INDIANA UNIVERSITY
SCHOOL OF PUBLIC AND ENVIRONMENTAL AFFAIRS
Center for Health Policy
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Evaluation Report VII:

State Maternal & Child Health Early Childhood Comprehensive Systems Grant Program

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Introduction

The Indiana State Maternal and Child Health Early Childhood Comprehensive System (ECCS) was conceived as an initiative to engage state agencies, community partners, and families of young children to develop a coordinated, comprehensive, community-based system of services for children from birth through age five. The ECCS system is designed to eliminate duplicated efforts in serving young children and their families while ensuring that services are available universally across the state. The initiative intends to support ease of access to needed services, increase the utilization of appropriate services, and ensure that a holistic system of care supports young children and their families.

The strategic plan, as well as requirements set forth by the Health Resources and Services Administration, Maternal and Child Health Bureau, requires an evaluation of this initiative. Since June 2006, the Indiana State Department of Health (ISDH) has worked with the Center for Health Policy at Indiana University–Purdue University Indianapolis to develop and execute an evaluation plan. This report evaluates the completion and efficacy of activities set forth in the strategic plan for this initiative, changes in outcome measures for Indiana families that may be a result of this initiative, and how well the strategic plan has been implemented. Where available, data from ISDH and other agencies are used to track changes in outcomes.

The time frame of this study limits the conclusions that can be drawn regarding the effect of the ECCS plan on Indiana families; however, the results of the evaluation will provide a benchmark for comparison as the initiative progresses and early indicators of potential longer term outcomes.

This report is the seventh evaluation report investigating the implementation of ECCS initiatives. Data and other information for this study come from a variety of sources, including the Indiana State Department of Health, the Indiana Family and Social Services Administration, Department of Child Services, the United States Census Bureau, and several other government entities and private organizations. The most recent available data were used for this report. Some data are for calendar years and some for fiscal years. Additional caveats concerning data are noted where appropriate in this report.

The Early Childhood Comprehensive System Initiative

The ECCS initiative began officially on July 1, 2003, with a grant from the Health Resources and Services Administration, Maternal and Child Health Bureau. As part of the project, The Indiana State Department of Health convened a group of Core Partners including representatives from several state and local agencies and individuals representing service organizations and families. The Core Partners serve as the steering committee for the ECCS project. The Core Partners meet quarterly and are charged with educating their organizations on the guiding principles of the ECCS initiative, sharing agency initiatives that impact children ages birth to 5, and establishing protocols to support communication across agencies and initiatives.

Completion of ECCS Strategic Goals

As part of its mission, the committee and the subcommittees have developed a strategic plan for achieving the goal of coordinated services. The strategic plan outlines seven primary objectives to realize coordinated and comprehensive services for young children. These objectives include:

- All children in Indiana will have a medical home.
- All children will be covered by a source of payment, either public or private, for medical and developmental services that are identified by the medical home.
- The medical home will facilitate developmental, behavioral, and mental health screening with appropriate treatment referrals to community resources.
- An information clearinghouse will be established that includes information about resources and supports for families of young children and providers of early childhood services at both the state and local level.
- Quality resources and supports will be integrated to create a coordinated and accessible early childcare system.
- Parents will have the necessary information, support, and knowledge about child development and will be able to recognize their child's progress.

- Families will have timely access to resources and supports to address their child's health, safety, and developmental needs.

The committee developed several goals for each objective in order to provide a plan for achieving each objective. Further details regarding these goals and objectives, as well as information on the accomplishments to date of the ECCS Committee, can be found at http://www.sunnystart.in.gov. Additionally, this and previous evaluation reports along with other resource materials can be found at http://www.in.gov/isdh/21192.htm.

Key accomplishments of the Sunny Start program and its partners to date include the Early Childhood Meeting Place Web site, a developmental calendar for children ages birth to five; Paths to Quality, a program to educate early childcare providers; the Zero To Three training program, a program that trains early childhood professionals to promote positive parenting with the goal of eliminating child abuse; and a comprehensive one-week Summer Institute to help mental health professionals gain expertise in the social and emotional development of young children, infants, and toddlers. These programs are described further throughout this report. Appendix C contains a table of Sunny Start goals and a description of the progress made to date.

Social and emotional development in young children continues to be a focus of Sunny Start. After receiving final approval from the Sunny Start Core Partners, the Social and Emotional Consensus Statement was finalized. A tool has been developed in conjunction with the Consensus Statement that will help individuals assess the social and emotional competencies that their training addresses. Sunny Start sponsored a comprehensive one-week Summer Institute in July 2007 to train child mental health professionals. Furthermore, in August 2008, Sunny Start sponsored additional training to help build competencies in the area of social and emotional development at the Indiana Infant and Toddler Mental Health Annual Conference.

Insurance Coverage and Access

Medical Home

A main goal of this initiative is to ensure that all children have access to health care services. To facilitate achievement of this goal, the ECCS program advocates the use of the medical home concept. A medical home provides a consistent point of entry to the medical system through a primary care physician or a team of caregivers. Prior research has shown that the comprehensiveness and coordination of care offered by a medical home improves health outcomes and reduces disparities in the use of health services (Starfield & Shi, 2004). The National Survey of Children's Health reports that 38.4 percent of Indiana children ages birth through five did not have a medical home in 2003. In the nation, 44.1 percent of children were without a medical home in 2003.

The Family Advisory Committee is working on an update of the medical passport along with the Maternal and Children's Special Health Care Services Division. A medical passport is a child's portable medical record file which can be shared by all of the child's caregivers. Currently, there are three versions of the medical passport in Indiana. These are: 1) the Department of Child Services' version, developed 10 years ago; 2) the Children's Special Health Care Services version that is aimed at children with special medical needs; and 3) the Wellness Passport that was designed to complement the Building Bright Beginnings Developmental Calendar.[1] The medical passport will serve as a central record of a child's health conditions and histories. The passport will consist of general medical information and special modules for specific areas. The three areas currently scheduled for development are children with special health care needs, children in foster care, and children with social-emotional issues. The goal is to develop a version of the medical passport that will be used by all children in foster care, thus making it easier to track the medical history of foster children.

[1] The Building Bright Beginnings Developmental Calendar was never published due to funding constraints.

The Medical passport will be available in print (12,000 copies), downloadable from the Early Childhood Meeting Place web site, and on flash drives (2,700 flash drives). The web site and flash drive versions will be accompanied with a narrated powerpoint file that introduces the user to the medical passport and other products from the Sunny Start Project. These products, including the Sunny Start financial resources fact sheets and the developmental calendar, will also be included on the flash drive and are presently downloadable off the web site.

Indiana has developed a new care management program, Care Select, to serve several populations including the blind, physically and mentally disabled, wards and foster children, and children receiving adoptive services. The Office of Medicaid Policy and Planning contracts with Care Management Organizations who are responsible for coordinating care to those enrolled in Care Select. Care Select members are also linked to a primary medical care provider, thus providing those enrolled in Care Select with a medical home.

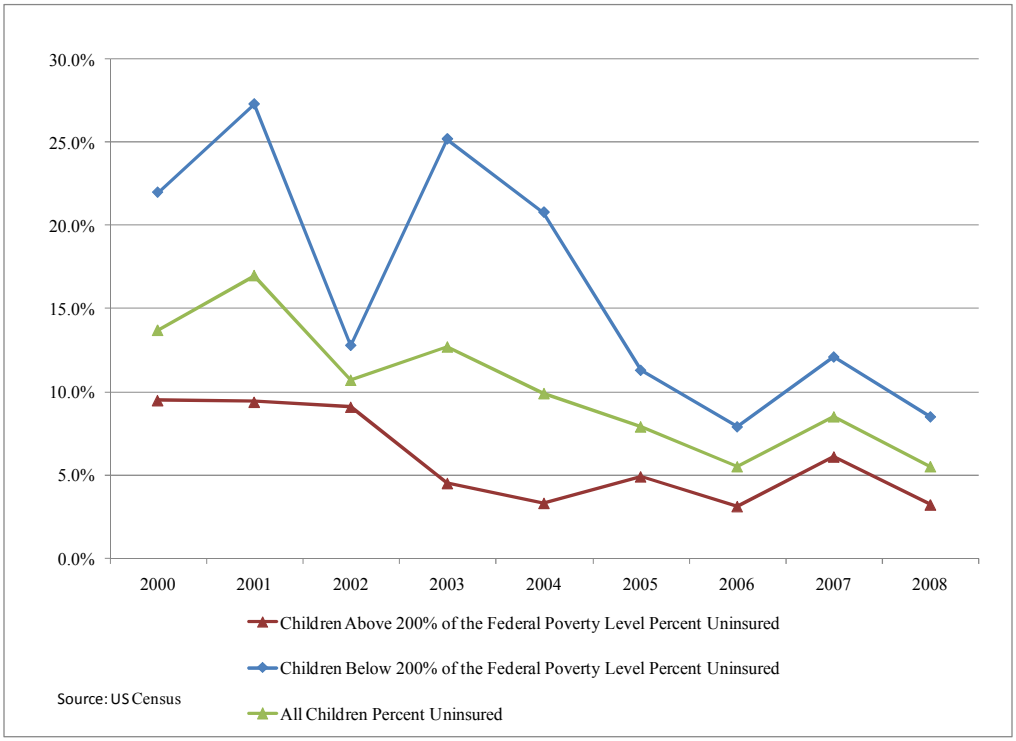
In addition to facilitating a medical home by each member through the assignment of a PMP to each member, Care Select ensures access to care for the members through care coordination. Care coordination is performed by a multidisciplinary team of Care Managers, including healthcare professionals such as nurses, social workers, and physicians. Care managers involve members in care coordination by developing individually tailored care plans that take into consideration a member's healthcare needs and personal goals towards improved functional status, improved clinical status, enhanced quality of life, member satisfaction, adherence to treatment or care plans, improved member safety, and member autonomy. Care coordination also involves collaboration with multiple providers in all care settings, including home, clinic, and hospital.

Since its inception, the Care Select program's enrollment has steadily increased. Implementation consisted of a three phase rollout with central region enrollment in November 2007, statewide enrollment in March 2008, and ward and foster children enrollment in July 2008. By December 2008, OMPP data showed that there were 4,726 children from birth to age five enrolled and enrollment increased to 6,659 as of April 2009.

