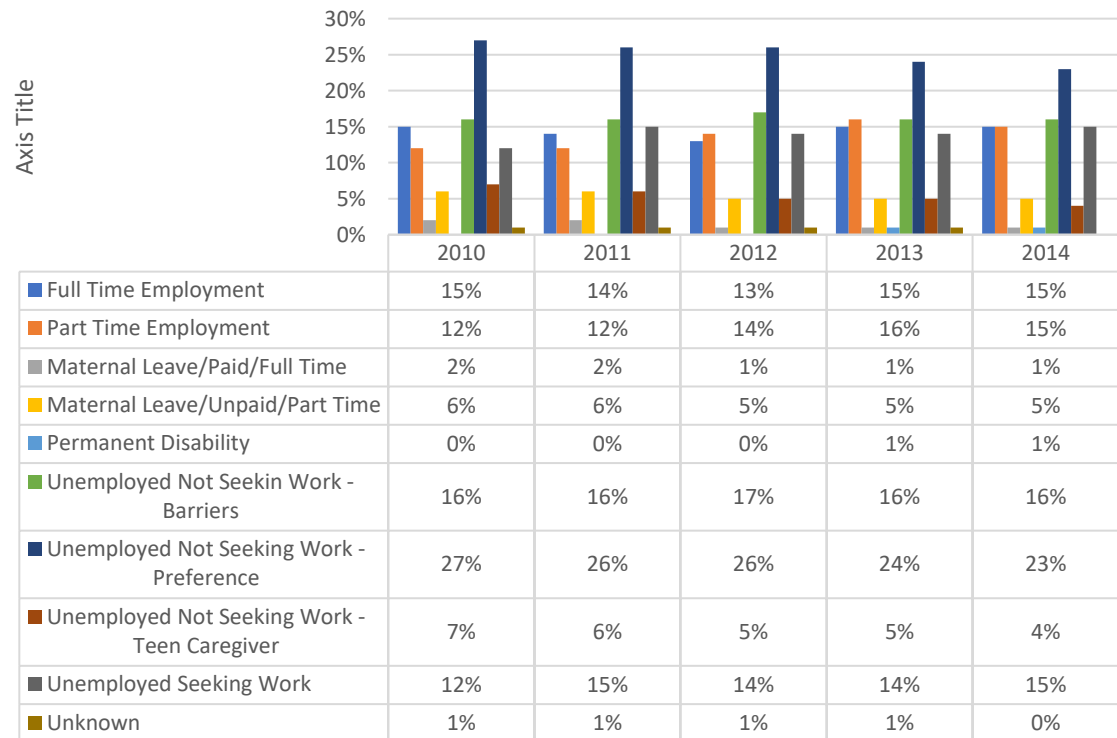
³¹ Healthy Families Indiana State Intake Report for 2010-2014



Education Status



Employment Status



In an October 2016 report,³² the Home Observation Measurement of Environment (HOME) Inventory records of 11,000 families enrolled from 7/1/2014-6/30/2015 were analyzed. “The HOME Inventory is designed to give a picture of the home learning environment from the child’s point of view. Scores are based on both observations and information obtained from the parent during the home visit...”. The inventory is recommended to be given at 2 months, at 4 months, at 12 months and at 18 months after birth to evaluate the impact of the Healthy Families program on the care and support provided by parents to their child. Data for the following Healthy Families goals were analyzed:

- Cultivate and strengthen nurturing parent child relationships;
- Promote healthy childhood growth and development; and
- Promote safe environments for children and families.

The data indicated that the families participating in the HFI programs are showing great improvement among most areas of the inventory. The only area where the desired result was not achieved related specifically to parents’ acceptance of less than optimal behavior and avoidance of undue restriction and punishment. The report attributed that to the child’s developmental milestones occurring during each of the measured time points (2 months to 18 months old).

4.2 Nurse Family Partnership

Nurse-Family Partnership® (NFP) is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child’s second birthday. Independent research conducted at the national level, proves that communities benefit from this relationship — every dollar invested in Nurse-Family Partnership can yield more than five dollars in return. The Nurse Family Partnership has three goals:

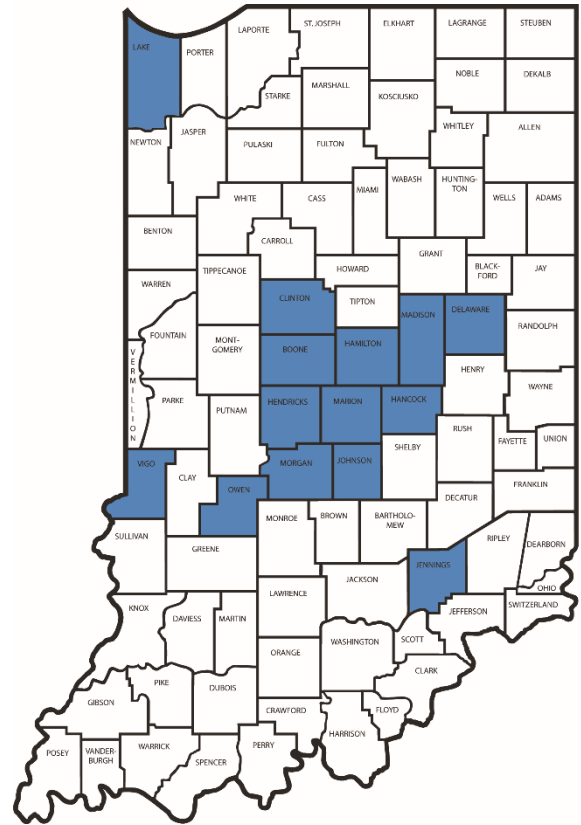
³² Home Observation Measurement of Environment (HOME) Inventory for Healthy Families Indiana FY 2015, October 2016

