

# Title V Block Grant Needs Assessment: MCH & CSHCS

Statewide Meeting  
January 14, 2021



## IN IT TOGETHER

Indiana Title V Needs Assessment

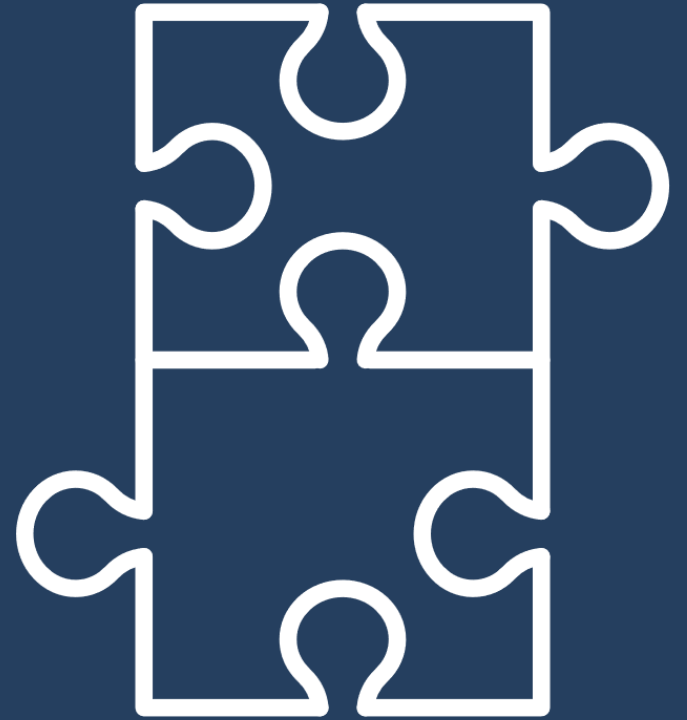


# Agenda

- ▶ **Title V Block Grant Overview**
- ▶ **Process and Timeline**
- ▶ **Primary Data Collection Summary**
  - Partner Survey
  - Community Focus Groups
  - Statewide Survey
- ▶ **Social Determinants of Health**
- ▶ **Annual Application**
  - Prioritization
  - State Action Plan
- ▶ **Next Steps & Future Funding Opportunities**

# **Title V**

## **Block Grant Overview**



# Title V Block Grant

- One of the largest (and the oldest) federal block grant programs.
- Funds support promoting and improving the health of mothers, infants, children, including children with special health care needs, adolescents, and their families.
- Each year, funds are allotted using a formula based on low-income children and are split between Maternal & Child Health (2/3) and Children and Youth with Special Healthcare Needs (1/3) in Indiana.
- In 2017, 59 states and jurisdictions were funded and served an estimated \$56 million (Indiana ~\$12 million).

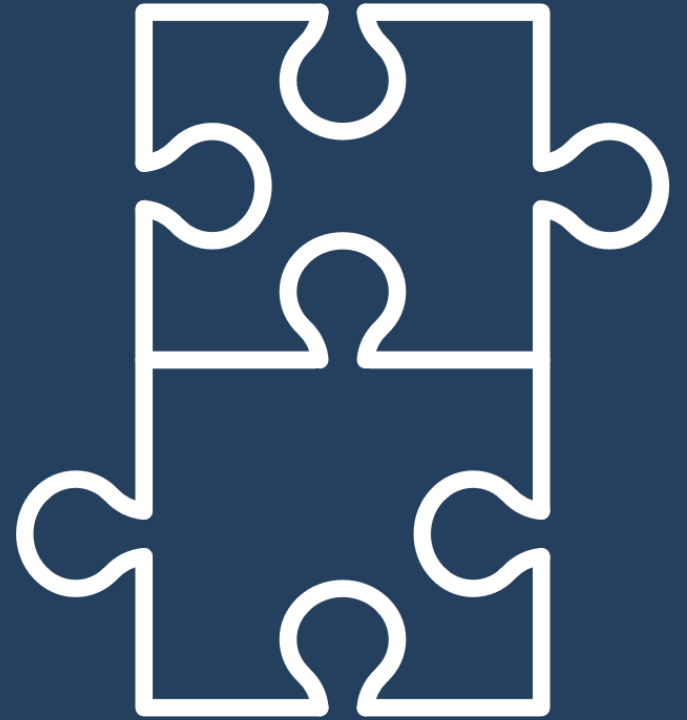
# Needs Assessment Requirements

- The Needs Assessment is required every 5 years as part of our application.
- Each state can conduct the Needs Assessment as it sees fit.
- From January 2019 to September 2020, IDOH conducted a statewide Needs Assessment for Maternal and Child Health Programs and Children with Special Health Care Needs supported by Title V.
- This Needs Assessment also runs in tandem with the MIECHV\* Needs Assessment.

# State Action Plan

- We are using the results from the Needs Assessment to drive the creation of our state action plan.
- Each state submits a 5-year action plan with:
  - National performance measures
  - State performance measures
  - Evidence-based strategy measures
- Reporting on these measures is required annually from 2020 to 2025.

# Process and Timeline



# Priority Populations

- We focused our Needs Assessment on the block grant population domains:
  1. Women/Maternal
  2. Perinatal/Infant
  3. Children
  4. Adolescents
  5. Children with special health care needs
- We wanted to reach those we are already serving and those whom we already partner with to understand the current use of programs.
- We also wanted to intentionally reach those who do not receive any services from IDOH.
- We strategically included Indiana populations that are harder to reach (Amish, refugees, immigrants, and dads) to make sure all voices were heard.



# Guiding Research Questions

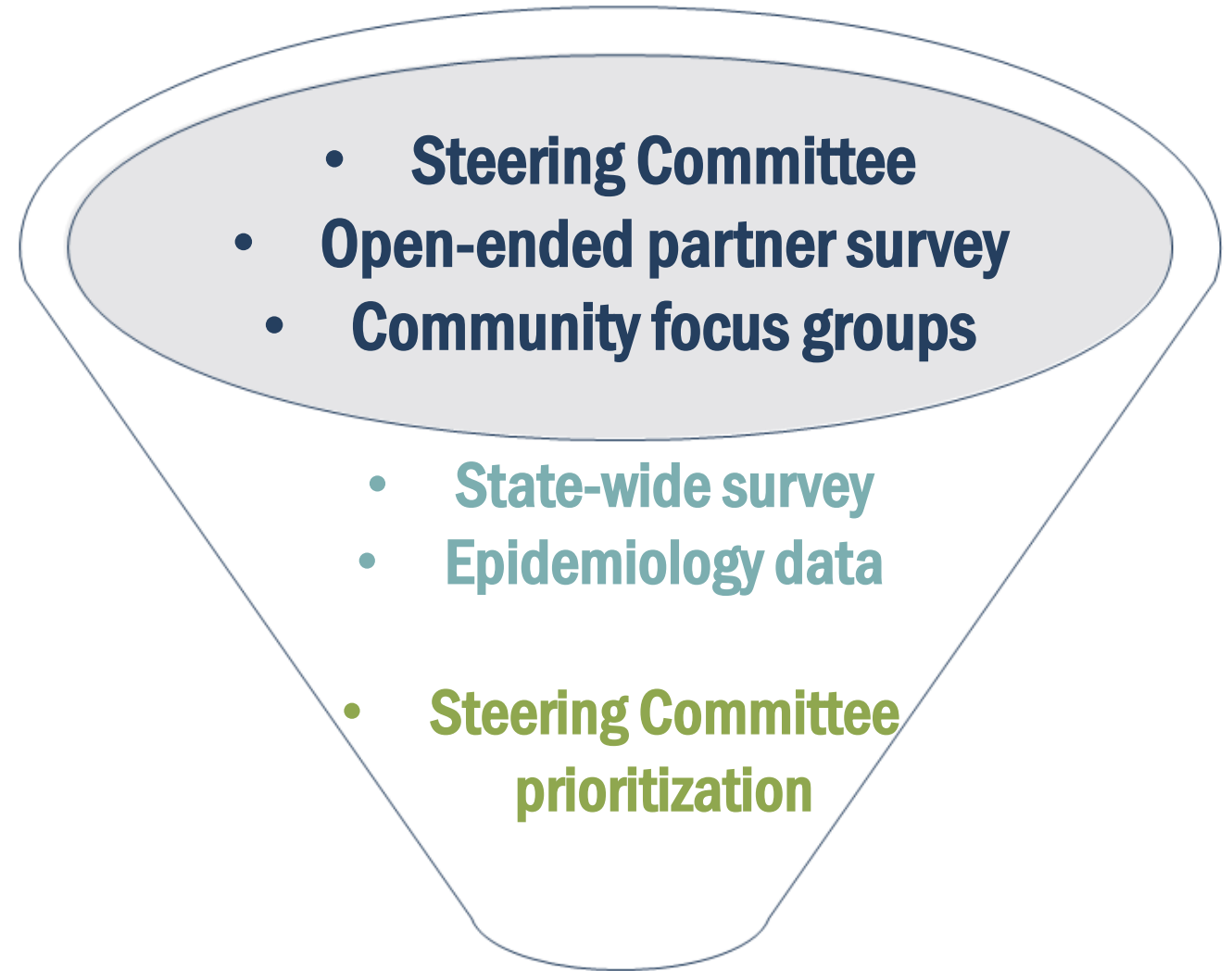
- ▶ What are the current needs of the MCH population in Indiana?
- ▶ What are the barriers to addressing these needs?
- ▶ To what degree are Indiana's MCH population needs already being met with existing resources?

# Our Team



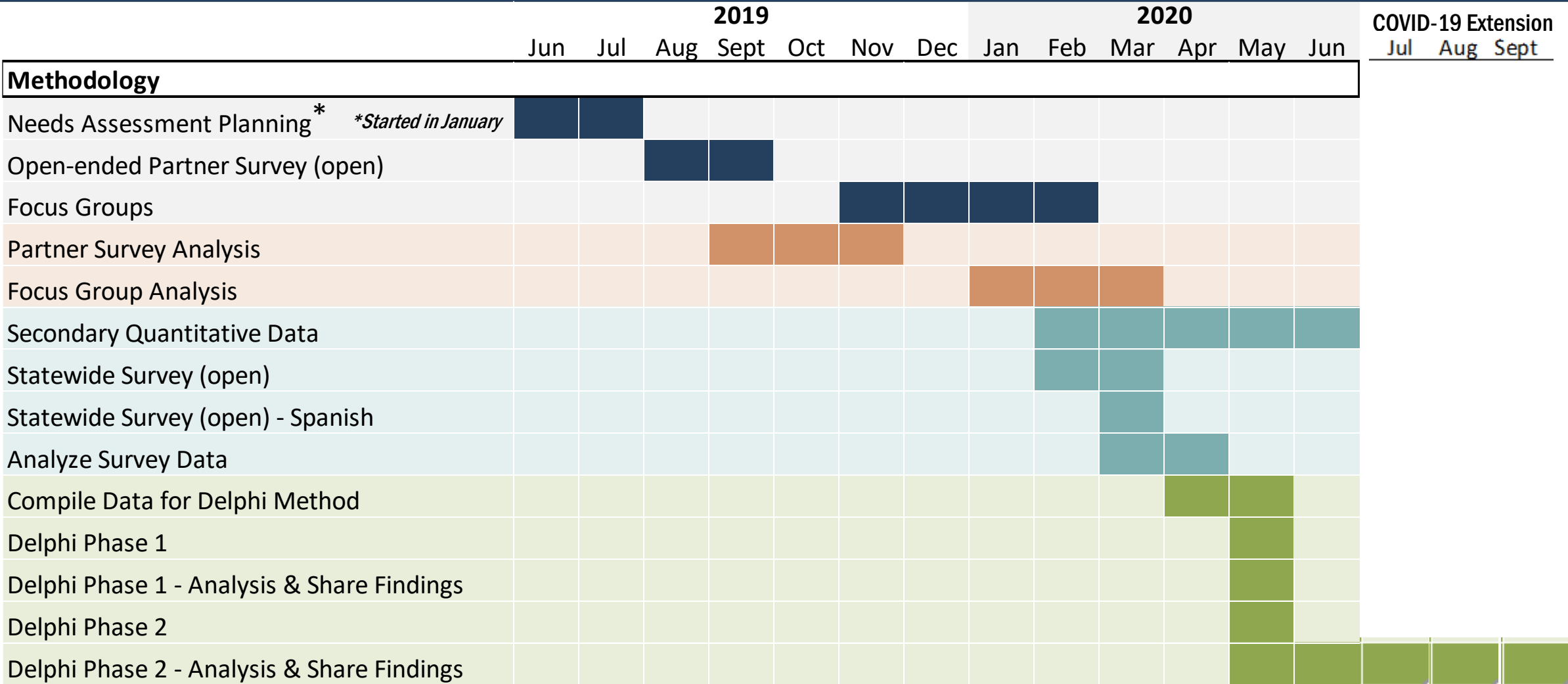
- ▶ **Leadership team**
- ▶ **Steering Committee**
- ▶ **MCH grassroots leaders**
- ▶ **Workforce Development cohort**
- ▶ **Partners and participants**
- ▶ **Diehl Consulting Group**

# Funnel Structure to Data Collection

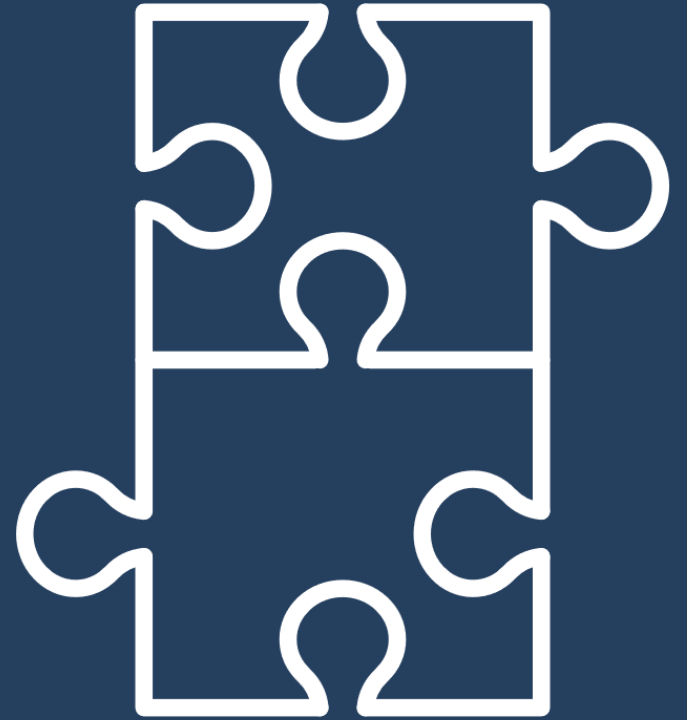


**Title V performance measures**

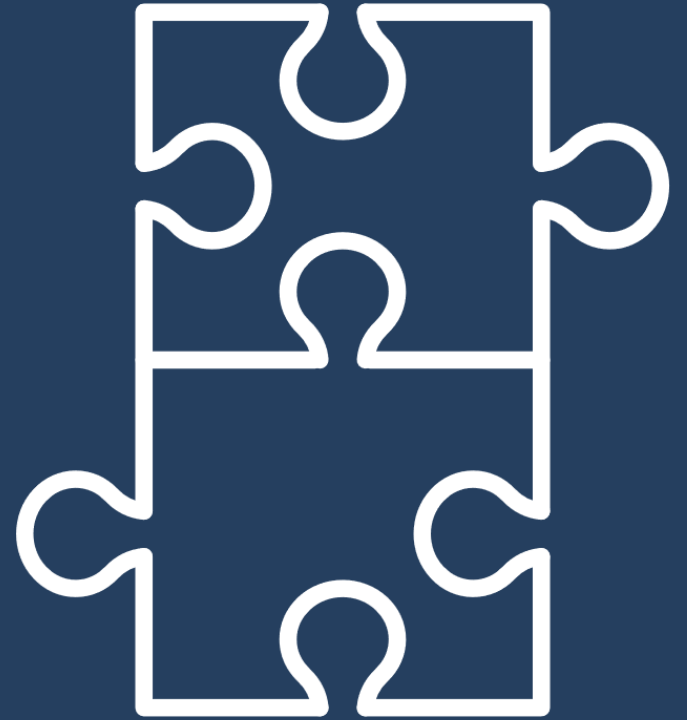
# Timeline



# Primary Data Collection Summary



# **Data Tool #1: Partner Survey**



# Timeline and Overall Responses

## Timeline

**August 22** survey opened

**September 13** survey closed

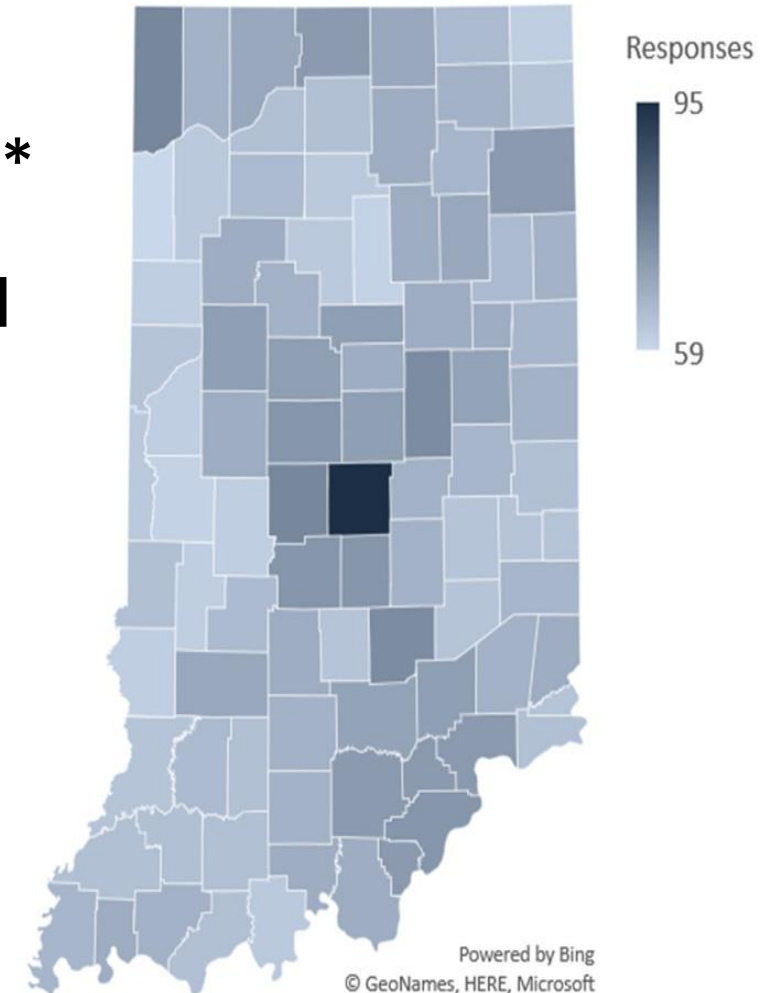
- ▶ Weekly follow-up emails sent to anyone who had not responded

## Responses

800 partners contacted\*

347 partners responded

43.4% response rate





# IN IT TOGETHER

Indiana Title V Needs Assessment

1. What is the greatest health need for the population(s) you serve?

2. What kinds of barriers prevent this health need from being met?

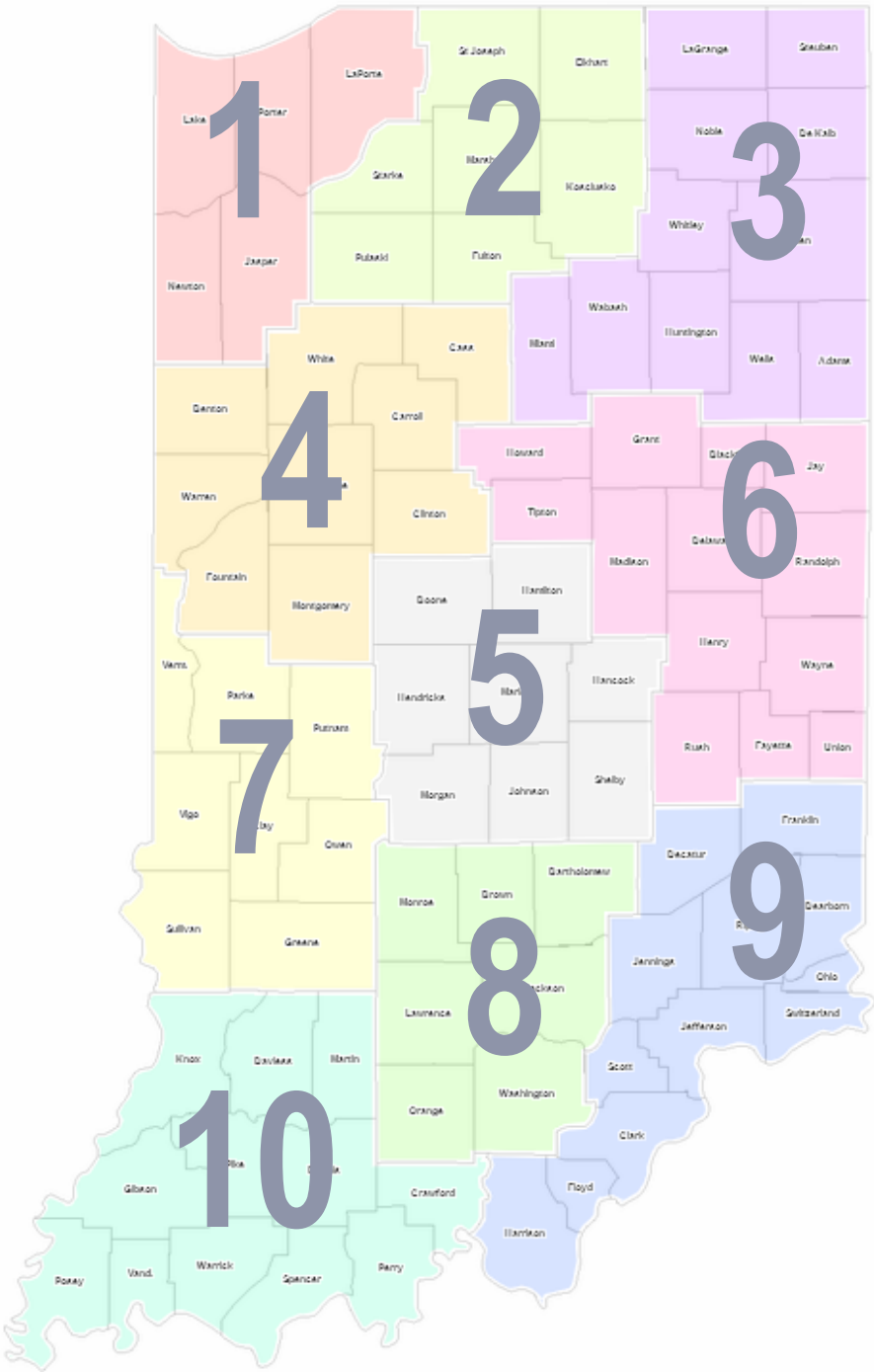
3. Which population(s) are primarily affected by this health need?  
(mark all that apply)

- Women/Maternal:** Women before, during, and beyond pregnancy and across their life course
- Perinatal/Infant:** Immediately before birth through the first year of life (<365 days)
- Children:** Ages 1 through 9
- Adolescents/Young Adults:** Ages 10 through 21
- Children with Special Healthcare Needs:** Children or adolescents who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally



# IDOH Regions

For regional representation



# Responses by Geography (County Served)

Region 1		Region 3		Region 4		Region 6		Region 7		Region 9		Region 10	
Jasper	62	Adams	67	Benton	61	Blackford	68	Clay	61	Clark	73	Crawford	68
Lake	76	Allen	72	Carroll	67	Delaware	70	Greene	69	Dearborn	68	Daviess	65
LaPorte	69	DeKalb	63	Cass	62	Fayette	63	Owen	65	Decatur	63	Dubois	64
Newton	59	Huntington	69	Clinton	71	Grant	68	Parke	60	Floyd	72	Gibson	64
Porter	67	LaGrange	65	Fountain	61	Henry	66	Putnam	61	Franklin	66	Knox	63
		Miami	60	Montgomery	68	Howard	71	Sullivan	61	Harrison	68	Martin	64
		Noble	67	Tippecanoe	71	Jay	66	Vermillion	62	Jefferson	72	Perry	62
		Steuben	61	Warren	63	Madison	75	Vigo	64	Jennings	71	Pike	64
		Wabash	68	White	68	Randolph	67			Ohio	63	Posey	66
		Wells	65			Rush	63			Ripley	67	Spencer	64
		Whitley	66			Tipton	68			Scott	72	Vanderburgh	68
				Region 5		Union	63	Region 8		Switzerland	64	Warrick	67
				Boone	73	Wayne	64	Bartholomew	75				
				Hamilton	71			Brown	63				
				Hancock	67			Jackson	70				
				Hendricks	76			Lawrence	67				
				Johnson	73			Monroe	68				
				Marion	95			Orange	67				
				Morgan	73			Washington	72				
				Shelby	67								

# Sorted Qualitative Themes

## Needs

- ▶ An underlying problem that needs to be addressed

Physical health

Mental health

Substance use/dependence

Reproductive care

## Barriers

- ▶ Something that prevents the need from being addressed

Access to care

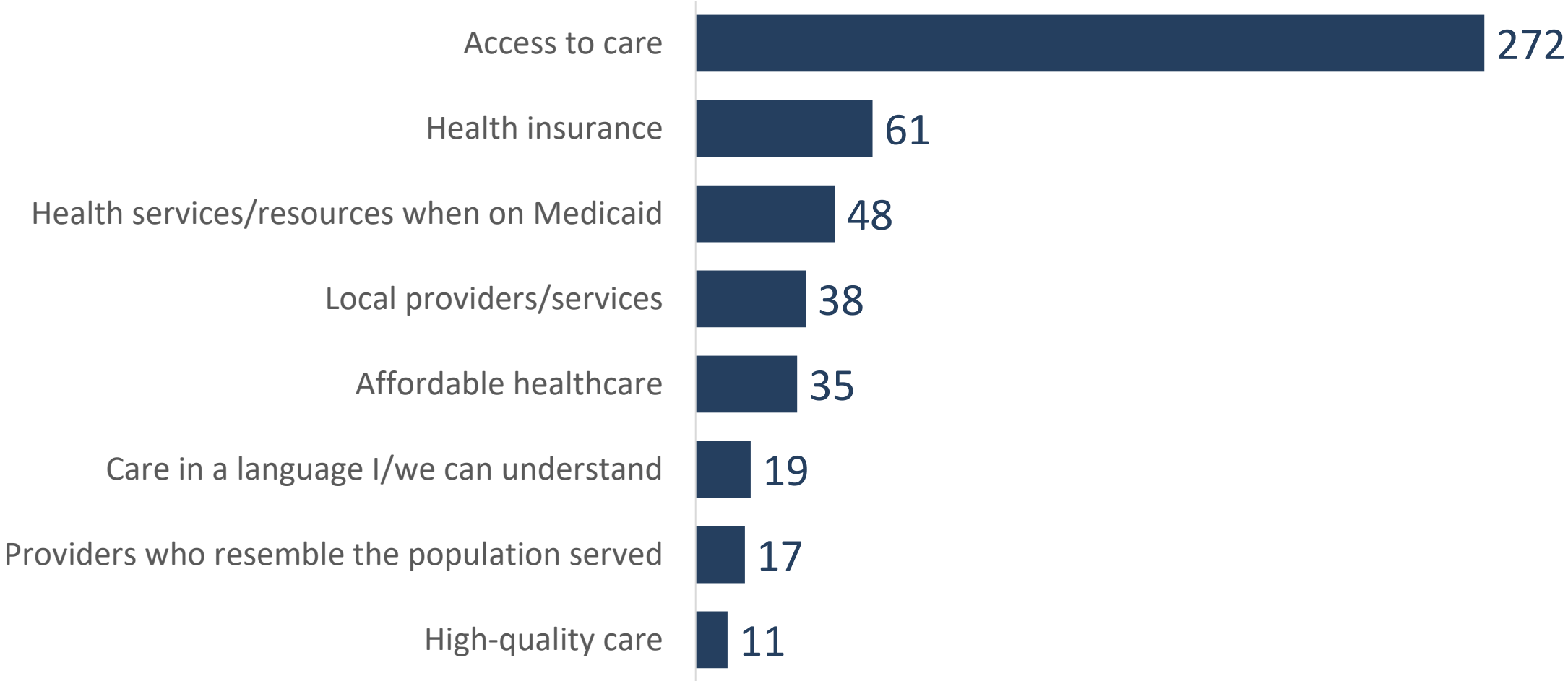
Transportation

Perception of other priorities\*

# Qualitative Themes

	Needs	Barriers
Access to Resources	236	215
Health	49	6
Disease	31	0
Personal Choices	68	59
Access to SDOH	49	275
Emotional	7	13
Social	12	72
Education/Awareness	30	127
Quality of Care Provided	33	131
Providers <i>(Limitations or Strengths)</i>	1	64
Policies	2	25

# Access to Resources

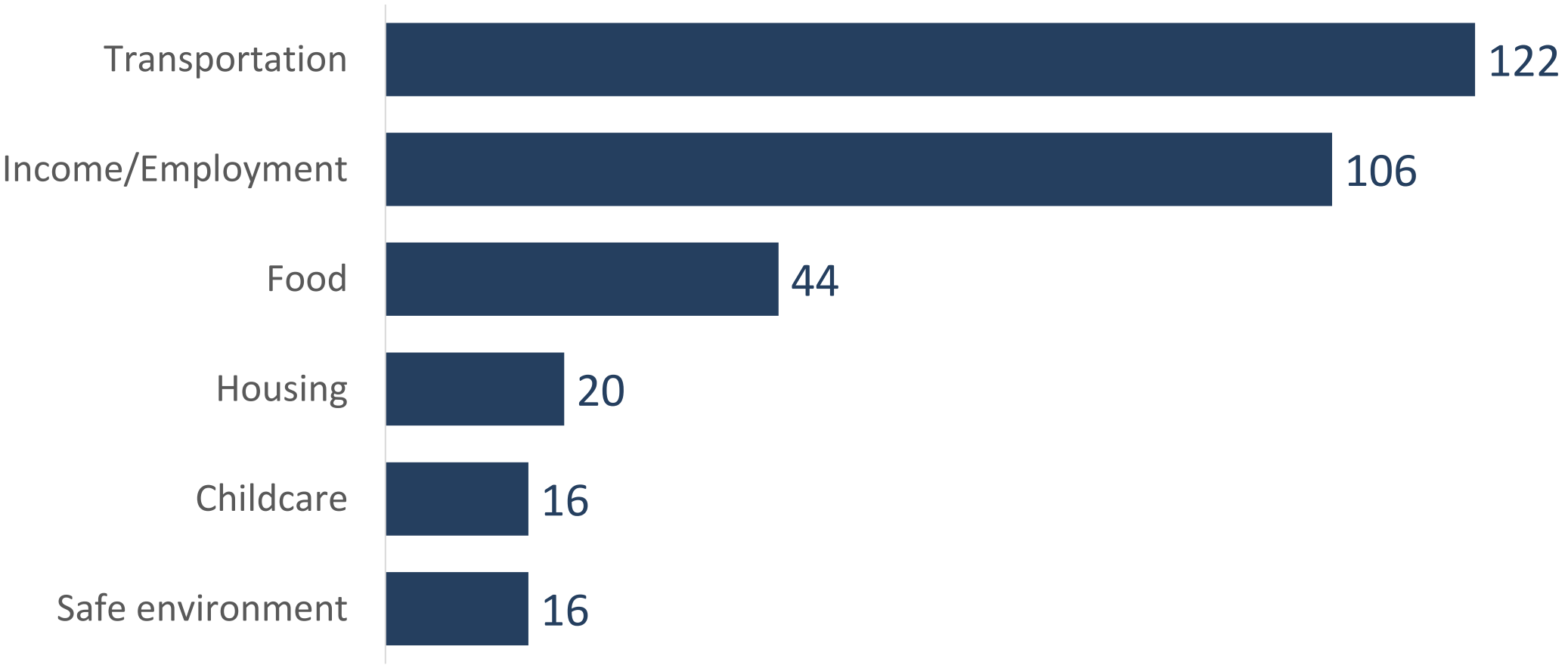


# Access to Care

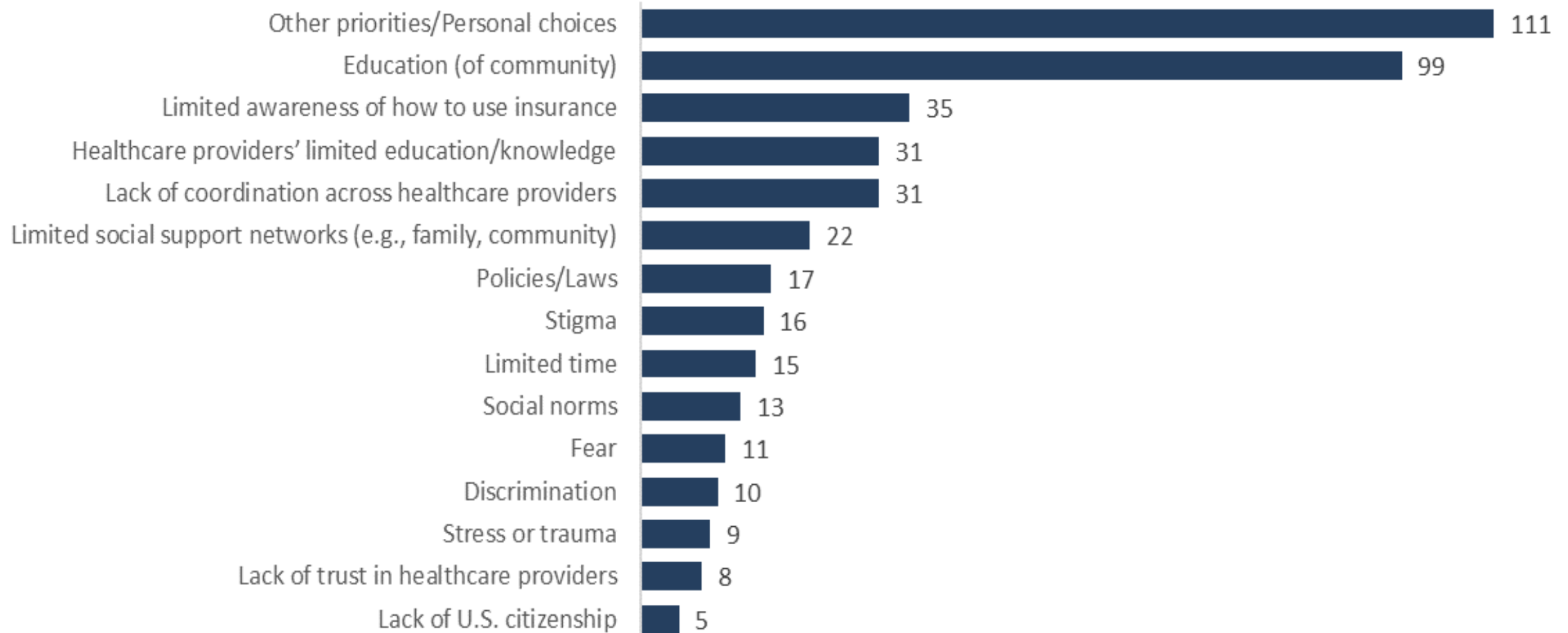


*“...the foundation [of healthcare] has to be accessibility, safety, and respect. Without those things, it doesn’t matter what’s available to me. If I don’t have a safe place to land, if it’s not easy for me to get to or get into, and I can’t expect to be listened to with respect and time and actually be heard, that container of healthcare is meaningless.”*