Source of Payment for Health Care

Inability to pay is one of the greatest barriers to health care access. Research confirms that disparities in the use of primary care exist between insured children and uninsured children (Newacheck, Hughes, & Stoddard, 1996). Children with no health care coverage are also significantly less likely to have a regular source of care and to consistently see the same physician. Furthermore, uninsured children are more likely to be inadequately vaccinated and have fewer annual physician visits (Newacheck et al., 1996). The ECCS initiative seeks to eliminate this disparity by promoting access to health care for all Indiana children.

Figure 1: Percent of Uninsured Children (five and younger) in Indiana.



To monitor progress toward this objective, data from the United States Census Bureau's *Current Population Survey–Annual Social and Economic Supplement* were used to estimate the number of uninsured children below 200 percent of the federal poverty level (FPL), as well as the total number of

uninsured children age five or younger (see Figure 1). As of March 2008, there were an estimated 542,402 children age five or younger in the state of Indiana, 29,781 (5.5 percent) of whom are not covered by any type of health insurance. Furthermore, 233,815 (43.1 percent) children age five or younger in Indiana lived in a household below 200 percent of the FPL, 19,971 (8.5 percent) of whom lacked any form of health coverage (U.S. Census Bureau, 2006). In comparison, only 3.2 percent of children living in households above 200 percent FPL lack health insurance. In other words, children living in households below 200 percent FPL are twice as likely to lack health insurance as those in households above 200 percent FPL. Families USA reports that 48.2 percent of Indiana's uninsured children of all ages come from low-income families who are likely eligible for Hoosier Healthwise. Furthermore, the Families USA report finds that despite the lower rate of insurance in low-income families, the majority of uninsured children (of all ages) in Indiana come from families living above 200 percent FPL (Families USA, 2008).

The Indiana WINS (Web-based Interagency Network for Services), was a universal application intended to assist families in finding out about eligibility and possibly enrolling in Medicaid, TANF, Maternal and Child Health, WIC, Food Stamps, and Children's Special Health Care applications for service. The idea was to combine enrollment processes to simplify the process for applicants and also to help applicants identify other programs for which they are eligible. The WINS project is no longer being pursued. The Family and Social Services Administration pursued a simultaneous initiative to automate Medicaid, TANF, and food stamp applications, which were also the core components for Indiana WINS. Because these two eligibility modernization efforts were incompatible, Indiana chose to pursue the more extensive modernization effort and the Indiana WINS effort was concluded.

Medicaid, Hoosier Healthwise, and SCHIP Enrollment and Utilization

Low-income children are less likely to be covered by health insurance and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is a paramount concern. Health care financing sources for low-income and disabled children include Medicaid and SCHIP funding, administered through Indiana's

Hoosier Healthwise, Care Select and fee-for-service programs. Medicaid eligibility and claims data are used to determine the number of children under the age of five enrolled in Indiana Medicaid.

Data from the Office of Medicaid Policy and Planning (OMPP) indicates that a total of 287,810 children age five and younger were enrolled in Indiana Medicaid programs, during state fiscal year 2007.[2] Indiana's SCHIP program is seamlessly integrated into Hoosier Healthwise, the managed care portion of Indiana's Medicaid program. As such, SCHIP enrollees have the same access to providers as all other Medicaid managed care members, including choice of primary medical provider (PMP). The Federal Poverty Level (FPL) plays an important role in determining how Hoosier children receive health coverage. The minimum amount of income that a family needs to sustain living expenses is what makes up the FPL. Public assistance programs, such as Medicaid, define eligibility income limits as some percentage of FPL. In Indiana, the FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. There is no difference in the access to or ability to provide services between SCHIP members and children in Hoosier Healthwise. The data included in this report are based on administrative claims, and likely represents an underestimate of actual utilization due to claims processing practices.

Of the 287,810 children enrolled at some point during state fiscal year 2007, the state attests that 265,971 (92 percent) were covered by a plan with capitated payments to a risk-based managed care (RBMC) delivery system (i.e., Hoosier Healthwise).[3] Indiana Medicaid claims data reveals the number of

[2] This total includes an unduplicated count of all children age five and younger who were enrolled for some portion of this period of time. State Fiscal Year 2007 is defined as July 1, 2006 to June 30, 2007.

[3] Some of the Medicaid managed care programs in Indiana provide a capitation payment to a managed care organization (MCO) which is then responsible for arranging, providing, and paying for the services of its members as designated by the OMPP.

enrolled children, age five years and younger, who visited any type of medical provider[4] to be 226,804 (79 percent); while 158,191, (55 percent) enrolled children were seen by a primary medical provider (PMP).[5] Forty percent (114,042) of enrolled children age five years and younger were seen in a clinic setting.[6] Thirty-five percent (98,975) of enrolled children age five years and younger were seen in a hospital setting (ER/Outpatient visits).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Individuals age five years and younger, enrolled in Medicaid and SCHIP are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), prevention-oriented services designed to assess health and development, vision, dental, and hearing in an effort to identify conditions that may impede natural growth. In addition to screening services, EPSDT encompasses diagnostic and treatment services for age <1 year through 21 years old.

Medical Services

The EPSDT Participation Report provides data to the Center for Medicare and Medicaid Services (CMS). CMS reporting requirements prescribe that Medicaid and SCHIP enrollees report data separately on the Participation Report. The number of initial or periodic screenings that a child should receive is dependent on the state's periodicity schedule. Data reported for SFY 2007 demonstrates that of the 256,395 non-SCHIP, Medicaid covered children, five years of age and younger, at least 201,118 (78

[4] Encounter claims data indicated that *any type of Medical Provider* included an extensive list of provider types, including specialist, advanced practice, and mental health.

5 Primary Medical Provider (PMP) is described as one of the following: Family Practitioner, General Practitioner, OB/GYN, General Internist, General Pediatrician, Emergency Medicine Practitioner, Neonatologist.

6 Clinic setting is defined to be Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and Medical Clinics.

percent) received at least one initial or periodic screening (Indiana Office of Medicaid Policy and Planning, 2007a). The data demonstrates an improvement over the SFY 2006 Participation Report, which revealed that of the 251,885 children, five years of age and younger, enrolled in Medicaid, at least 187,794 (75 percent) received at least one initial or periodic screening (Indiana Office of Medicaid Policy and Planning, 2006a).

Data for SFY 2007 demonstrates that of the 11,428 SCHIP eligible children, five years of age and younger, at least 7,956 (70 percent) received at least one initial or periodic screening (Indiana Office of Medicaid Policy and Planning, 2007b). This is an improvement over the SFY 2006 Participation Report, which revealed that of the 12,474 children, five years of age and younger, enrolled in SCHIP, at least 8,002 (64 percent) received at least one initial or periodic screening (Indiana Office of Medicaid Policy and Planning, 2006b).

Dental Services

Oral health can be overlooked in this very young population, often when dental care is critical. Medicaid eligible children receiving dental care is captured in the EPSDT Participation report. SFY 2007, the report indicates that 65,046 (25 percent) non-SCHIP covered children enrolled in Medicaid, five years of age and younger, received any dental service (Indiana Office of Medicaid Policy and Planning, 2007a). Twenty-two percent (57,508) of children received preventive dental services (Indiana Office of Medicaid Policy and Planning, 2007a), while nine percent (23,530) of Medicaid enrolled children received dental treatment services (Indiana Office of Medicaid Policy and Planning, 2007a). When compared to SFY 2006, the number of children five years and younger receiving dental services remained consistent. Medicaid data confirmed that 62,244 (25 percent) children age five years and younger, enrolled in Medicaid during SFY 2006, received some type of dental services (Indiana Office of Medicaid Policy and Planning, 2006a). Twenty-two percent (54,648) of children received preventive dental services (Indiana Office of Medicaid Policy and Planning, 2006a), while nine percent (23,081) of Medicaid enrolled children received dental treatment services (Indiana Office of Medicaid Policy and Planning, 2006a).

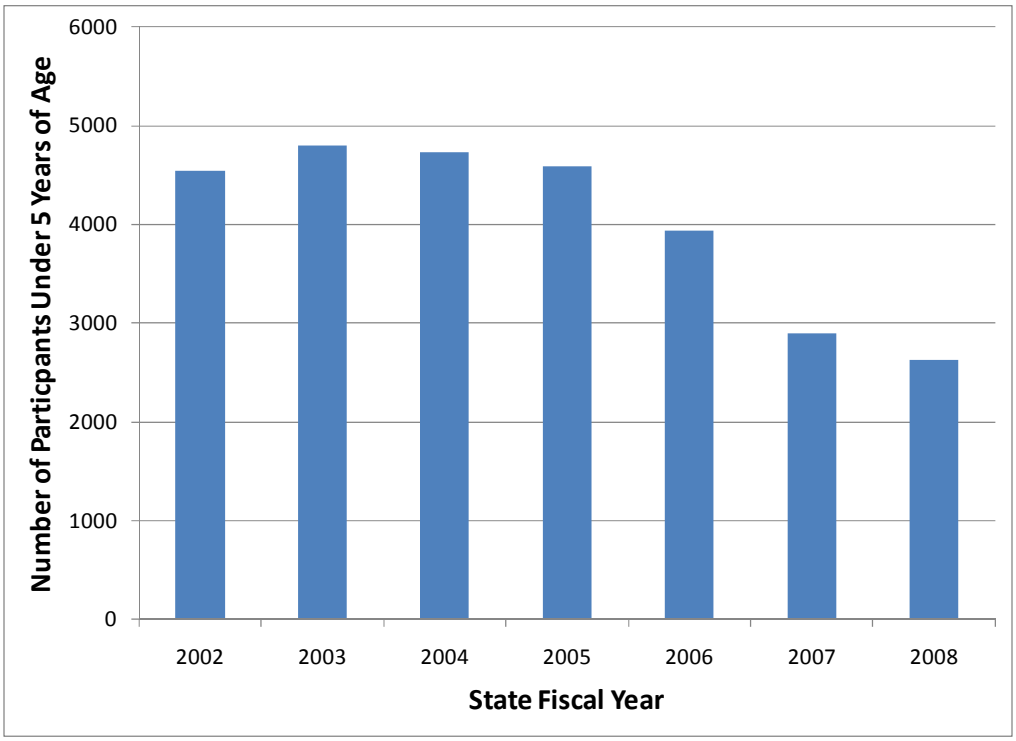
Statistics of oral health care performed on the SCHIP population are similar. SFY 2007, the CMS report indicates that 3,210 (28 percent) children enrolled in SCHIP, five years of age and younger, received any dental service (Indiana Office of Medicaid Policy and Planning, 2007b). Twenty-five percent (2,839) of SCHIP enrolled children received EPSDT preventive dental services (Indiana Office of Medicaid Policy and Planning, 2007b), while nine percent (1,024) of SCHIP children received EPSDT dental treatment services (Indiana Office of Medicaid Policy and Planning, 2007b). When comparing SFY 2007 to SFY 2006, the percentage of children five years and younger receiving dental services demonstrates a slight improvement. SCHIP data confirmed that 3,424 (27 percent) children in this age five years and younger, enrolled in SCHIP during SFY 2006, received dental services (Indiana Office of Medicaid Policy and Planning, 2006b). Twenty-three percent (2,924) of SCHIP eligible children received preventive dental services (Indiana Office of Medicaid Policy and Planning, 2006b), while nine percent (1,156) of SCHIP eligible children received dental treatment services (Indiana Office of Medicaid Policy and Planning, 2006b).