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.³³

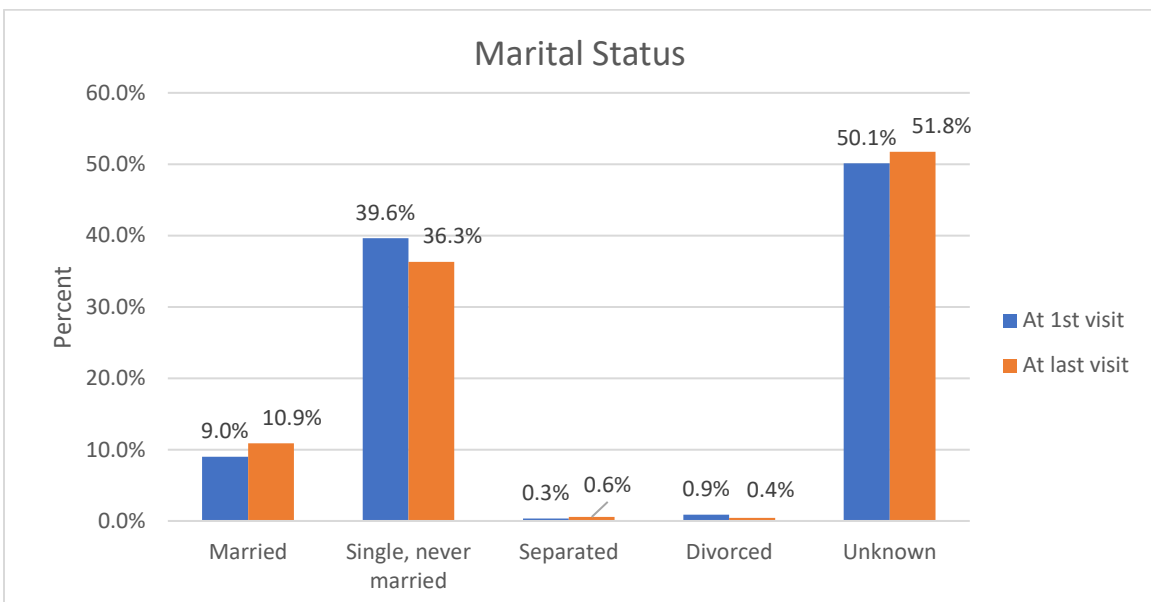
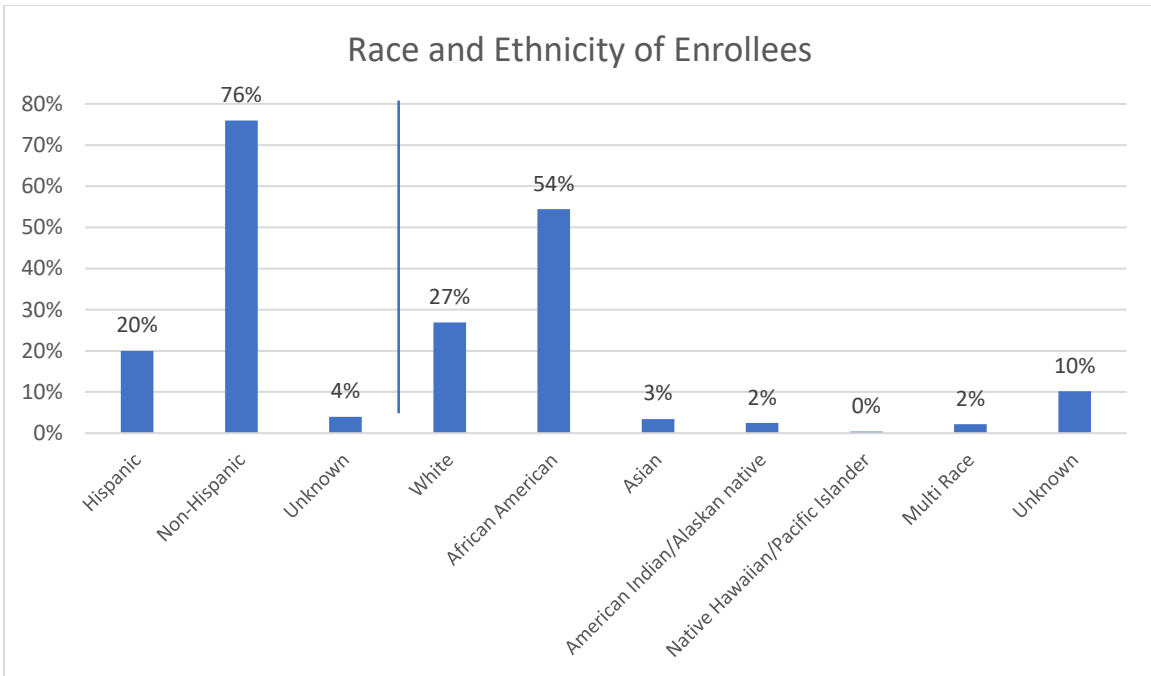
In 2011, the Nurse Family Partnership (NFP) was established in collaboration with Goodwill of Central and Southern Indiana with funding through MIECHV. In 2016, 148 women and their children completed the NFP program. Indiana’s implementation of NFP was recognized as a model for a two-generation approach to combat generational poverty by the Aspen Institute.

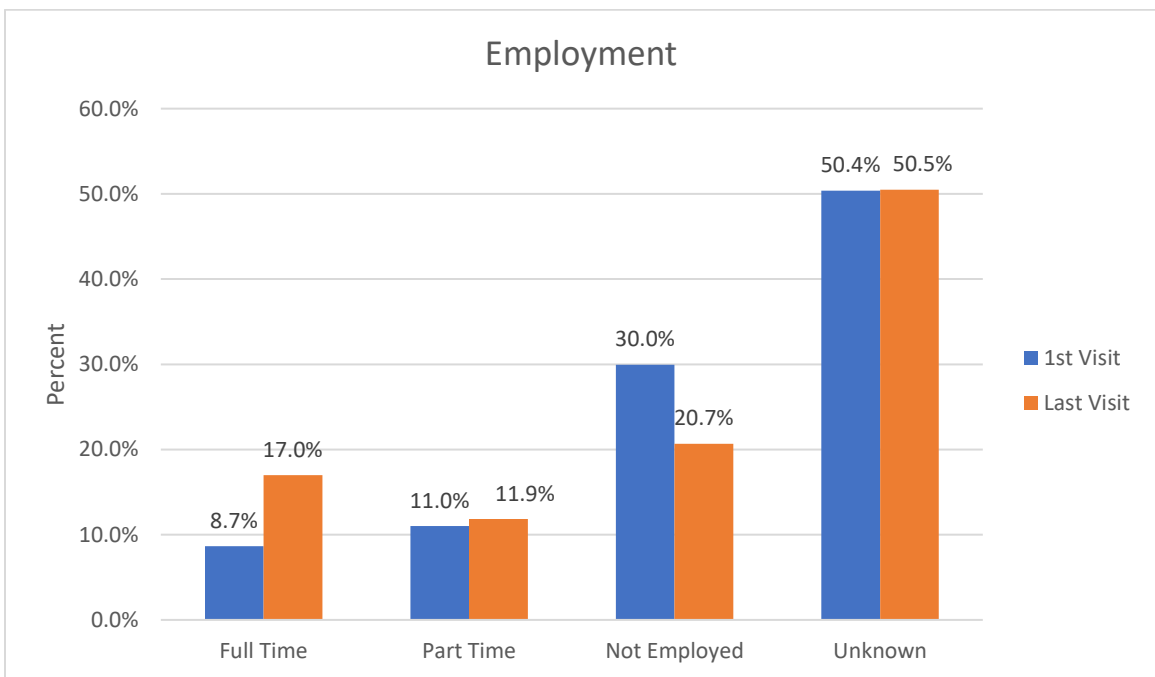
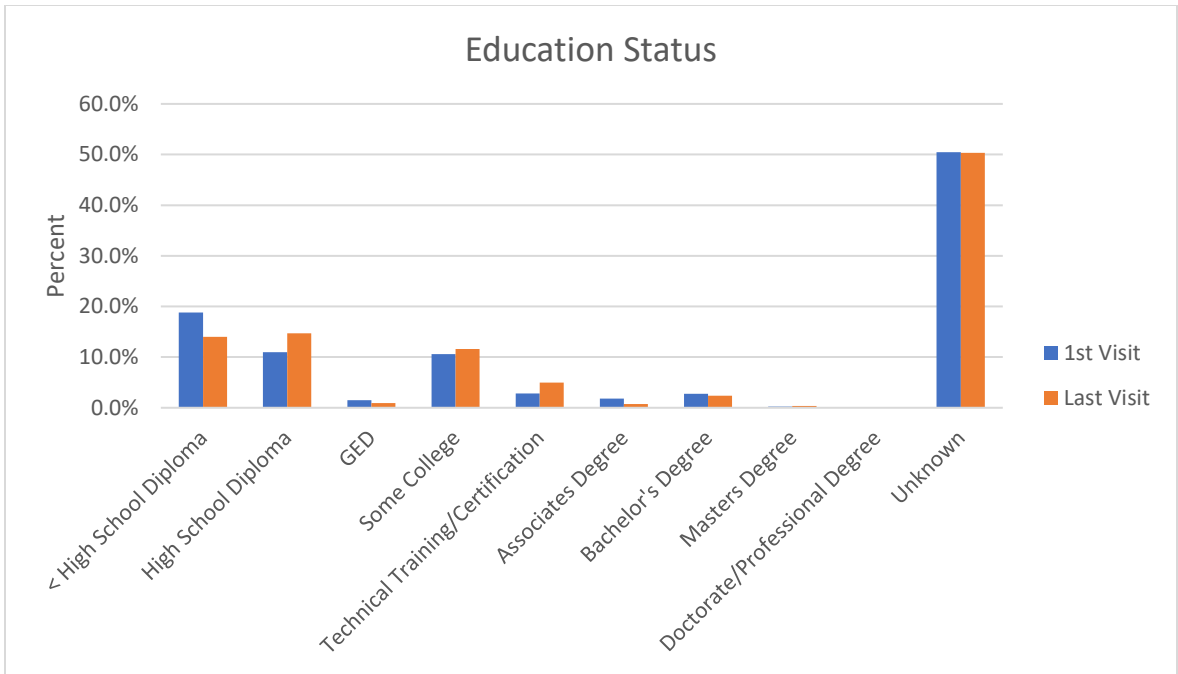
The following charts provide a demographic profile of NFP participants.