# Social Determinants of Health



# Barriers – All Other

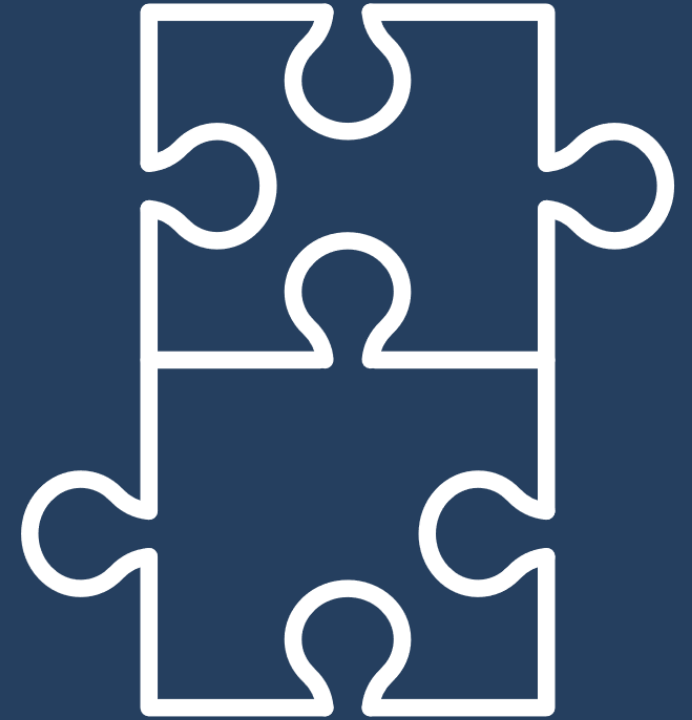




# Top Strengths



# **Data Tool #2: Community Focus Groups**

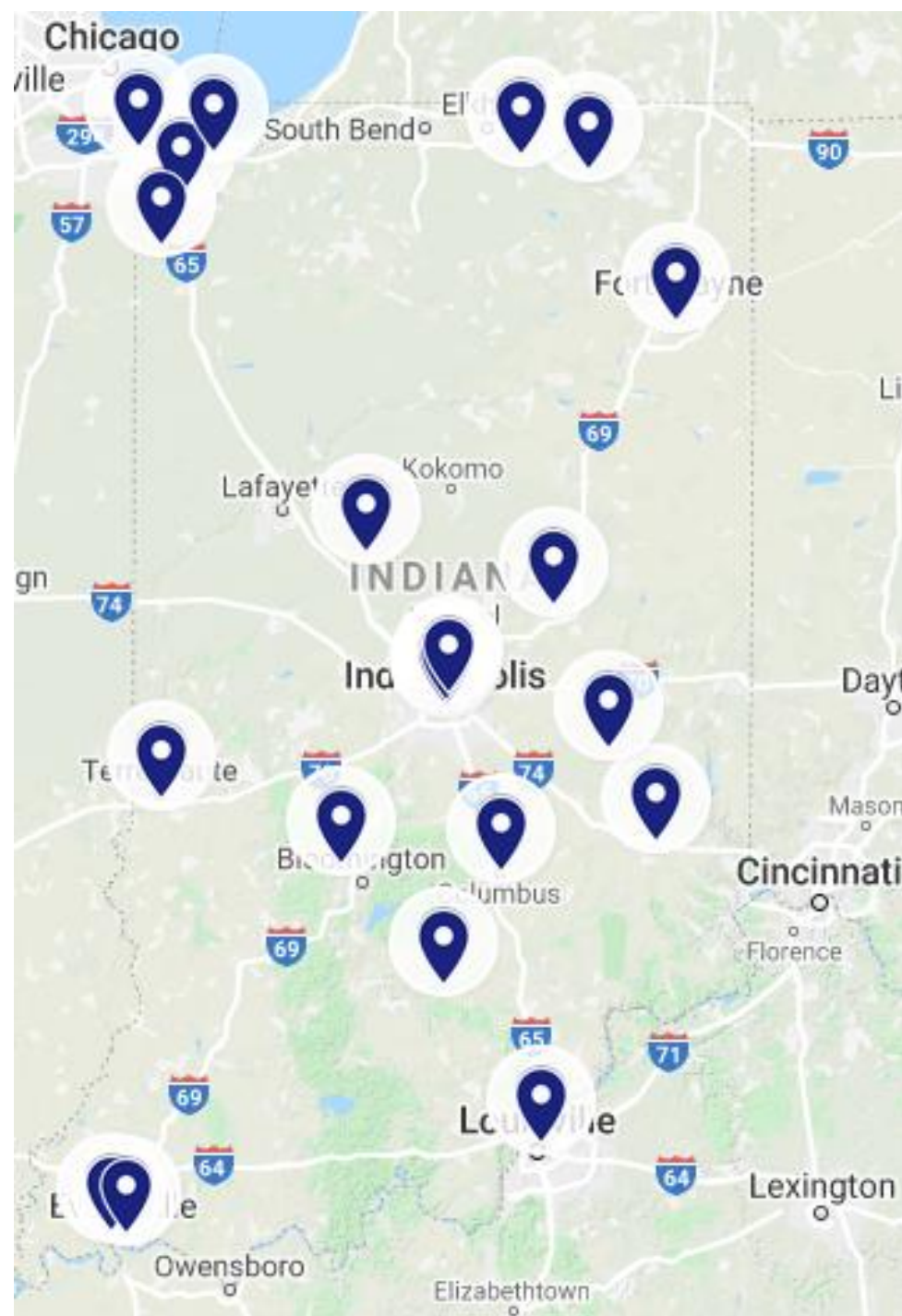


# Community Focus Groups

- ▶ **WHO:** Individuals who can speak to the health needs, barriers, and strengths in their communities
- ▶ **WHY:** To dive deeper into community feedback and perceptions and to better inform the state-wide survey
- ▶ **HOW:** Semi-structured, small group conversations with community members

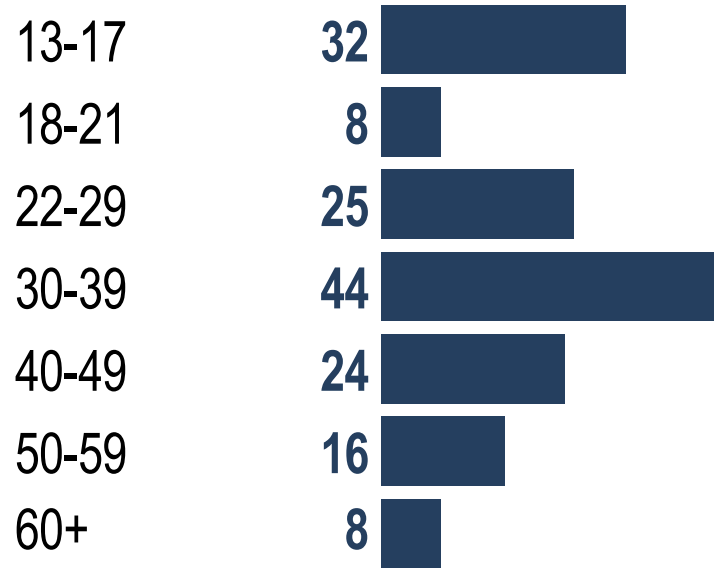
**25  
Focus Groups**

**168  
Participants**

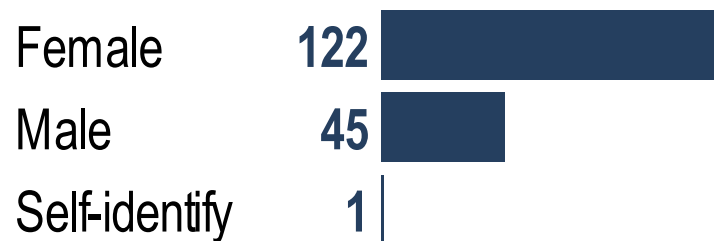


# Demographics

## Age



## Gender



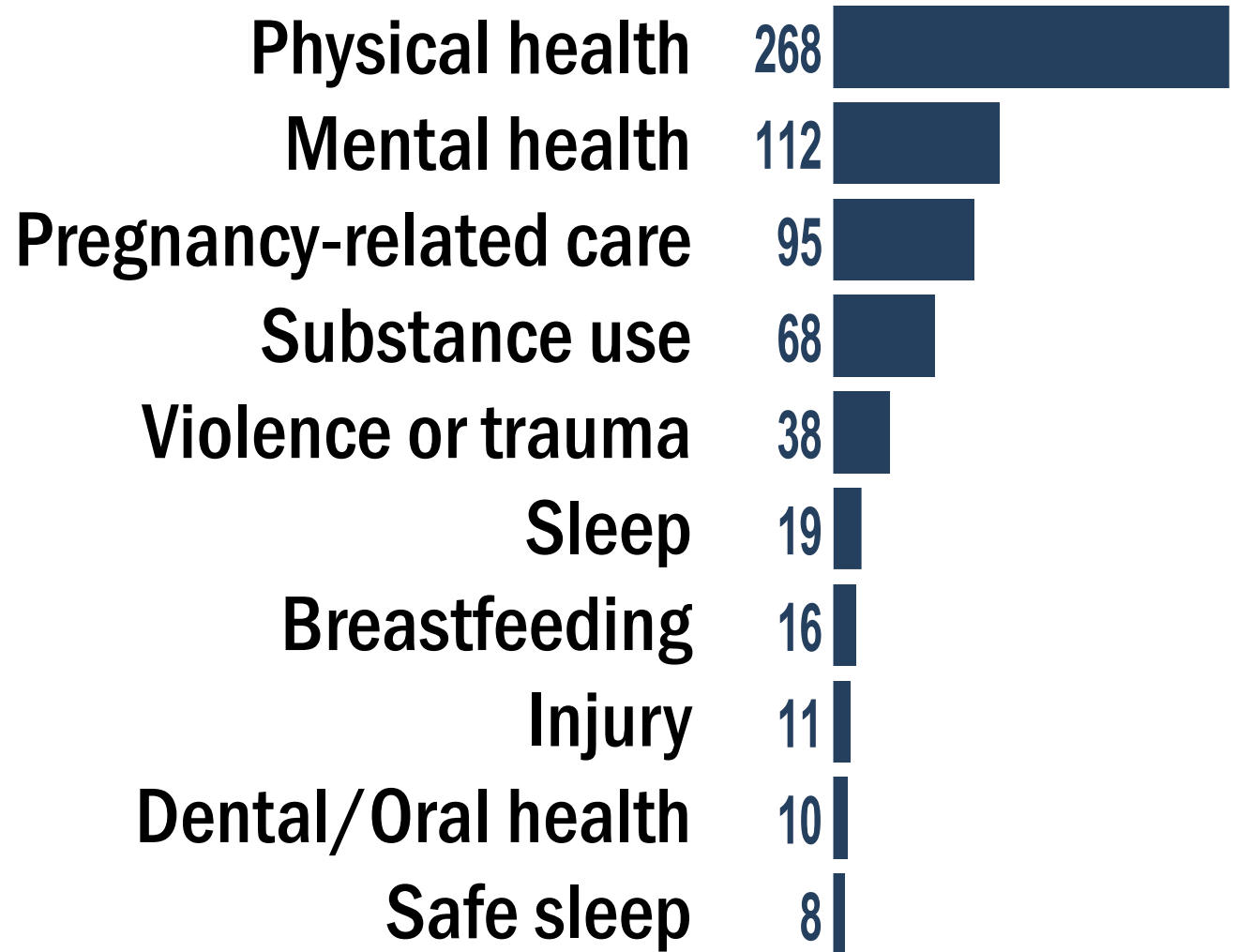
## Race



## Ethnicity



# Top Needs/ Challenges

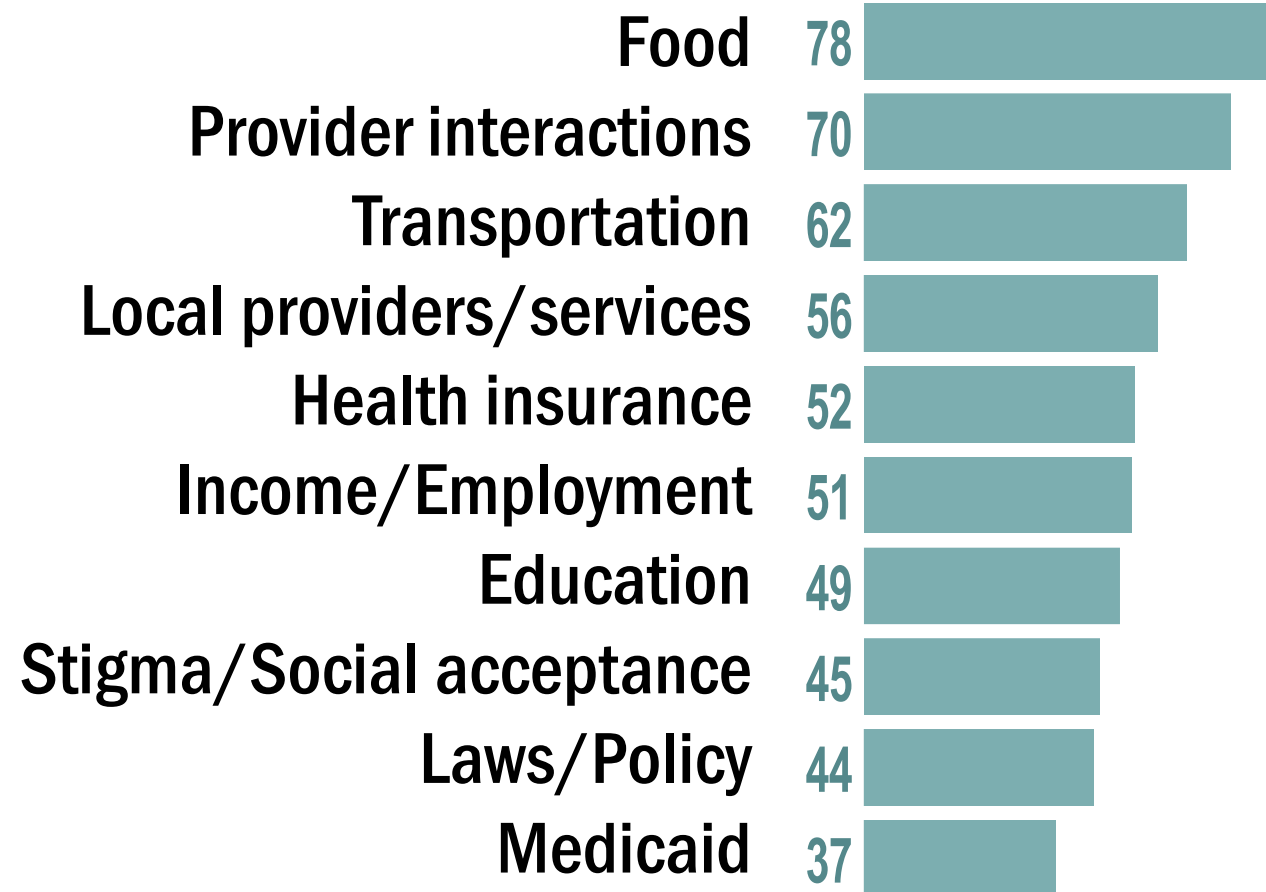


# Substance Use: Teens



*“Yeah. It gets worse in high school. There’s a few kids that smoked weed when I was in middle school, but once I got into high school, there’s barely anyone that doesn’t.”*

# Top Barriers





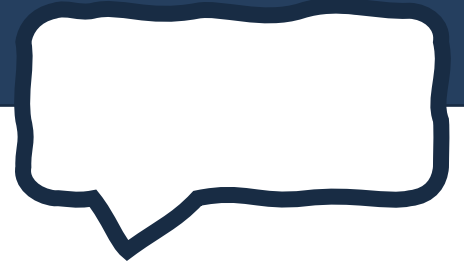
# Provider Interactions



*“I shouldn’t have to take my ex-husband everywhere I go just so people listen to me.”*

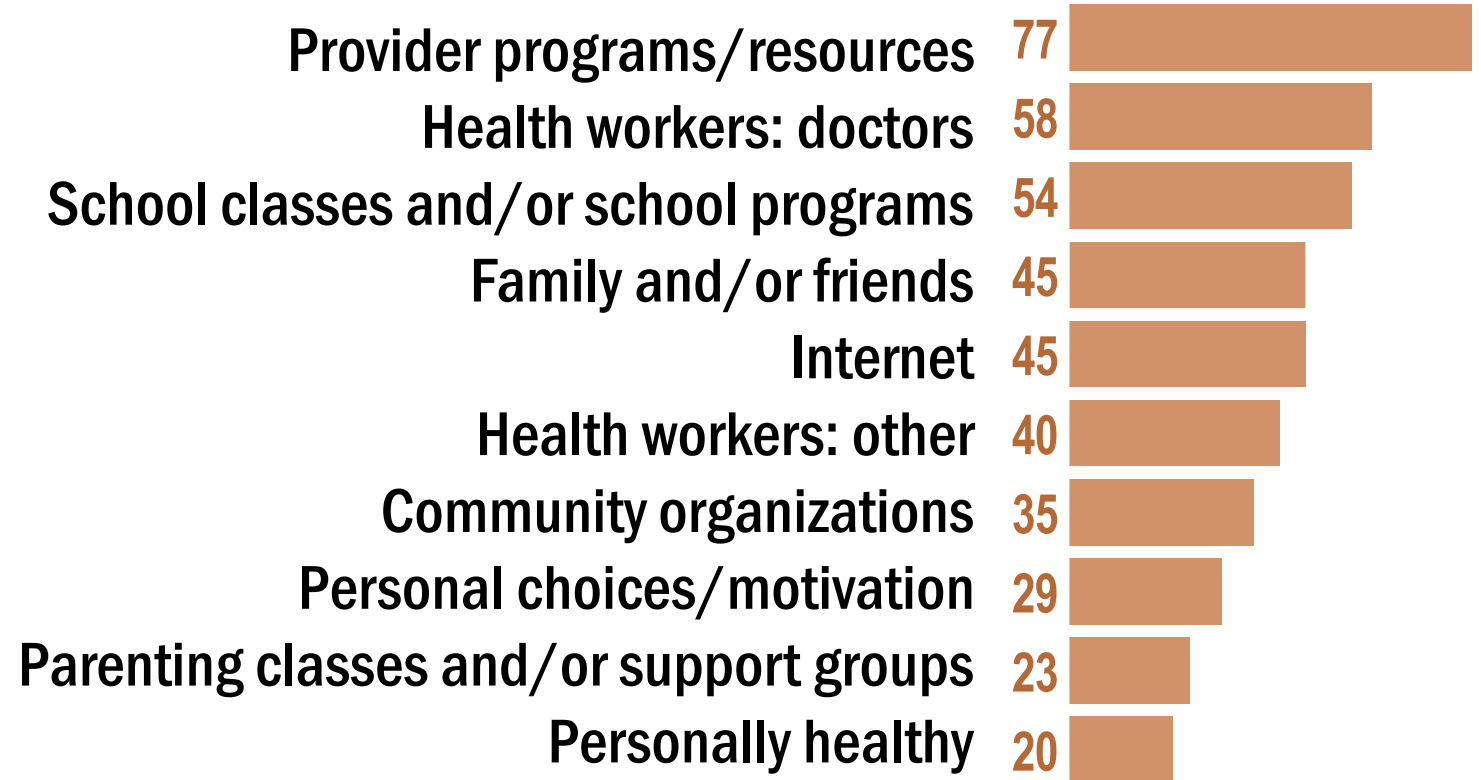
*“As an African-American mother, as it pertains to maternal healthcare, I think there is definitely a disconnect with providers. I’m going to say providers that may not understand that because you have a degree doesn’t mean you can tell me what’s exactly going on with me. So, if I come in with a concern, this is my body. It’s what I’ve experienced; it’s what I know. That should be taken into consideration versus telling me what some textbook is saying or generally what your experience has been. In my experience, when you are educated about medication or a procedure, they’ll say for 98% of the population... 2% of people, which is a very small number, I’m always in that very small percentage.”*

# Local Providers/Services



*“It seems like there are a lot of practices and there are a lot of good doctors, but it’s really hard. I don’t think there’s enough. We need more doctors actually. It seems you can’t get your kid in to get seen ‘cause they don’t have enough...”*

# Top Strengths/ Resources



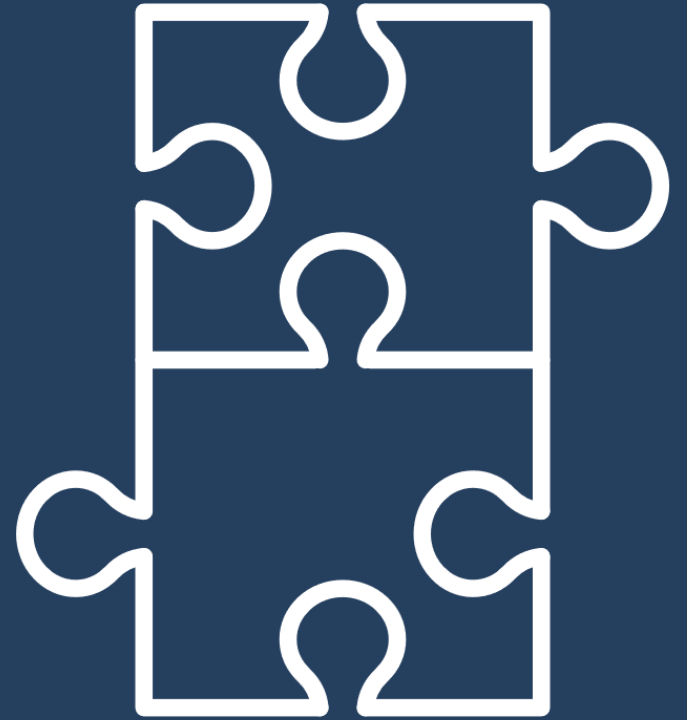
# Health Workers: Doctors and Family/Friends



*“I guess if anything I can honestly say I’m satisfied with, it would be my son’s pediatrician and the way that they stay on top of their preventative measures with them.”*

*“I would say when we first started walking down this road, we felt very, very alone. Very alone. I’m getting emotional. Very alone. I think it’s because of groups like this and making friends with other parents that they have kids on the spectrum. So, you can have a support and know that they get it. They get it. You know?”*

# **Data Tool #3: Statewide Survey**



# Survey Overview

## ▶ Demographics

- Individuals not living in Indiana or under 18 were directed to the end of the survey

## ▶ Your health

## ▶ Your child's health & CYSHCN

- Baby or young child (0-5)
- Child (6-12)
- Teen or young adult (13-21)

## ▶ Your community

## ▶ Additional demographics

# Survey Responses

## Survey Period

### English Survey

February 10 – March 20

### Spanish Survey

March 9 – April 3

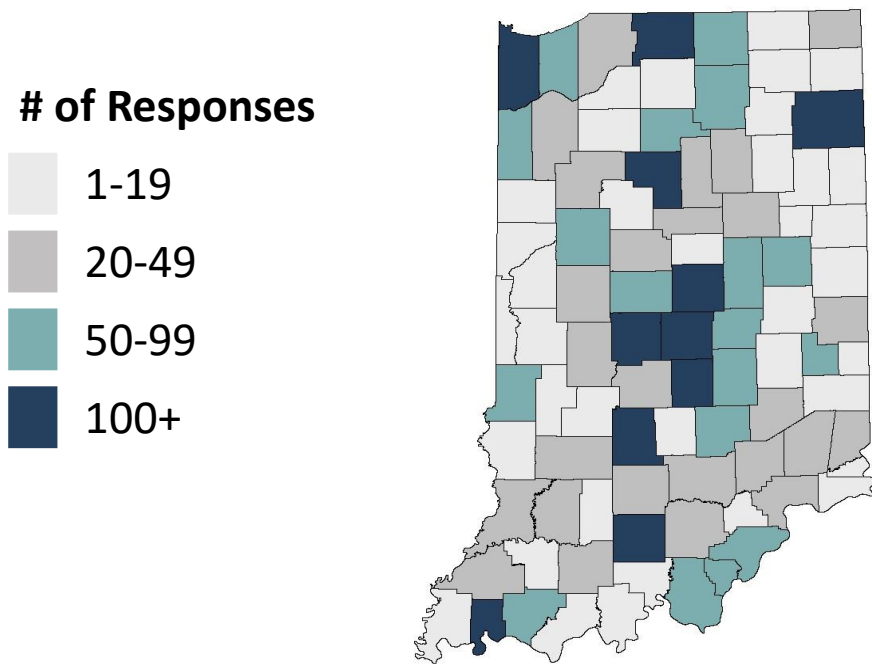
## Survey Responses

**5,019** total responses

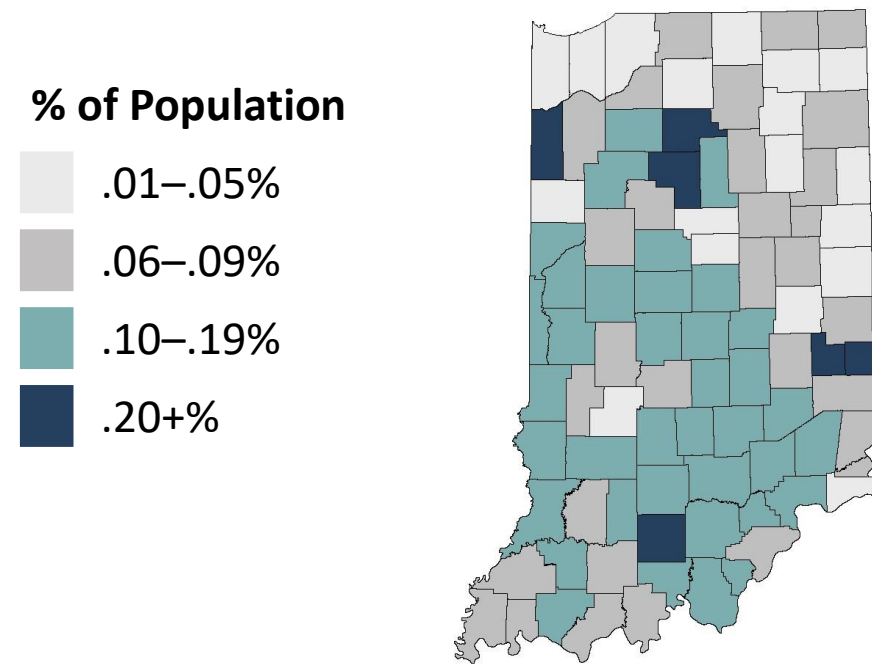
**4,934** lived in Indiana

# Responses by County

## Number of Responses by County



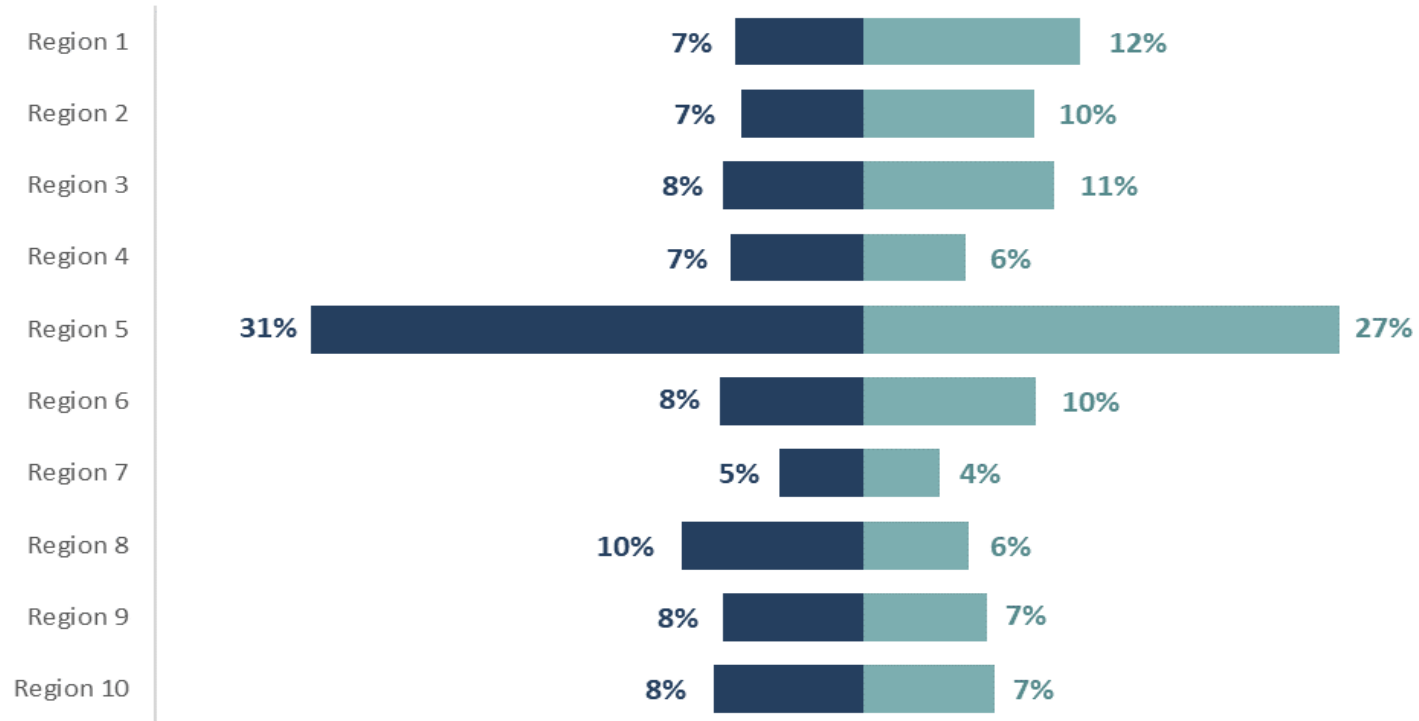
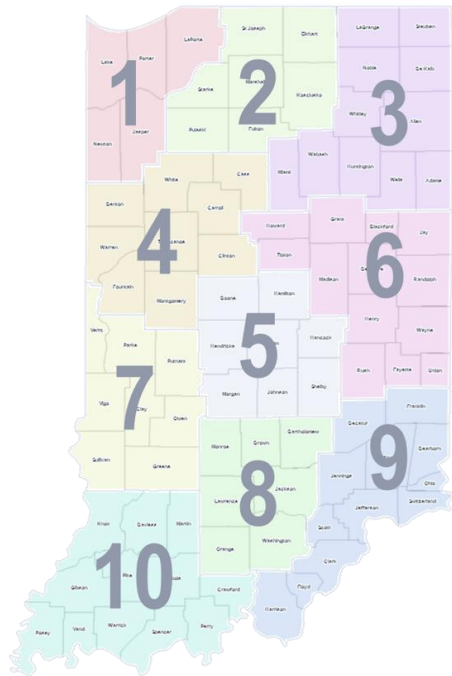
## Response by Percent of Population