The state of Indiana has placed special emphasis on the receipt of primary care and dental services, having put pay for performance measures in place for well-child, adolescent, and dental visits during the 2009 contract year. Further measures to engage providers in EPSDT programs are a cornerstone of the state's 2009 quality strategy.

Children with Special Health Care Needs

Access to health care is particularly important for children with special health care needs. The number of children enrolled in the Indiana State Department of Health Children's Special Health Care Services (CSHCS) program serves as an additional measure of health care access. In 2008, a total of 2,624 children age five and younger participated in the CSHCS program (see Figure 2). This is one percent of the population age five and younger and is also a decrease of 42 percent from the 4,538 children enrolled during 2002 (Indiana State Department of Health).

Figure 2: Children with Special Health care Needs: Total Number of Participants Age Five and Under

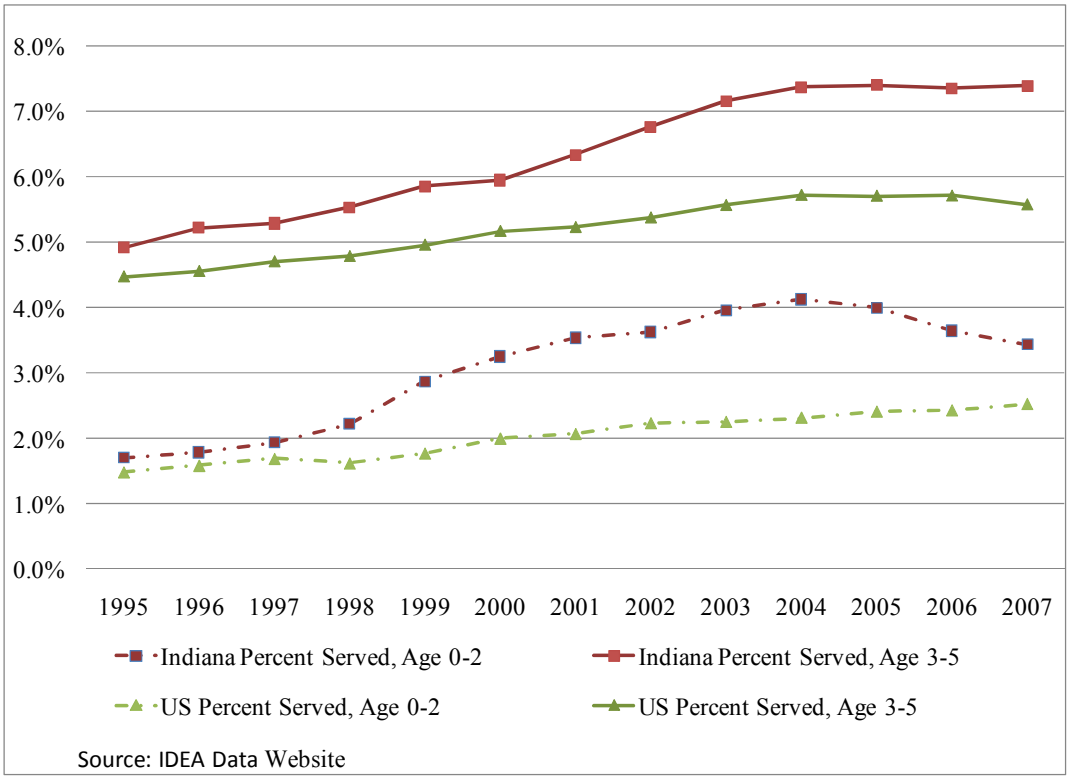


Another program that supports access for children with special health care needs is the Individuals with Disabilities Education Act (IDEA). This program provides services to children with disabilities. On December 1, 2007, 28,544 children age five and under were served by this act, an increase of 74 percent in the number served on December 1, 1995 (see Figure 3). Of these children, 19,530 were between the ages of 3 and 5, an increase of 59 percent since 1995. The remaining 9,014 children were age two or younger and were provided services through the Early Intervention Program for Infants and Toddlers with Disabilities coordinated by First Steps, an increase of 115 percent since December 1, 1995 (IdeaData.org, 2006; Indiana Family and Social Services Administration. First Steps, 2006). The number of children two and younger who were served peaked at 10,738 (4.1 percent of all children two or younger) on December 1, 2004, and has since decreased to 9,014 children two or younger (3.4 percent of all children two or younger) on December 1, 2007.

An evaluation of the First Steps program identified that the implementation of new eligibility criteria on May 1, 2006, was responsible for some of the decrease in enrollment in the First Steps program (Conn-Powers, Piper, & Traub, 2008). Indeed, the steepest decreases in enrollment shown in Figure 3 occur

after 2005. The change in eligibility criteria removed the biologically at risk category and increased the amount of developmental delay required for a child to be eligible for First Steps (Indiana First Steps, 2006).

Figure 3: Percentage of Children (Ages 0-2 and Ages 3-5) Served By IDEA



Source: IDEA Data Website

Identification of children with developmental, behavioral, and mental health needs is another component of high quality continuous care. Establishment of a medical home for young children will help increase the likelihood that care providers will recognize symptoms early through the use of screening tools, and will also aid physicians in providing comprehensive and coordinated services. Research indicates that facilitating this type of coordination improves the quality of life for young children identified as needing developmental, behavioral, and mental health services, children who may not have received treatment prior to ECCS (American Academy of Pediatrics Committee on Children with Disabilities, 2001).

Outcomes

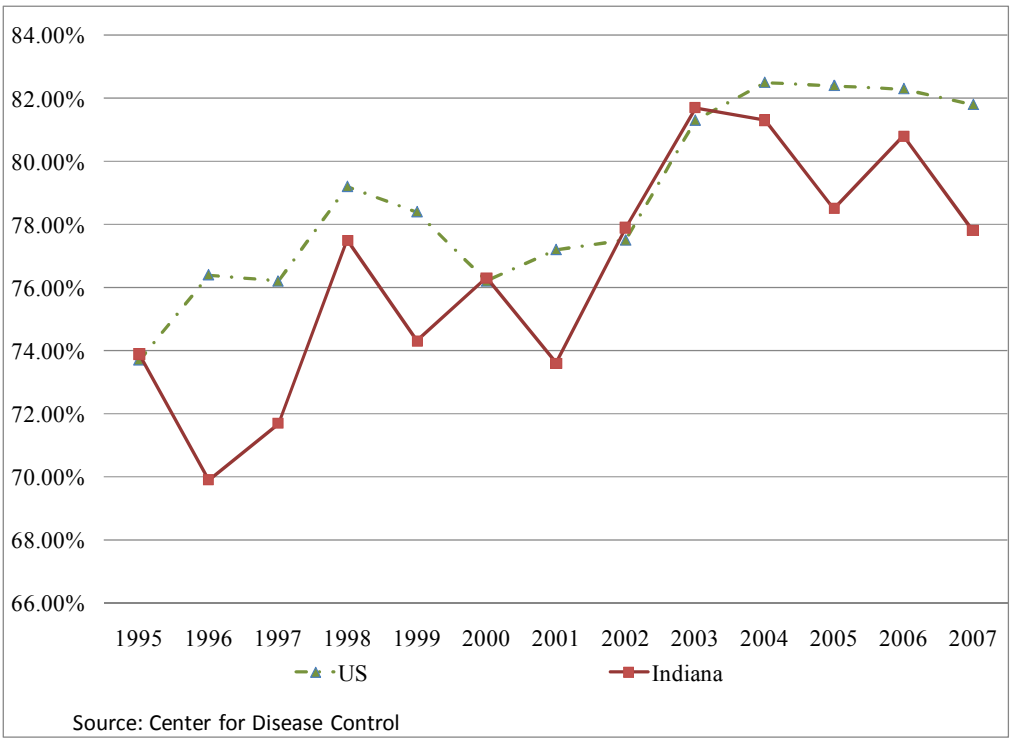
Several outcomes related to the goals of the ECCS Initiative are evaluated here. These include:

- immunization rates,
- infant and child mortality,
- child neglect and abuse,
- teen pregnancy, and
- expulsion from early care and early education.

Immunization Rates

As mentioned previously, the goal of providing continuity of care through the use of a medical home is to improve the health and well-being of young children in Indiana. Along with evaluating medical visits, one way to measure trends in the well-being of children is to investigate the immunization rates of young children. To be considered complete by the ISDH, a child must have age-appropriately received vaccines for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus influenzae type b, pneumococcus, and chickenpox**.** According to the Indiana State Department of Health, data for the 2004-2005 child care immunization assessment indicate that of those children enrolled in a licensed child care center, 77 percent of children ages 15 to 23 months and 83 percent of children ages two to five received complete vaccines (Indiana State Department of Health, 2005).