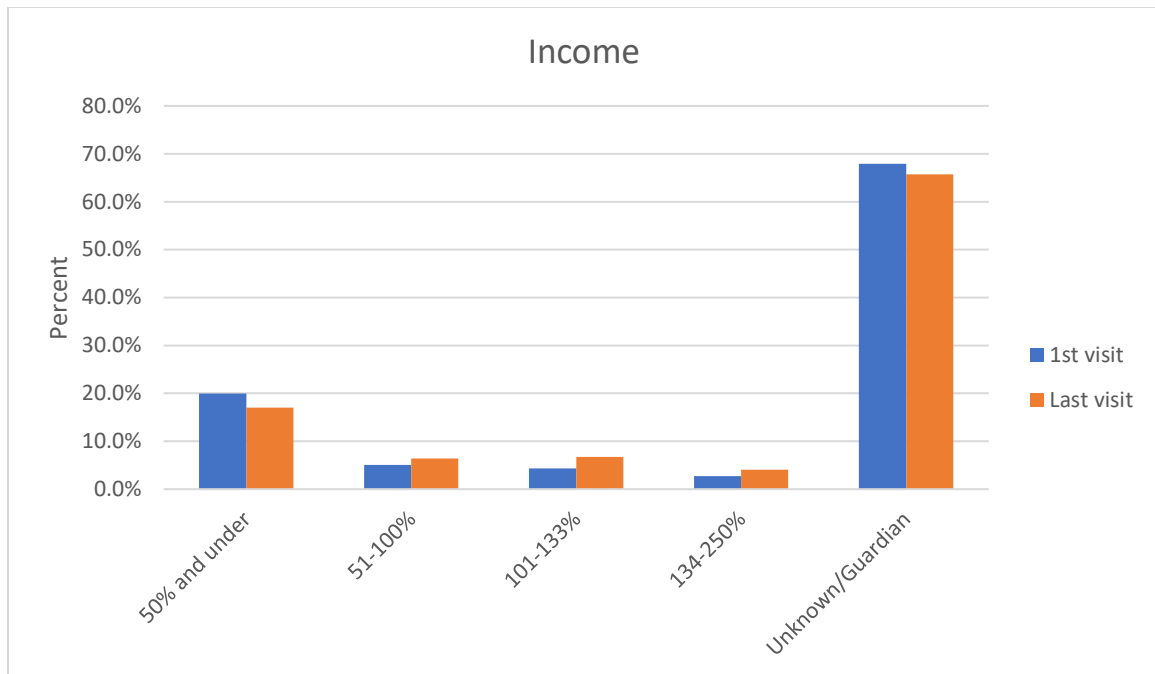
Figure 15: Nurse Family Partnership Counties



³³ http://www.goodwillindy.org/wp-content/uploads/2016/09/NFP-2016-IN_State_Profile.pdf





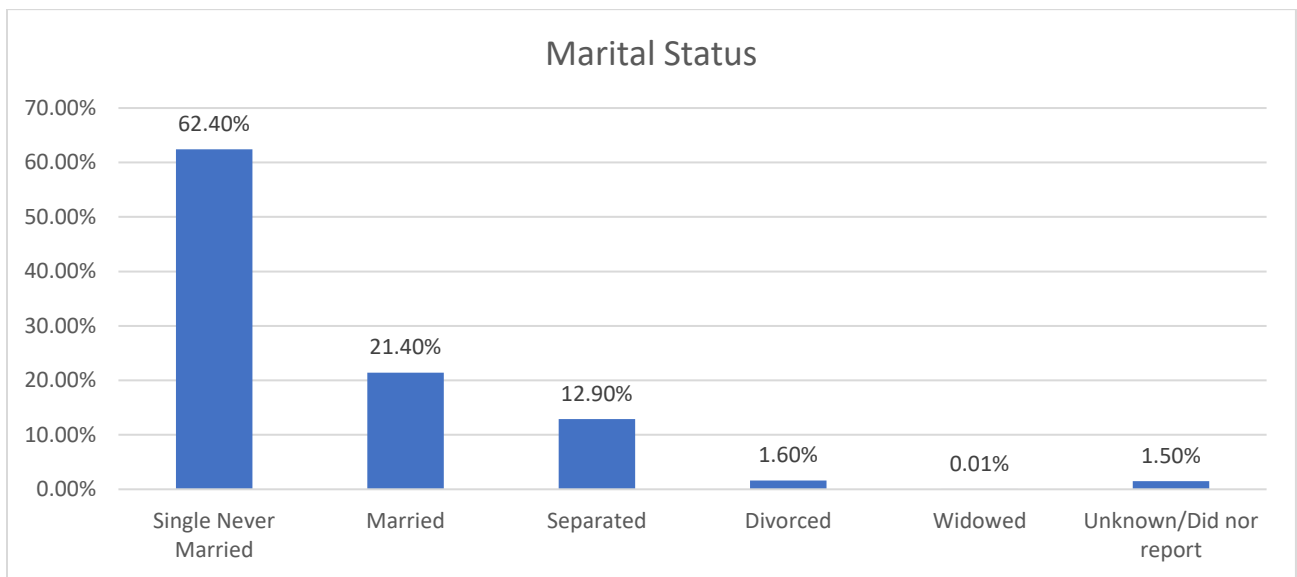
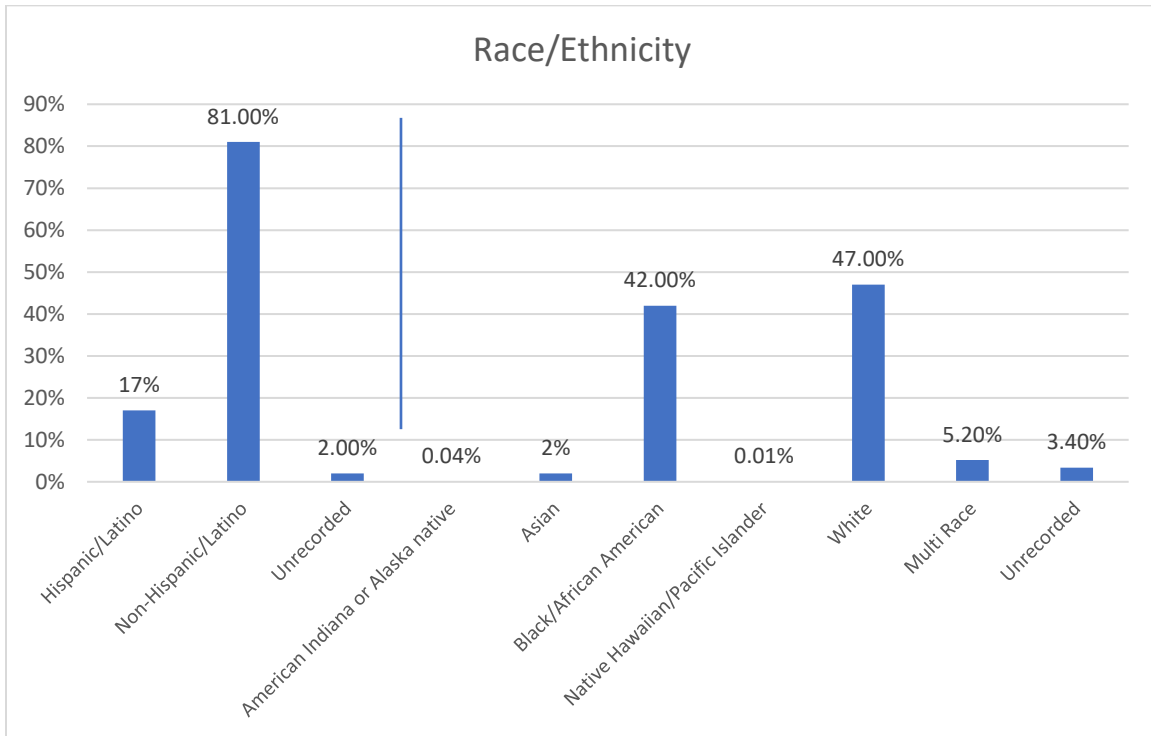


In the 2016 annual report for Indiana, NFP reported the following outcomes:

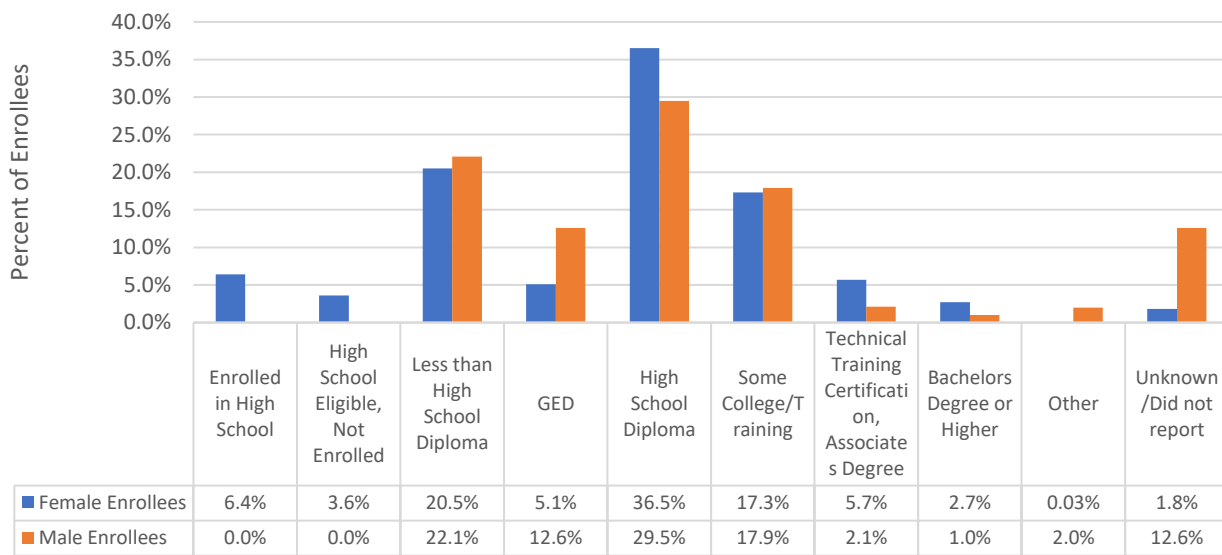
- On average NFP moms began prenatal care at nine weeks.
- 90% of babies were born at 5.5 pounds or more (Healthy People 2020 goal is 92%).
- 93% of babies were born at full term (Healthy People 2020 goal is 89%).
- 93% of mothers initiated breastfeeding.
 - 41% still breastfeeding at 6 months.
 - 34% at 12 months.
- 12% of mothers self-reported tobacco use during pregnancy.
 - 56% quit tobacco use before their child's birth.
 - 93% quit or reduced tobacco use before their child's birth.
- 98% of babies were up-to-date with immunizations at 6 months.
 - 98% up-to-date at 12 months.
 - 96% up-to-date at 24 months.

4.3 MIECHV Demographics

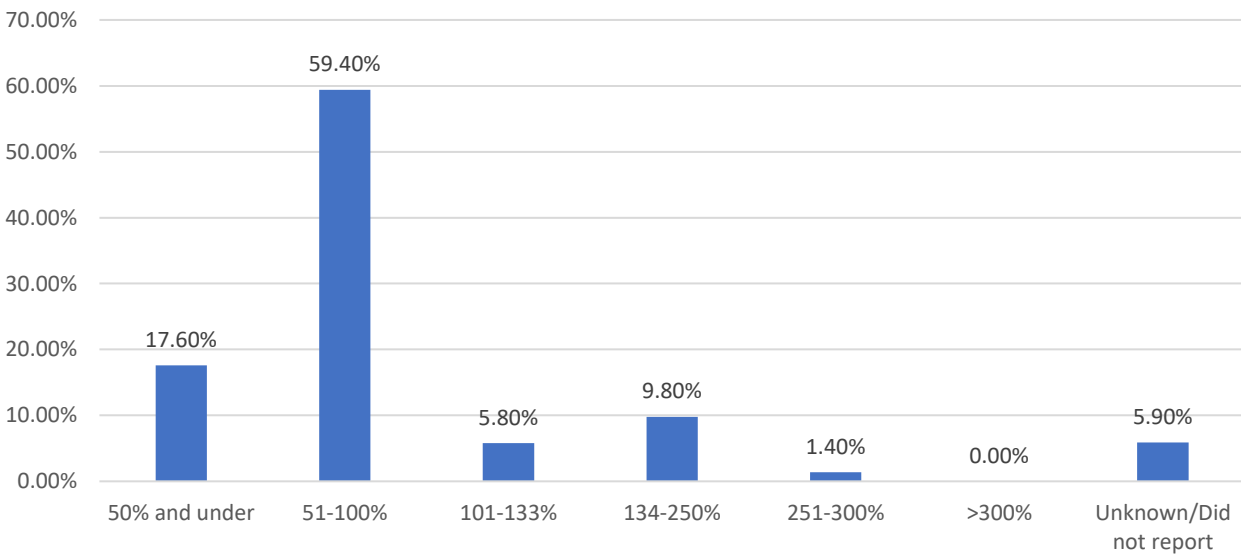
During the MIECHV reporting period of October 1, 2015 to September 30, 2016, HFI and NFP enrolled 1,447 new households into MIECHV-funded home visiting. The following charts look at demographic characteristics of the MIECHV-funded participants during the reporting period.

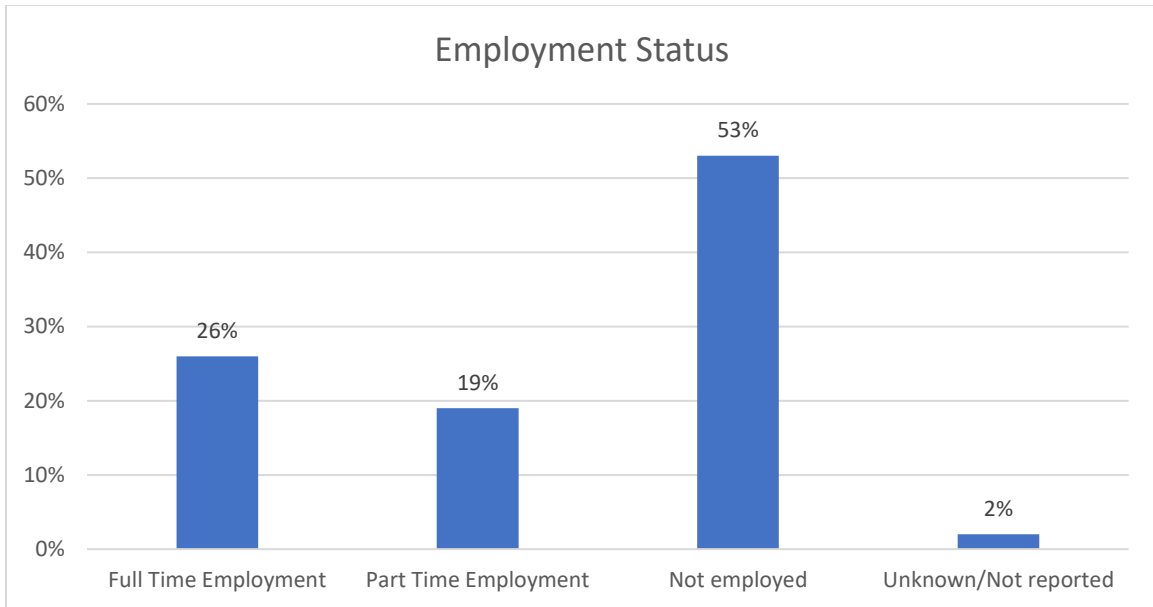


Educational Status



Household Income in relation to Federal Poverty Guidelines





4.4 Early Head Start

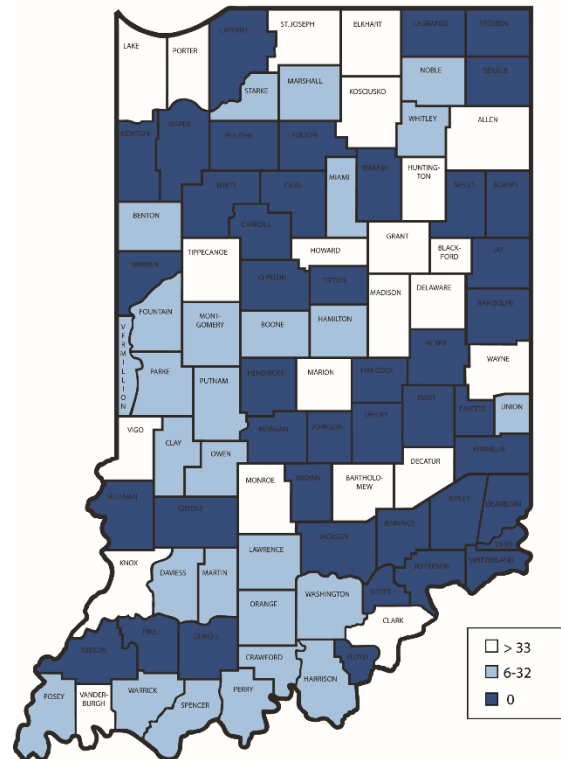
Early Head Start³⁴ provides early, continuous, intensive, and comprehensive child development and family support services to low-income infants and toddlers and their families, and pregnant women and their families. The Goals of Early Head Start are:

- To provide safe and developmentally enriching care-giving which promotes the physical, cognitive, social and emotional development of infants and toddlers, and prepares them for future growth and development;
- To support parents, both mothers and fathers, in their role as primary caregivers and teachers of their children, and families in meeting personal goals and achieving self-sufficiency across a wide variety of domains;
- To mobilize communities to provide the resources and environment necessary to ensure a comprehensive, integrated array of services and support for families; and
- To ensure the provision of high quality responsive services to family through the development of trained, and caring staff.

³⁴ http://www.in.gov/fssa/files/2015_Needs_Based_Assessment.pdf

All Early Head Start programs serve families through a full day, full year program option that best meets the needs of their families. Program options are determined through the data collected from their community needs assessment and conversations with families, provide them with the ability to comprehensively and flexibly meet the needs of families. As infants and toddlers grow and change, and as family needs evolve, diverse program options can support them over time. This ensures that families can grow within a consistent, supportive setting, buttressed by strong relationships and developmentally-appropriate care and services.

Figure 16: Early Head Start Slots



Program options for EHS include the following:

- Center-Based services provide early learning, care and enrichment experiences to children in an early care and education setting. Staff members also visit family homes at least twice per year.
- Home-Based services are provided through weekly home visits to each enrolled child and family. The home visitor provides child-focused visits that promote the parents' ability to support the child's development. Twice per month, the program offers opportunities for parents and children to come together as a group for learning, discussion, and social activity
- Family Child Care services provide care and education to children in a private home or family-like setting.
- Combination services combine both home- and center-based services.

Children from birth to age five who are from families with incomes below the poverty guidelines are eligible for Head Start and Early Head Start services. Children from homeless

families and families receiving public assistance such as TANF or SSI are also eligible.

Foster children are eligible regardless of their foster family's income.

In 2016, Indiana reported 28 Early Head Start programs, with cumulative enrollment of 3,746 children and 293 pregnant women.

4.5 Parents as Teachers

The goal of the Parents as Teachers (PAT) program is to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The PAT model includes one-on-one home visits, monthly group meetings, developmental screenings, and linkages and connections for families to needed resources. Parent educators conduct the home visits using structured visit plans and guided planning tools. Local sites offer at least 12 hour-long home visits annually with more offered to higher-need families. PAT serves families for at least two years between pregnancy and kindergarten. PAT affiliate programs select the target population they plan to serve and the program duration. While the PAT model is utilized in Indiana, there is no state-level data available.

5.0 Substance Abuse Counseling and Treatment Capacity

Neonatal Abstinence Syndrome (NAS) is a drug withdrawal syndrome that presents in newborns after birth when transfer of harmful substances from the mother to the fetus abruptly stops at the time of delivery. NAS most frequently is a result of opioid use in the mother but may also occur because of exposure to benzodiazepines and alcohol. Fetal exposure most frequently occurs for one of three reasons:

- The pregnant woman is dependent/addicted to opioids, either prescribed or illicit;
- The pregnant woman requires treatment with prescription opioids for another disease process; or
- The pregnant woman is receiving prescribed opiate replacement therapy.

The incidence of NAS has increased significantly over the last fifteen years across the United States. In 2000, the rate per 1,000 births was 1.2. In 2009, the rate was 3.39 per 1,000 births. Maternal opiate use has increased even more dramatically. In 2000, the rate was 1.19 per 1000 births per year and in 2009 the rate was 5.63 per 1,000 births per year. The cost of care for infants diagnosed with NAS has also increased from \$190 million in 2000 to \$720 million in 2009.³⁵

In a report released by the Centers for Disease Control and Prevention (CDC),³⁶ prescribers wrote 82.5 Opioid Pain Reliever (OPR) prescriptions and 37.6 benzodiazepine prescriptions per 100 persons in the United States in 2012. The range nationally for OPR was a high of 142.9 per 100 persons for Alabama and a low of 57.0 per 100 persons for California. The range for benzodiazepine prescriptions was a high of 41.5 per 100 persons for Delaware and a low of 34.2 per 100 persons for Illinois. Only eight states had a higher prescribing rate for opioid pain relievers than Indiana's rate of 109.1 per 100 persons and 16 states had a higher prescribing rate for benzodiazepine than Indiana's rate of 42.9 per 100 persons.

In 2014, the 118th Indiana General Assembly passed Senate Bill 408 which added Section 244.8 to Indiana Code 16-18-2 stating:

"Neonatal abstinence syndrome" and "NAS", for purposes of IC 16-19-16, refer to the various adverse effects that occur in a newborn infant who was exposed to addictive illegal or prescription drugs while in the mother's womb.

The legislation added IC 16-19-16 which required that the Indiana State Department of Health (ISDH) establish a task force that included, at a minimum, representatives from the Indiana Hospital Association, the Indiana Perinatal Network, the Indiana State Medical Association, the Indiana Chapter of the American Academy of Pediatrics, the Indiana

³⁵ Patrick S, Schumacher R, Benneyworth B, *et al.* "Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009." *JAMA*. 2012. 307(18):1934-40.

³⁶ http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm?s_cid=mm6326a2

Section of the American Congress of Obstetricians and Gynecologists, and the Indiana Chapter of the March of Dimes. The task force was charged with five deliverables:

- (1) The appropriate standard clinical definition of "Neonatal Abstinence Syndrome";*
- (2) The development of a uniform process of identifying Neonatal Abstinence Syndrome;*
- (3) The estimated time and resources needed to educate hospital personnel in implementing an appropriate and uniform process for identifying Neonatal Abstinence Syndrome;*
- (4) The identification and review of appropriate data reporting options available for the reporting of Neonatal Abstinence Syndrome data to the state department, including recommendations for reporting of Neonatal Abstinence Syndrome using existing data reporting options or new data reporting options; and*
- (5) The identification of whether payment methodologies for identifying Neonatal Abstinence Syndrome and the reporting of Neonatal Abstinence Syndrome data are currently available or needed.*

The Task Force was convened in May 2014 with approximately 50 members who met monthly to accomplish the deliverables. The committee reviewed national guidelines, relevant literature and practices related to NAS developed by other states to fully inform the decision-making process. After completion of the review process and substantive discussion of the issues related to NAS, the Task Force recommended that the diagnosis of NAS should be applied to babies who meet the following criteria:

- Symptomatic;
- Have two or three consecutive Modified Finnegan scores equal to or greater than a total of 24; and
- Have one of the following:
 - A positive toxicology test, or
 - A maternal history with a positive verbal screen or toxicology test.

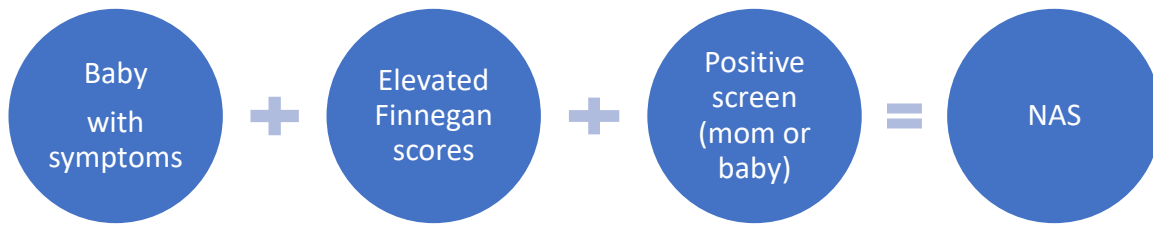


Figure 17: NAS Diagnosis Pathway

Additional recommendations included an identification process for the pregnant woman and her newborn along with a discussion of screening tools, an educational agenda for hospital and other medical personnel, and data elements that need to be collected to document the prevalence of this diagnosis.