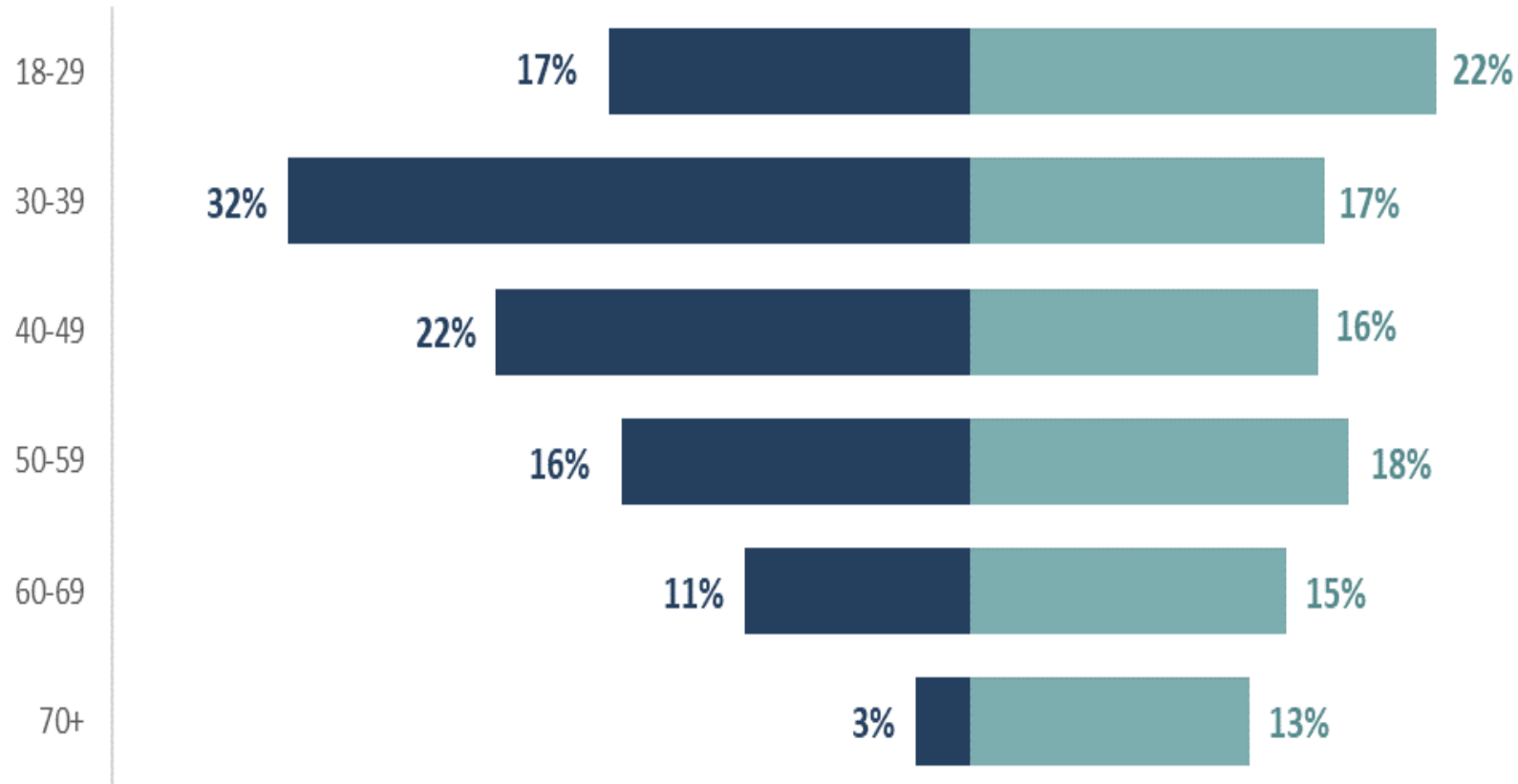
# Responses by Region

## Percent of survey respondents compared to percent population



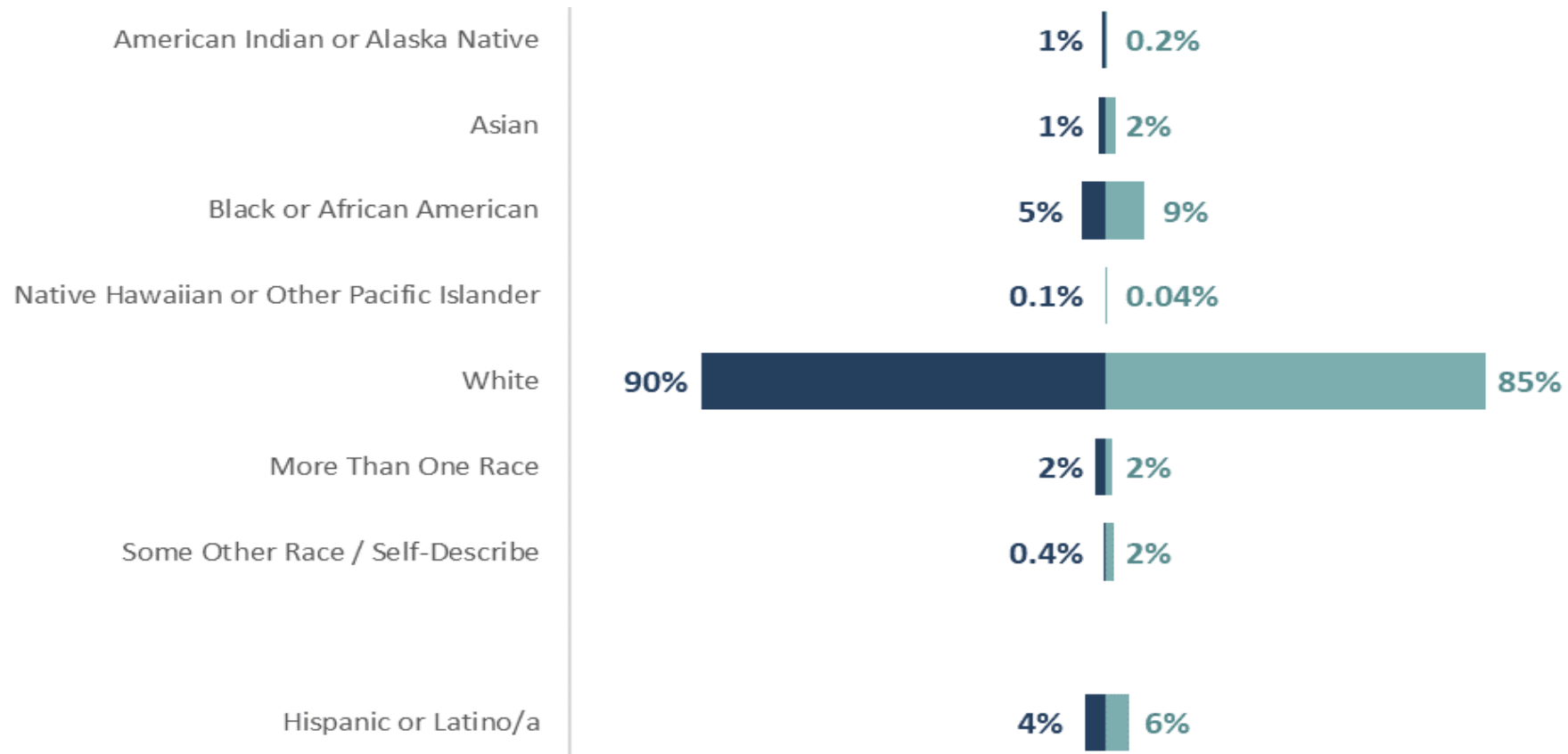
# Demographics: Age

Age: 54% are 30-49 years old



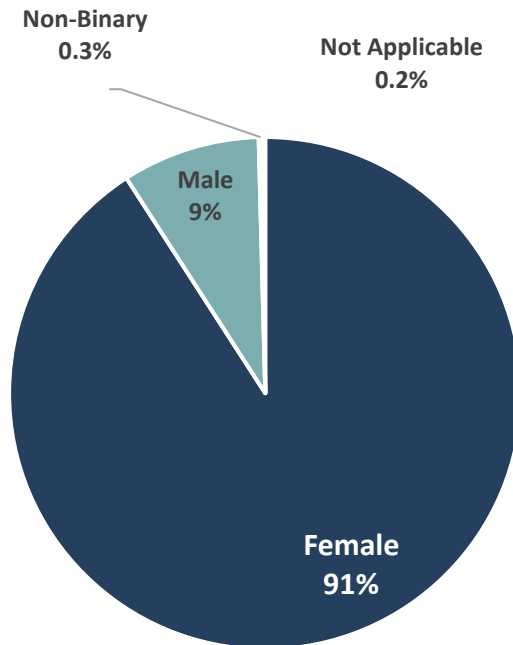
# Demographics: Race and Ethnicity

Percent of survey respondents by race and ethnicity compared to percent of population



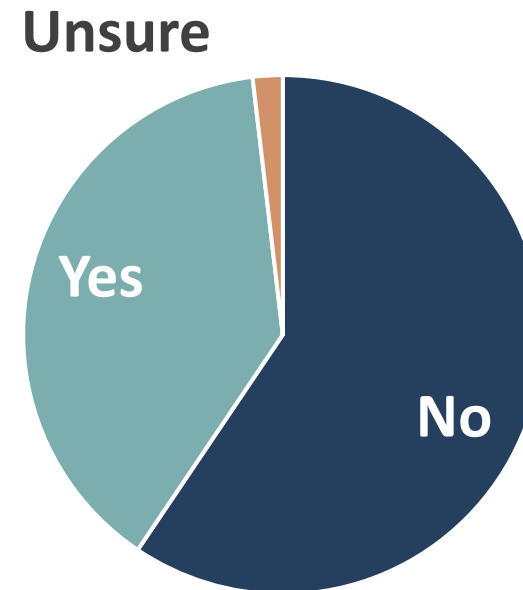
# Demographics: Gender & Healthcare professional status

Gender: 91% Female



N = 4,612

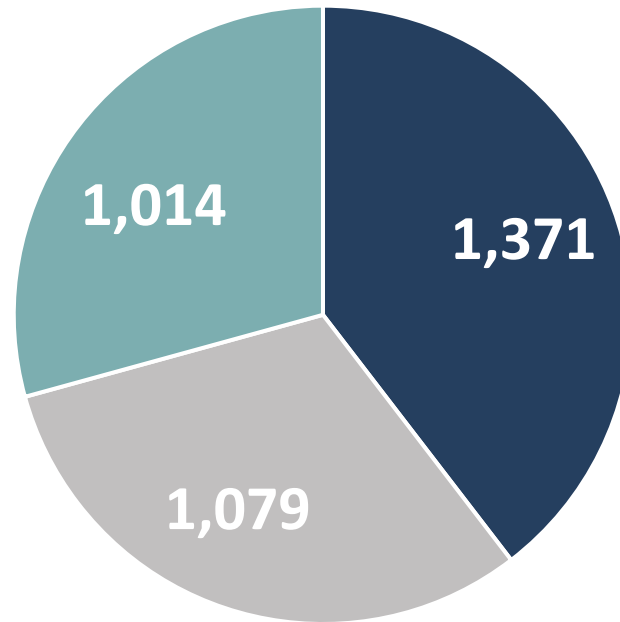
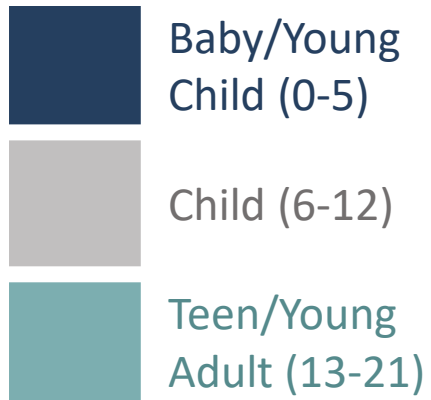
Healthcare Provider: 59% No



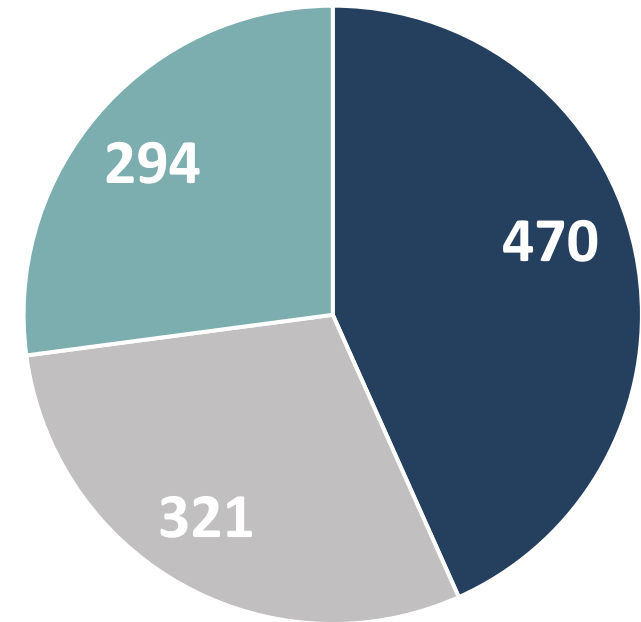
N = 4,618

# Demographics: Parents/Caregivers of Children

## Children and youth



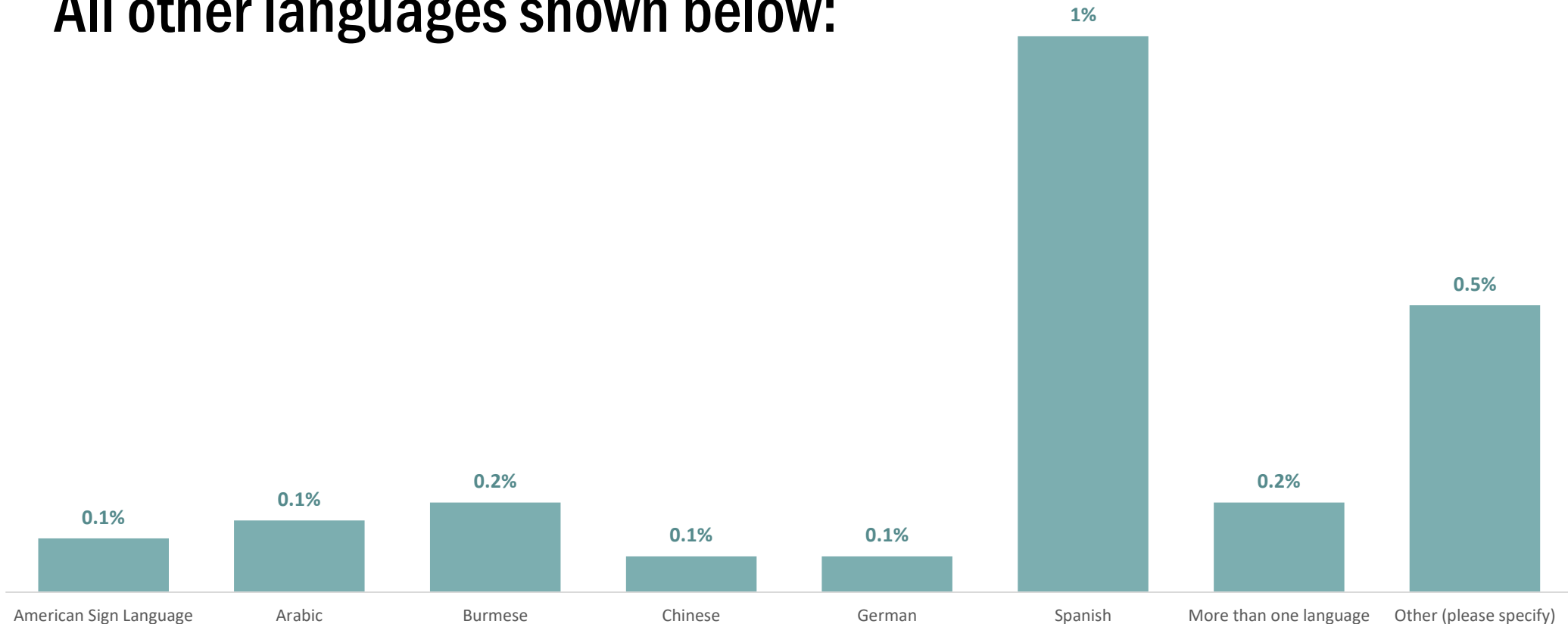
## CYSHCN



# Demographics: Primary Language

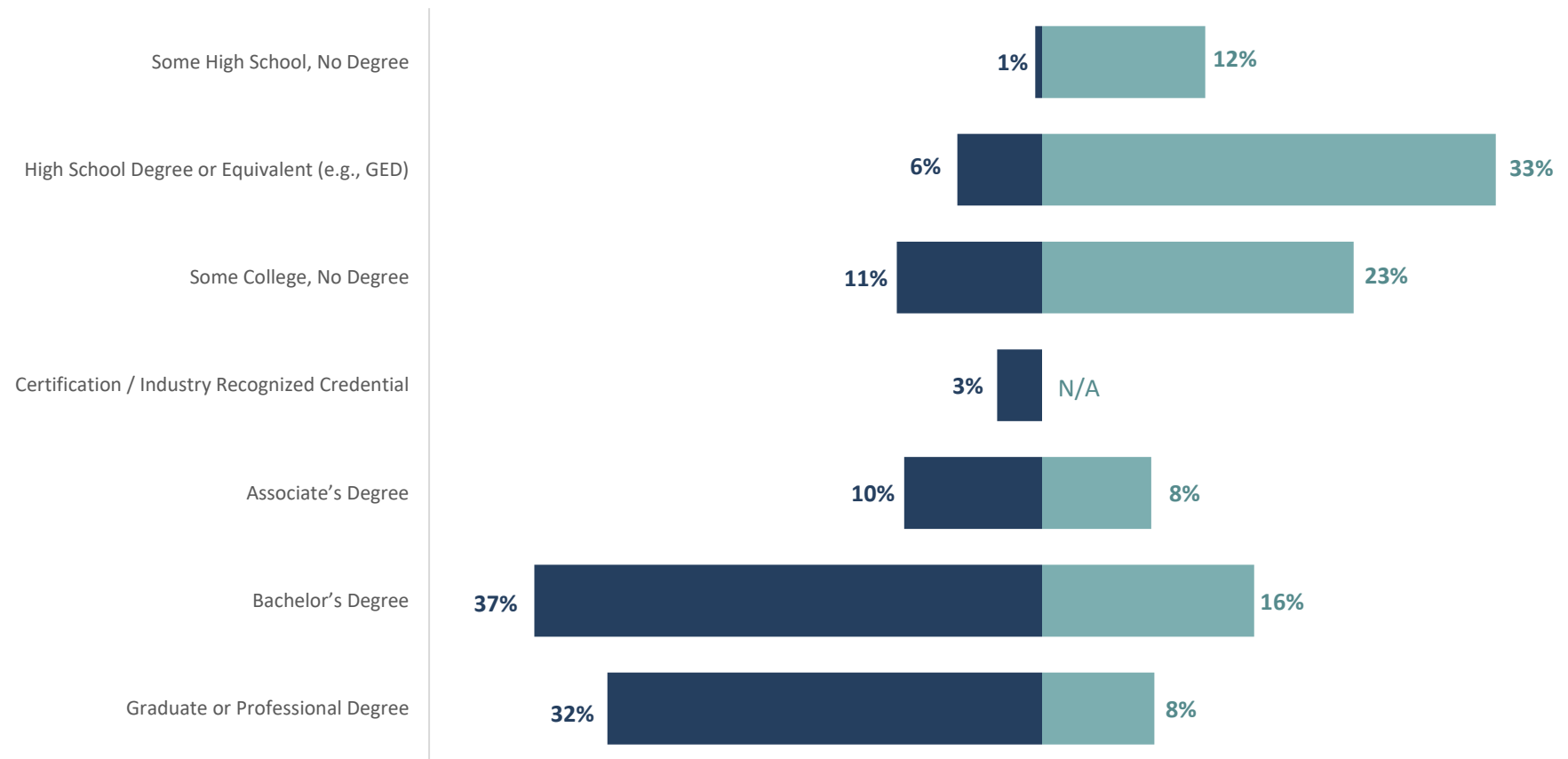
Language: 98% mainly spoke English in their home

All other languages shown below:



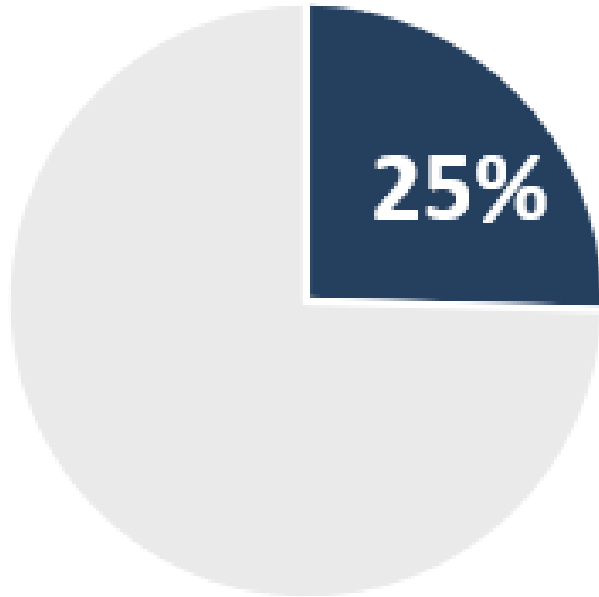
# Demographics: Education

## Percent of survey respondents compared to total population

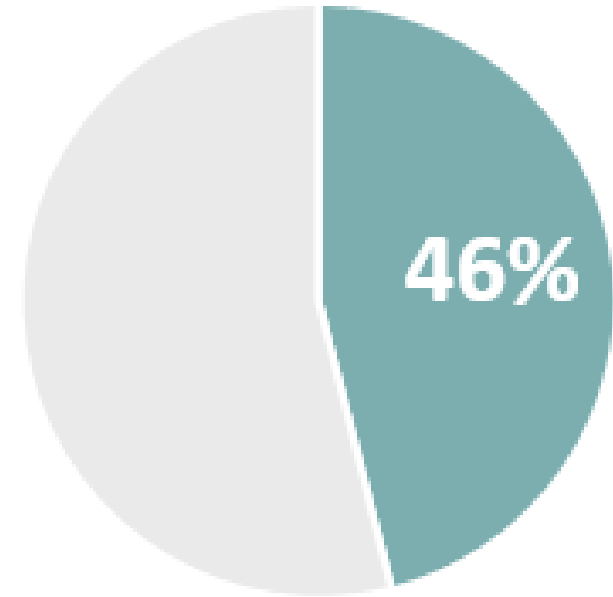


# Demographics: Annual Household Income

**Survey respondents** with household income  
\$49,000 or below



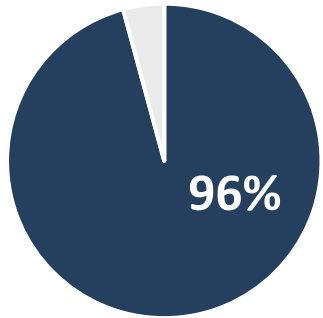
**Indiana** households with income  
\$49,000 or below



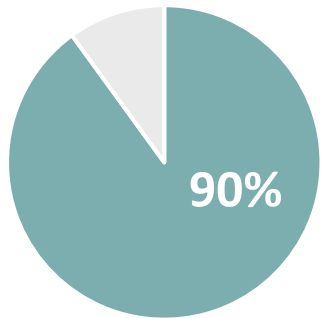


# Demographics: Health Insurance

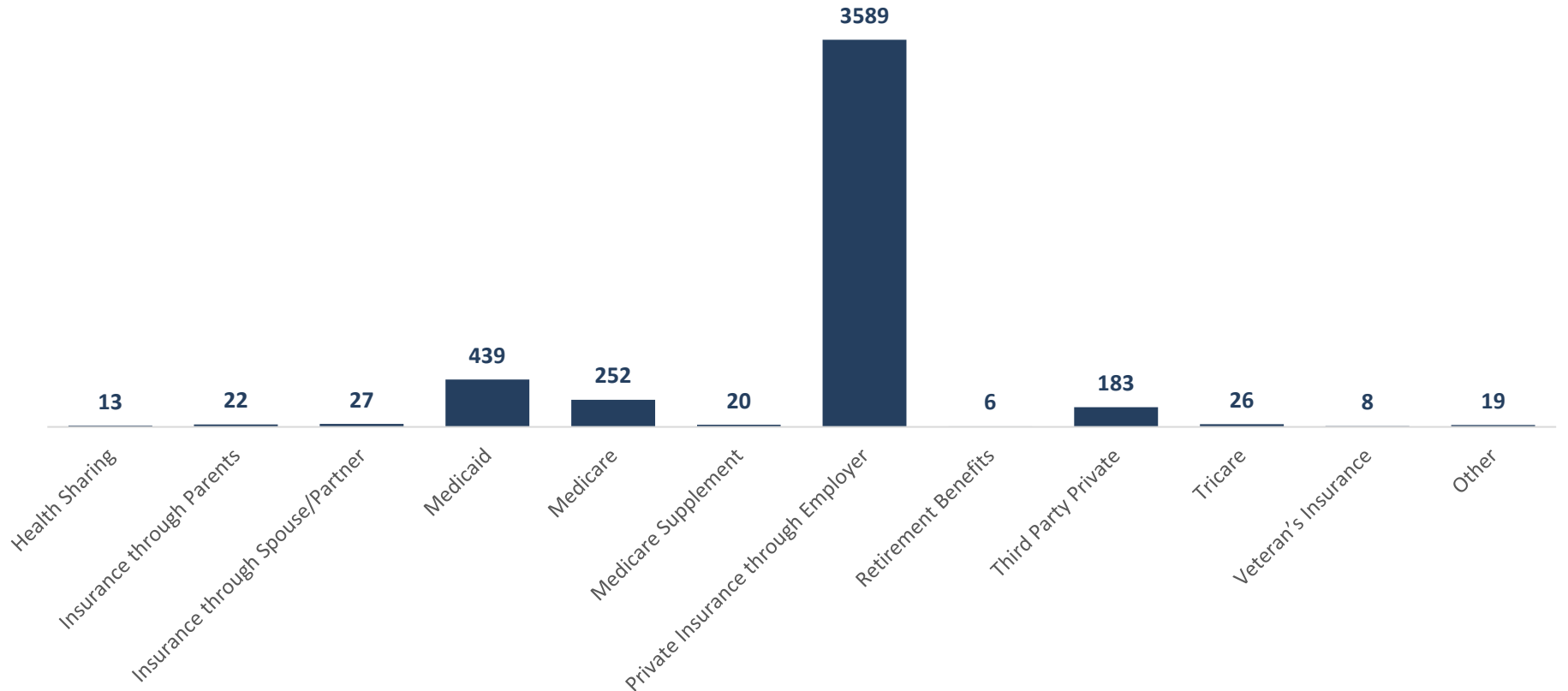
Survey respondents with health insurance



Indiana residents with health insurance



Survey respondents: health insurance type



# Your Health

Individuals responded to questions about their own health. This data is disaggregated by women and men, with feedback from the young adults (18-21 years old) incorporated into the adult sections.

# Women-specific Demographics

# Men-specific Demographics

## 4,026 Women

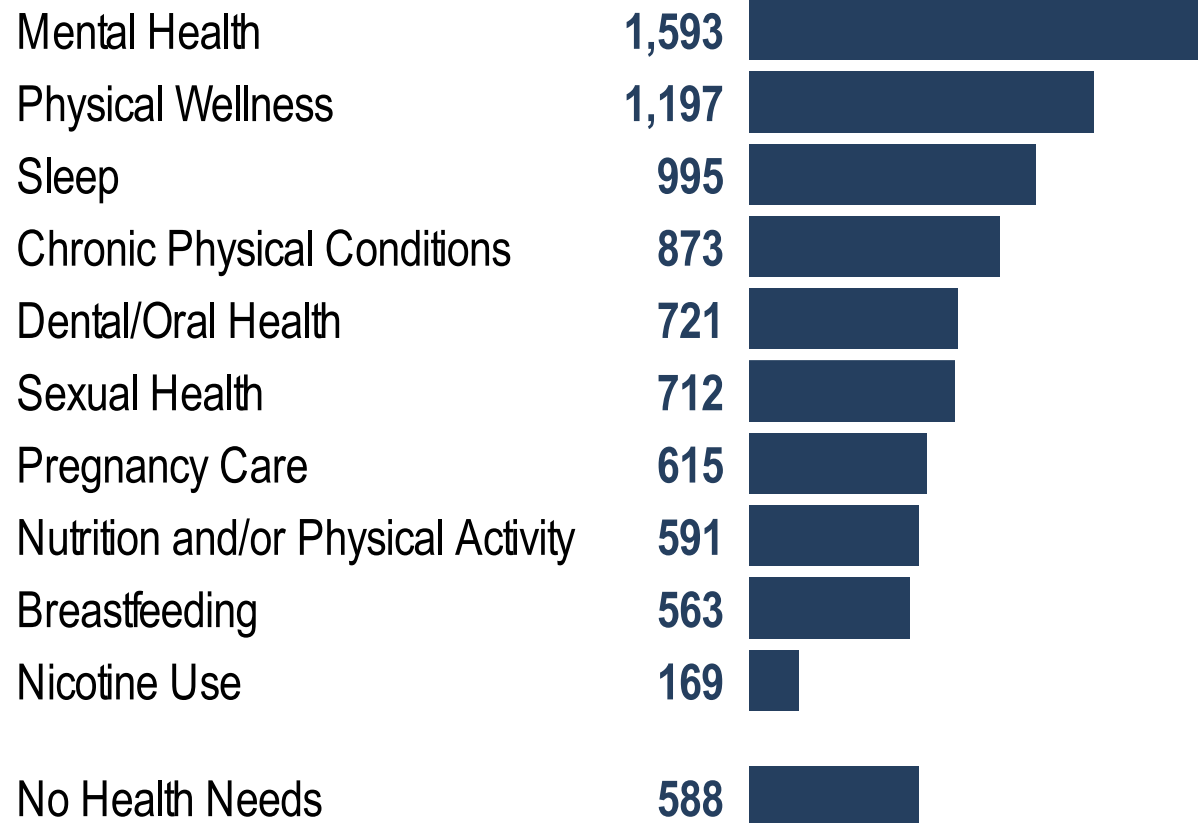
- 4% of respondents are Hispanic or Latino.
- 98% of respondents speak English as their primary language at home.
- 69% of respondents have bachelor's degree or higher.
- 96% of respondents have health insurance.
- 40% of respondents are a healthcare services provider.
- 3,354 respondents have ever been pregnant.
- 141 respondents are currently pregnant.

## 382 Men

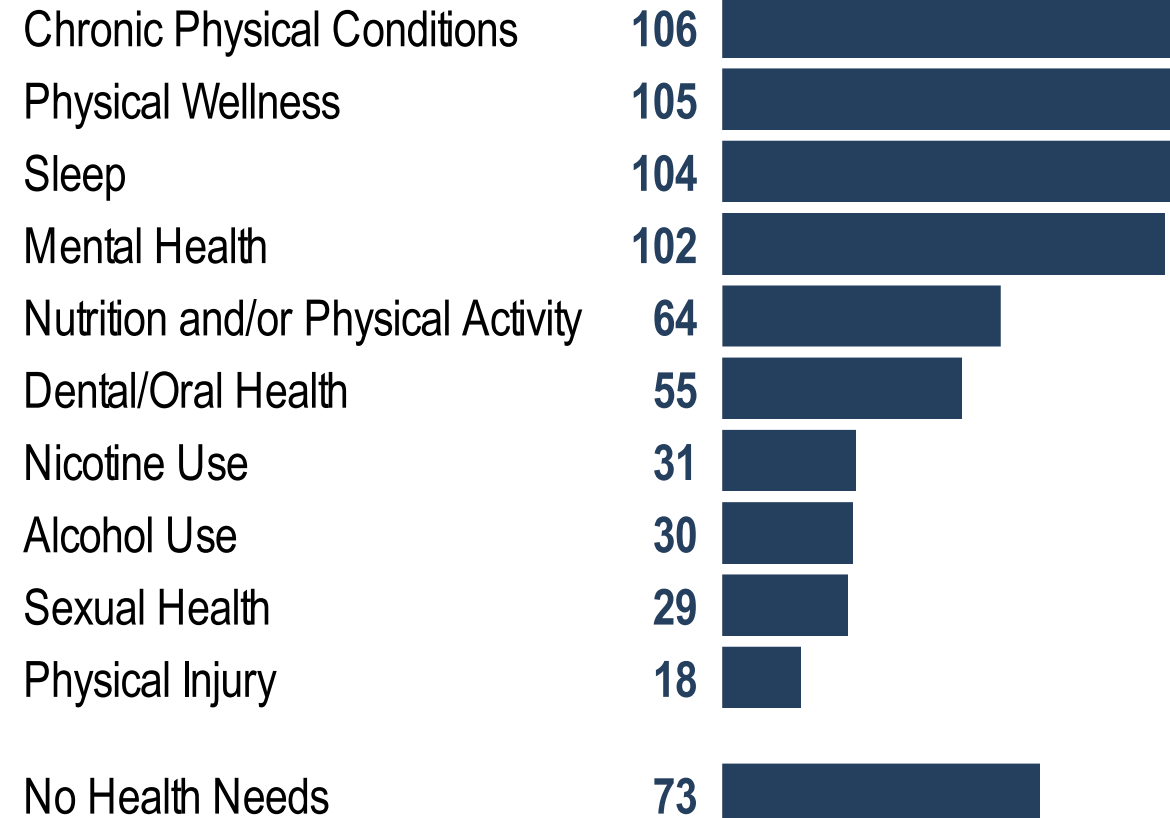
- 3% of respondents are Hispanic or Latino.
- 97% of respondents speak English as their primary language at home.
- 68% of respondents have bachelor's degree or higher.
- 96% of respondents have health insurance.
- 31% of respondents are a healthcare services provider.