Figure 4: Immunization Rates for Children 19-35 Months of Age (4:3:1:3 Combined Series).[7]



Additionally, 94 percent of children enrolling in kindergarten, 96 percent of children enrolling in first grade, and 98 percent of children enrolling in sixth grade at reporting Indiana schools during 2006-2007 were fully vaccinated (Indiana State Department of Health, 2004). The National Immunization Survey, conducted for the Centers for Disease Control by the National Opinion Research Center at the University of Chicago, provides an additional measure of immunization (see Figure 4). Data from the National Immunization Survey show that 77.8 percent of Indiana children ages 19 to 35 months were immunized

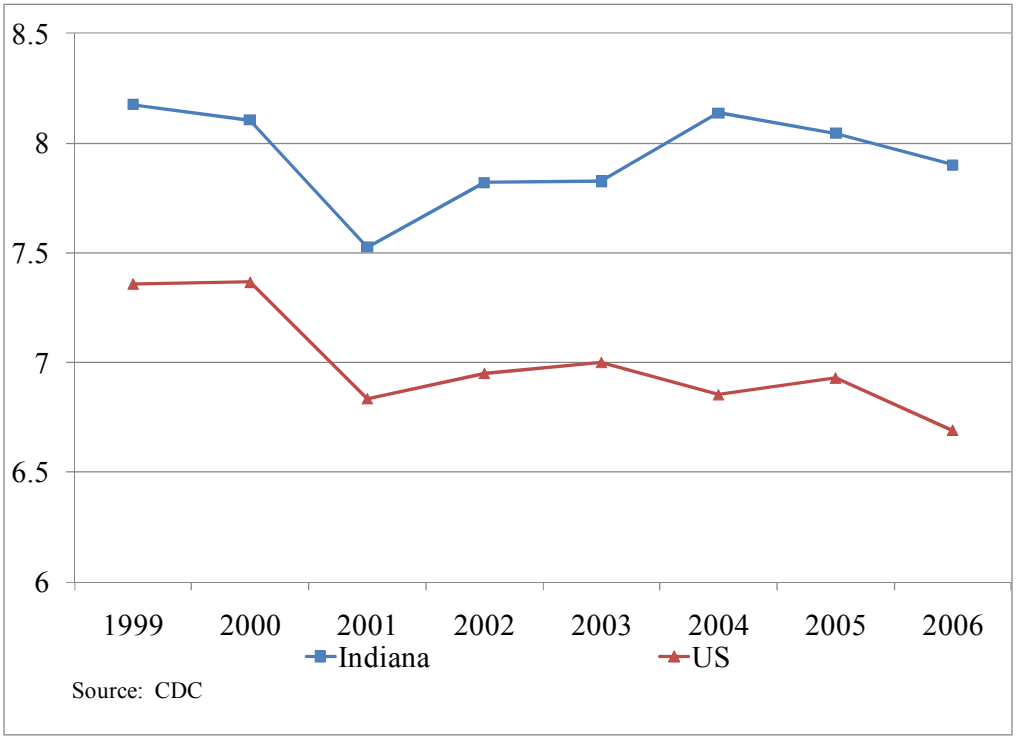
[7] Immunization in this case refers to children who received the 4:3:1:3 combined series that includes four or more doses of diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, or diphtheria and tetanus toxoids and acellular pertussis vaccine; three or more doses of any poliovirus vaccine; one or more doses of a measles containing vaccine; and three or more doses of Haemophilus influenzae type b vaccine

in 2007 compared to a national rate of 81.8 percent (U.S. Department of Health and Human Services (DHHS). National Center for Health Statistics, 2007).

Infant and Child Mortality Rates

The infant mortality rate (for children under one year of age) for the state of Indiana was 8.05 deaths per 1,000 in 2005 (Centers for Disease Control and Prevention, 2007a). The infant mortality rate for the United States was 6.93 deaths per 1,000 (see Figure 5). The infant mortality rate in Indiana has consistently been higher than the rate for the nation and has also followed a trend similar to that of the nation from 1999 through 2005.

Figure 5: Infant Mortality Rate (per 1,000 Children under one Year of Age)



During 2005, the mortality rate for children 1-4 years of age in Indiana was 0.38 per 1,000, compared to a rate of 0.29 per 1,000 for the United States (see Figure 6). The rate in Indiana is higher than for the nation, and the gap between the two rates narrowed between 1999 and 2001, but has been widening since 2003.

Figure 6: Child Mortality Rate (per 1,000 children age 1-4 years).

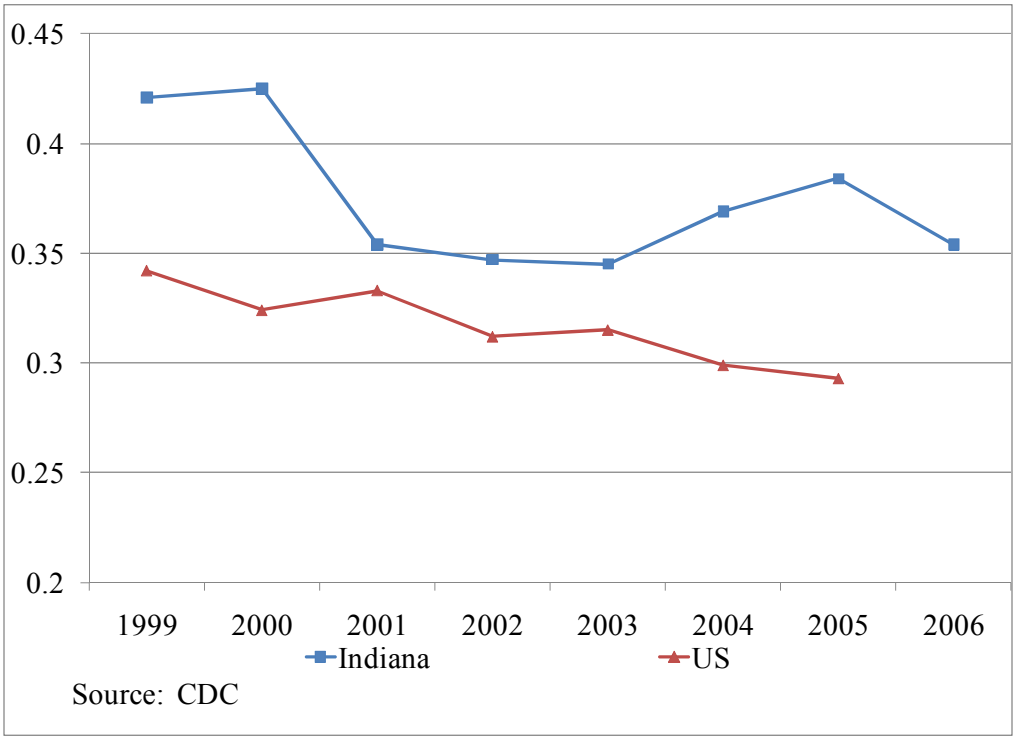
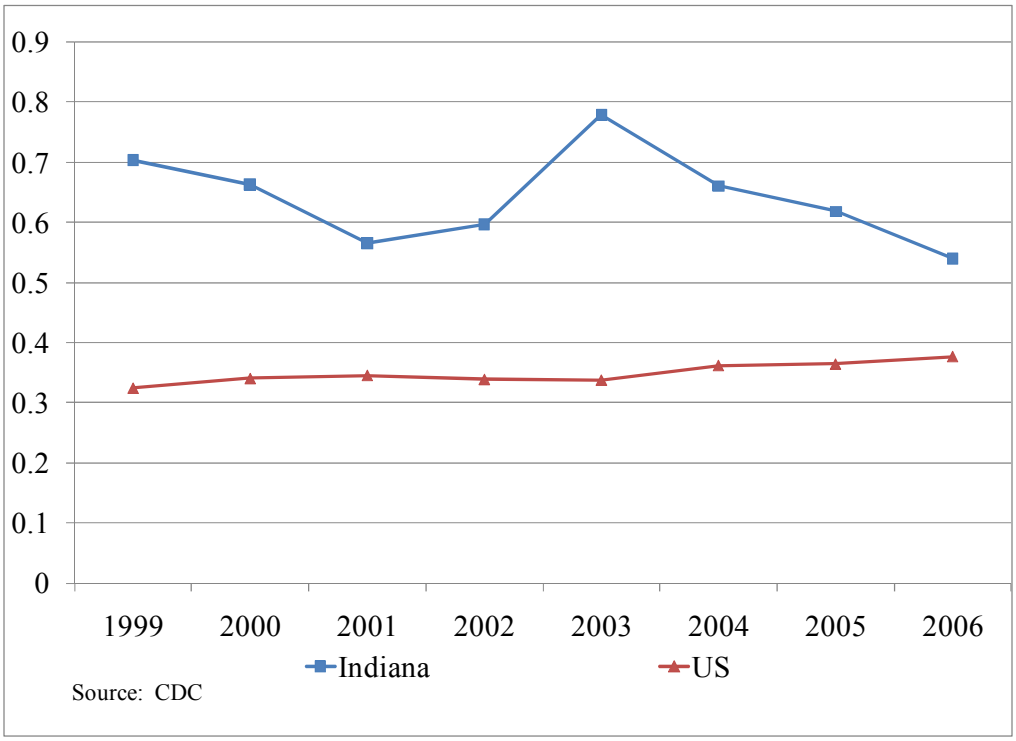
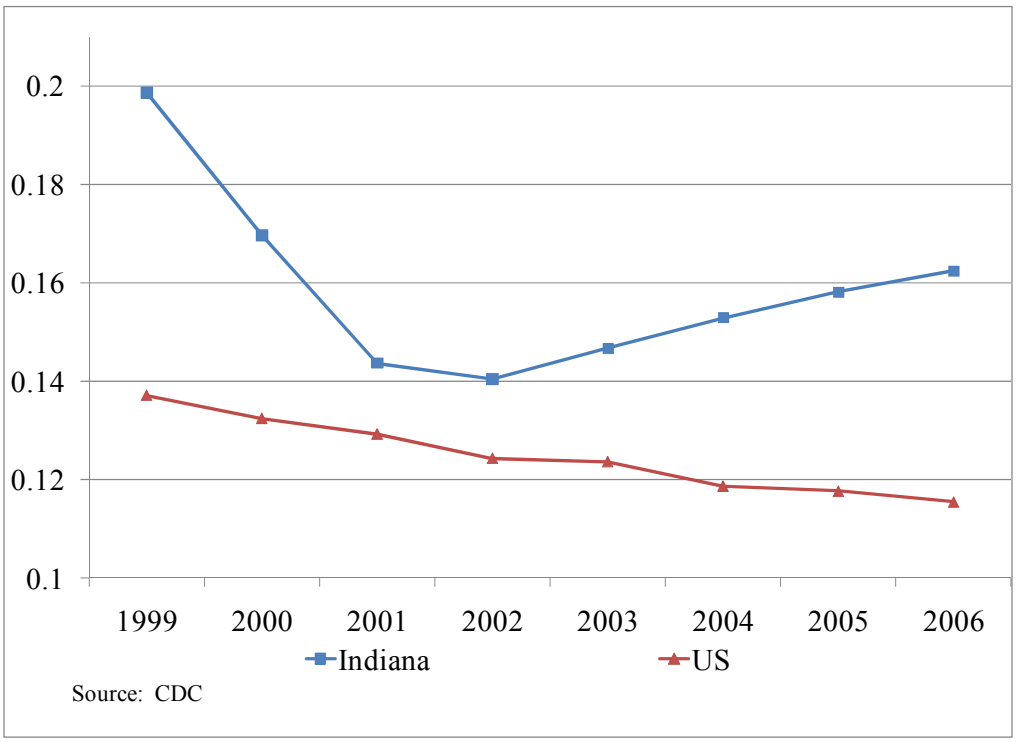