The task force completed their report to the General Assembly in October 2014. While the work described above was completed, the Senate bill had also requested that the State Department of Health establish one (1) or more pilot programs with volunteer hospitals to implement appropriate and effective models for Neonatal Abstinence Syndrome identification, data collection, and reporting.

In 2016, Indiana implemented a pilot process with four delivering hospitals. The goal of the pilot was to establish the prevalence of NAS in Indiana and to test the processes used for expansion to all delivering hospitals. There were two major components to the pilot process:

1. Prenatal Care: The protocol included a verbal screen using the 4Ps and based on the results of the screen, a confirmatory urine toxicology test. This would be conducted at the first prenatal visit. The same process is implemented at presentation at the hospital for delivery. Because this was not legislatively mandated, pregnant women could exercise and opt-out from the verbal and toxicology screening.
2. Newborn Care: Cord tissue testing is conducted if there was a maternal positive verbal screen or urine test or if there are symptoms indicating the need for testing.

The hospitals tested the following components:

- A common definition of NAS;
- Comprehensive and uniform staff training in the use of the Finnegan Neonatal Abstinence Scoring Tool to determine the newborn's status;
- Universal screening of pregnant women at the first prenatal visit and when presenting for delivery;
- Screening of newborns whose mothers have had a positive screen or who have opted out of the screening protocol;
- Therapy protocol for providers for the treatment of pregnant women dealing with dependence/addiction
- Educational materials for patients (in English and Spanish) and providers
- Referrals for behavioral health supports; and
- Collection of a common set of data.

At the end of six months, the pilot hospitals deemed the protocols and materials as needing no additional changes. The ISDH then invited additional hospitals to participate in the next phase of the initiative expecting that and additional four to five hospitals would volunteer. Twenty-seven hospitals responded to the request. Twenty-three hospitals have become part of the Phase Two initiative. The response was the result of increased numbers of newborns exposed to substances in hospitals from small rural hospitals to major metropolitan hospitals. After orientation, four hospitals

Figure 18: Certified Outpatient Addiction Providers



decided they were not ready for the pilot process. Combine with the four pilot hospitals, Indiana will have 27 hospitals participating in Phase Two which will allow ISDH to have a more accurate assessment of the prevalence of substance use among pregnant women.

One of the challenges identified through the initial pilot hospitals was the lack of MAT providers and support services for the pregnant woman. The Medicaid Managed Care Entities (MCE) have been involved with the pilot process and all of them provide high risk nurse case

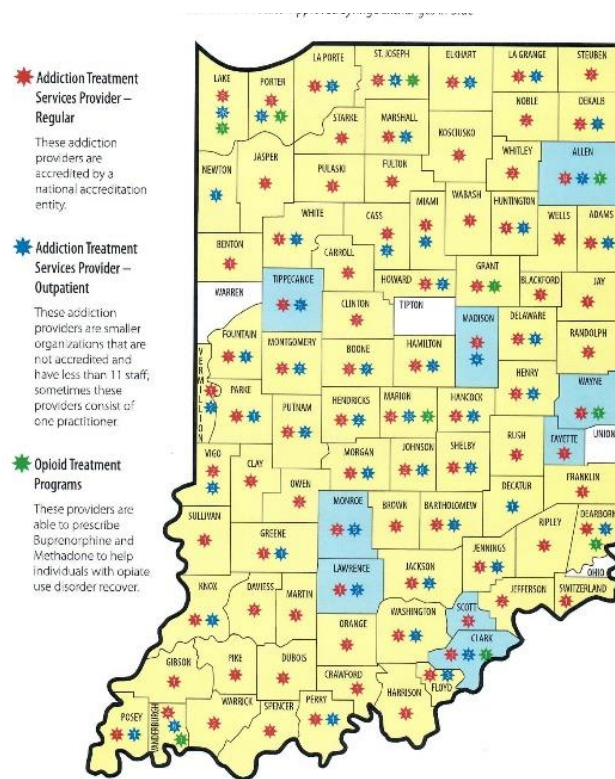
managers to support these women if they agree to the support. The MCEs and the Community Mental Health Centers (CMHC) are partnering to address this issue in a pilot entitled MOMentum. The goals of this project are to:

- Expand access to Medication Assisted Treatment for pregnant women;
- Decrease length of stay in NICU and improve health outcomes for the women and babies;
- Develop effective relationships among medical providers and addictions treatment providers (CMHCs); and
- Build effective relationships between the NAS hospitals and the CMHCs

The enhanced case management that is provided through this project includes:

- Thorough screening to evaluate medical, behavioral, social and functional needs;

Figure 19: Certified Outpatient Addiction Providers



1/8/17

- Coordination of care between the primary medical provider, the obstetrician n the neonatal intensive care unit, behavioral care and other specialty care as appropriate; PMP, OB, NICU, other specialty care, and behavioral care;
- Education (prenatal care, nutrition, preterm labor, delivery, newborn care, withdrawal symptoms, NAS, pregnancy signs and symptoms); and
- Referrals to behavioral health, community supports, WIC, infant resources, etc.

Figure 20: Addiction Inpatient Units and Residential Facilities



While these resources will support up to 200 pregnant women and their newborns who are Medicaid enrolled, there is a

significant gap in resources to the remaining women. The data from the pilot hospitals indicate that Indiana has a growing population of pregnant women who will need substance use supports both during and after the birth of their babies. While pregnant women remain a priority population for the CMHCs, there are simply not enough programs to meet the needs of all individuals with addictions.

6.0 High Risk County Rankings

In deciding which counties were at the highest risk, thirty-four indicators (Table 1) with established rates and percentages were used to rank the 92 counties. These indicators are the same ones that were used for the 2010 needs assessment. This was purposeful to be able to compare the two rankings. Indiana ranked all 92 counties individually by the 34 different measures. For example, for the infant mortality rate, all the counties were ranked

from 1 through 92, with 92 representing the county with the worst rate. The same process was repeated for each of the indicators for each county. All the measures were given equal weight. Once all the measures were completed, the overall scores for each county were combined, then divided by the overall measures to give a score ranking the counties overall for all the measures, with the possibility of being 1 through 92 (Table 2). Through this process, the county with the highest risk score across all indicators in 2017 is Marion County. Marion County was the county with the highest risk when the needs assessment was conducted in 2010. Five of the ten top counties for risk in 2010 remain in the top 10 in 2017: Marion, LaPorte, St. Joseph, Jennings and Elkhart. A comparison of the rankings in 2010 and 2017 is in Appendix A.