# Needs

## Women (N=4,026)



## Men (N=382)



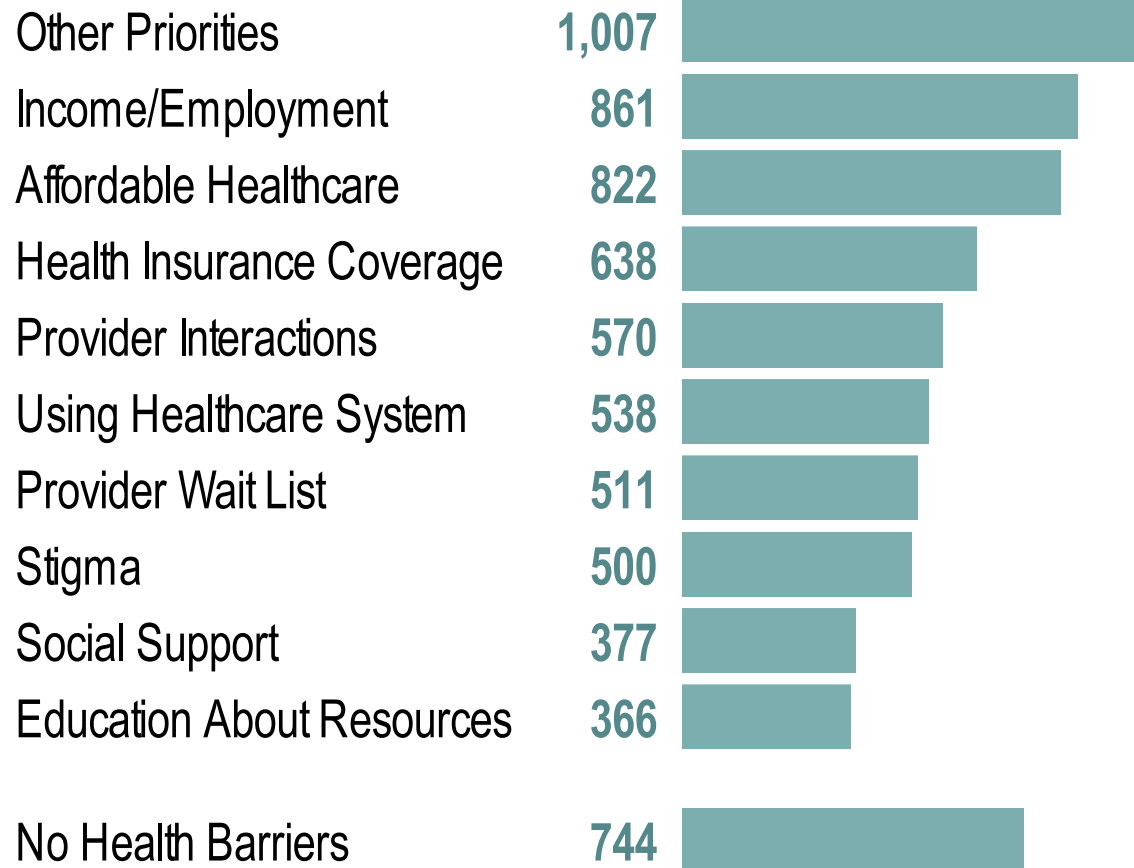
# Mental Health



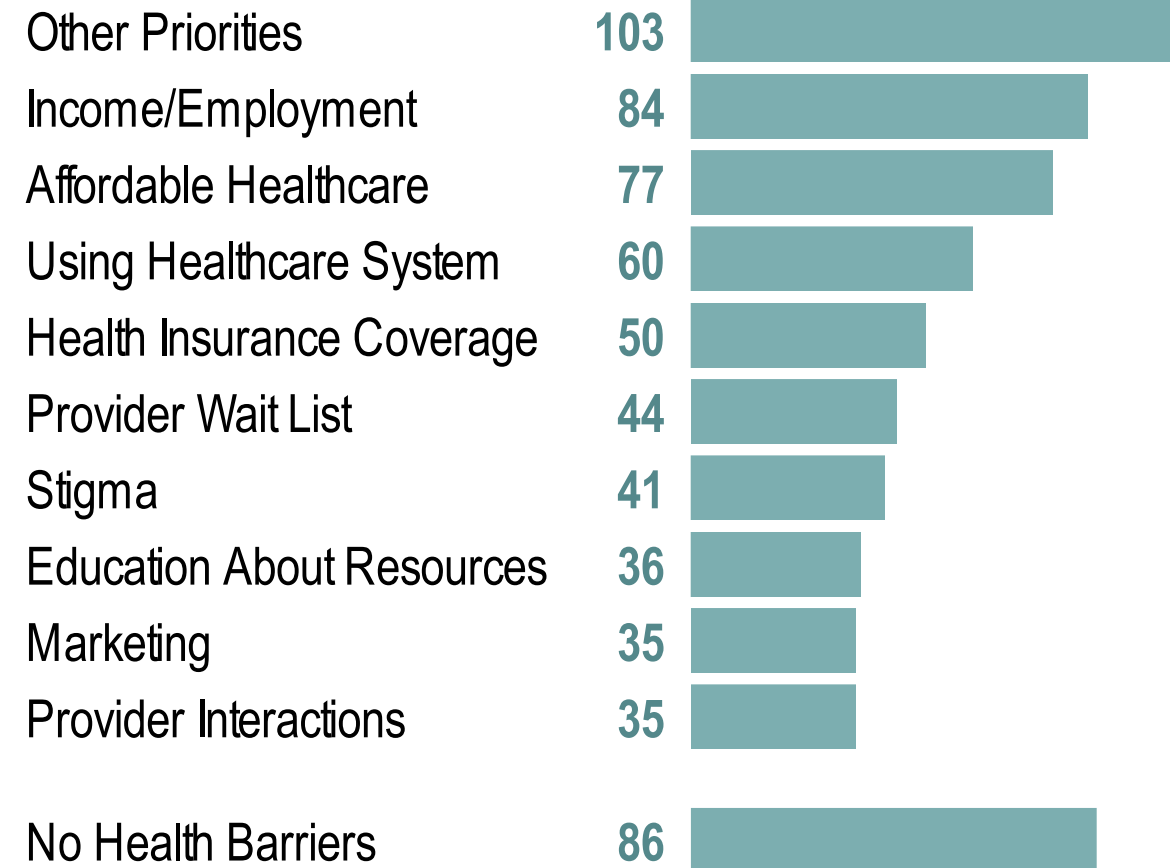
*“We still don’t have enough psychiatrists. We have a shortage. We should have 14 more psychiatrists than we do based on population size. We should have 15 or 16.”*

# Barriers

## Women (N=3,002)



## Men (N=288)



# Other Priorities



*“I realized the most important person is myself, so if I’m good, my family will be good. I feel like I’m always thinking I need to do my best to take care of me so that my family can be taken care of and be fine, but at the end I always forget about myself.”*

# Resources

## Women (N=2,636)



## Men (N=259)

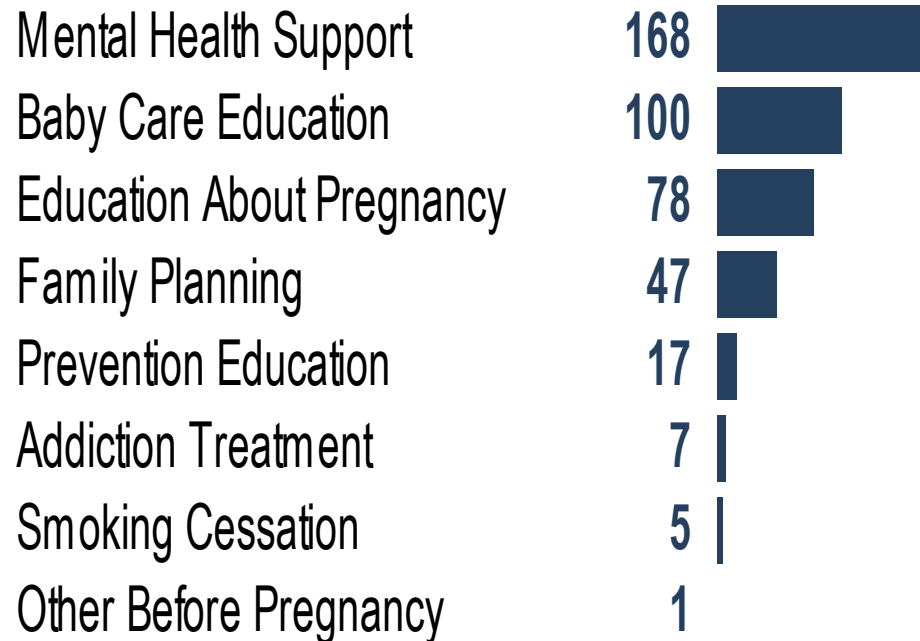




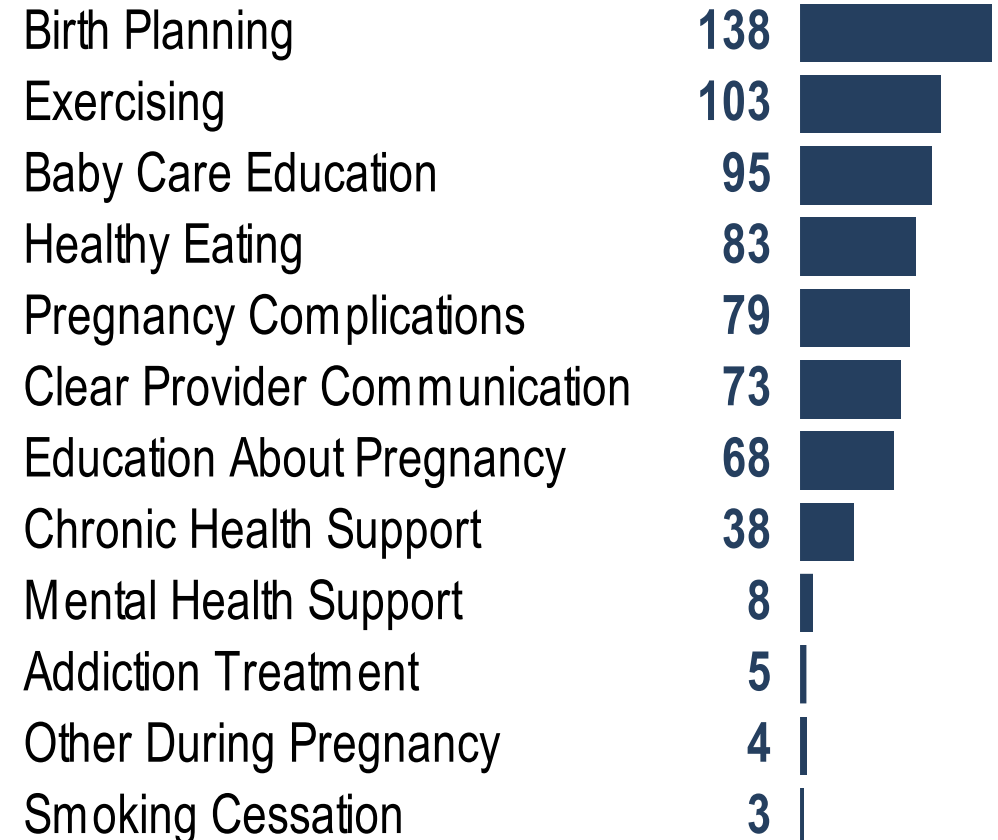
# Needs: Pregnancy-Related Care

Care before, during, or after pregnancy

## Before Pregnancy



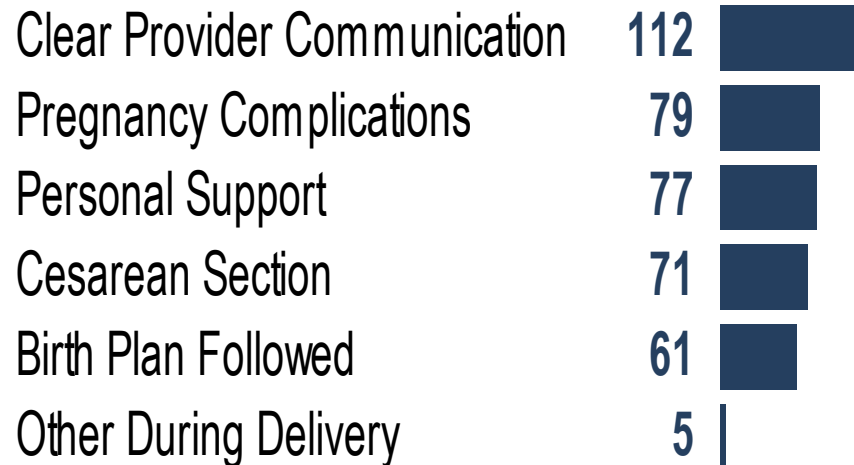
## During Pregnancy



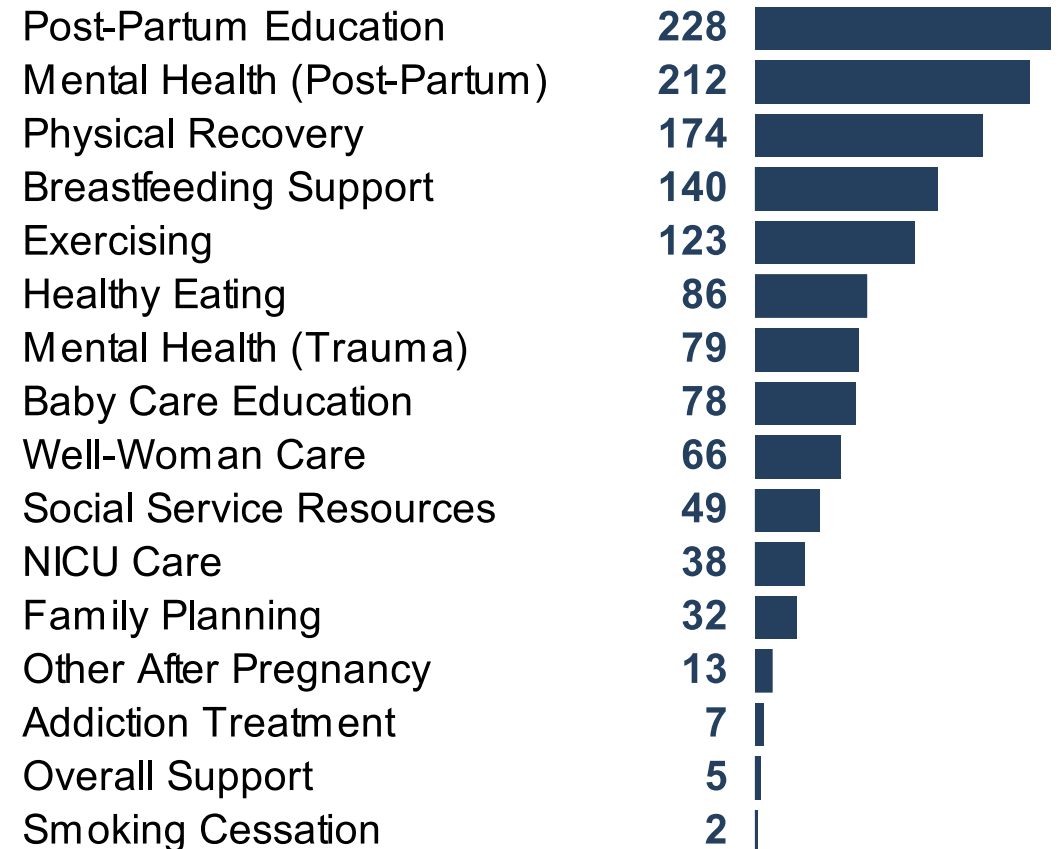
# Needs: Pregnancy-Related Care

Care before, during, or after pregnancy

## During Labor and Delivery



## After Pregnancy





# Pregnancy-Related Care

*“All these moms here, if they live here, they have to go to other hospitals to deliver. We don’t have in [our city] anywhere they can deliver... making sure they’re prepared for that and ready for that. That’s a big issue”.*

*“I was very honest with my survey that I had terrible service. It was bad. It was not good. I think that’s what made me want to be a birth doula, honest. It wasn’t the C-section. It was my care before and after that I feel like was more traumatic for me. It was way more traumatic when I look back on it; that’s what makes me upset. That’s what makes me want to cry is how I was treated.”*

# Pregnancy-Related Care



*“So, we’re going to have these women, making minimum wage, who have to take an entire afternoon to get to their OB or are beholden to the public transportation system, and then if they’re late, they have the stress of are they going to be able to keep their provider. So, we’ve got systems upon systems working against our most vulnerable mothers.”*



# Pregnancy-Related Care: Provider Interaction

*“I had to see 7 different physicians because I’m 38 having my first child, and then I had to do a lot of maternal/fetal medicine. My husband’s white. He’s 41. I would ask a question and I kid you not, every single doctor that we ever saw, these 7, they would say, ‘That happens to every woman ever when they’re pregnant,’ or some paraphrase of that. So, then I would look at my husband, because I’m like that’s an unsatisfactory answer. So, in the beginning, I had to repeat myself. Towards the middle of it, he would re-ask the question. It’s the same physician, and they would actually answer [his] question. And I’m looking at it like I have a master’s degree... So, I feel like as long as there is a robe, a gown, or whatever on, the conversation is not an equitable one and the physician sees the patient as a less than.”*

# Pregnancy-Related Care: Mental Health



*“I didn’t know I had [severe post-partum depression] until I was 8 months post-partum with him... I remember thinking, ‘No one cries all the time.’ It goes back to proper obstetric practices. Because I can remember being asked every time I took my baby in how I felt. ‘It’s the baby blues’ is what I [was] told. ‘Post baby blues.’ Tell me more about the symptoms of it. Because it’s not just being sad. There’s so much more to post-partum depression.”*



# Pregnancy-Related Care: Post-partum Mental Health

*“I think the biggest thing was with mental health services in my post-partum period. Having providers who had tried to call back to refer and then not getting call backs from the referral sources. Getting into that referral pattern that you were talking about... I was in a position in my post-partum period where I was becoming significantly depressed to the point where my therapist and I had to put a care plan in place for my son because I couldn't be alone with him in the car and we were telling behavioral health that and [they had] a three-month window. That was it. That was the best access I could get.”*

*“I want to share my mental health with post-partum. I went to see somebody finally and after four appointments she wouldn't schedule with me anymore and told me I was fine. It's like, just because I am able to cope doesn't mean that something's not wrong. After that, every therapist that I've had, I've sat down and I just say I need you to believe me. That's all I need from you. I finally found someone I've been with for a few years. I couldn't believe it that she just wouldn't schedule with me.”*

# Perinatal/Infant

Two primary data sources for this Title V population:

- (1) Your Health data from women who were currently pregnant and
- (2) Child (0-5) data for those who said they were caring for an infant less than a year old



# Demographics:

**141** respondents are currently pregnant

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**89%** of respondents are White.

**6%** of respondents are Black or African American.

**5%** of respondents are Hispanic or Latino.

**99%** of respondents speak English as their primary language at home.

**81%** of respondents have bachelor's degree or higher.

**97%** of respondents have health insurance.

**35%** of respondents are a healthcare services provider.

**281** parents/caregivers of a baby less than one year old

---

**93%** of respondents are female.

**90%** of respondents are White.

**4%** of respondents are Black or African American.

**5%** of respondents are Hispanic or Latino.

**97%** of respondents speak English as their primary language at home.

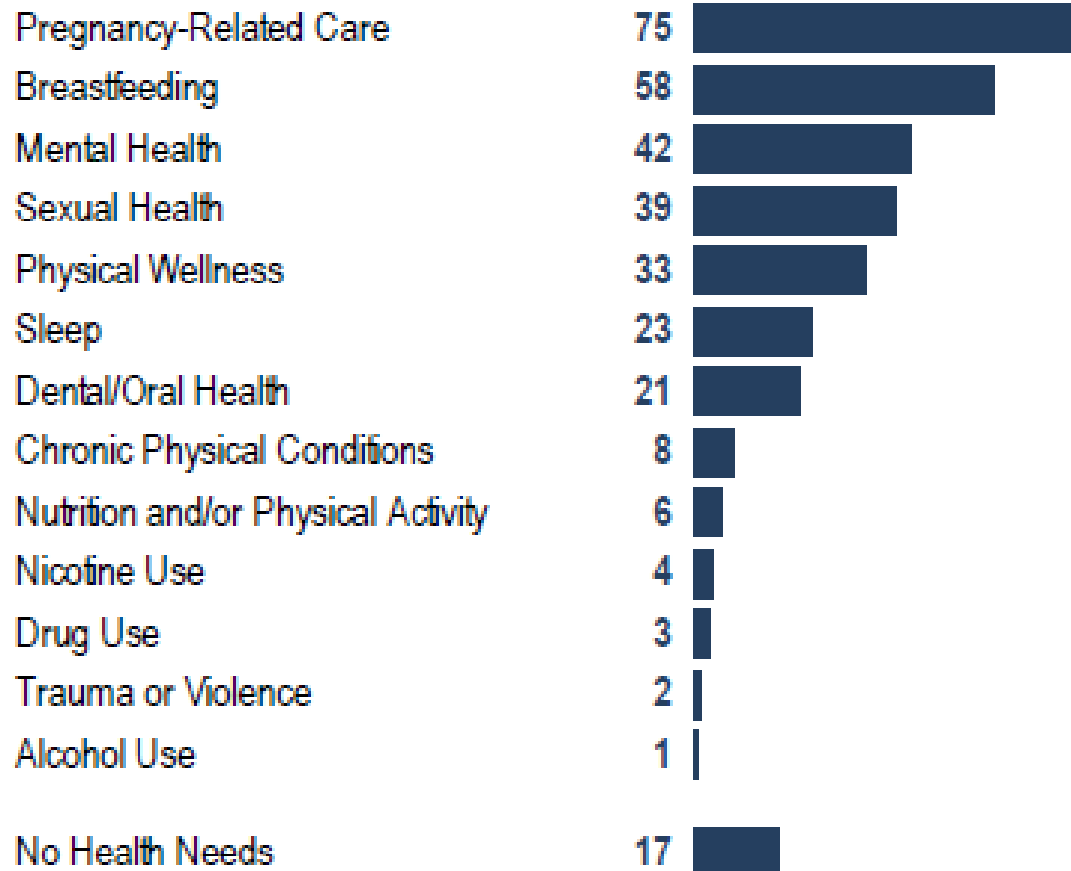
**68%** of respondents have bachelor's degree or higher.

**98%** of respondents have health insurance.

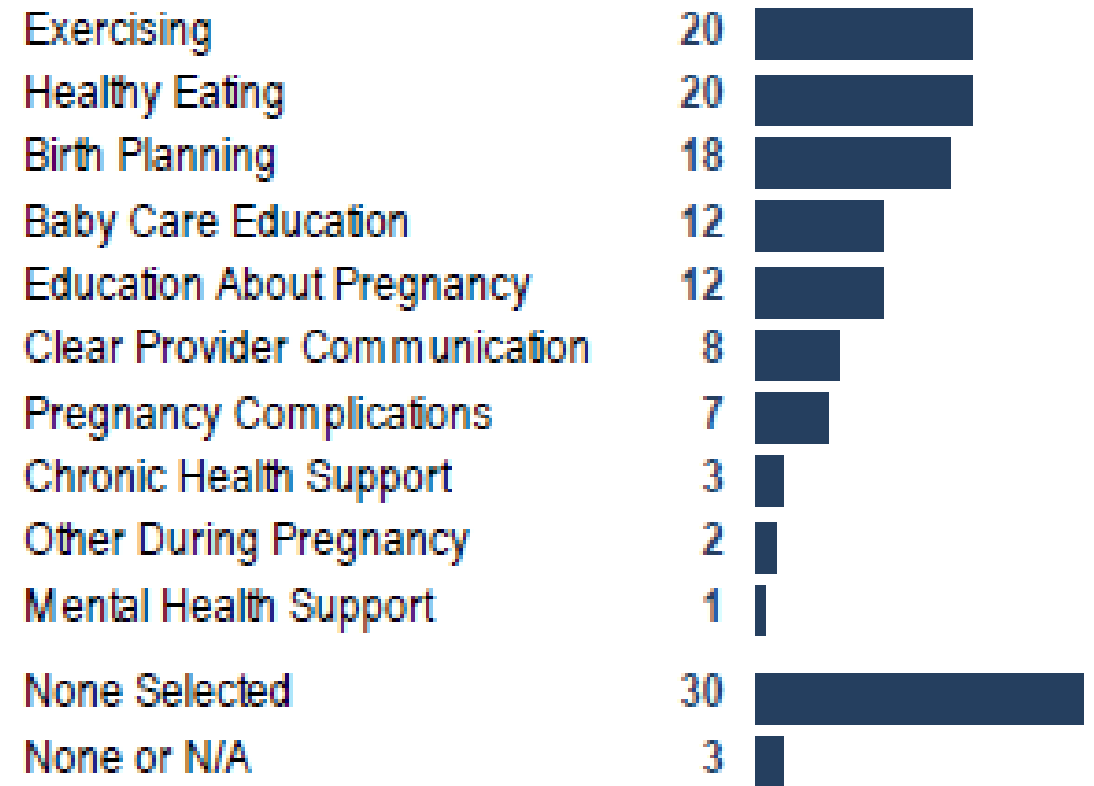
**34%** of respondents are a healthcare services provider.

# Needs: Currently Pregnant Women

## Overall (N= 315)

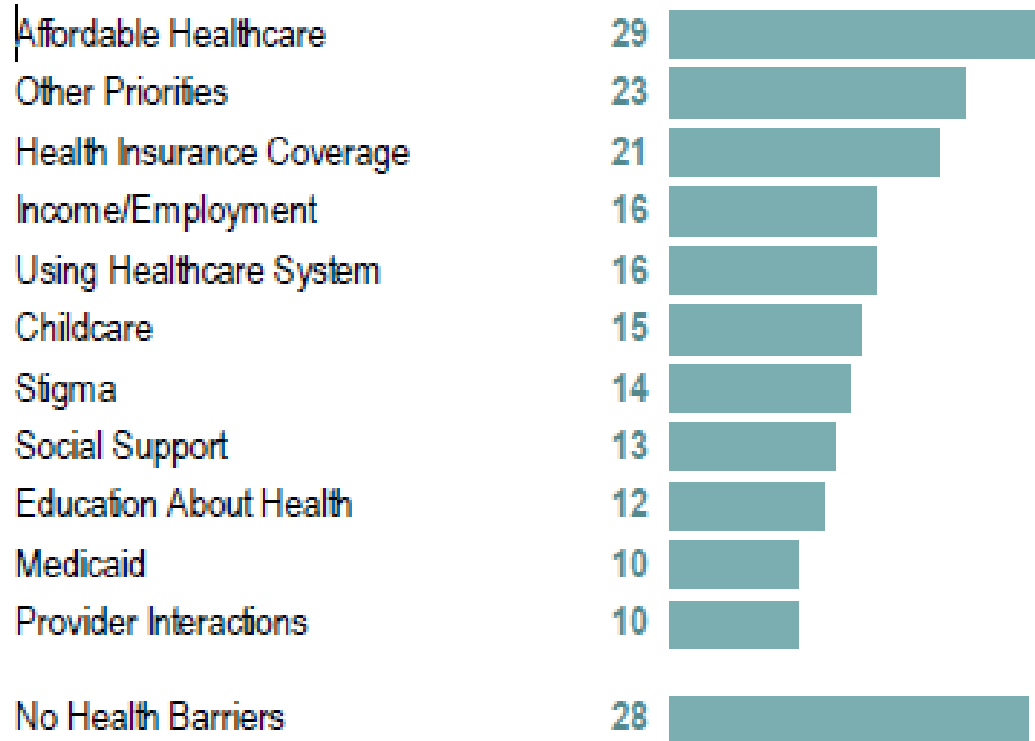


## During Pregnancy (N = 136)



# Barriers: Currently Pregnant Women

## Overall (N = 93)

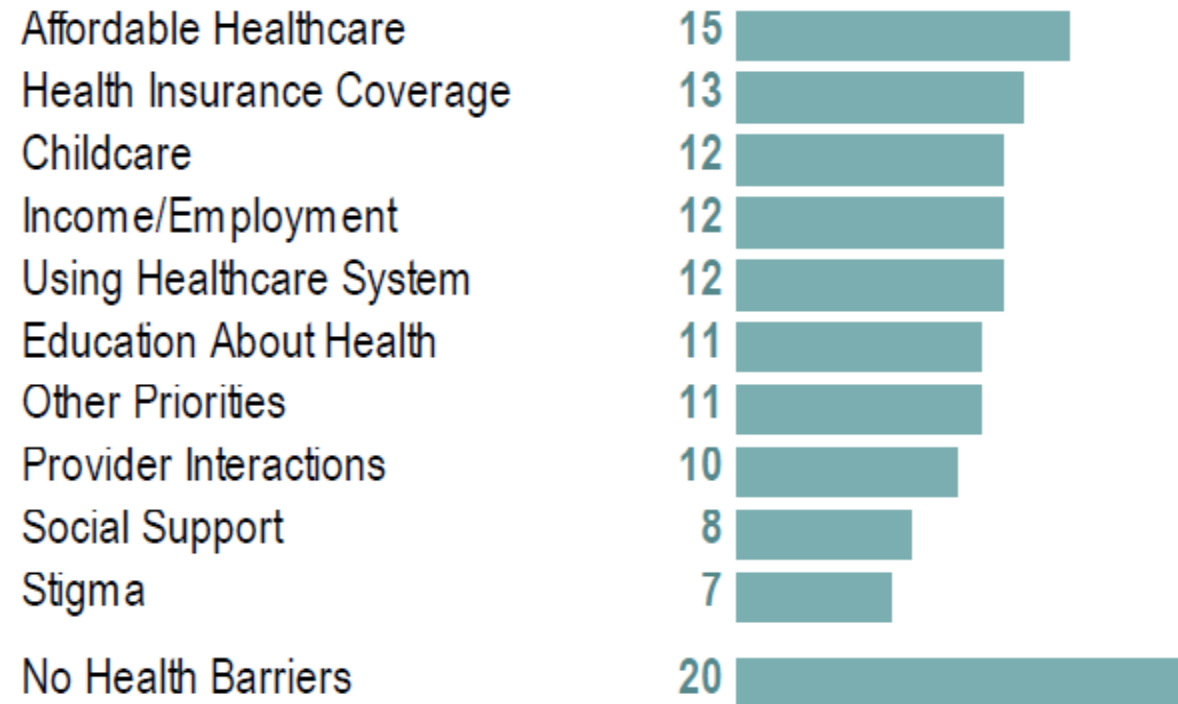


# Barriers: Currently Pregnant Women

## Breastfeeding (N=56)



## Pregnancy-Related Care (N=60)

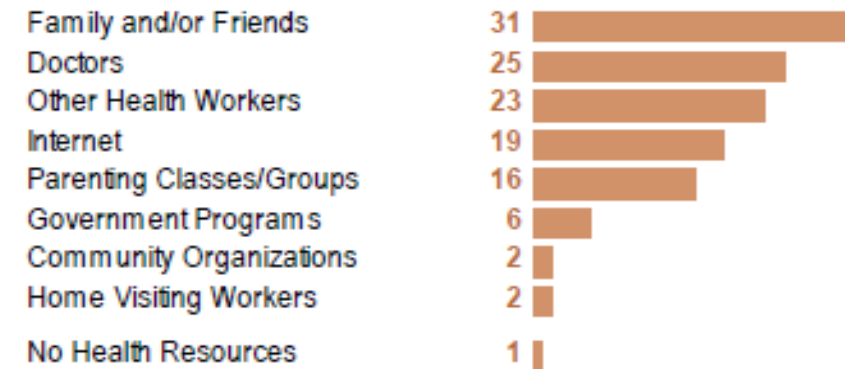


# Resources: Currently Pregnant Women

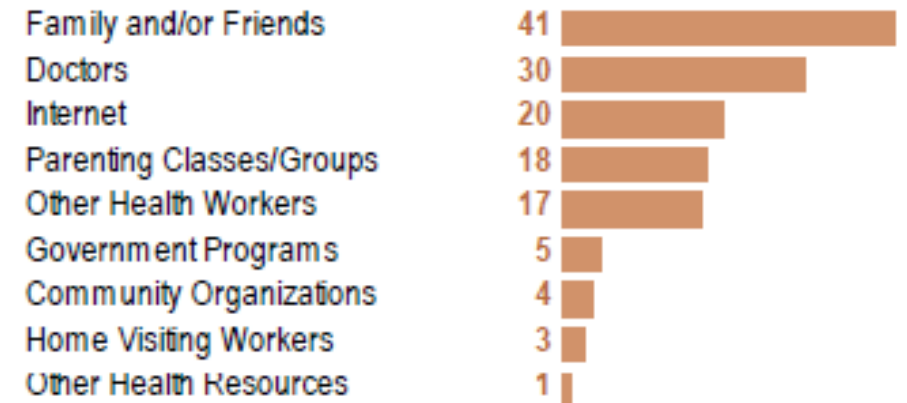
## Overall Resources (N=79)



## Breastfeeding Resources (N=51)



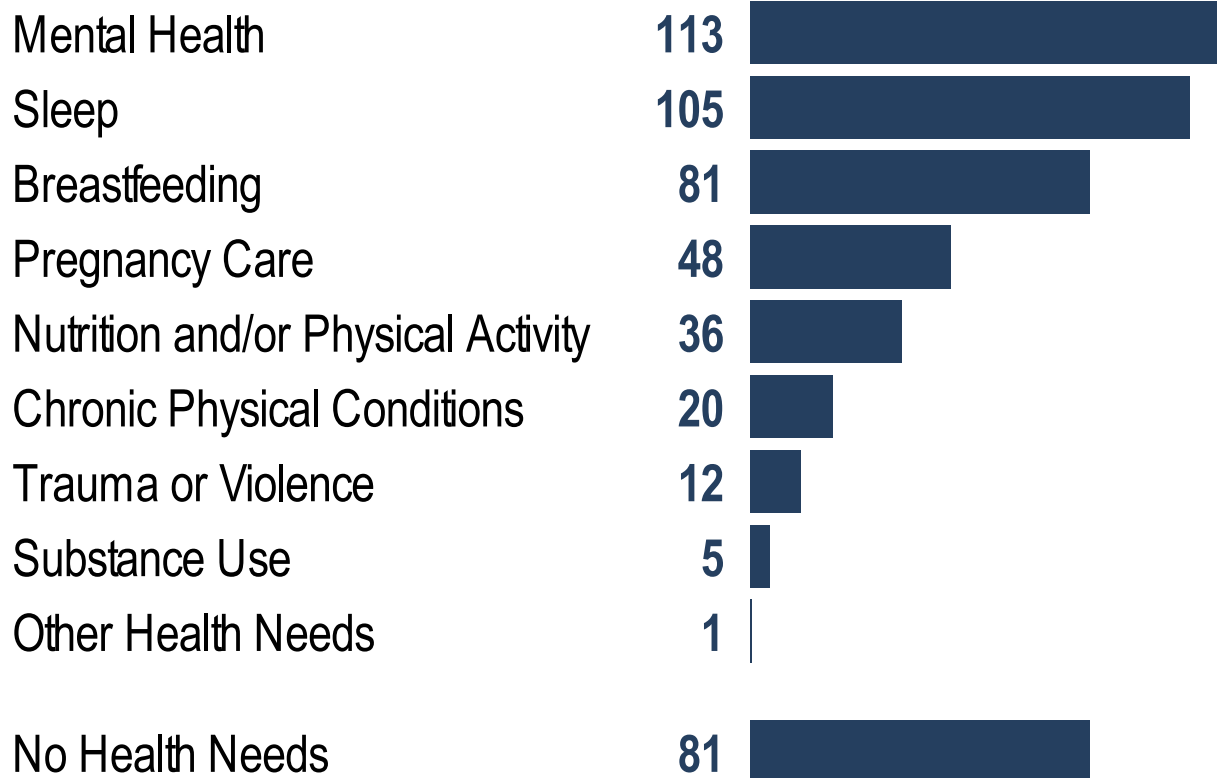
## Pregnancy-Related Care (N=57)



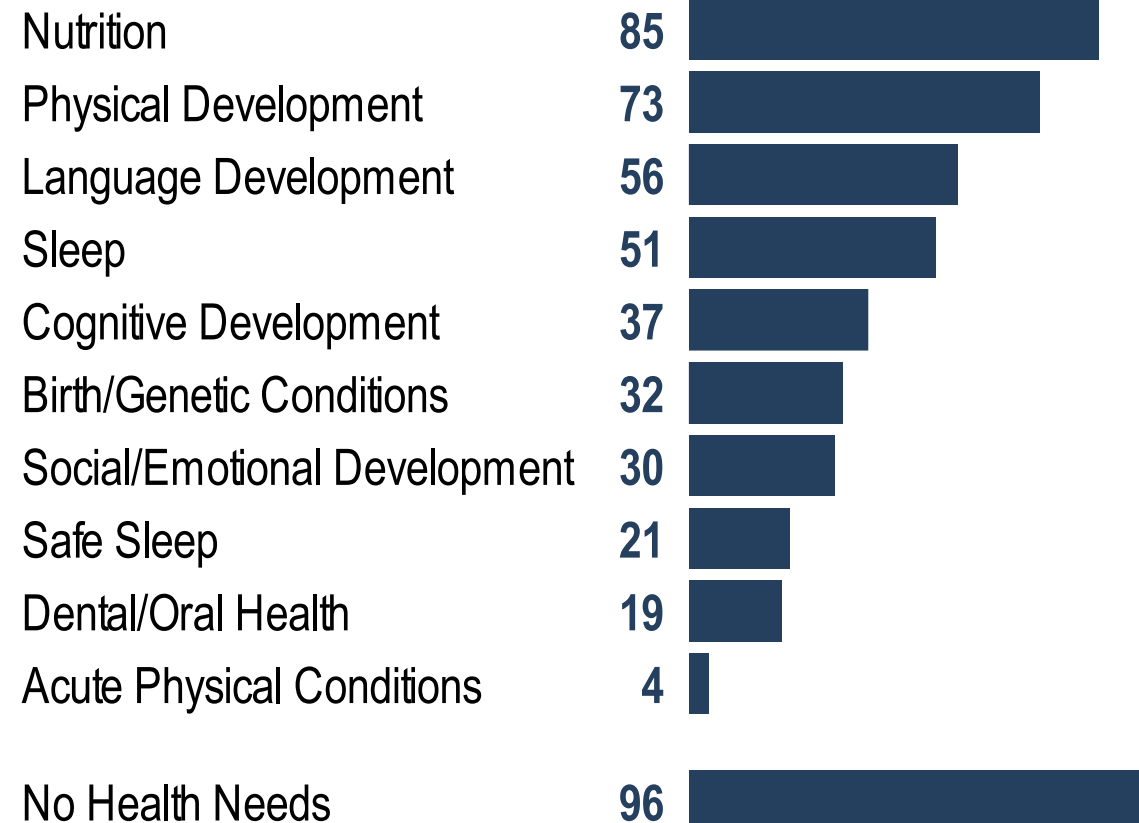
# Needs

For those caring for a baby less than a year old

## Parent/Caregiver (N=298)



## Baby (N=299)



# Nutrition/Breastfeeding



*“When I had to take my kid, it was actually the first time we went out of the house when she was born, and we went to go get her weight. So, I went to the doctor’s office and got her weighed and I was going to come over here next because we were having nursing issues. The nurse there, she said, ‘Well, she’s hungry. Let’s give her a bottle, I have one ready.’ ‘Oh no, no, no, no, no, I’m breastfeeding.’ And she goes, ‘No, I think she needs a bottle.’ She tried to push a bottle on me and I said, ‘No, I’m not taking a bottle.’”*

*“I have a mom that I’m working with right now who’s baby is having breastfeeding issues and what this looks like is that there’s an airway patency issue. So, this baby’s at high risk for SIDS... this mom needs to get in for some PT and OT and some speech to help deal with this airway patency issue and she’s on a 3-week wait to get her insurance provided. So like I said, we can have all these initiatives on how we’re going to prevent SIDS, but if moms and parents can’t get their kids in to their care providers, based on insurance approval, when we have a limited number of providers with that skill anyway, what good does it do?”*