Figure 7: Infant Injury Mortality Rate (per 1,000 children under one year of age).



The injury mortality rate in 2006 for infants under one year of age was 0.54 per 1,000, compared to a national rate of 0.38 per 1,000 (see Figure 7). Injury deaths include unintentional injuries, violence-related injuries (homicide, legal intervention, and suicide), as well as injuries in which the intent was undetermined (Centers for Disease Control and Prevention, 2007b). The injury mortality rate in 2006 for children ages one to four was 0.16 per 1,000, compared to a national rate of 0.12 per 1,000 (see Figure 8).

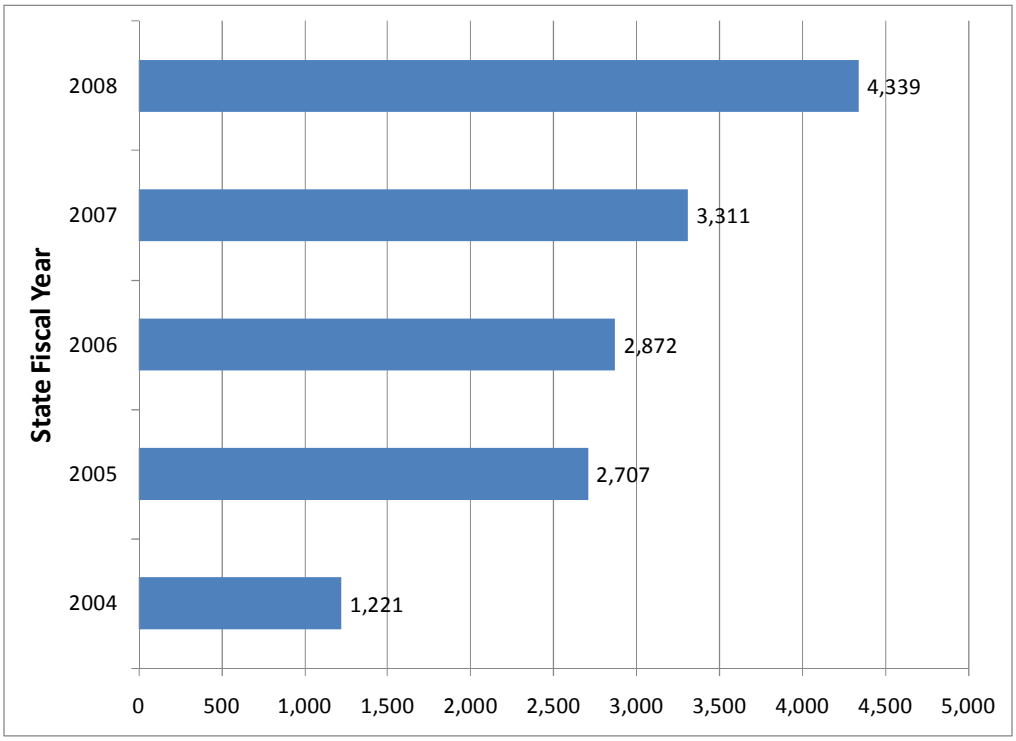
Figure 8: Child Injury Mortality Rate (per 1,000 children age 1-4).



Child Neglect and Abuse

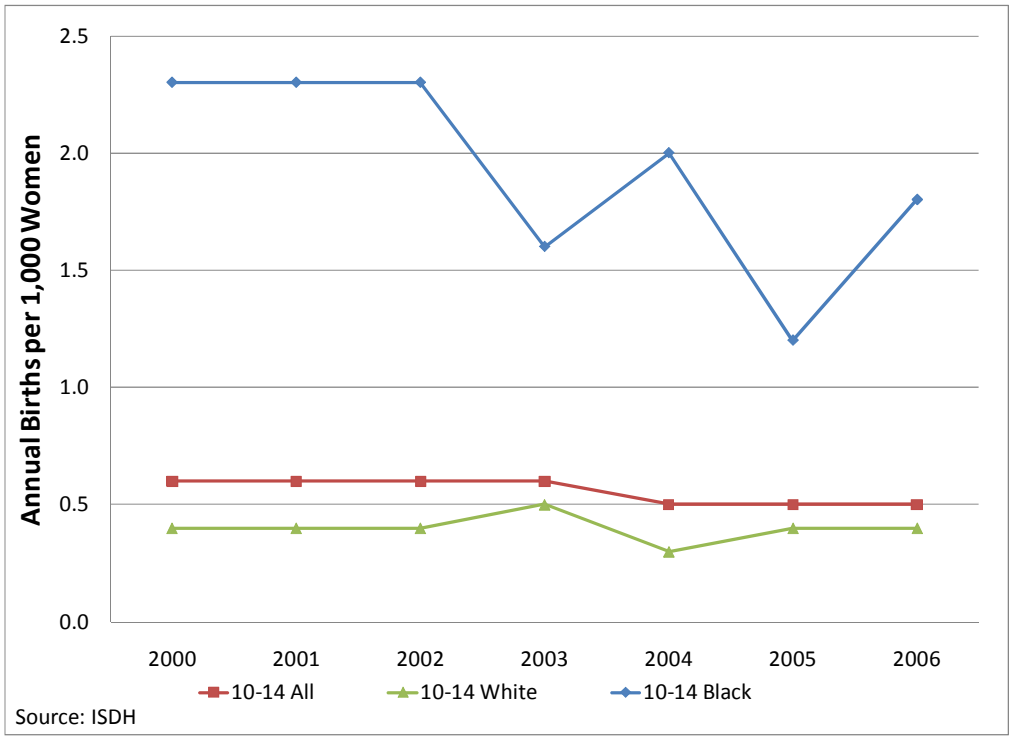
An additional measure of childhood well-being is the number of children reported as abused or neglected. During state fiscal year 2008, 4,339 children age five and under were abused and/or neglected and consequently declared a child in need of services (CHINS). This is approximately eight tenths of one percent (.008 percent) of children under age five in Indiana that were reported as being abused or neglected during 2008. There has been a notable increase in the number of CHINS since 2004; however, this does not indicate the welfare of children is becoming worse in Indiana. The Department of Child Services was established in January 2005 by executive order of the governor. The creation of the department and the governor's emphasis on protecting children has almost certainly led to a higher rate of identification of children in need of services and accounts for some of the increase in CHINS from 2004 onward. During 2006 there were a total of 53 child fatalities due to abuse and neglect, of which 66 percent were children of 0-3 years of age.

Figure 9: Number of Children (Age Five and Younger) Declared a Child in Need of Services by State Fiscal Year



The Zero to Three training program trains childcare professionals with the goal of reducing child abuse. Funding from ECCS , the Indiana State Head Start Collaboration Office, and Healthy Families Indiana was used to purchase the required curricula and other materials which provided training to 38 trainers from throughout Indiana. The initial training occurred in April 2008 as part of the Healthy Families Indiana (the state's home visiting program to prevent child abuse) three-day conference. This training has produced a statewide, specialized group of individuals who will help the child care community understand their role in the prevention of child abuse. Those individuals who have completed the training are now qualified to train others. A total of 28 trainers provide training statewide. To date, these trainers have provided 128 hours of training to a total of 1,137 primary child care providers.

Figure 10: Birth Rates for Indiana Women Age 10-14 by Race.