Table 1: Risk Factors
% Low Birth Weight
% Very Low Birth Weight
% Preterm Birth
Infant Mortality Rate
Rate of Neonatal Deaths
Rate of Post Neonatal Deaths
% of Women with Late or No Prenatal Care
% of Women Smoking during Pregnancy
Teen Birth Rates per 1,000 females (15-19)
% of Pregnant Women on WIC
% of Women Breastfeeding at Discharge
% of Births to Unmarried Parents
% of Births to Mothers w/o High School Diploma
% of Substantiated Child Abuse
% of Substantiated Child Neglect
% of Immunizations
% of Adult Obesity (BMI of 30 or more)
% of Binge Drinking
% of Uninsured Children under Age 19
% of Children with Confirmed EBL (pre-1980 housing)
Number of Slots Available in Licensed Child Care per 100 (Age 0-4)
% of Children in Public Schools with Limited English Proficiency
% of Public School Dropouts
% of 4 th Graders Passing Their ISTEP Exams
% of Unemployment (Annual Average)
% of Children in Poverty under Age 19

Table 1: Risk Factors
% of Children receiving Free/Reduced Lunch
Monthly Number of People Receiving Food Stamps
Monthly Average of Households on TANF
% of Adults (25 and older) with a High School Diploma
% of Adults with College Education
% of Single Parent Households
of Calls to MOMS Helpline

Table 2. County Ranking by Risk Level			
County	Risk Level	Ranking	Average
Marion	2012.60	1	59.19
La Porte	1896.60	2	55.78
Miami	1858.60	3	54.66
Grant	1829.80	4	53.82
Jennings	1809.10	5	53.21
Cass	1806.80	6	53.14
Vanderburgh	1799.00	7	52.91
Wayne	1790.70	8	52.67
Fayette	1782.40	9	52.42
Starke	1750.30	10	51.48
Elkhart	1719.70	11	50.58
St. Joseph	1710.20	12	50.30
Lake	1698.90	13	49.97
Madison	1696.30	14	49.89
Vigo	1663.20	15	48.92
Jefferson	1650.40	16	48.54
Jay	1648.70	17	48.49
Scott	1645.30	18	48.39
Fulton	1602.80	19	47.14
Switzerland	1599.60	20	47.05
Allen	1598.20	21	47.01
Blackford	1571.80	22	46.23
Delaware	1566.80	23	46.08
Washington	1558.40	24	45.84
Sullivan	1554.10	25	45.71
Noble	1550.90	26	45.61
Henry	1548.60	27	45.55
Newton	1531.80	28	45.05

Table 2. County Ranking by Risk Level

County	Risk Level	Ranking	Average
Shelby	1521.40	29	44.75
Lawrence	1519.00	30	44.68
Owen	1512.20	31	44.48
Clinton	1508.10	32	44.36
Orange	1500.60	33	44.14
Clark	1497.00	34	44.03
Clay	1494.00	35	43.94
Parke	1482.20	36	43.59
Knox	1477.90	37	43.47
Greene	1464.60	38	43.08
Crawford	1457.20	39	42.86
Vermillion	1450.20	40	42.65
Jackson	1438.20	41	42.30
Randolph	1438.00	42	42.29
Montgomery	1422.90	43	41.85
Fountain	1401.80	44	41.23
Pike	1391.90	45	40.94
Daviess	1390.40	46	40.89
Rush	1385.70	47	40.76
Howard	1382.10	48	40.65
Kosciusko	1371.70	49	40.34
Floyd	1326.40	50	39.01
Marshall	1318.30	51	38.77
DeKalb	1304.20	52	38.36
Wabash	1303.70	53	38.34
Adams	1298.20	54	38.18
Huntington	1291.90	55	38.00
White	1291.30	56	37.98
Bartholomew	1285.20	57	37.80
Tippecanoe	1279.90	58	37.64
Putnam	1274.20	59	37.48
Steuben	1270.70	60	37.37
Monroe	1252.20	61	36.83
Morgan	1218.00	62	35.82
Pulaski	1217.10	63	35.80
Lagrange	1214.70	64	35.73
Perry	1194.20	65	35.12
Jasper	1190.80	66	35.02
Benton	1182.80	67	34.79

Table 2. County Ranking by Risk Level

County	Risk Level	Ranking	Average
Union	1161.30	68	34.16
Franklin	1152.40	69	33.89
Gibson	1135.20	70	33.39
Dearborn	1126.50	71	33.13
Wells	1119.00	72	32.91
Tipton	1114.30	73	32.77
Carroll	1103.60	74	32.46
Porter	1066.70	75	31.37
Decatur	1041.70	76	30.64
Dubois	1037.70	77	30.52
Ohio	1024.90	78	30.14
Harrison	1017.40	79	29.92
Spencer	1016.30	80	29.89
Posey	1014.30	81	29.83
Martin	1009.50	82	29.69
Hancock	1008.70	83	29.67
Brown	1005.10	84	29.56
Whitley	992.30	85	29.19
Ripley	982.60	86	28.90
Warren	954.30	87	28.07
Johnson	924.50	88	27.19
Hendricks	887.70	89	26.11
Warrick	834.60	90	24.55
Hamilton	819.30	91	24.10
Boone	768.30	92	22.60

Appendix A: Comparison of County Ranking 2010-2017

2010	Ranking	2017
Marion	1	Marion
Lake	2	La Porte
Scott	3	Miami
Elkhart	4	Grant
St. Joseph	5	Jennings
Fayette	6	Cass
Jennings	7	Vanderburgh
Starke	8	Wayne
LaPorte	9	Fayette
Grant	10	Starke
Owen	11	Elkhart
Madison	12	St. Joseph
Cass	13	Lake
Switzerland	14	Madison
Wayne	15	Vigo
Randolph	16	Jefferson
Vanderburgh	17	Jay
Clark	18	Scott
Jefferson	18	Fulton
Vigo	20	Switzerland
Wabash	21	Allen
Noble	22	Blackford
Blackford	23	Delaware
Allen	24	Washington
Washington	25	Sullivan
Crawford	26	Noble
Clinton	27	Henry
White	28	Newton
Orange	29	Shelby
Rush	30	Lawrence
Vermillion	31	Owen
Sullivan	32	Clinton
Fulton	33	Orange
Miami	34	Clark
Fountain	35	Clay
Steuben	36	Parke

2010	Ranking	2017
Henry	37	Knox
Montgomery	38	Greene
Jackson	39	Crawford
Howard	40	Vermillion
Jay	41	Jackson
Clay	42	Randolph
Delaware	43	Montgomery
Newton	44	Fountain
Pulaski	45	Pike
Lawrence	46	Daviess
Greene	47	Rush
Shelby	48	Howard
Marshall	49	Kosciusko
Decatur	50	Floyd
Kosciusko	51	Marshall
Daviess	52	DeKalb
Morgan	53	Wabash
Union	54	Adams
Parke	55	Huntington
Knox	56	White
Perry	57	Bartholomew
Floyd	58	Tippecanoe
Putnam	59	Putnam
Tippecanoe	60	Steuben
Adams	61	Monroe
Martin	62	Morgan
Harrison	63	Pulaski
Bartholomew	64	Lagrange
Huntington	65	Perry
Ohio	66	Jasper
Jasper	67	Benton
Ripley	68	Union
Pike	69	Franklin
Warren	70	Gibson
LaGrange	71	Dearborn
Whitley	72	Wells
DeKalb	73	Tipton

2010	Ranking	2017
Wells	74	Carroll
Porter	75	Porter
Monroe	76	Decatur
Franklin	77	Dubois
Benton	78	Ohio
Dearborn	79	Harrison
Tipton	80	Spencer
Brown	81	Posey
Posey	82	Martin
Spencer	83	Hancock
Johnson	84	Brown
Carroll	85	Whitley
Warrick	86	Ripley
Gibson	87	Warren
Dubois	88	Johnson
Hancock	89	Hendricks
Hendricks	90	Warrick
Hamilton	91	Hamilton
Boone	92	Boone

Appendix B: Indiana Home Visiting Advisory Board Membership

Indiana State Department of Health		
Martha Allen	Director	Maternal and Child Health
Shirley Payne	Director	Children's Special Health Care Services
Rebecca Cunningham	Director	Early Hearing Detection and Intervention Program
Department of Child Services		
Sam Criss	Deputy Director	Child Welfare Services
Cynthia Smith	Prevention Manager	Child Welfare Services
Carrie Higgins	MIECHV Grant Coordinator	Child Welfare Services
Family and Social Services Administration		
Nicole Norvell	Director	Office of Early Childhood and Out of School Learning
Nancy Ward	Chief Nurse Consultant	Office of Early Childhood and Out of School Learning
Rhonda Clark	Deputy Director	Office of Early Childhood and Out of School Learning
Christina Commons	Director	First Steps/Bureau of Child Development Services
Meghan Smith	Policy Manager	First Steps/Bureau of Child Development Services
Lacey Kottkamp	Director	Indiana Head Start Collaboration
Sirrilla Blackmon	Deputy Director	Office of Youth Services, Division of Mental Health and Addictions
Valerie Washington	Administrative Assistant	Division of Mental Health and Addictions
David Smalley	Deputy Director	Policy (TANF)
Linda Koch		Policy (TANF)
Gary Parker	Program Director	Office of Medicaid Policy and Planning
Vickie Trout	Director	Quality & Outcomes, Office of Medicaid Policy and Practice
Department of Workforce Development		
Alishea Hawkins	Director	Adult Education Policy and Programs
Department of Education		
Kristy Wright	Special Education Specialist	
Nathan Williamson	Director	Title Grants and Supports
Department of Corrections		
David Liebel	Director	Religious Services