# Caregiver Mental Health



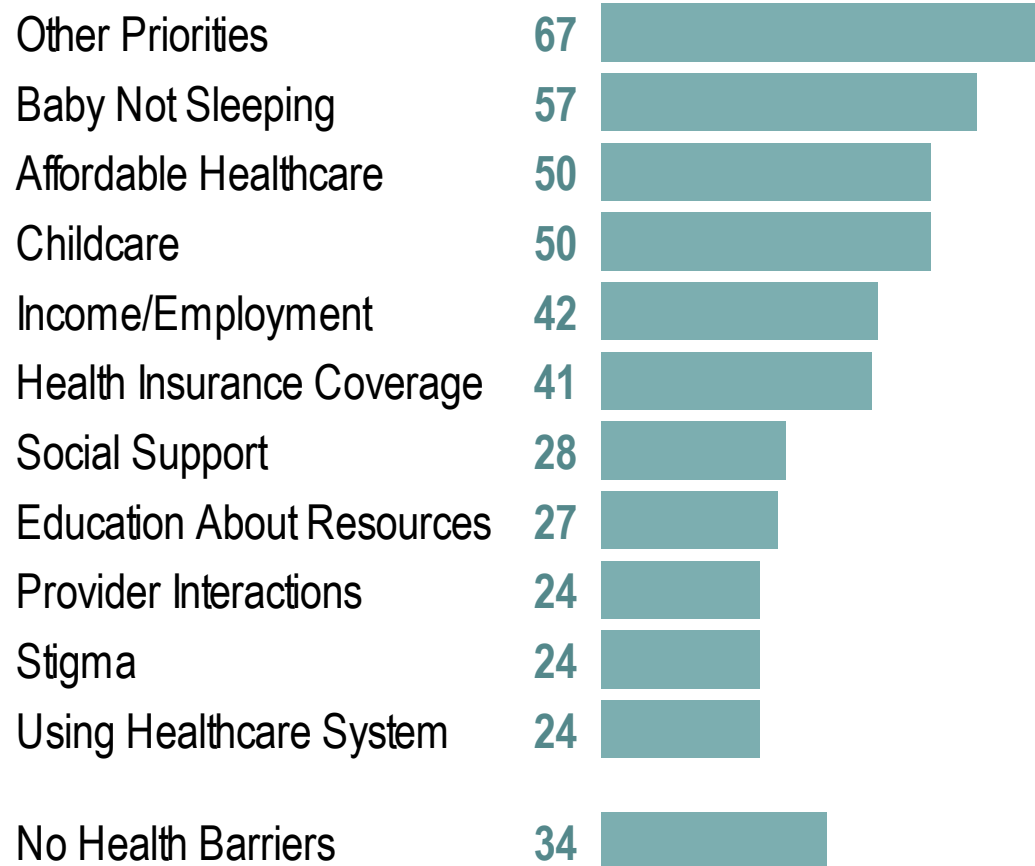
*“My nurse who came in, came into my room and clearly saw that there was an emotional breakdown...and I'm just like boo hooing and crying just like nobody's business. And she never came back to me and said, ‘Hey, is there anything else I can help you with? Maybe we need to revisit this postpartum checklist that you talked about.’ There was none of that. You know, I'm sitting here, you know, literally having an out-of-body experience trying to figure out why I can't stop crying. And there was nothing else. Nobody came in and told me how to swaddle my baby. So, you know, there was none of that. And I think we let moms go like, ‘there's your baby, buh bye.’ And there's a huge issue there.”*



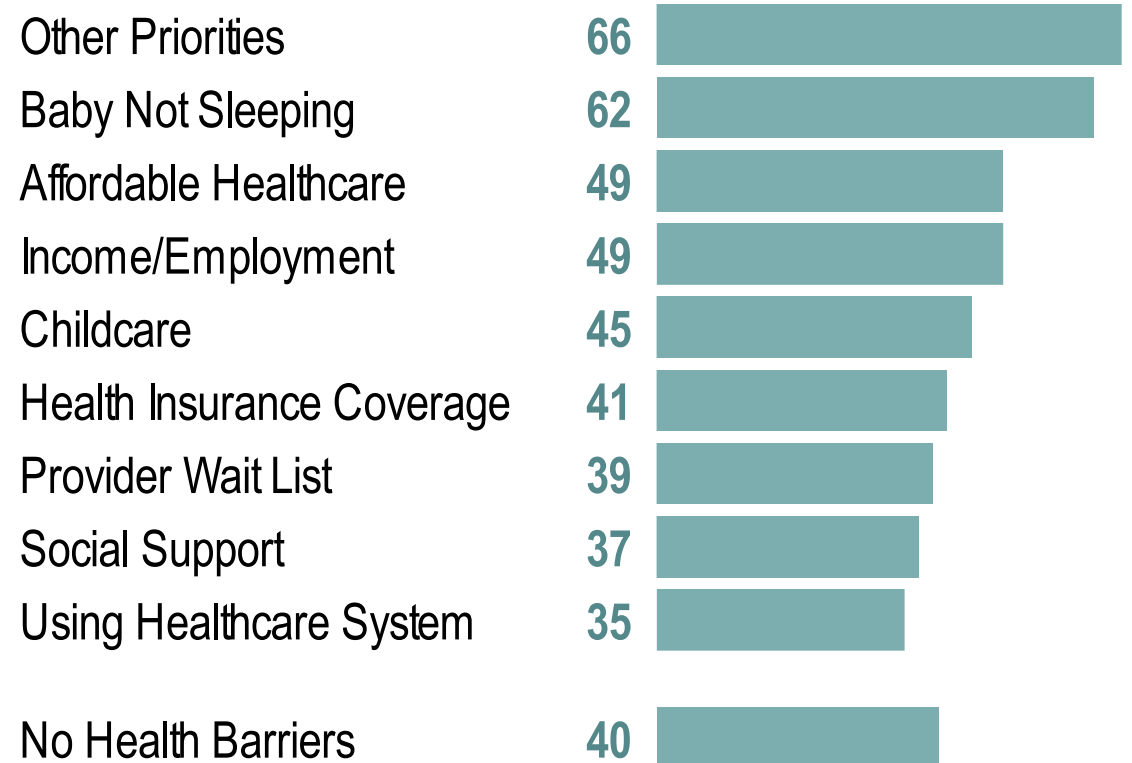
# Barriers

For those caring for a baby less than a year old

## Parent/Caregiver (N=184)



## Baby (N=220)



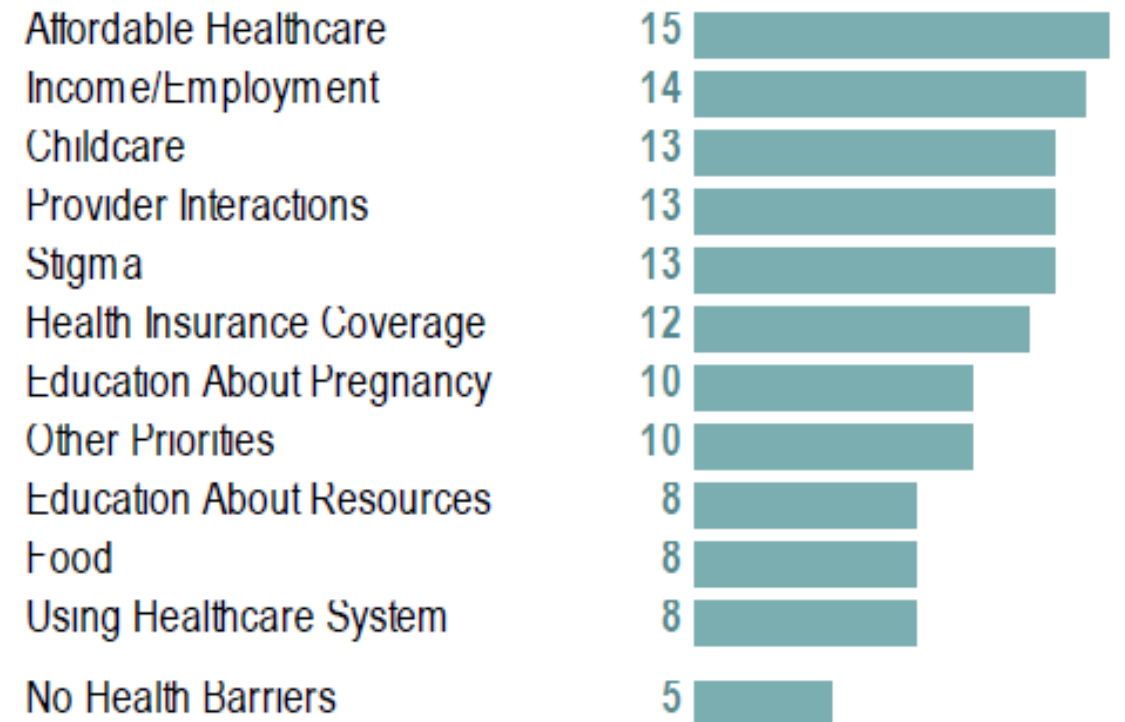
# Barriers

For those caring for a baby less than a year old

## Breastfeeding (N=72)



## Pregnancy-Related Care (N=36)



# Resources

For those caring for a baby less than a year old

## Parent/Caregiver (N=163)

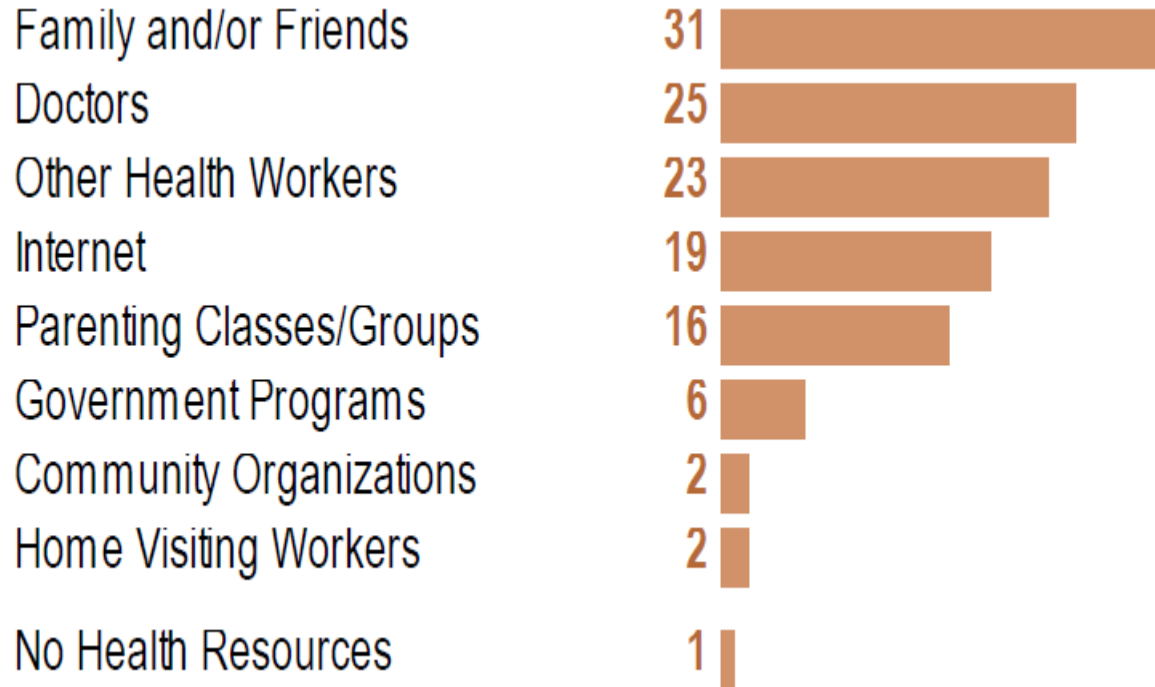


## Baby (N=202)

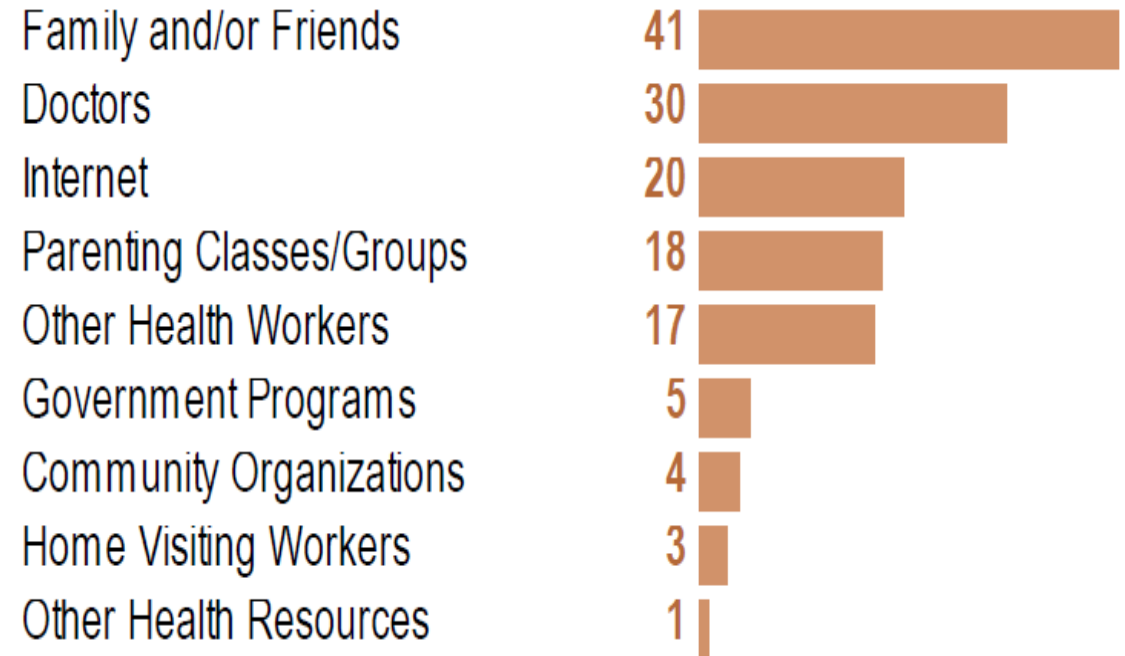


# Resources

## Breastfeeding Resources (N=51)



## Pregnancy-Related Care (N=57)



# Resources: Lactation Consultants



*“I think there’s a huge increase in breastfeeding support because I probably wouldn’t have breastfed if I hadn’t come here.... So, I think that’s one thing that we do right, and I wish everyone had these resources, easily accessed lactation consultants with times which you can go visit, openly visit so it isn’t awkward. I remember I didn’t feel awkward because it’s come and go as you please where you don’t have to call someone up and say will you please meet me?”*

# Baby/Young Child

Babies or young children 0-5 years old

# Demographics: 0 - 5

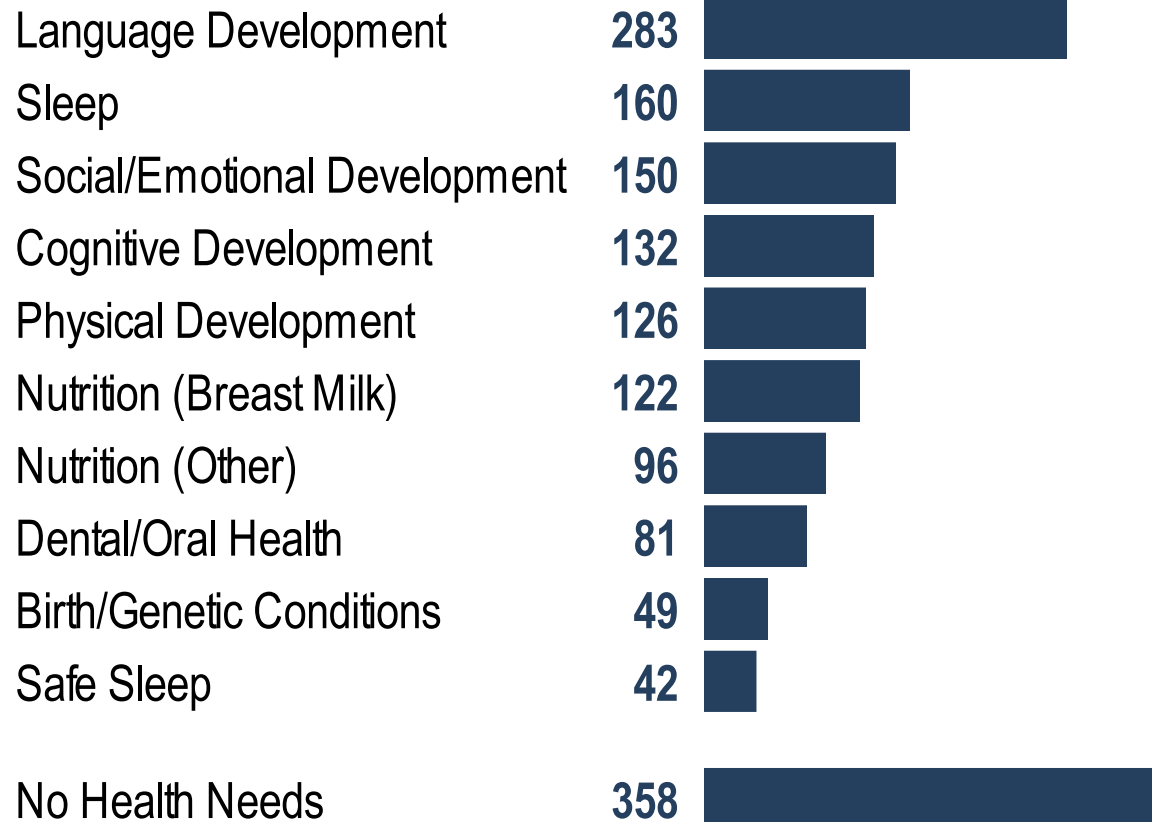
1,041 parents/caregivers of young children 0 – 5 years old

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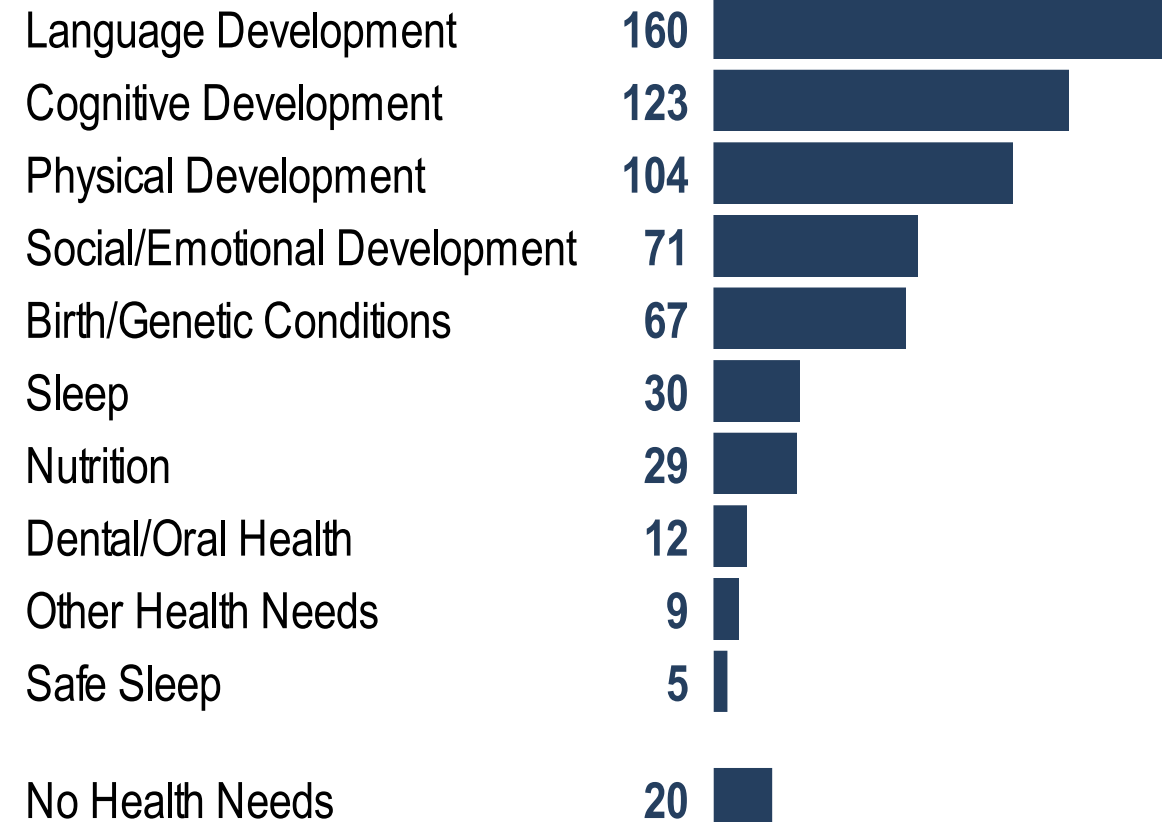
- 94%** of respondents are female.
- 91%** of respondents are White.
- 6%** of respondents are Hispanic or Latino.
- 4%** of respondents are Black or African American.
- 97%** of respondents speak English as their primary language at home.
- 69%** of respondents have bachelor's degree or higher.
- 95%** of respondents have health insurance.
- 33%** of respondents are a healthcare services provider.

# Needs (Baby/Young Child)

## Non-SHCN (N=1,041)



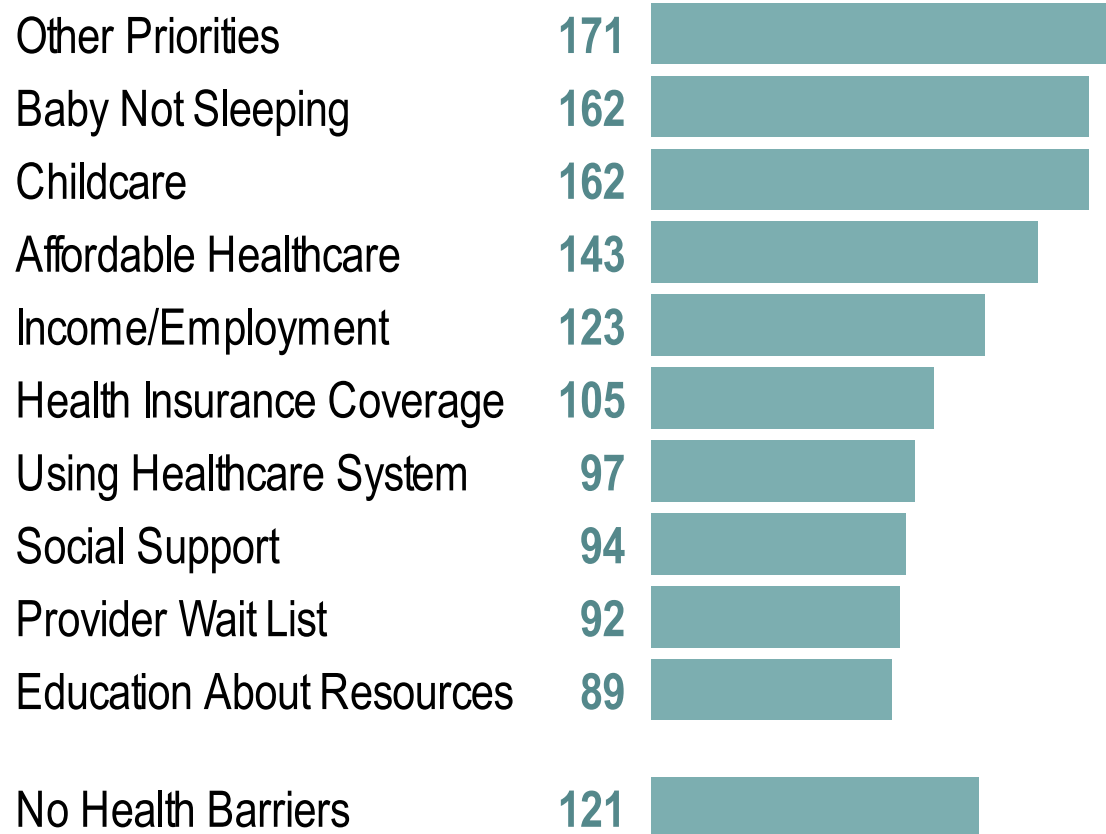
## CYSHCN (N=279)



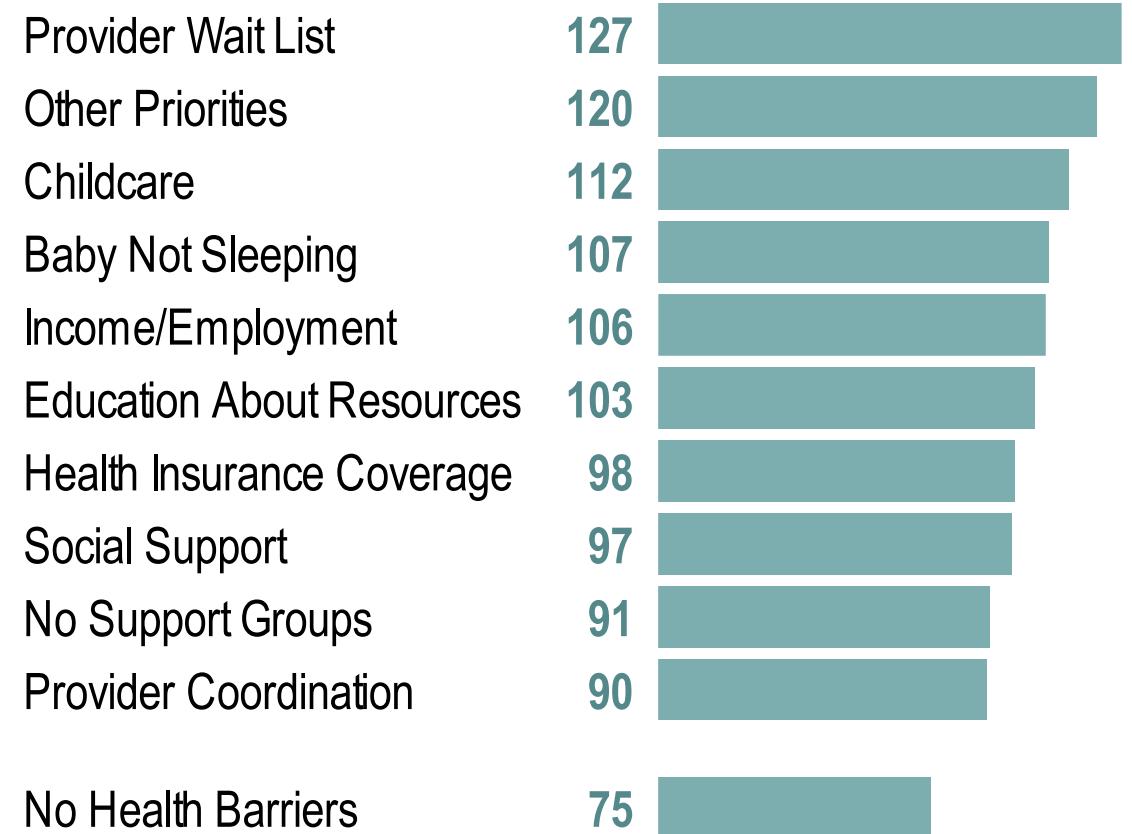


# Barriers (Baby/Young Child)

## Non-SHCN (N=604)



## CYSHCN (N=506)



# Barrier: Coverage and Access



*“At the pediatric office, if you ask for extra information when you go there, you get charged \$35. Double that, depending on how many questions you have. You go in for whatever and I ask a few questions, 5 [years old] is different from an infant. And then you get the paperwork and you’re like well this wasn’t after hours so why did I get a bill? And she said, ‘Oh, well, we had to bill that because of extra.’ So, my questions become extra. So, I have a five-year-old. I have other children, but that was because I had questions on him. Then I’m ‘extra.’ I’m going to be [spending] several thousand by the time he grows up.”*

*“One of the barriers is access to a qualified physician for a Medicaid patient... I want to make sure that my child gets appropriate care, but I don’t have access to those doctors, so I have to basically take what I get. If I don’t like those doctors, then I’m out of options.”*

# Resources (Baby/Young Child)

## Non-SHCN (N=549)

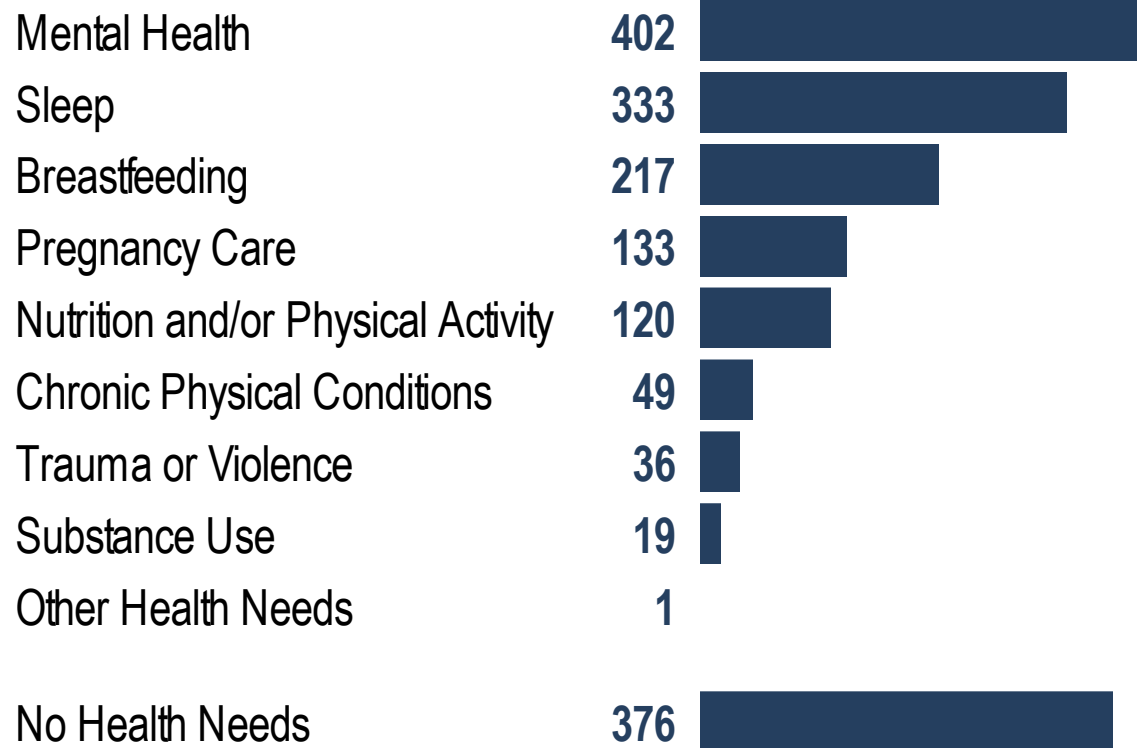


## CYSHCN (N=481)

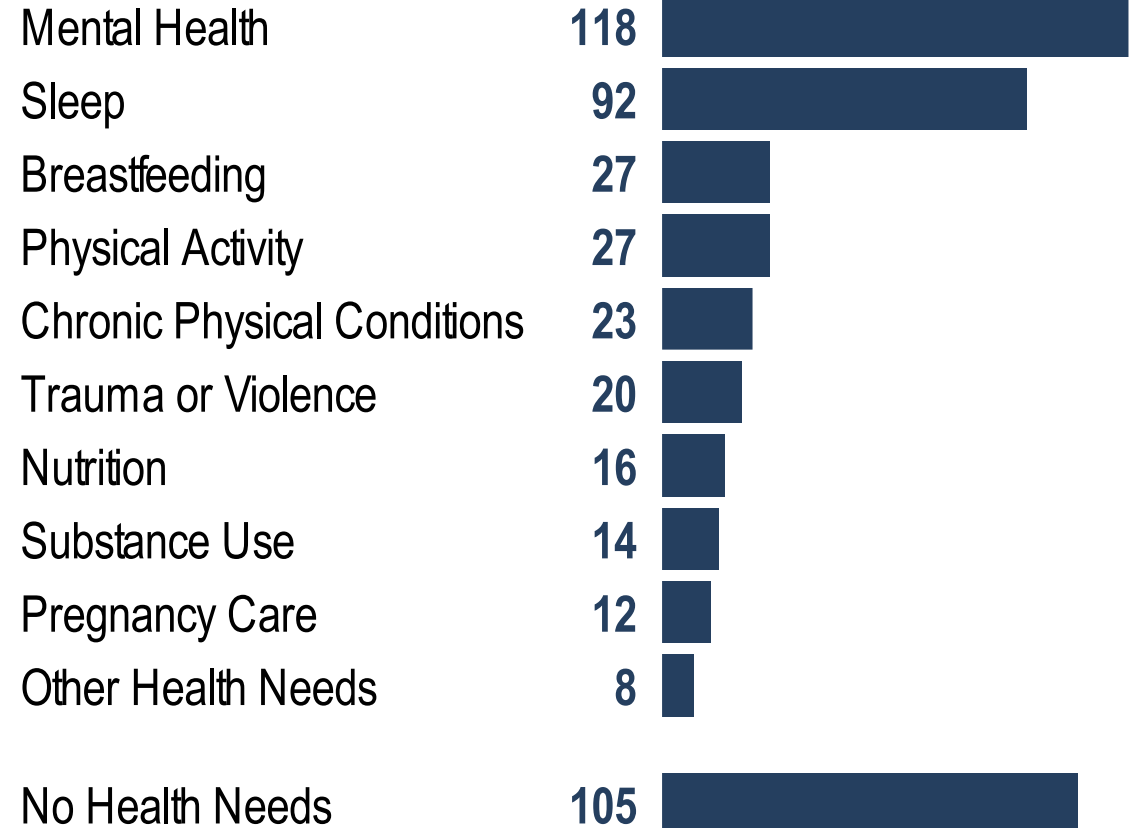


# Needs (Caregiver)

## Non-SHCN (N=1,040)



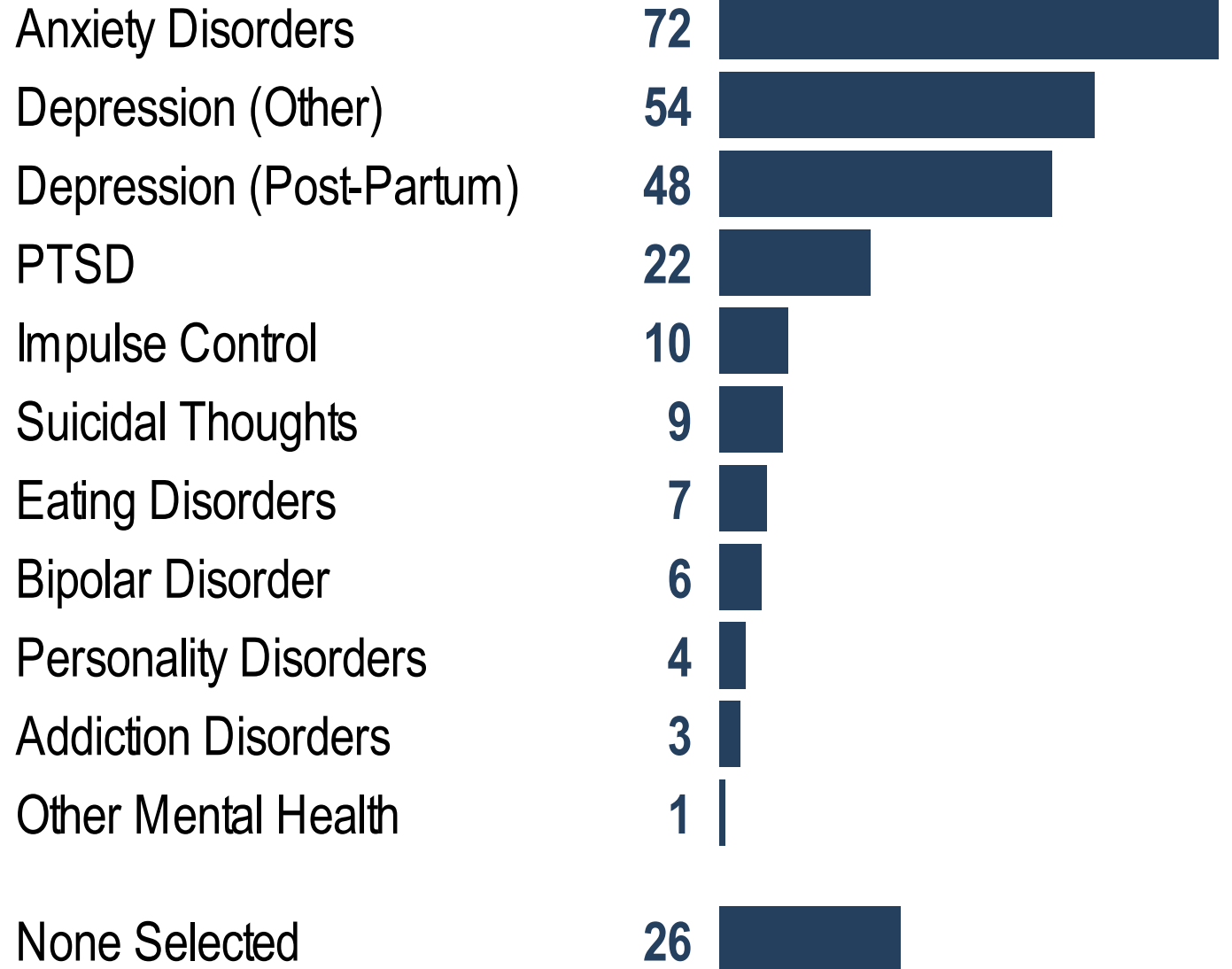
## CYSHCN (N=279)



# Mental Health #1 CYSHCN Caregivers

**N = 118**

## Mental Health



# Child

Children 6-12 years old

# Demographics: 6-12

872 parents/caregivers of children 6 – 12 years old

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**91%** of respondents are female.