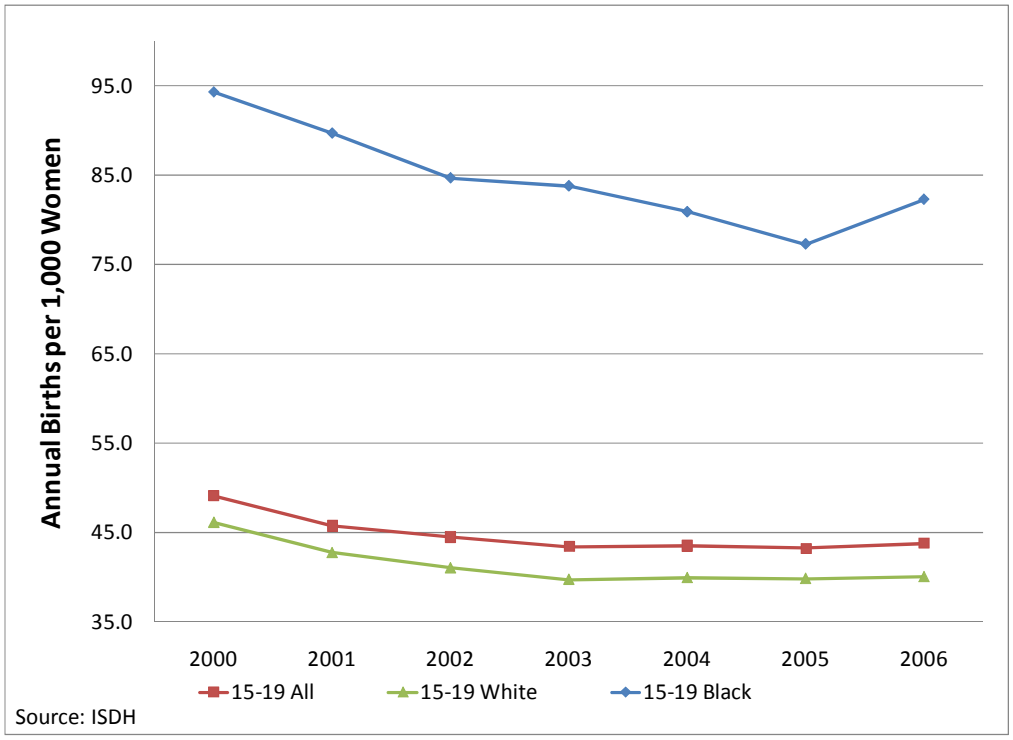


The U.S. teenage pregnancy rate is among the highest for industrialized nations (The Guttmacher Institute, 2002). The National Campaign to Prevent Teen Pregnancy estimated that $9.1 billion in public funding was expended on teenage childbearing in 2004 (Hoffman, 2006). According to data from the National Center for Health Statistics, in 2004 the teen pregnancy rate for women ages 15 to 19 in Indiana (43.5 births per 1,000 women, annually) was higher than that for the nation (41.1 births per 1,000 women, annually) (National Center for Health Statistics, 2008).

More recent data for Indiana available from the ISDH reports that the birth rate for mothers ages 10 to 14 was 0.5 per 1,000 females in 2006, down from 1.1 per 1,000 in 1995 (see Figure 10). The annual birth rate for white mothers ages 10 to 14 was 0.4 per 1,000, while that for black mothers of the same age was 1.8 per 1,000. The birth rate for mothers ages 15 to 19 was 43.8 per 1,000 females in 2006, down

from 57.2 per 1,000 in 1995 (see Figure 11). The birth rate for white mothers ages 15 to 19 was 40.0 per 1,000, while that for black mothers of the same age was 82.3 per 1,000.

Figure 11: Birth Rates for Indiana Women Age 15-19 by Race.



Expulsions and Suspensions from Early Care and Early Education

Currently, there are no data available on the number of expulsions and suspensions from private early care and schools. Because of this, all numbers reported below are for the public school system which provides pre-kindergarten and kindergarten. The number of children expelled from early care or early educational settings due to behavioral problems provides a measurement of child behavioral and mental health. Among kindergarten students, there were 510 in-school suspensions, 1,001 out-of-school suspensions, and less than 10 expulsions during the 2007-2008 school year. Eighty-four of the in-school suspensions and 219 of the out-of-school suspensions were for special education students. Among pre-

kindergarten students during the 2007-2008 school year, there were less than ten in-school and out-of-school suspensions of pre-kindergarten students and less than ten expulsions as well (Lane, 2009).

Early Child Care Resources, Support, and Development

To create a coordinated and accessible early childhood system, quality resources and supports must be fully integrated. By assessing quality standards and focusing on local resources and supports, this part of the evaluation examines the effectiveness of the ECCS initiative with regard to child care resources, available supports, and educational development opportunities.

Licensed Child Care Facilities

Licensed child care facilities in the state of Indiana are required to meet certain minimum standards in order to remain licensed, thus the quality of these facilities should be assured. The number of licensed facilities and the overall licensed capacity provide one measure of the availability of childcare. Using data from the Bureau of Child Care (BCC), as of February 2, 2008, there were 3,645 licensed child care facilities (this includes child care centers and homes but not ministry-based care) in the state with a total licensed capacity for 109,314 children. This licensed capacity could serve up to 20.2 percent of all Indiana children age five and younger. Child care centers also report their capacity by age group. The total capacity of child care centers in Indiana is 71,624 with a capacity of 3,904 infants, 5,185 toddlers, and 62,535 children. For home-based child care, the BCC only reports the number of children that each center is licensed to accommodate and the ages of children for which the facility is licensed. The 3,039 home-based child care facilities in Indiana provide a total capacity of 37,690 children. Among these home-based facilities, 2,898 (95 percent) provide services to infants and toddlers ("CareFinder Indiana,") . Additional children could be cared for in ministry-based child care facilities which are not subject to licensing. While not subject to licensing, ministry-based care must meet minimum requirements regarding sanitation and fire and life safety. Information regarding the capacity of unlicensed, registered childcare ministries is not reported.

The number and percent of children enrolled in the Child Care Development Fund (CCDF) who are enrolled in licensed child care centers or homes is determined using data from the BCC. The CCDF is a federal fund providing needy families with assistance obtaining child care so that parents may work or attend training or education. During state fiscal year 2007, a total of 58,268 children were served by the CCDF, 71.1 percent of whom were enrolled in a licensed child care setting, while the remaining 28.9 percent received services from a ministry or faith-based day care setting (Indiana Family and Social Services Administration, 2007).

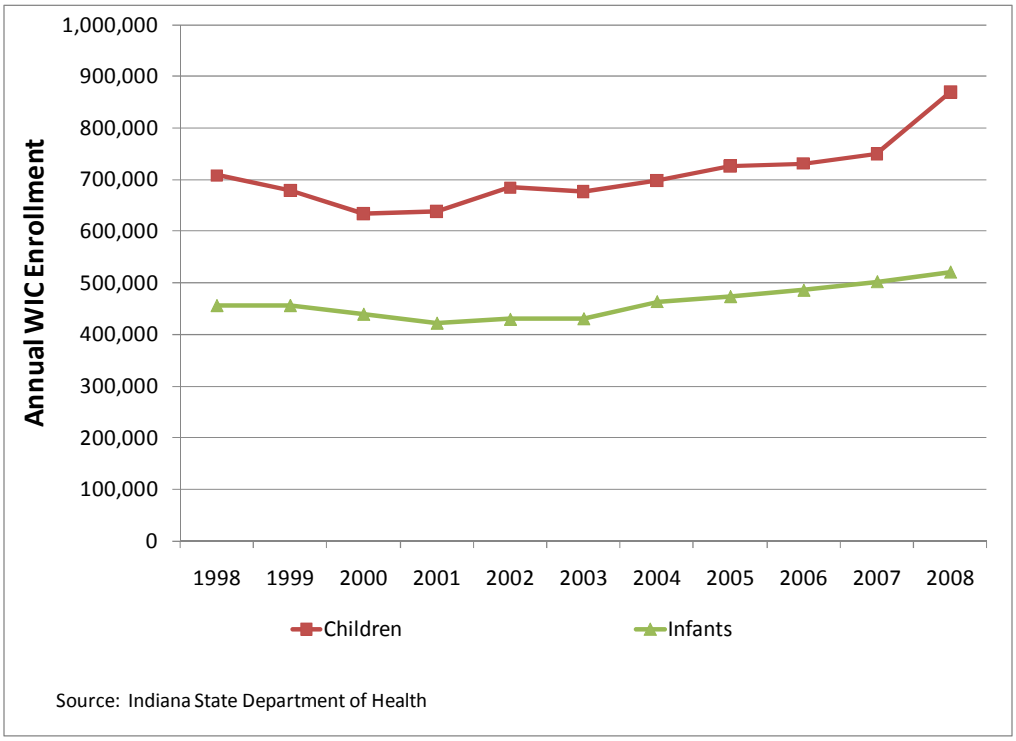
The Family and Social Service Administration's Bureau of Child Care began implementing a statewide Quality Rating system on October 1, 2007, as a strategy to drive improvements in the quality of early child care and education and to aid parents in selecting a high quality early care and education provider. The program, called Paths to Quality, began its rollout in January 2008, and is planned to be completed by January 2009. More information regarding Paths to Quality can be found at http://www.childcarefinder.in.gov.

Special Nutrition Program for Women, Infants, and Children

For parents to quickly and effectively address their child's health, safety, and developmental needs, families must have access to resources that enable them to fulfill their children's basic needs. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) assists families in meeting their children's nutritional needs by providing food stamps. According to the U.S. Department of Agriculture, the Indiana WIC program served an average of 155,761 individuals each month during federal fiscal year (FFY) 2008[8] (United States Department of Agriculture). The Indiana State Department of Health reports that the Indiana WIC program served an average of 43,326 infants per month in 2008 (a 3.6 percent increase from the average of 41,809 infants served per month in 2007) and served an average of 72,513 children between one and five years of age during state fiscal year 2008 (a 16 percent increase from the 62,511 children served in 2007)(Thomas, 2009).

[8] October 2007 – September 2008.

Figure 12: Annual Enrollment in the Special Supplemental Nutrition Program for Women, Infants, and Children



Early Child Care Information and Resources

Research shows that increased parental involvement in child care is correlated with better outcomes for the children. Despite the positive outcomes associated with increased parental involvement, some parents remain unwilling or unable, due to stress and/or fear, to get involved because of a lack of information regarding their child's care (Coyne, 1995). One of the ECCS's objectives is to provide parents with the information and knowledge about their child's development to help them overcome any stresses and fears they may feel and encourage them to become more involved. This is an important step in improving the well-being of Indiana children because parents, who see their children frequently, can potentially recognize symptoms of delayed progression earlier than a physician.