Healthy Start Marion County		
Yvonne Beasley		
Consultant		
Amanda Lopez	HFI Think Tank and Early Learning Advisory Council	

Appendix C: Indiana Home Visiting Needs Assessment Data Sources

Improved Maternal and Newborn Health

- % Preterm Birth: 2014 ISDH Natality Report
<http://www.in.gov/isdh/reports/natality/2014/toc.htm>
- Infant Mortality Rate: 2014 ISDH Natality Report
<http://www.in.gov/isdh/reports/natality/2014/toc.htm>
- % of Women Receiving Prenatal Care in 1st Trimester: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/5647-mothers-who-received-first-trimester-prenatal-care-2003-revised-birth-certificate?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/12238>
- % of Women Smoking during Pregnancy: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/5645-mothers-who-reported-smoking-during-pregnancy-2003-revised-birth-certificate?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/12237>
- % Adult Smokers: 2014 County Health Rankings & Roadmaps
<http://www.countyhealthrankings.org/app/indiana/2014/measure/factors/11/map>
- % of Births to First Time Mothers: Indiana State Department of Health, Maternal & Child Health Epidemiology Division [October 19, 2016]
- Teen Birth Rates Per 1,000 Females (15-19): 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/9354-teen-birth-rate-per-1000-females?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/182,183,139/18474>
- % of Pregnant Women on WIC: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1117-women-infants-and-children-wic-participants?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/3994,3995,3996,3997,3998,3999/14861,14860>
- % of Women Breastfeeding at Discharge: 2014 ISDH Natality Report
http://www.in.gov/isdh/reports/natality/2014/tbl32_t.htm
- % Births to Unmarried parents: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1151-births-to-unmarried-parents?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/2509>
- % of births to Mothers on Medicaid: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/8972-births-to-mothers-on-medicaid?loc=16&loct=5#detailed/5/2292-2383/false/869,36,868/any/17919>
- % of Births to Mothers w/o High School Degree: Indiana State Department of Health, Maternal & Child Health Epidemiology Division [October 19, 2016]
- % of Pre-1980 Housing: 2014 ISDH Lead & Healthy Homes Surveillance Report
http://www.in.gov/isdh/files/Lead_Report_2014.pdf
- % Binge Drinking: 2014 County Health Rankings & Roadmaps
<http://www.countyhealthrankings.org/app/indiana/2014/measure/factors/11/map>
- % Adult Obesity (BMI of 30 or more): 2014 County Health Rankings & Roadmaps
<http://www.countyhealthrankings.org/app/indiana/2014/measure/factors/11/map>

Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits

- % of substantiated child physical abuse: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/7805-substantiated-abuse-and-neglect-cases-by-type?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/2581,4092,4093/15068,15069>
- % of substantiated child sexual abuse: 2014 Kids Count
- <http://datacenter.kidscount.org/data/tables/7805-substantiated-abuse-and-neglect-cases-by-type?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/2581,4092,4093/15068,15069>
- % of substantiated child neglect: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/7805-substantiated-abuse-and-neglect-cases-by-type?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/2581,4092,4093/15068,15069>
- % of children with immunizations: 2013 Indiana State Department of Health, Immunization Division
[http://www.in.gov/isdh/files/Immunization Rates by County 2015.pdf](http://www.in.gov/isdh/files/Immunization_Rates_by_County_2015.pdf), Appendix B
- Uninsured Children Under Age 19: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/5644-uninsured-children-under-age-19?loc=16&loct=5#detailed/5/2292-2383/false/869,36,868,867,133/1536,1537/12236>

Improvement in school readiness and achievement

- % First Steps Enrollment: 2014 Enrollment numbers provided by First Steps
Percentages calculated by Emerald Consulting
- Early Head Start slots: 2013 Kids Count <http://datacenter.kidscount.org/data/tables/5191-early-head-start-and-head-start-funded-enrollment-slots?loc=16&loct=5#detailed/5/2292-2383/false/36,868,867,133,38/1292,1293,4101/11662>
- Head Start Slots: 2013 Kids Count
- <http://datacenter.kidscount.org/data/tables/5191-early-head-start-and-head-start-funded-enrollment-slots?loc=16&loct=5#detailed/5/2292-2383/false/36,868,867,133,38/1292,1293,4101/11662>
- Monthly Average # of Children on Waiting List for Child Care Vouchers: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1171-monthly-average-number-of-children-on-waiting-list-for-child-care-vouchers?loc=16&loct=5#detailed/5/2292-2383/false/870,573,869,36,868/any/2549>
- % passing IREAD: 2014 Kids Count
- <http://datacenter.kidscount.org/data/tables/8974-iread-3?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868/any/17926>
- 4th Graders Passing ISTEP: 2014 Kids Count <http://datacenter.kidscount.org/data/tables/4691-4th-graders-passing-istep?loc=16&loct=5#detailed/5/2292-2383/false/870,573,869,36,868/834,835,836/10956>

- Licensed Child Care Slots per 100 children Ages 0-5: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1160-licensed-child-care-slots-per-100-children-ages-0-5?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/2527>
- Children receiving child care vouchers: 2014 Kids Count
- <http://datacenter.kidscount.org/data/tables/1170-children-receiving-child-care-vouchers?loc=16&loct=5#detailed/5/2292-2383/false/870,573,869,36,868/any/2547>
- % of children in public school w/limited English proficiency: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1184-english-language-learner-students?loc=16&loct=5#detailed/5/2292-2383/false/870,573,869,36,868/any/2575,17922>
- % adults with high school diploma or equivalency: 2014 Indiana Department of Workforce Development
http://www.hoosierdata.in.gov/maps/thematic/edattain/HOnly_2014.pdf

Reduction in crime or domestic violence

- Drug related arrest rate per 1000: 2012 Indiana Prevention Resource Center
<https://docs.google.com/spreadsheets/d/10Dq4croWYlfasoBcXJ0NNQR4kc81B35axY6mXu0Eix4/e/dit#gid=0>
- Alcohol related arrest rate per 1000: 2012 Indiana Prevention Resource Center
<https://docs.google.com/spreadsheets/d/10Dq4croWYlfasoBcXJ0NNQR4kc81B35axY6mXu0Eix4/e/dit#gid=0>
- Domestic Violence residential/non-residential: 2014 Indiana Coalition Against Domestic Violence
<http://www.icadvinc.org/wp-content/uploads/2010/07/2013-2014-Indiana-Service-Fatality-Statistics-FINAL-1.pdf>

Improvements in family economic self sufficiency

- % of Children receiving Free/Reduced Lunch: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/5187-public-school-students-receiving-free-or-reduced-price-lunches?loc=16&loct=5#detailed/5/2292-2383/false/871,870,573,869,36/1279,1280,1281/13762,11655>
- Monthly average number of families receiving TANF: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1114-monthly-average-number-of-families-receiving-tanf?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/2435>
- Monthly average # of persons issued food stamps: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1113-monthly-average-number-of-persons-issued-food-stamps-snap?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/2433>
- % of High School Drop Outs: 2014 Stats Indiana
http://www.stats.indiana.edu/dms4/new_dpape.asp?profile_id=326&output_mode=1
- % of adults with a college education: 2010 Indiana Dept. of Workforce Development
<http://www.hoosierdata.in.gov/nav.asp?id=116>

- % Children with Food Insecurity: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/7809-child-food-insecurity?loc=16&loct=5#detailed/5/2292-2383/false/869,36,868,867,133/any/15078>
- % of unemployment (annual average): 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1112-unemployment-rate-annual-average?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/2431>
- % of Children under 18 in poverty: 2014 Kids Count
<http://datacenter.kidscount.org/data/tables/1115-children-under-age-18-in-poverty?loc=16&loct=5#detailed/5/2292-2383/false/573,869,36,868,867/any/9429>
- % Single parent households: 2014 Stats Indiana
http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18000
- % Two Parent Households: 2014 Stats Indiana
http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18000