**91%** of respondents are White.

**5%** of respondents are Black or African American.

**5%** of respondents are Hispanic or Latino.

**98%** of respondents speak English as their primary language at home.

**70%** of respondents have bachelor's degree or higher.

**94%** of respondents have health insurance.

**43%** of respondents are a healthcare services provider.

# Needs (Child)

## Non-SHCN (N=872)



## CYSHCN (N=233)





# Emotional Development



*“I've had to videotape her having the meltdowns because service providers wouldn't believe me, because they see her in their environment, where she's on guard. She's not herself. So, I have to videotape her what she is like with us.”*

# Barriers (Child)

## Non-SHCN (N=473)



## CYSHCN (N=420)



# Provider Wait List



*“Right now, I’m going through trying to get my son diagnosed with autism and I’m really struggling with the referral process where one doctor says, ‘Okay, we’ll refer you.’ Well it’s been over a week and I haven’t heard. So, I call, ‘Oh there’s no referral on file.’ So, I leave a message. I wait a few more days. They call me back, ‘Oh there is a referral on file all the sudden and yeah, we’ve called them. They’ll call you.’ I’m still waiting. It’s like how many times do I have to reach out to make this thing happen that I’ve been trying for years to get to happen? ... how many doctors do I have to call before I can find one that will take me?”*

*“I mean the hardest thing is getting diagnosed and then having a waitlist. There's a waitlist to be evaluated and now we have the diagnosis now there's a waitlist for services and it's like all this wasted time.”*

# Resources (Child)

## Non-SHCN (N=430)



## CYSHCN (N=399)



# Resources



*“**The library** has a lot of programs... It helps mental development. They categorize [their reading times] by age group.”*

*“**The parks and rec department** is really good here with activities for all ages. Different programs for kids of all ages.”*

*“I get notifications from [my **online support groups**]. So, every time somebody posts something I look to see if it's really, you know, relatable to me or maybe I can answer the question [that was posted].”*

# Teen / Young Adult

Adolescents 13-17 years old

# Demographics

852 parents/caregivers of teens 13 - 17

---

**91%** of respondents are female.

**91%** of respondents are White.

**5%** of respondents are Black or African American.

**4%** of respondents are Hispanic or Latino.

**99%** of respondents speak English as their primary language at home.

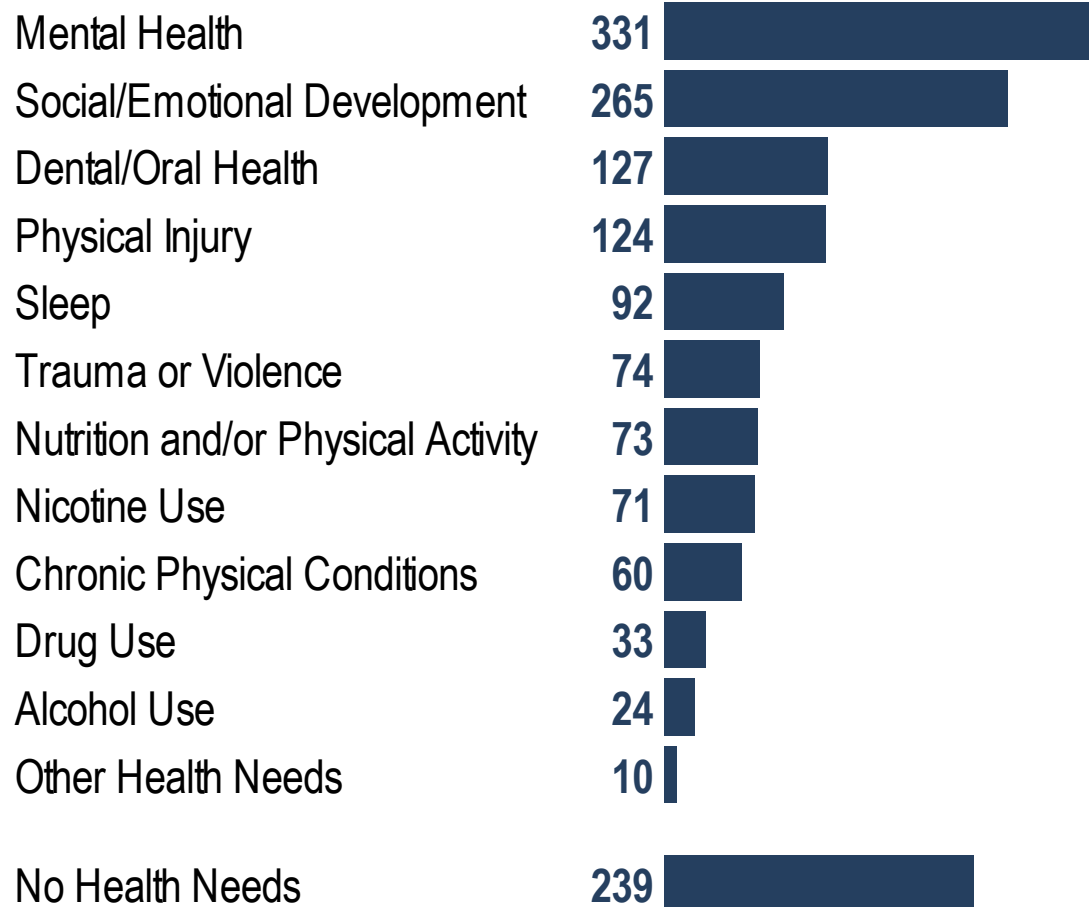
**66%** of respondents have bachelor's degree or higher.

**96%** of respondents have health insurance.

**45%** of respondents are a healthcare services provider.

# Needs (Teen/Young Adult)

## Non-SHCN (N=852)



## CYSHCN (N=224)

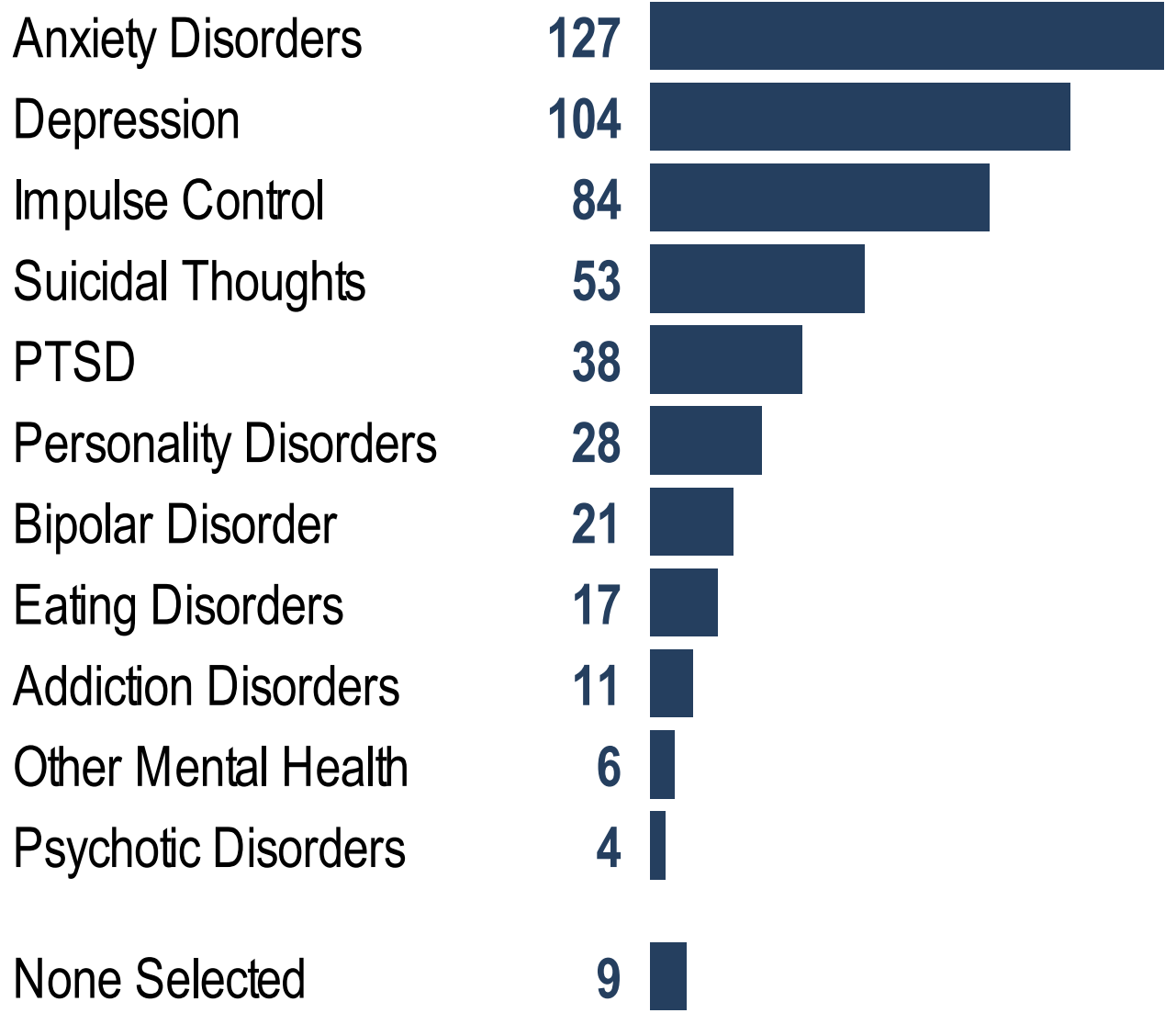




# Mental Health #1 CYSHCN

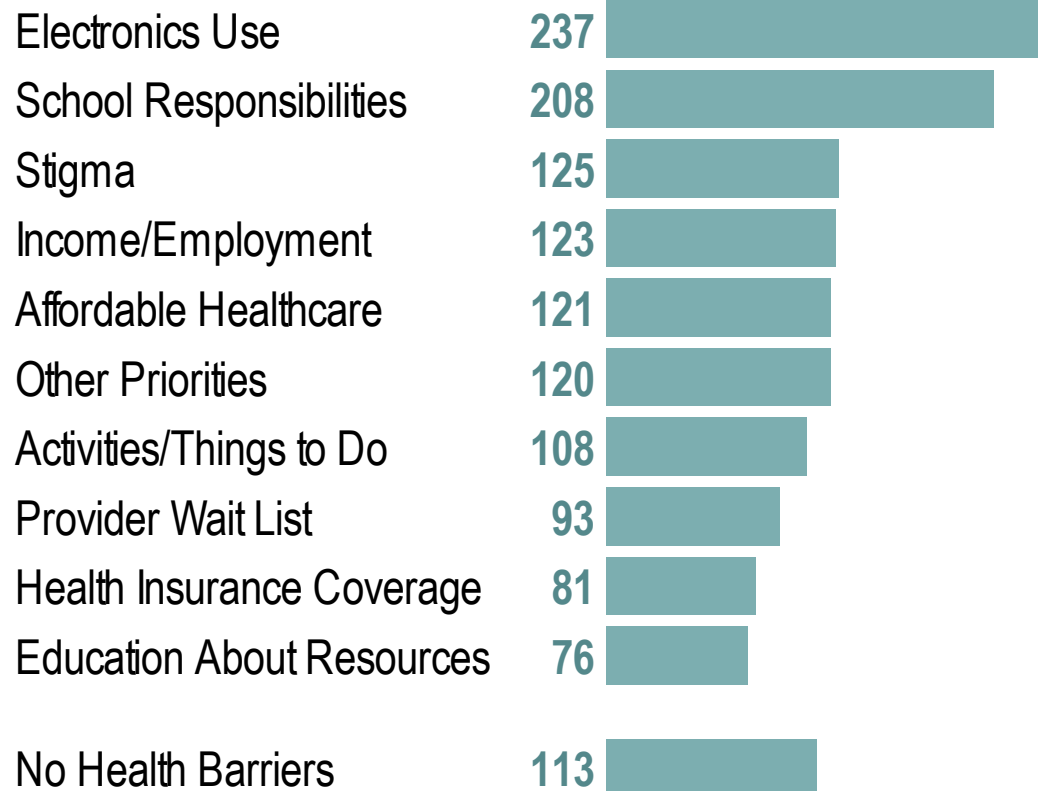
**N = 158**

## Mental Health

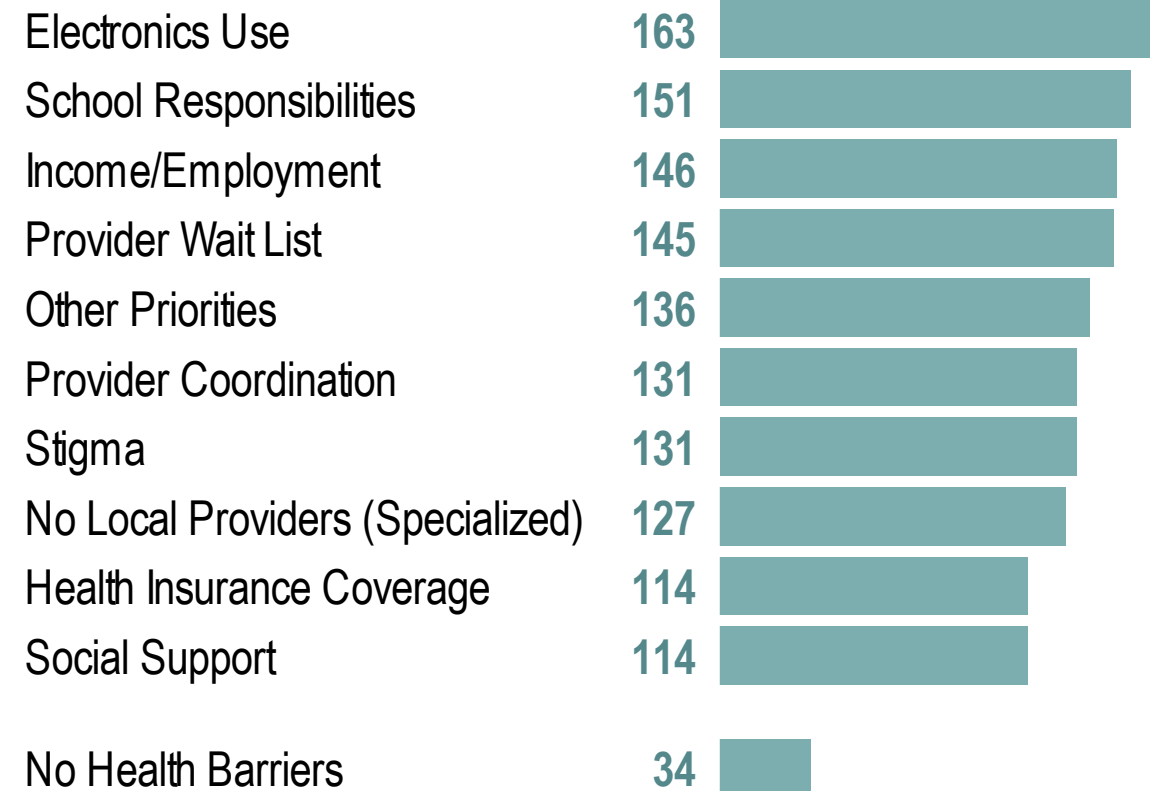


# Barriers (Teen/Young Adult)

## Non-SHCN (N=584)

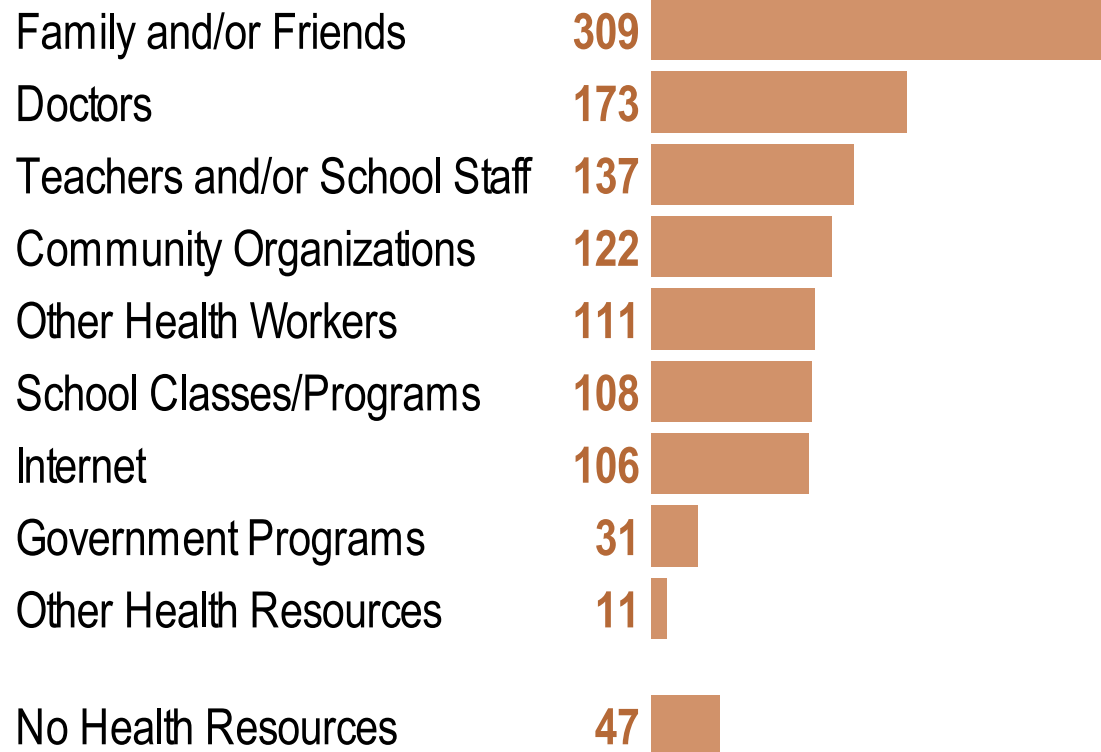


## CYSHCN (N=440)



# Resources (Teen/Young Adult)

## Non-SHCN (N=518)

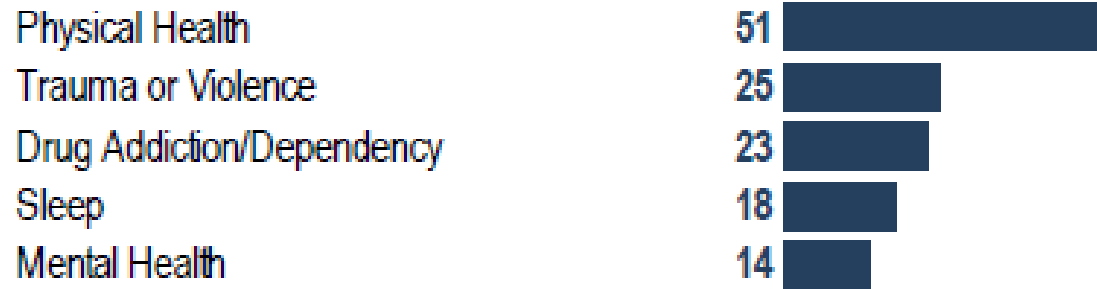


## CYSHCN (N=415)

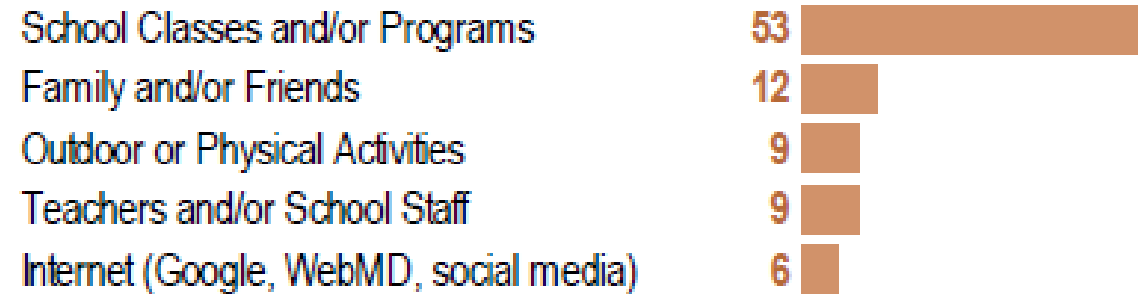


# Focus Group (Teen/Young Adult) (n=23)

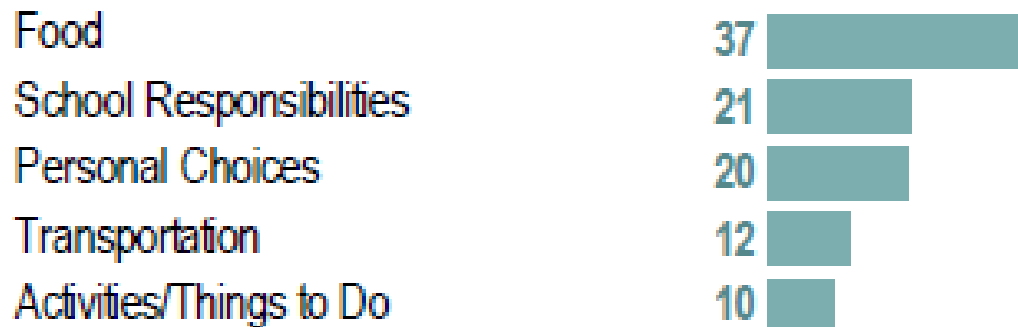
## Focus Group Needs



## Focus Group Strengths/Resources



## Focus Group Barriers



# Your Community

What needs, challenges, and/or barriers to health does your community experience? (open-ended)

# Demographics:

1,997 respondents

**91%** of respondents are female.

**91%** of respondents are White.

**5%** of respondents are Black or African American.

**4%** of respondents are Hispanic or Latino.

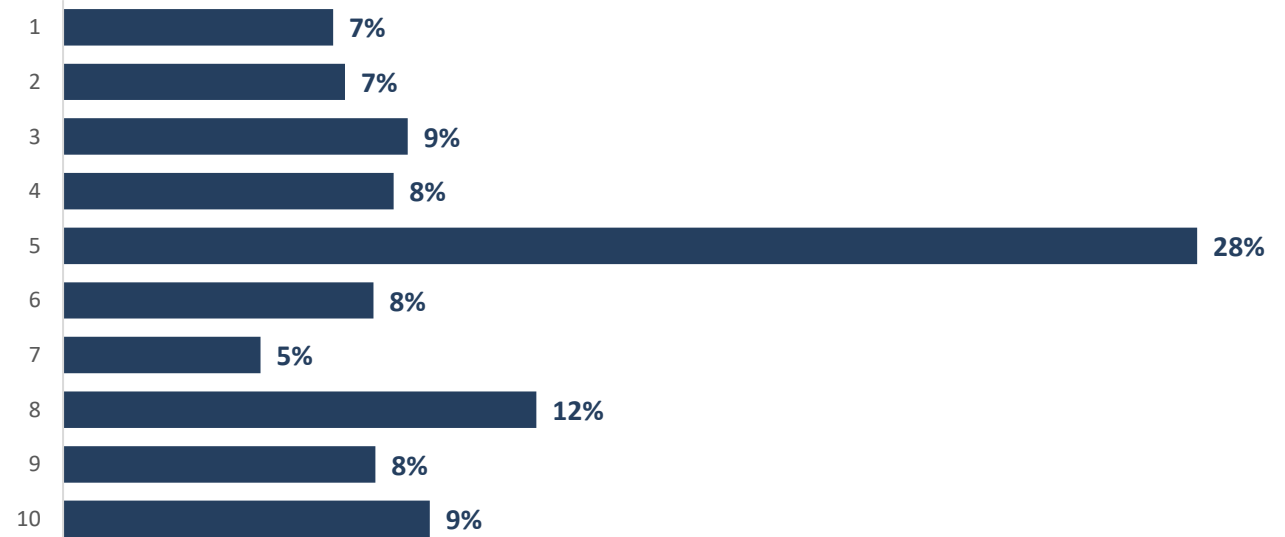
**49%** of respondents are between 30 – 49 years old.

**74%** of respondents have bachelor's degree or higher.

**96%** of respondents have health insurance.

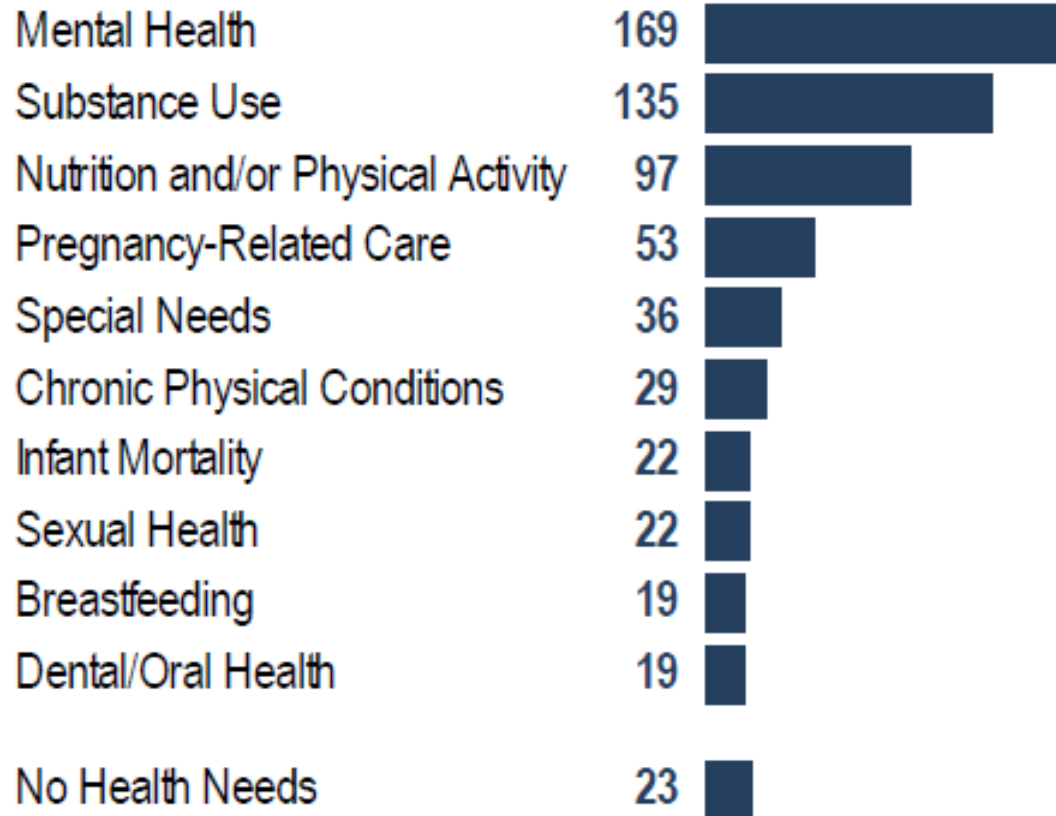
**45%** of respondents are a healthcare services provider.

# Responses by Region:

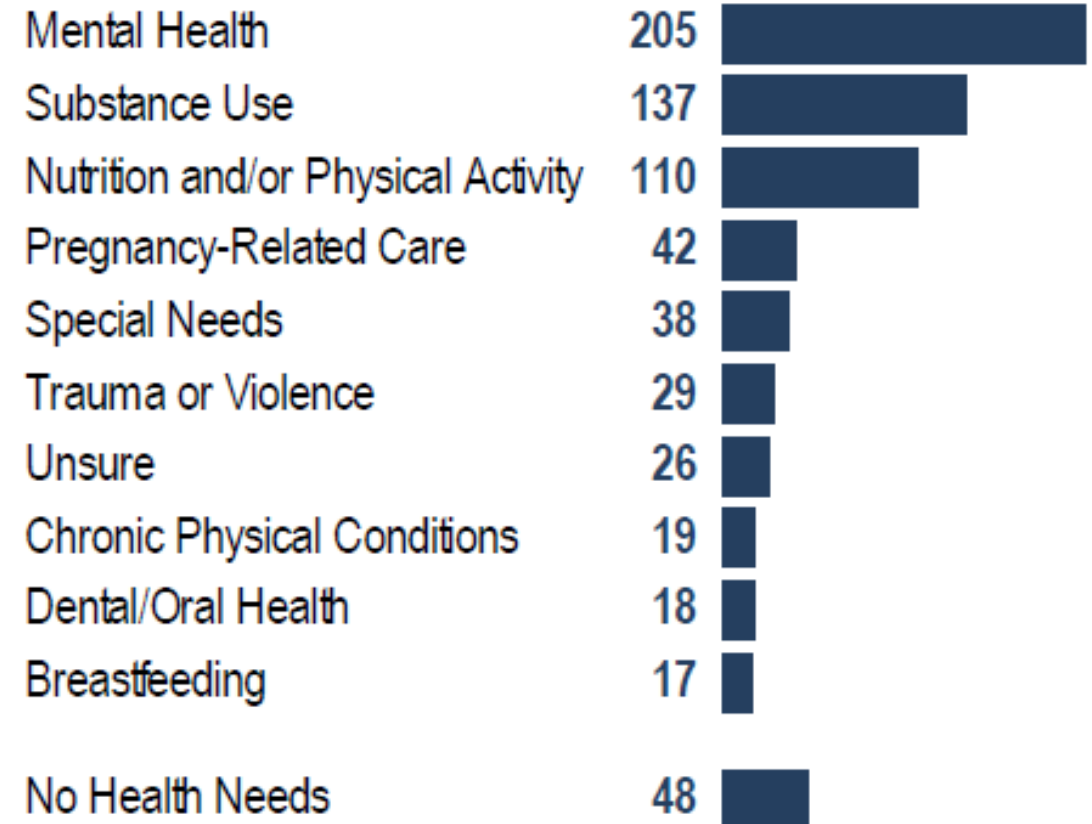


# Community Needs

## Healthcare Provider (N=477)



## Non-Healthcare Provider (N=551)



# Mental Health and Substance Use



*“Mental health issues are not adequately covered by insurance, and qualified providers have limited schedules.”*

*“There needs to be better supports for mental health and preventative mental health such as coping skills, developing healthy relationships etc.”*

*“One of the biggest needs I would say is more mental health availability. A barrier that is in my community is access for people who are trying to recover from addiction. It's a long process to get a person into this program, and sometimes this causes discouragement among the person.”*

*“...we've added treatment options in the past year [for substance use] but all are nearly full.”*





## Nutrition and/or Physical Activity

*“We have too many restaurants and fast-food restaurants in our community. Our farmer's market is small and is lacking in variety. We need more produce stands, education on healthy eating, and better awareness of the benefits of plant-based diets. I think our community could benefit from more community gardens.”*

*“There’s not much to do in the winter for adults or children. No place to be active together indoors except places like [name], which aren’t appropriate for babies and toddlers.”*

# Community Barriers

## Healthcare Provider (N=824)



## Non-Healthcare Provider (N=935)



# Accessing Local Providers



*“More and more we are asked to wait longer to not even see our own care provider. We should get to see the same doctor every single time we are sick or for check-ups unless we are sick while they are not working. Even for children, they are moving to a system in which you do not get to see a regular provider. I have shown up for an appointment with a specialist only to find that I have been assigned to someone new and have to go through all my past stuff again, and believe me, they do not care!”*



# Transportation

*“Transportation is a problem for many, especially in rural areas. When folks from a rural area need to travel to a larger community for services, paying for the travel can be an issue.”*

*“We could really use a better public transit system and more bike-friendly areas and more pedestrian-friendly public spaces in the city!”*

# Affordable Healthcare and Price Transparency



*“Low income and elderly have government insurance while the working class pays greatly for private insurance and still can’t use it due to high deductibles.”*

*“Very expensive insurance and high deductibles. Not knowing what healthcare will cost until AFTER you receive services. Not being able to afford said services or pay the bills.”*

# Community Strengths and Resources

## Healthcare Provider (N=753)



## Non-Healthcare Provider (N=890)



# **Social Determinants of Health**



**A very special thank you to Madelyn Good, MPH from Yale School of Public Health**

<b>Economic Stability</b>	<b>Neighborhood and Physical Environment</b>	<b>Education</b>	<b>Food</b>	<b>Community and Social Context</b>	<b>Health Care System</b>
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