To provide families of young children with a single comprehensive guide to available resources throughout the state and in their community, the ECCS initiative established an information clearinghouse. This clearinghouse, known as the *Early Childhood Meeting Place* (ECMP, http://earlychildhoodmeetingplace.indiana.edu) is maintained by the Indiana Institute on Disability and Community at Indiana University (IDC). As of 2008, the ECMP lists a vast array of resources, including 112 community resources, 42 child care and early education resources, 233 health and safety resources, and 234 parenting and family resources. The usage of this site was monitored to aid in evaluating the success of the clearinghouse. During state fiscal year 2007, there were 18,696[9] visits to the Family Section of the ECMP site made by 6,598 unique visitors. The average number of visits per month was 1,700 during SFY 2007; however, the number of visits increased from just 1,696 in May 2007 to 7,095 during June 2007. This spike in visitors is likely due to an ad for the ECMP in the *Indianapolis Star* that summer and may also have been due to the distribution of promotional materials for the ECMP in the spring of that year. The number of visits decreased after the spike in June; however, the trend since August 2007 has been a continuing increase in the number of visitors. To further increase awareness of the ECMP Web site, displays promoting the web site have also been developed for distribution to doctors' offices.

Visit data from December 2007 through September 2008 is not available, unfortunately, because someone tampered with the ECMP web site. It is also thought that this event is responsible for the high level of visits during October 2008 as those who tampered with the site were probably attempting to do so again, before finally giving up. For those months in late 2008 and early 2009 for which we have data, the number of unique visitors and the number of visits is similar to the levels at the end of 2007.

Starting in February of 2009, a number of financial resource fact sheets have been available on the Early Childhood Meeting Place web site. A total of 3,580 facts sheets were downloaded from February to May of 2009, with downloads peaking at 1,410 downloads during March. The number of visits to the Family Section of the Early Childhood Meeting Place web site also spiked during these months.

[9] The data exclude September 2006 for which data were unavailable.

The availability of information and knowledge about child development and the ability to recognize progress is another component of resources, support, and development. The Early Childhood Meeting Place (ECMP) Web site's events calendar was used to assess the availability of development opportunities offered throughout the state with regard to infant and toddler developmental, behavior, and mental health. A total of 1,073 unique events occurring in Indiana during fiscal year 2008 were listed on the ECMP Web site. Of these 1,073 events, 962 had a location assigned. The distribution of these 962 events by county is shown in the appendices of this report.[10]

An additional source of information for young children is the Sunny Start Developmental Calendar, *A Parent's Guide to Raising Healthy, Happy Babies*. This calendar contains parenting guidelines and suggestions for children from birth to age five and also provides space to record information about the child, including doctor visits and growth and immunization records. In addition, the guide provides a list of developmental benchmarks to aid parents in monitoring the development of their child and to assist in the identification of areas needing further attention from a doctor or nurse. The calendar has been such a success that the Peyton Manning Children's Hospital at St. Vincent's Hospital will be distributing a version of the calendar bearing their logo to all new mothers upon discharge as well as to the families of young children visiting their primary care clinics. The cost of printing will be covered by the hospitals. Additionally, Clarian Health Systems and Anthem/Wellpoint are both considering distribution of the calendar. The calendar is also available electronically from the ECMP Web site in both English and Spanish.

Conclusion

The ECCS initiative seeks to improve the health and well-being of children in Indiana by ensuring the continuity of care and by increasing parental involvement. The Core Partners, acting as the steering

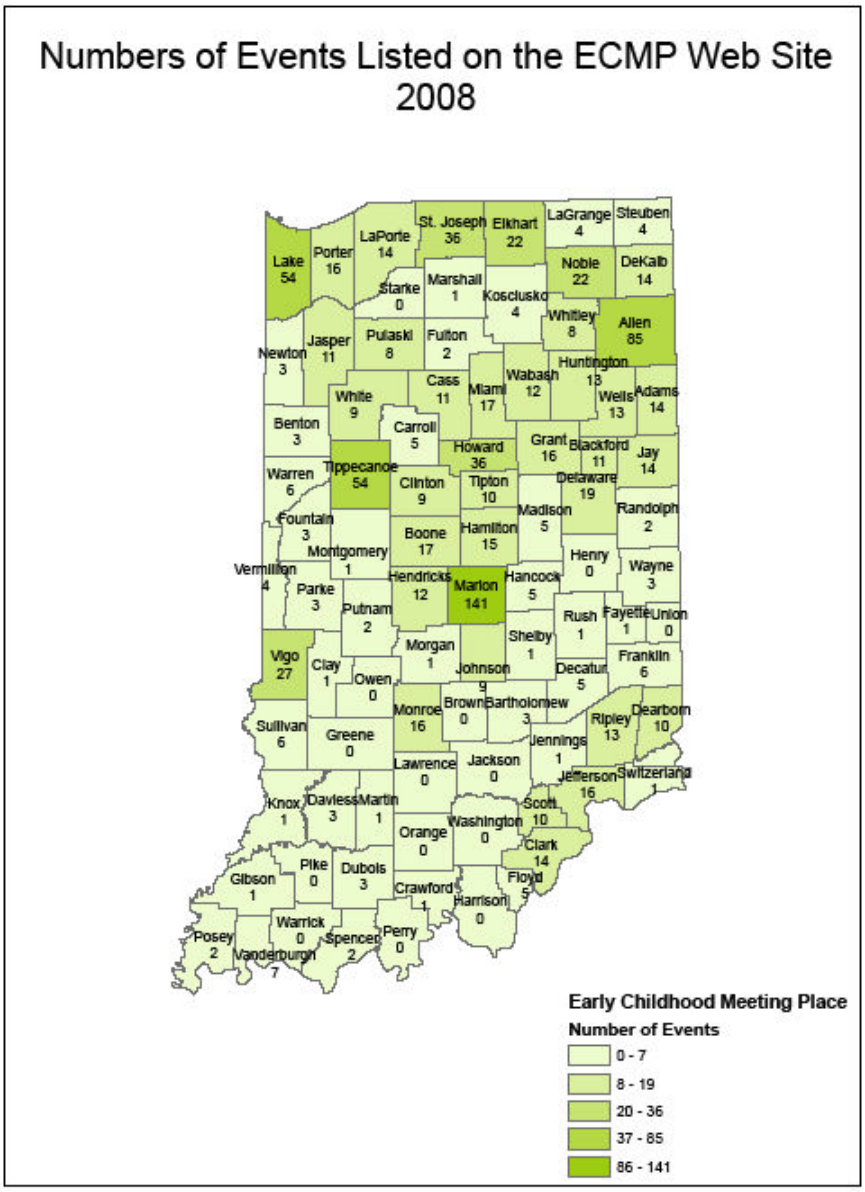
[10] Please note that the maps show only the number of events listed on the ECMP Web site. There are certainly other relevant events, but since there is no central clearinghouse, this report is unable to account for other events.

committee, have acted quickly to implement the changes necessary to achieve the objectives set forth in the ECCS initiative.

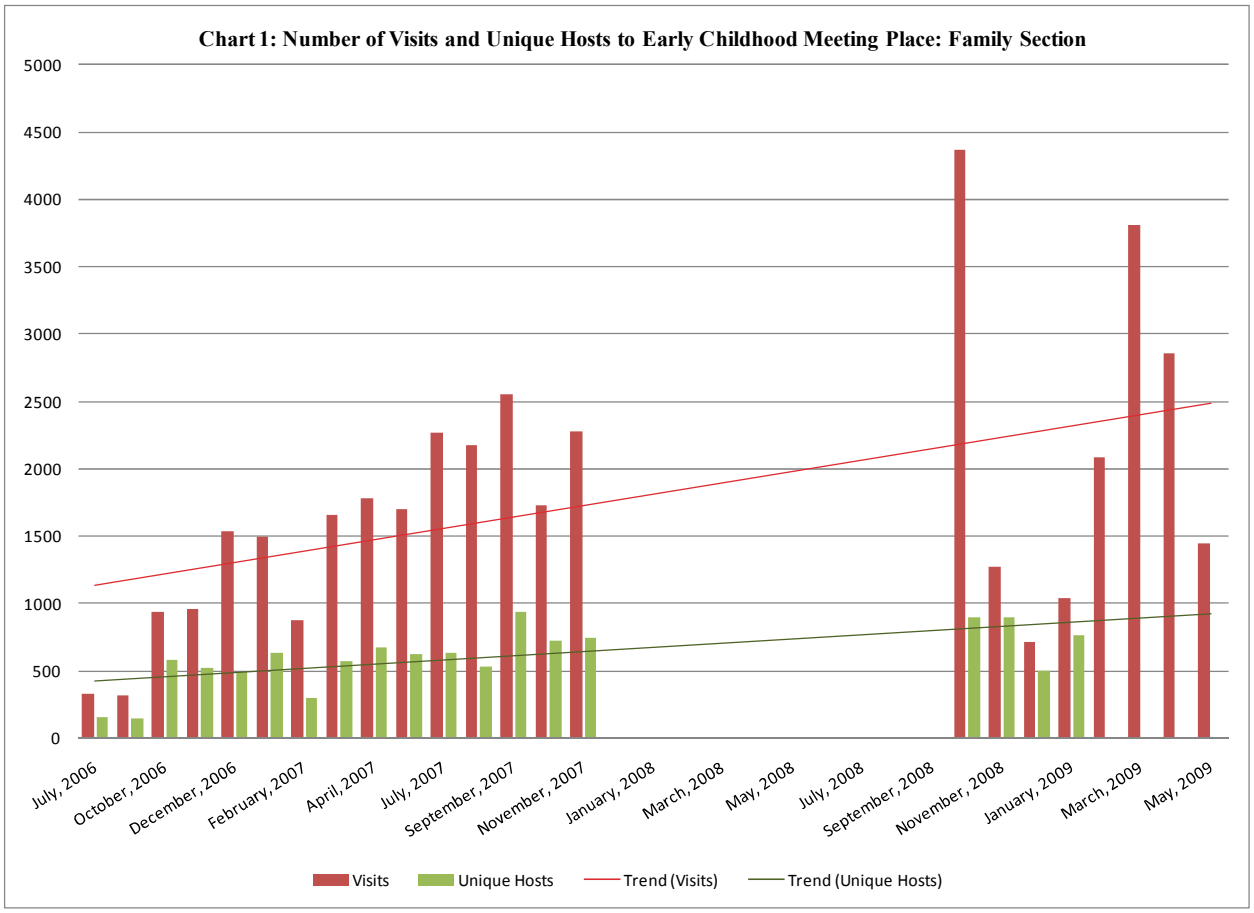
Several areas for improvement are identified in this report:

- The usage of dental care by children ages one through five who are on Medicaid is very low. Children in this age group should be visiting the dentist twice a year; however, only 25 percent of children five and younger who receive Medicaid visited a dentist and only 28 percent of children five and younger who are enrolled in SCHIP visited a dentist.
- The number of children enrolled in the Indiana State Department of Health Children's Special Health Care Services (CSHCS) has decreased precipitously. In 2008, a total of 2,624 children age five and younger participated in the CSHCS program, a decrease of 42 percent from the 4,538 children enrolled during 2002 (Indiana State Department of Health). This issue will be further evaluated by the Children's Special Health Care Services of the Indiana State Department of Health.
- Areas that were lauded were mainly those involved with the dissemination of information to parents and childcare professionals, an area in which the Sunny Start Program has excelled. The ECMP Web site, the Sunny Start Developmental Calendar, and the Financial Fact sheets are all excellent information resources which the Sunny Start Program should distribute as widely as possible. The developmental calendar also provides a way to reach families who do not have internet access.