### **Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations



# Data Source

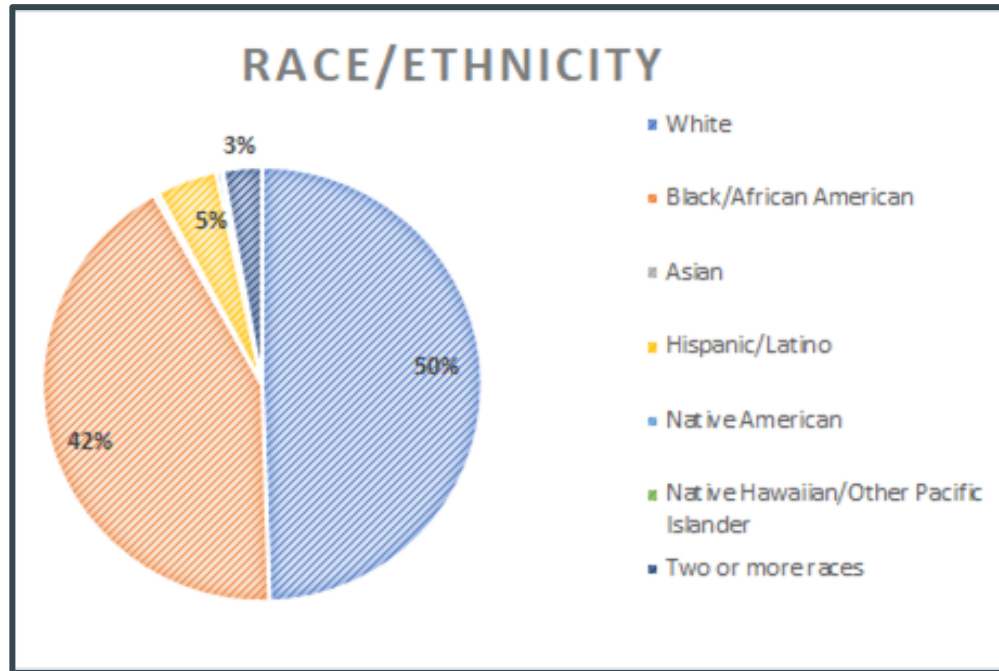
## INDIANA 2-1-1

- Data collected: July 2, 2018, to Jan. 1, 2020
- Total sample: 298,063 surveys
- Analytical sample differed per question (missing or “refused” data points)

# Survey Questions

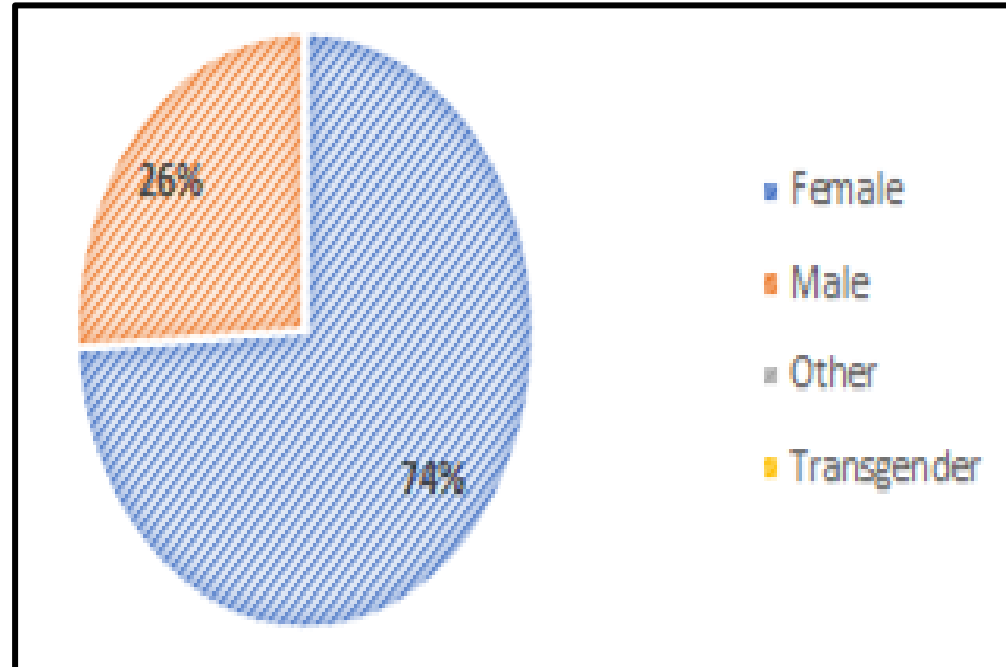
1. Race/Ethnicity
  2. Gender Identity
  3. Employment Status
  4. Annual Household Income
  5. Completed Education Level
- 
6. Housing
  7. Utility Needs
  8. Food Insecurity
  9. SNAP Benefits
  10. Transportation
  11. Health Insurance Coverage and Type
  12. Interpersonal Safety

# 1. Race/Ethnicity



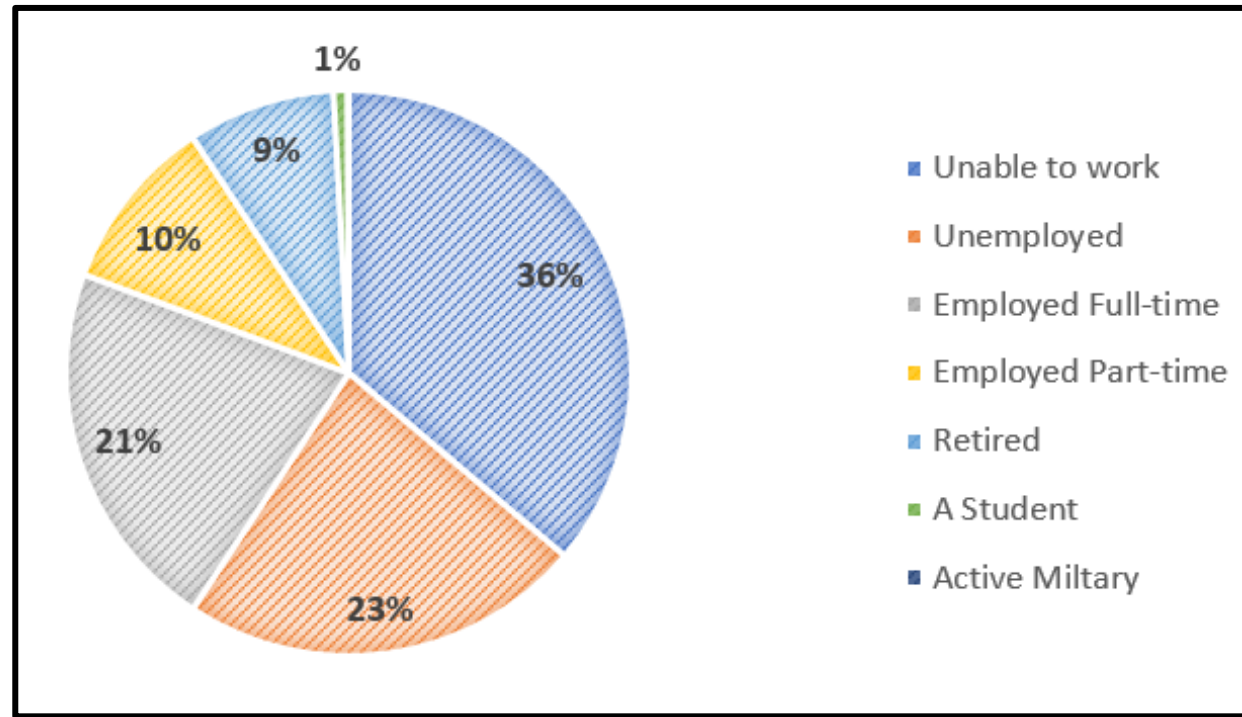
N = 106,386

# 2. Gender Identity



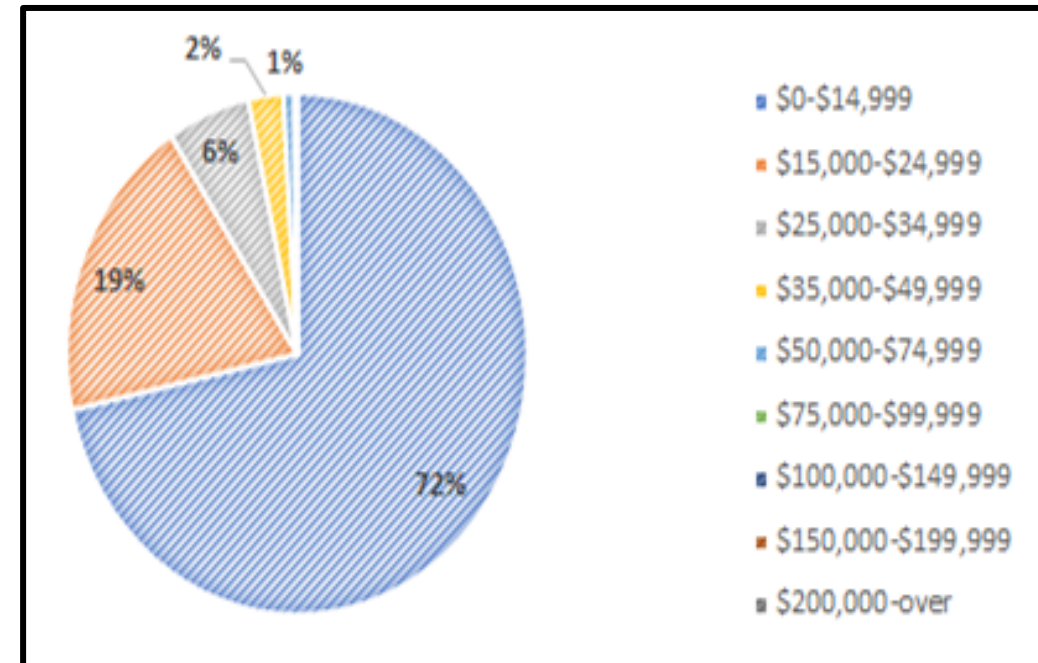
N = 173,306

### 3. Employment Status



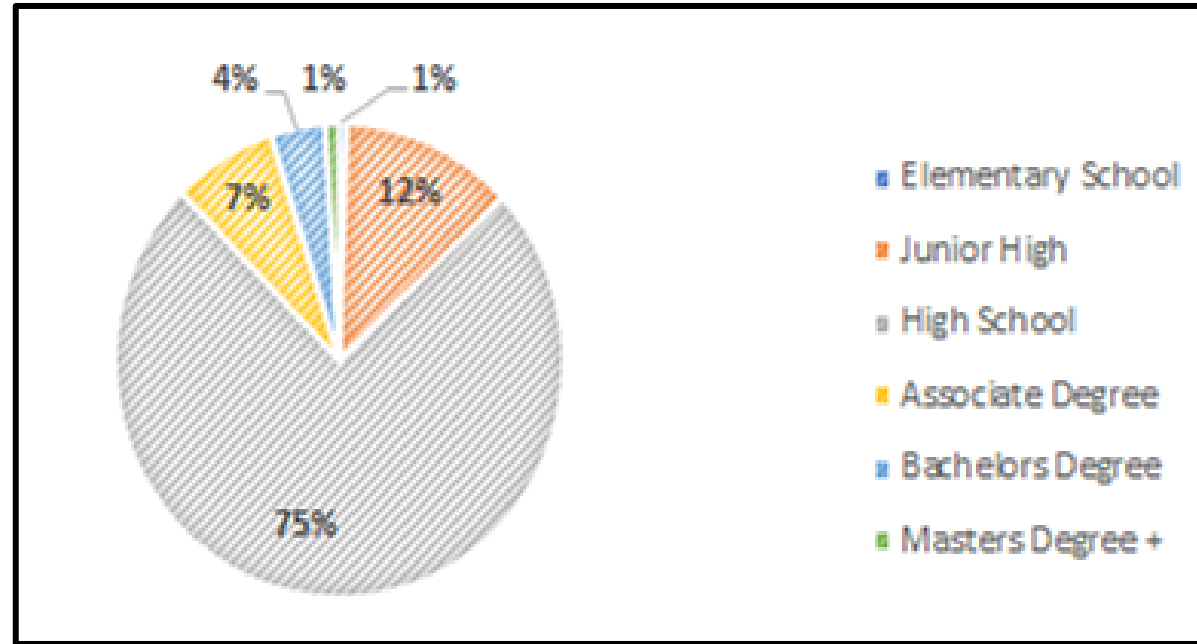
N = 84,273

### 4. Annual Household Income



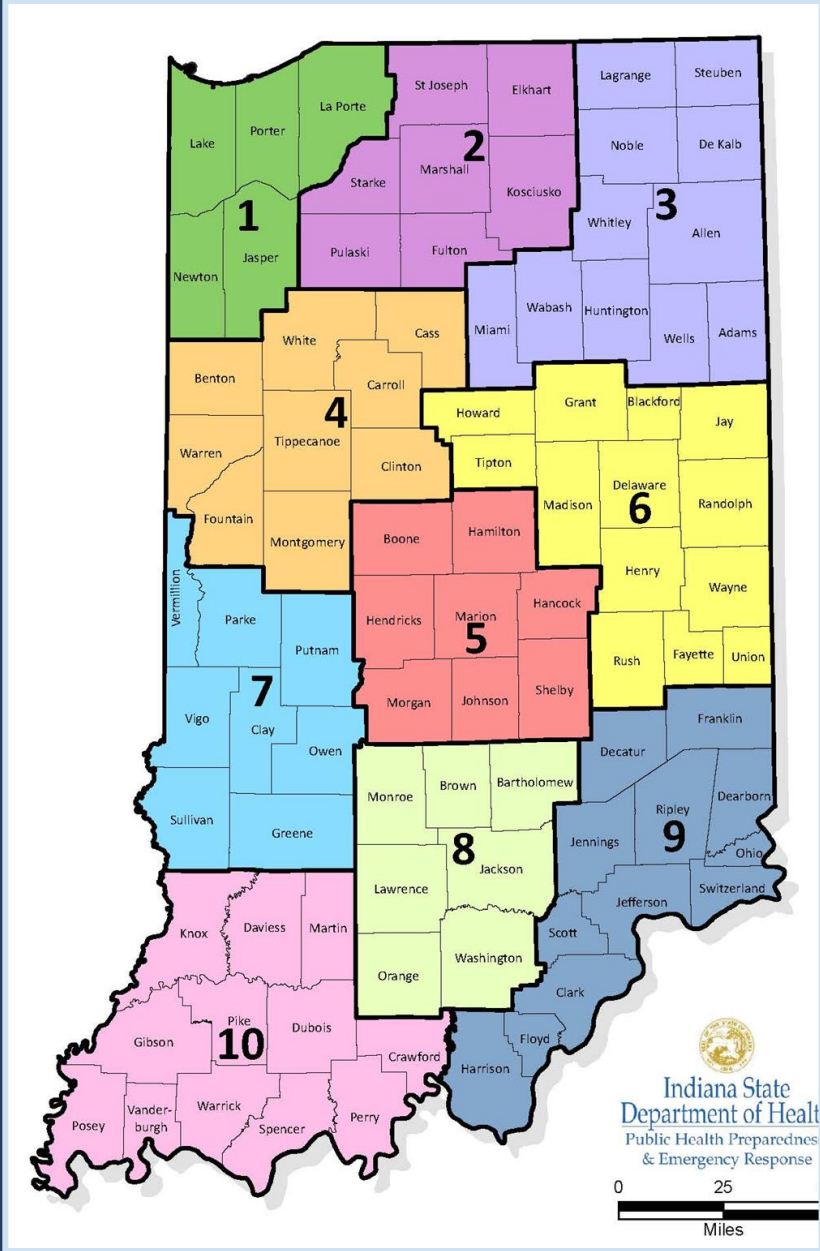
N = 35,558

# 5. Completed Education Level



N = 14,840

# Reminder: Regional Breakdown



## 6. Housing Situation

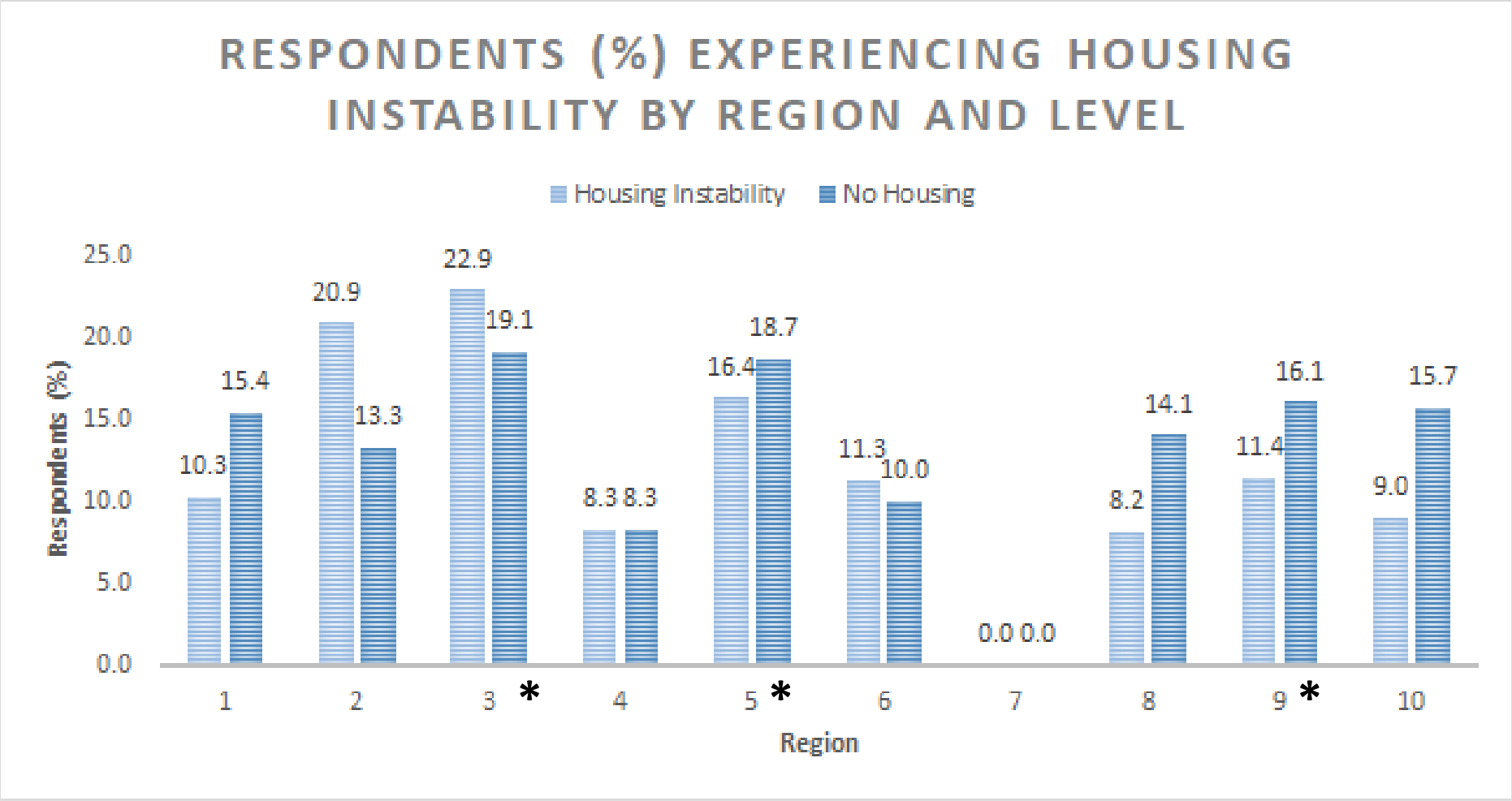
“What is your housing situation today?”



N = 87,215

*Note: Housing Instability includes those who answered, “I have housing today but am worried about losing it in the future” and “Currently facing eviction”.*

# Experiencing Housing Instability, by Region

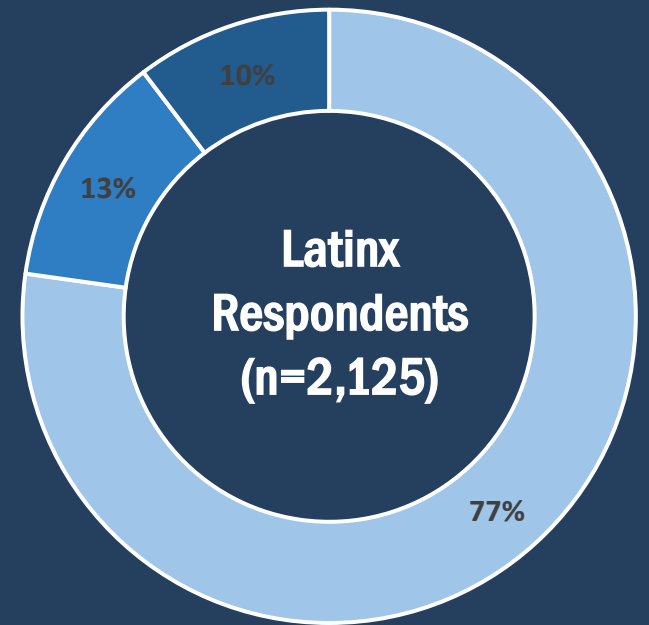
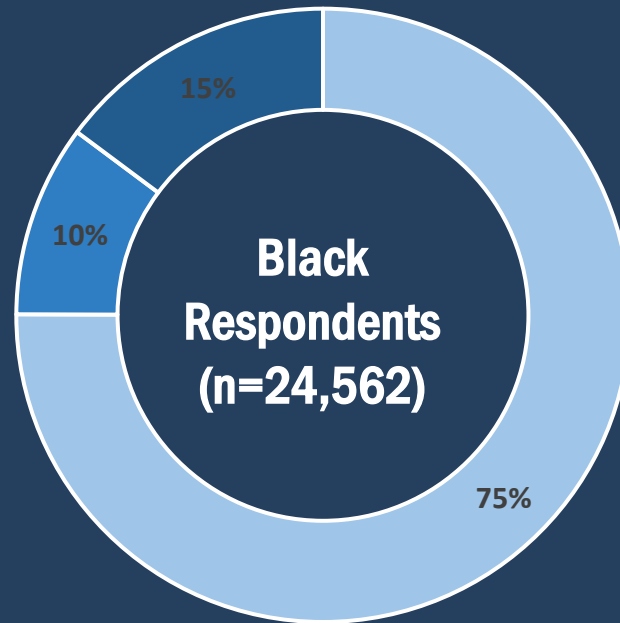
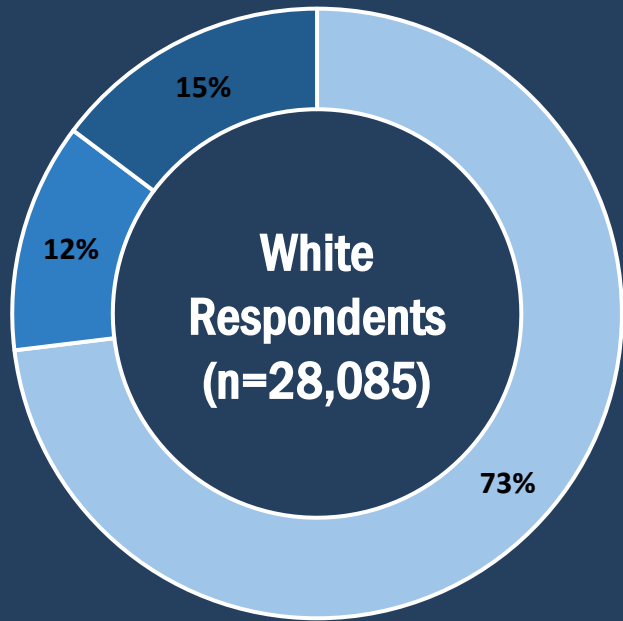


\* statistical significance at the  $p = 0.05$  level

Note: Only 10 participants answered the question in Region 7.



# Housing Instability, by Race/Ethnicity



 No Housing

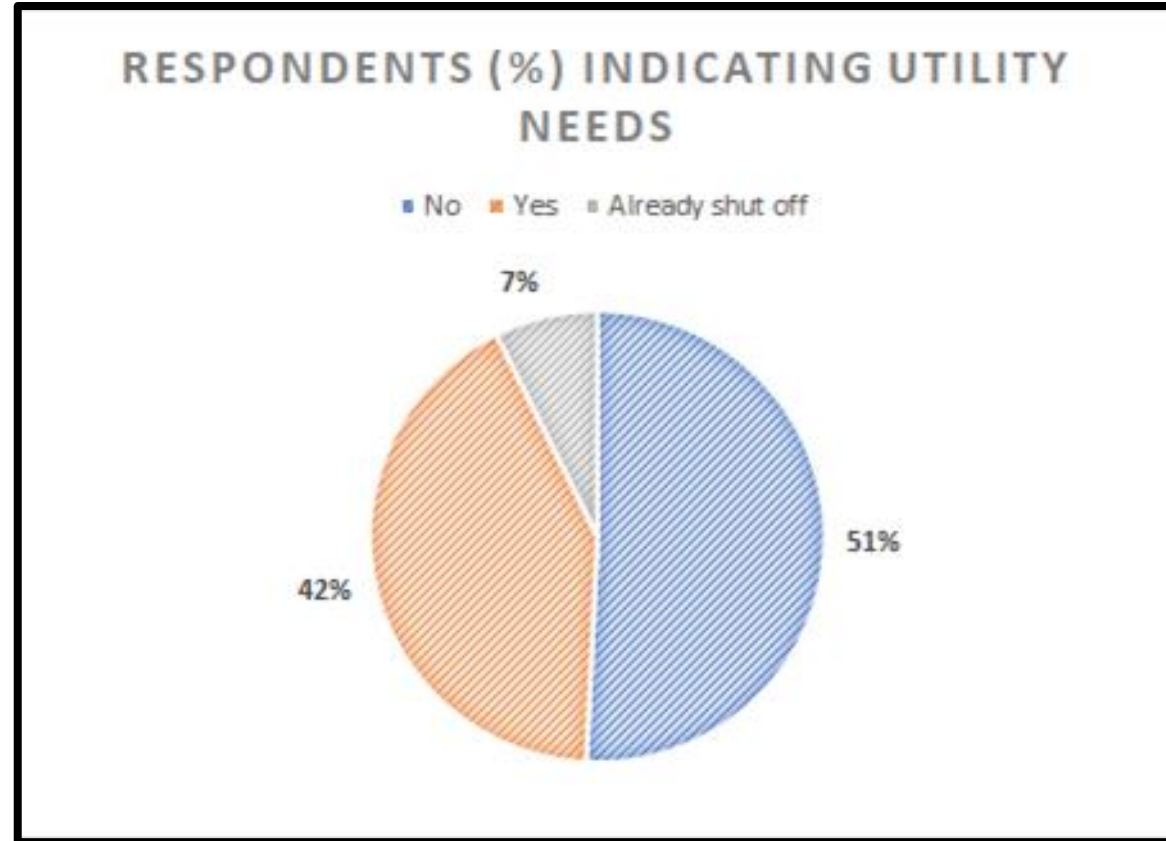
 Housing Instable

 Stable Housing



## 7. Utility Needs

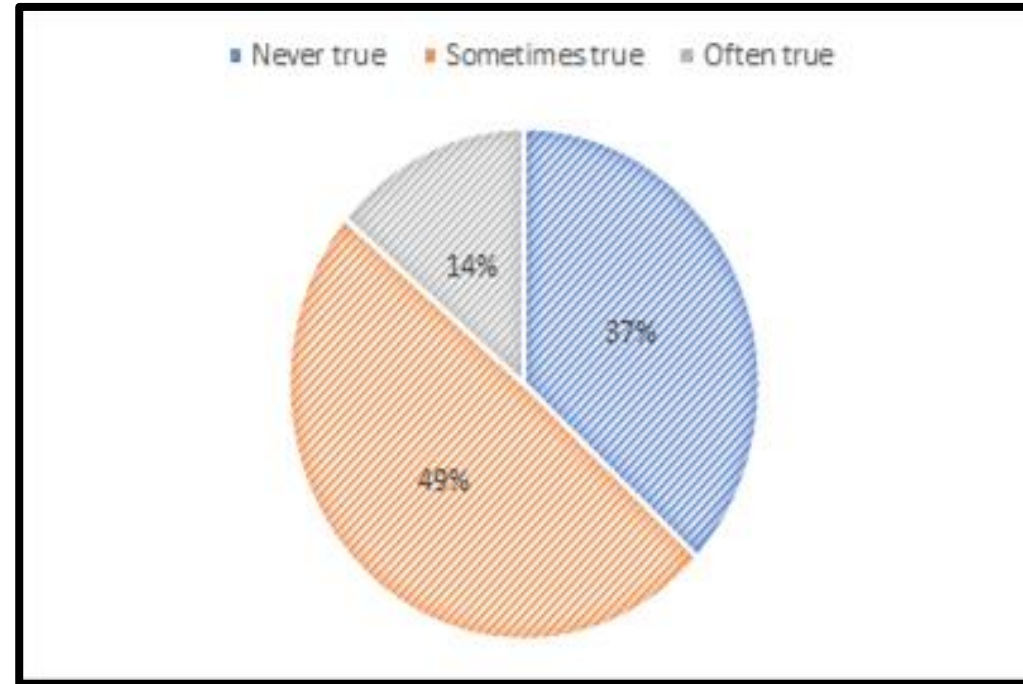
**“In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?”**



N = 45,765

## 8. Food Insecurity

“Within the past 12 months, have you worried that your food would run out before you had money to buy more?”

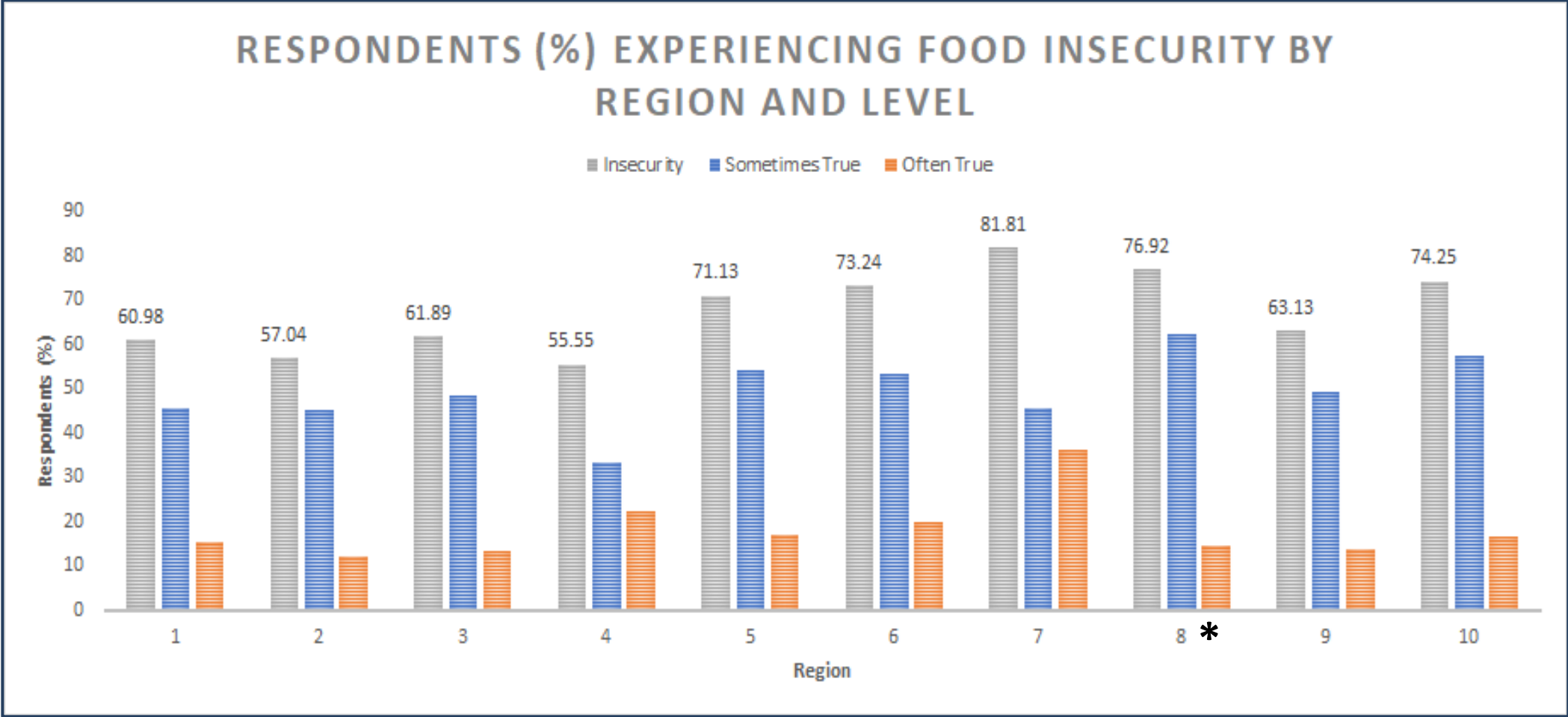


N = 32,420

## 9. Supplemental Nutrition Assistance Program (SNAP)

- Indiana Residents receiving benefits each month: 741,610
- 2-1-1 Sample: 52% receive SNAP benefits

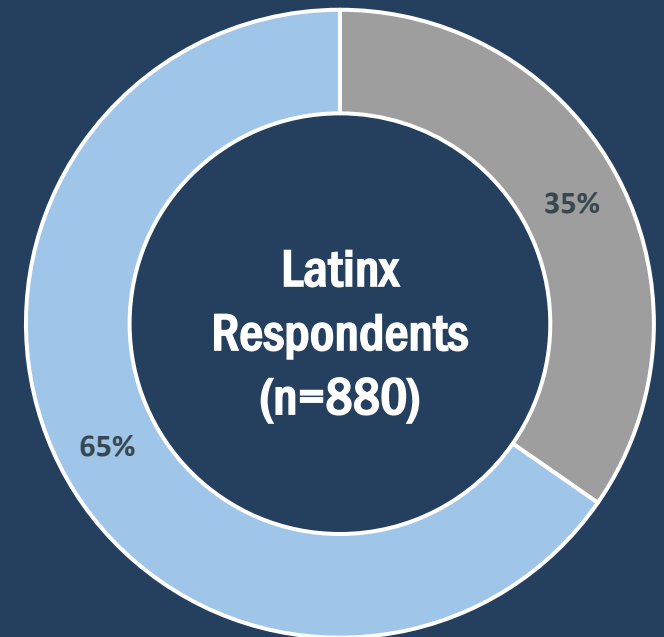
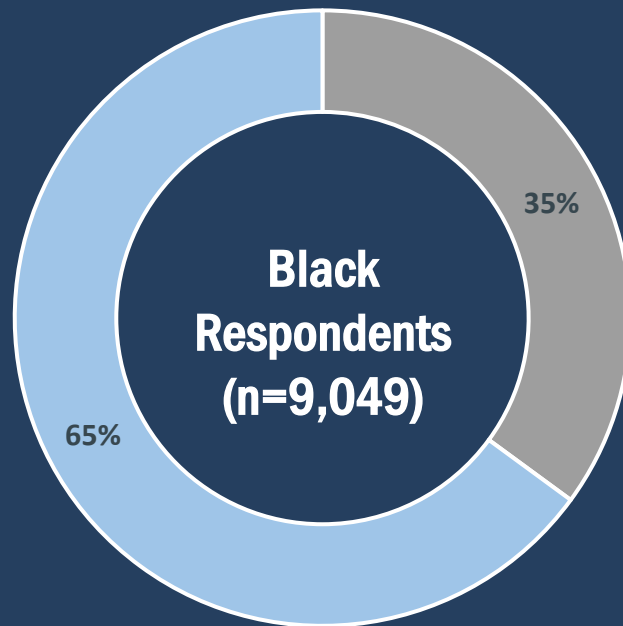
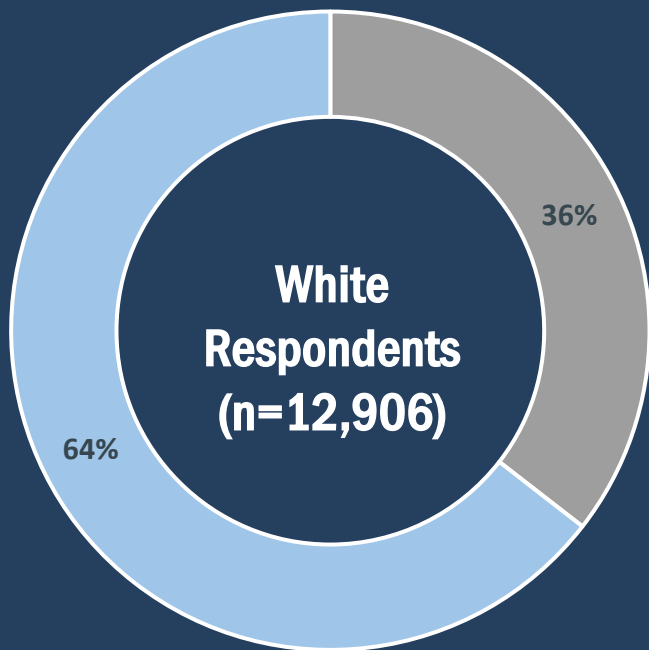
# Experiencing Food Insecurity, by Region