We hope that this evaluation will serve as an objective gauge of the Sunny Start Programs progress and will provide a benchmark from which to measure future progress. While the ability to attribute changes in outcomes to the ECCS initiative is limited by both the extraordinary breadth of system changes and by gaps in the availability of data, this evaluation seeks to provide some insight into the progress of the initiative and a baseline for future comparisons.


Numbers of Events Listed on the ECMP Web Site
2008
Lake 54
Porter 16
LaPorte 14
St. Joseph 36
Elkhart 22
LaGrange 4
Steuben 4
Starke 0
Marshall 1
Kosciusko 4
Noble 22
DeKalb 14
Whitley 8
Allen 85
Newton 3
Jasper 11
Pulaski 8
Fulton 2
Huntington 13
Wabash 12
Cass 11
Miami 17
Wells 13
Adams 14
White 9
Benton 3
Carroll 5
Howard 36
Grant 16
Blackford 11
Jay 14
Warren 6
Tippecanoe 54
Clinton 9
Tipton 10
Delaware 19
Randolph 2
Madison 5
Fountain 3
Montgomery 1
Boone 17
Hamilton 15
Henry 0
Wayne 3
Vermillion 4
Parke 3
Hendricks 12
Marion 141
Hancock 5
Putnam 2
Rush 1
Fayette 1
Union 0
Shelby 1
Morgan 1
Johnson 9
Vigo 27
Clay 1
Owen 0
Decatur 5
Franklin 6
Monroe 16
Brown 0
Bartholomew 3
Dearborn 10
Ripley 13
Sullivan 6
Greene 0
Jennings 1
Lawrence 0
Jackson 0
Jefferson 16
Switzerland 1
Knox 1
Daviess 3
Martin 1
Scott 10
Orange 0
Washington 0
Clark 14
Pike 0
Dubois 3
Floyd 5
Gibson 1
Crawford 1
Harrison 0
Warrick 0
Perry 0
Posey 2
Vanderburgh 7
Spencer 2
Early Childhood Meeting Place
Number of Events
0 - 7
8 - 19
20 - 36
37 - 85
86 - 141

Appendix B: Visits and Unique Hosts to the Family Section of the ECMP Web site



Appendix C: Sunny Start Completed Tasks Through Year Three

	Sunny Start - Completed Tasks Through Year Three	
Item #	**Description**	**Comments**
1.2.1	MCSHCS and the Department of Child Services will meet to review and revise the Medical Passport document.	Draft of a general passport completed by Sunny Start work groups.
1.2.2	The medical passport will include a section on dental care and available resources.	
3.2	***An outreach program to providers will be implemented statewide regarding the information clearinghouse of community resources to enhance appropriate referral/treatment.***	Marketing of the ECMP continues to target providers through mass mailings and conferences.
3.3	***Personnel preparation efforts will be increased to recruit qualified early childhood mental health providers.***	The Summer Institute was held in August 2007. A mentorship program for providers
3.3.1	A task force of stakeholders including parents will be convened to identify current personnel preparation efforts.	The S/E Training Technical Assistance Committee has developed a set of competencies S/E Consensus Statement) to address social and emotional training. An intensive training institute was provided to early childhood mental health professionals in July 2007. A follow-up to that conference is scheduled for August 2008
P.O. 4	**An information clearinghouse will be established that includes information about resources and supports at the state and local level for families of young children and providers of early childhood services.**	
4.1	***The Early Childhood Meeting Place will be expanded to include families.***	
4.1.2	Based on the recommendations of the task force, the Early Childhood Meeting Place will be expanded to include resources and supports for families of young children.	In early 2006 the Early Childhood Meeting Place was expanded to include resources for families. The Meeting Place continues to be marketed to providers and families through mass mailings and conference attendance. The last mailer went to Indiana physicians in June 2008.
4.1.3	The Early Childhood Meeting Place will be marketed to families and providers as a central source of information about child development and community resources.	
	Sunny Start - Completed Tasks Through Year Three (Continued)	
4.1.4	Technical Assistance will be provided to users of the Early Childhood Meeting Place to ensure optimum	Requests are responded to via e-mail and telephone. A tip sheet with suggestions for

	access to available resources and supports.	navigating the site is posted.
P.O. 5	**Quality resources and supports are integrated to create a coordinated, accessible early childhood system.**	
5.1	***The Core Partners will continue to guide ECCS activities.***	
5.1.1	New representatives from state agencies, including the newly formed office of faith based initiatives, will be identified and invited to sit on the Core Partners Steering Committee.	Efforts have continued in this area each year. New Partners from the Office of Faith Based and Community Initiatives, the Indiana Minority Health Coalition, Commission on Hispanic/Latino Affairs, Indiana Department of Environmental Management have been recruited.
5.1.2	MCH staff will provide an orientation to all new members.	In the process of updating orientation process.
5.1.3	Core Partners will continue to meet on a quarterly basis to coordinate efforts across existing initiatives..	Core Partner meetings have taken place on a quarterly basis. Minutes from each meeting are posted on the Sunny Start Web site - www.sunnystart.in.gov
5.2	***Core Partners will promote leadership within their respective agencies and organizations.***	
5.2.1	Core Partners will develop a process to provide leadership within their agencies/organizations.	
5.2.2	Core Partners will educate their organizations on the guiding principles for the ECCS initiative.	
5.2.3	Core Partners will establish a protocol to support communication across agencies and initiatives.	
5.4	***Coordinate Training and Technical Assistance.***	
5.4.1	The Core Partners will serve in a coordination capacity to promote the commonality of training content and provide leadership in the development of additional training curricula.	Core Partners approved Social and Emotional Consensus Statement, which was developed by the S/E Training and Technical Assistance Committee.
5.4.3	Additional training content will be developed and delivered to address any gaps identified.	Sunny Start is sponsoring additional days for the IAITMH conference bringing in speakers to help early childhood mental health providers.
5.4.6	The Early Childhood Meeting Place will collaborate with the Core Partners and others to notify families and providers of training opportunities.	Training opportunities for providers and families are posted on the Early Childhood Meeting Place.
5.4.7	Core Partners will support the reduction in duplication of training efforts.	
	Sunny Start - Completed Tasks Through Year Three (Continued)	
5.4.8	Core Partners will continue to gather information about training and education needs throughout the state.	
5.5	***National Quality Standards will be implemented***	

	in all early care settings.	
5.5.1	ICCHCP staff will educate early care setting providers on the standards.	Paths to Quality began in January 2008 and is being implemented in stages throughout the state for the remainder of the year.
5.5.2	Progress on the use of the standards will be monitored.	
5.5.3	Policy development templates will be created and made available to care providers.	
6.0	Parents have the necessary information, support, and knowledge about child development and are able to recognize their child's progress.	Family Advisory Committee, along with the support of other Sunny Start members and members of the community, have developed a calendar which highlights issues related to child development.
6.1	Elected resources about child development will be used with and by parents to educate families about child development.	Resources and links for families are regularly posted to the ECMP.
6.1.2	The committee will review existing developmental resources to determine those most appropriate as educational tools for families	In the process of developing documents to help families understand services and financial resources available to their family.
6.1.3	The developmental resources selected by the committee will be posted to the Early Childhood Meeting Place	Ongoing and will continue in Year Three.
6.2	Create electronic version of a developmental calendar for children birth to five.	Calendar complete in fall 2007 with 17,000 copies printed and information posted on the ECMP. A Spanish version is in development.
6.2.1	Gather samples of developmental calendars that are currently being used by other states.	
6.2.2	Permission will be sought to utilize the developmental calendar that is selected by the committee.	
6.2.3	Modifications will be made on the selected calendar to include Indiana resources.	
6.3	The Early Childhood Meeting Place will be marketed as a central source of information about child development.	Marketing of the ECMP continues to target families. The last mass mailing went to Indiana physicians to display in their waiting room where families are gathered.
6.4	Families have a meaningful role in the development of policies and programs at the state and local level.	
	Sunny Start - Completed Tasks Through Year Three (Continued)	
6.4.1	Parents will receive support to serve on boards, committees, and task forces related to early childhood opportunities	Implemented Family Stipend Program to alleviate costs involved for families to participate in Sunny Start.
6.4.2	Leadership training opportunities will be provided for families.	
6.4.3	Core Partners will implement methods to gather input from parents on policies and programs related to	Family members participate in all sub-committee and core partner activities.

	early childhood on a regular basis.	
7.0	Families have timely access to resources and supports to address their child's health, safety and developmental needs.	
7.1	The Early Childhood Meeting Place will maintain current information about resources related to children's health safety and development.	Continued efforts to market the ECMP expansion to providers of early childhood services - information conveyed at ten conferences in the last year.
7.2	Child Care Health Consultants will educate child care providers regarding health, safety and developmental issues.	
7.2.1	See 4.1-Early Childhood Meeting Place expansion, 5.3-Training and Technical Assistance, 6.1 Selected child development resources, 6.3-Electronic developmental calendar	
7.3	Training and technical assistance will be readily available and affordable to families throughout the state.	
	See 5.3 Training and Technical Assistance System.	
7.4	Training and technical assistance will be provided to those serving young children and their families.	Zero to Three Training - April 2008 - ongoing training for providers in the area of child abuse.

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