\* statistical significance at the  $p = 0.05$  level



# Food Insecurity, by Race/Ethnicity

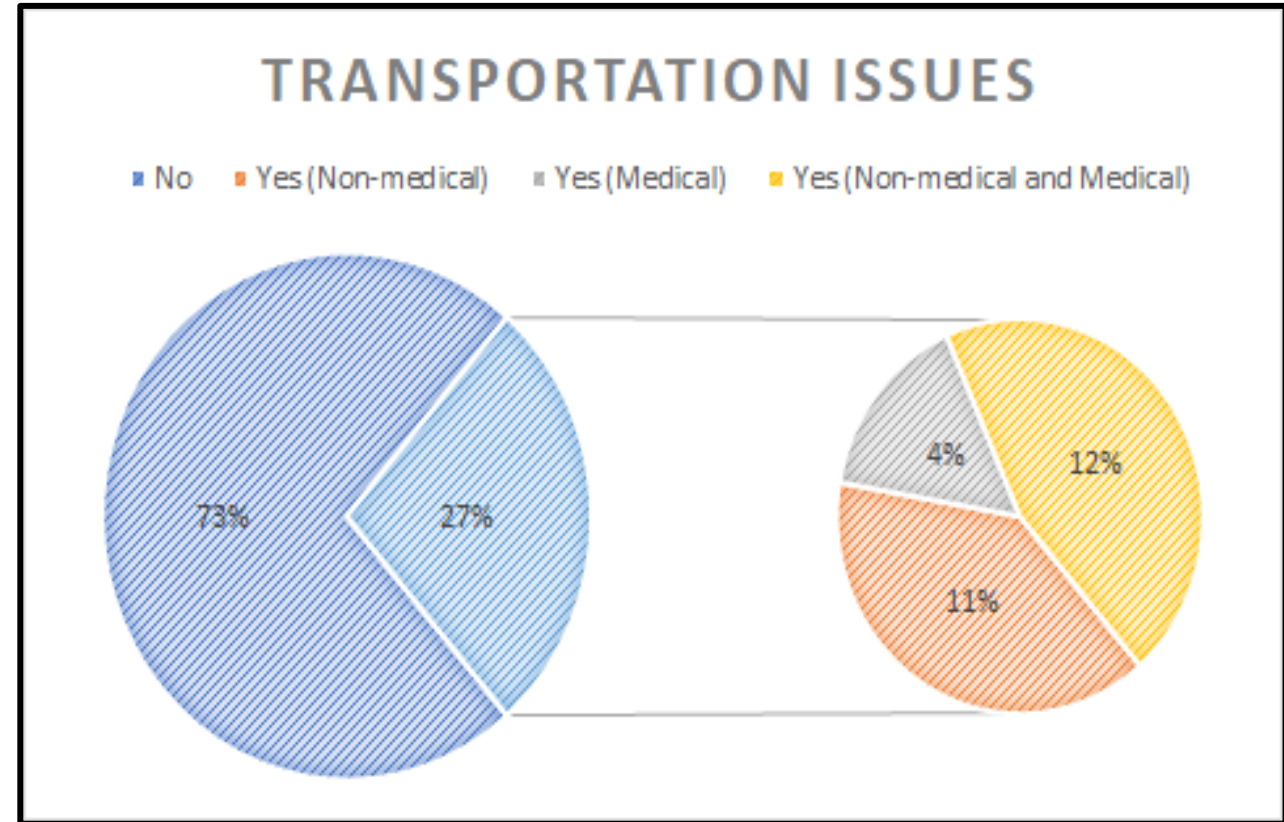


Food Secure

Food Insecure

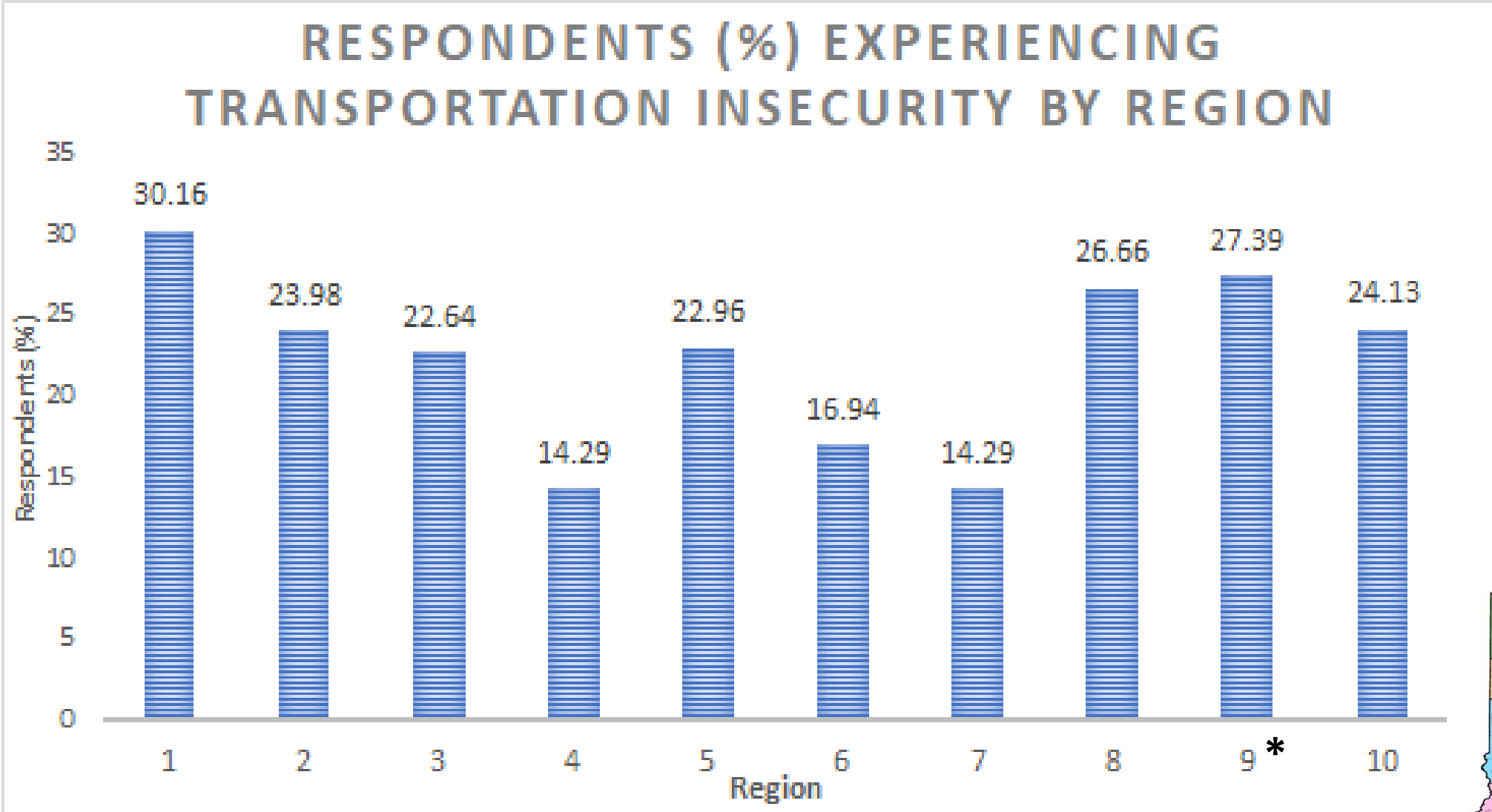
# 10. Transportation Insecurity

“In the past 12 months, has a lack of transportation kept you from medical appointments, meetings, work or from getting things you need for daily living?”



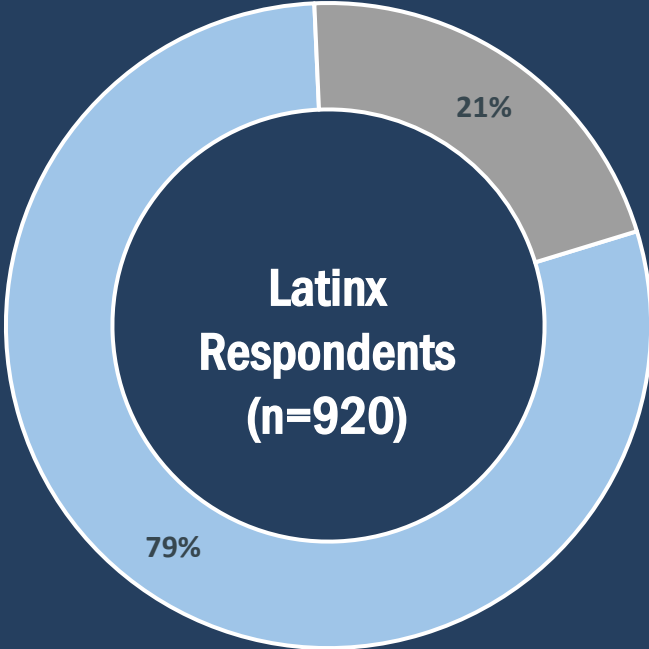
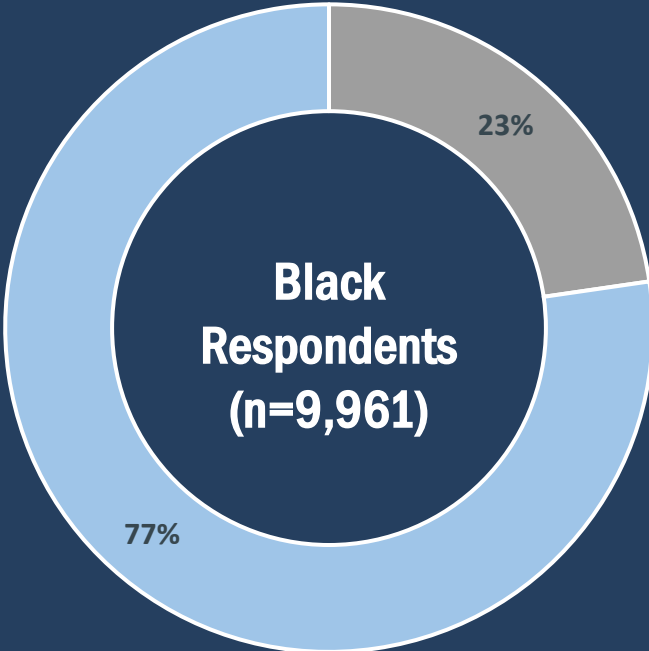
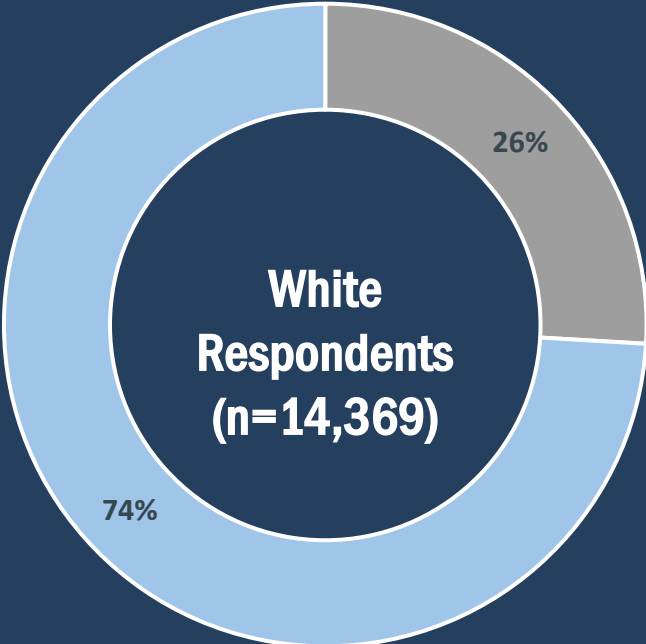
N = 35,658

# Experiencing Transportation Insecurity, by Region



\* statistical significance at the p = 0.05 level

# Transportation Insecurity, by Race/Ethnicity

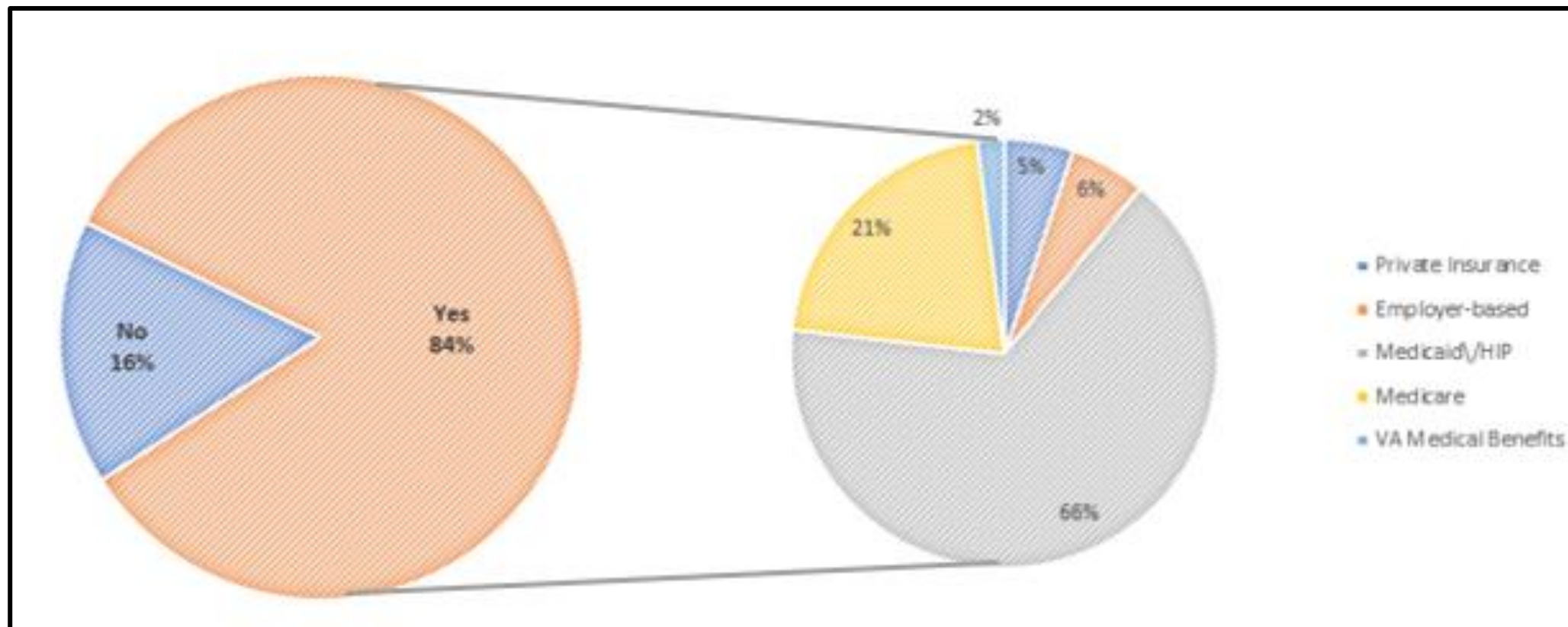


■ Transportation Secure

■ Transportation Insecure

# 11. Health Insurance Coverage and Type

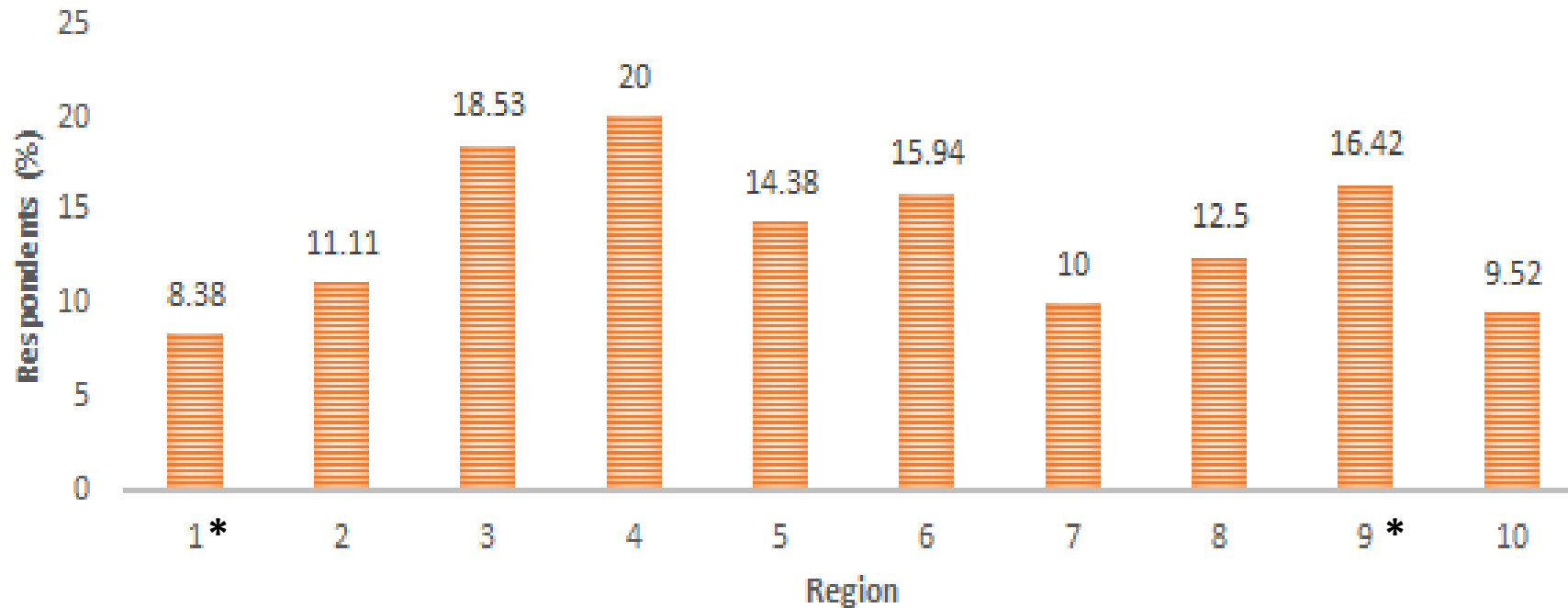
- ▶ “Do you currently have health insurance?”
- ▶ “What type of health coverage do you have currently?”





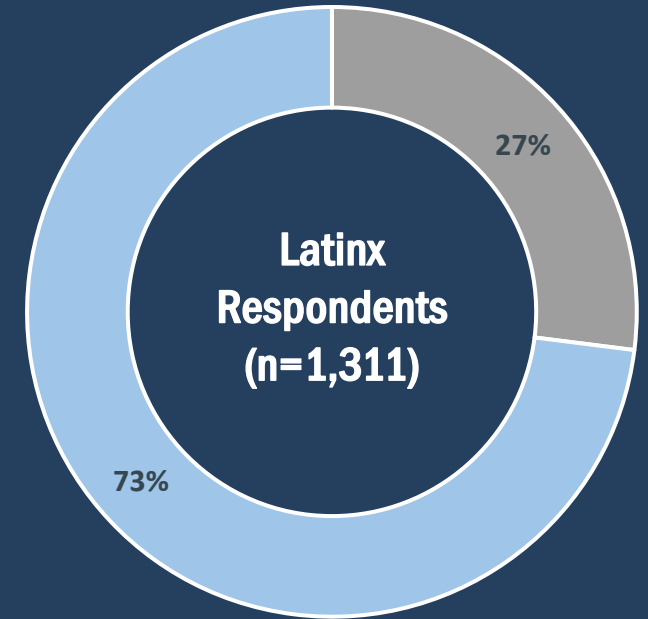
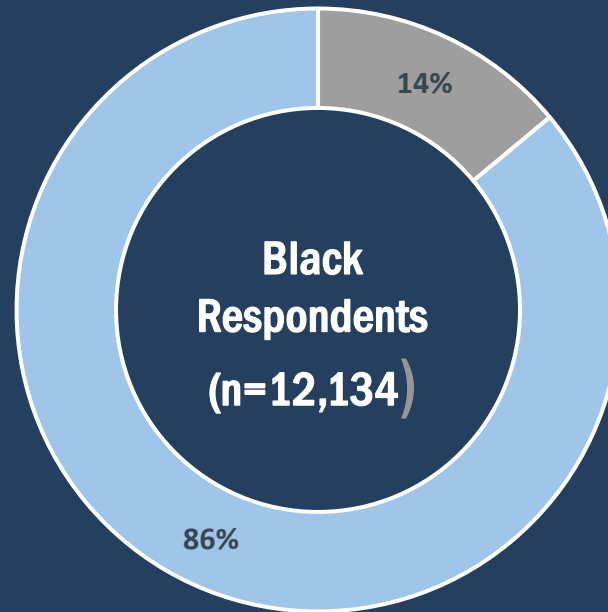
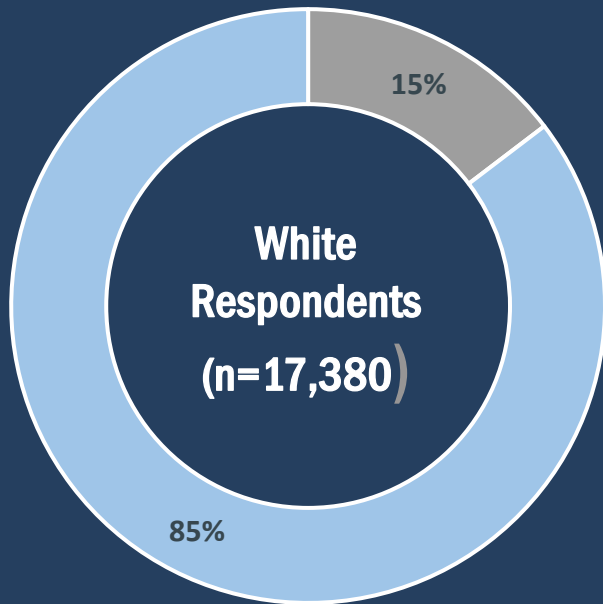
# No Health Insurance Coverage, by Region

## RESPONDENTS (%) WITH NO HEALTH INSURANCE BY REGION



\* statistical significance at the  $p = 0.05$  level

# Health Insurance Coverage, by Race/Ethnicity



■ No Health Insurance    ■ Health Insurance

# 12. Interpersonal Safety

How often does anyone, including family, insult or talk down to you?

(n=298,063)

**9.2%**

Indicated a serious enough threat of harm  
(next question)

How often does anyone, including family, physically hurt you?

(n=1,851)

**24.9%**

Indicated a serious enough frequency of physical harm  
(next question)

Are you in a safe place?

(n=315)

**25.4%**

Indicated that they were not in a safe place

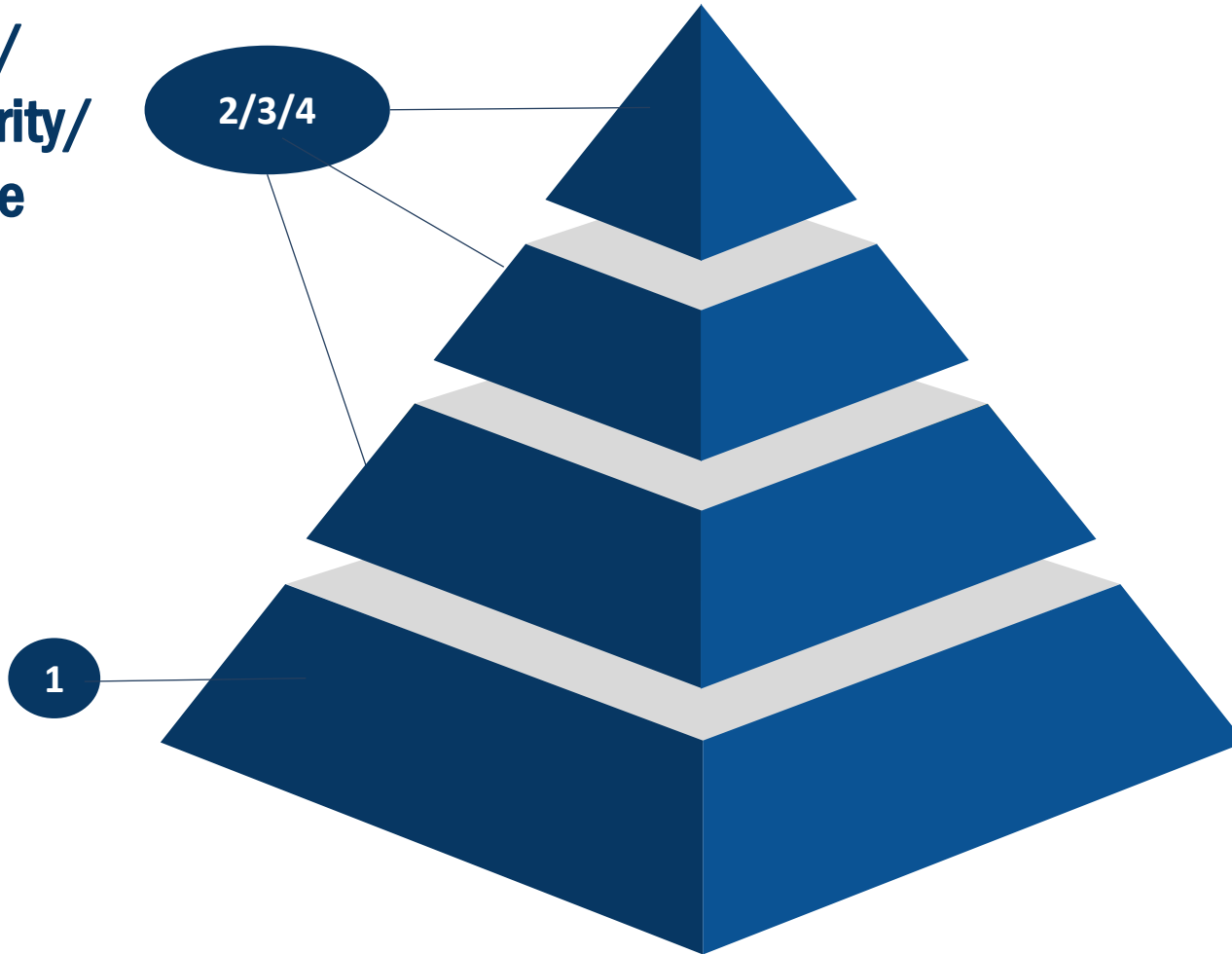




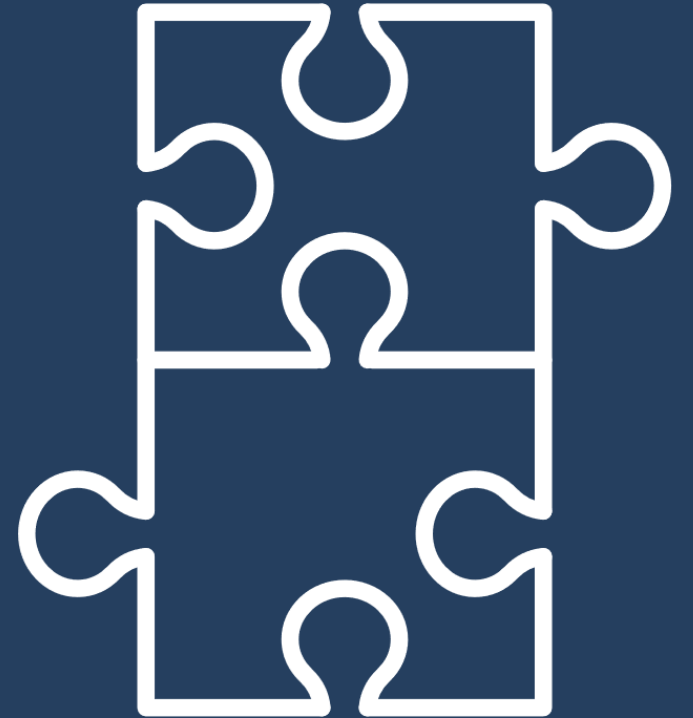
# SDOH Tiering: Regions 6, 7, and 8

**Housing Instability/  
Transportation Insecurity/  
No health insurance**

**Food Insecurity**



# Data Synthesis & Prioritization



# Delphi Method

- ▶ Provides a **structure for prioritizing** needs/barriers.
- ▶ Based on the principle that **expert groups** can make better decisions than individuals when there is a structured decision-making process in place.
- ▶ To facilitate the transition to the Title V action planning process, the Delphi method will focus on the **Title V populations.**



# Delphi Method

- ▶ Each team member was provided **fact sheets** for a Title V population domain that presented all data collected throughout the Needs Assessment.
- ▶ Data in these summaries included:
  - Partner survey
  - Focus groups
  - State-wide survey
  - Epidemiological data
  - IDOH internal data
  - External partner data

## Selected Review Criteria



**Magnitude**

*Extent of need*



**Trend**

*Pattern over time*



**Health and Racial Equity**

*Extent of disparities*

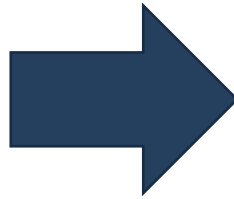


**Organizational Capacity**

*Staff capacity to carry out work*

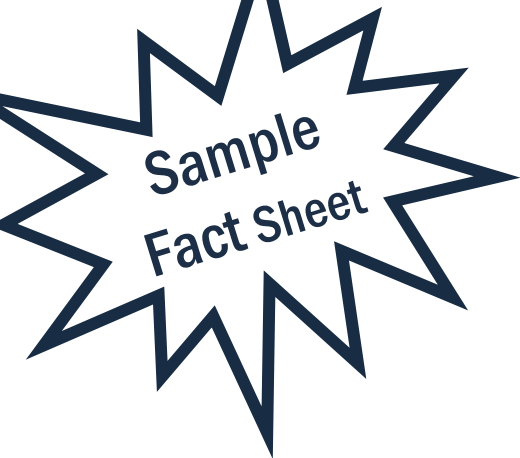
# Delphi (cont.)

- ▶ Team members individually reviewed the fact sheets and ranked each need using the four selected criteria.
- ▶ DCG **compiled and shared results** from Phase 1.
- ▶ In Phase 2, team members rated needs based on priority level (high priority to low priority).



# Additional Meetings

- ▶ **Steering Committee:**
  - Narrowed down priorities for each population
- ▶ **Workforce Development Cohort:**
  - Reviewed notes
  - Brainstorm: Results-Based Accountability Tools
- ▶ **MCH, CSHCS, FRP, TIP, and DNPA:**
  - Selected final national performance measures and state performance measures
  - Created goals and strategies and how to measure each one



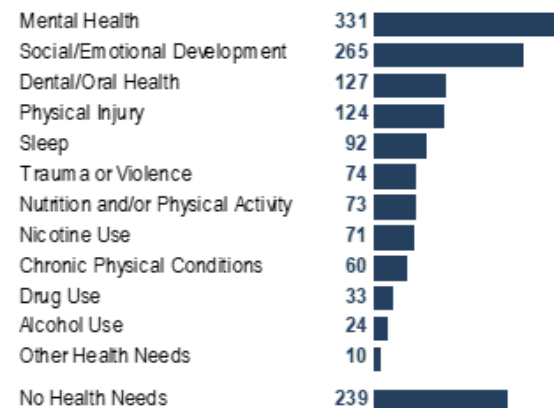
# Adolescent

Definition: In the Statewide Survey, adolescents were defined as individuals 13-21 years old. Age ranges for adolescents will vary depending on the data source.

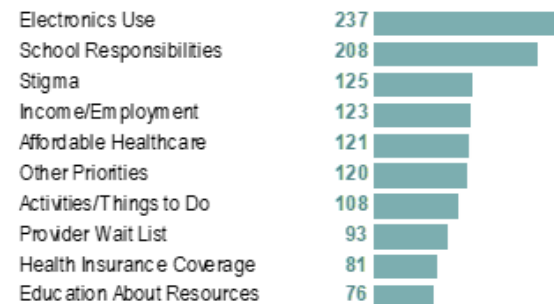
## Statewide Survey

### Needs

Out of 852 responses, parents/caregivers shared that the following were needs for their adolescent:



### Barriers



### Resources



## Facts & Focus Groups

### Needs from Secondary Data



20% of high school students seriously considered attempting suicide (during the 12 months before the YRBS 2015 survey).



16% of high school students were electronically bullied during the 12 months before the YRBS 2015 survey. This percent is greater for girls; 21% of high school girls reported being electronically bullied, with the highest percent of bullying taking place in 9<sup>th</sup> grade (23%).



14% of high school students are obese ( $\geq$  95<sup>th</sup> percentile for body mass index), and an additional 17% of high school students are considered overweight ( $\geq$  85<sup>th</sup> percentile and  $<$  95<sup>th</sup>) (YRBS 2015).



44% of high school students have used an electronic vapor product (e.g., e-cigarette), and 24% of students were currently using electronic vapor products (on at least 1 day during the 30 days before the YRBS 2015 survey). This rate is higher than the percent of students who were currently smoking cigarettes (11%).

### Barriers from Focus Groups

Adolescents shared that their top barriers included limited access to healthy food, needing to focus on school responsibilities, and their own personal choices (e.g., choosing to stay up late on their electronic devices).

*"All of the restaurants here are fast food except for Subway."*

*"You have 8 classes, and so homework keeps piling up."*

*"A lot of kids are addicted to their phones, and so it's a lot harder for them to rest."*

### Resources from Focus Groups

Adolescents identified their connection to their school (e.g., classes, afterschool programs) as a top resource.

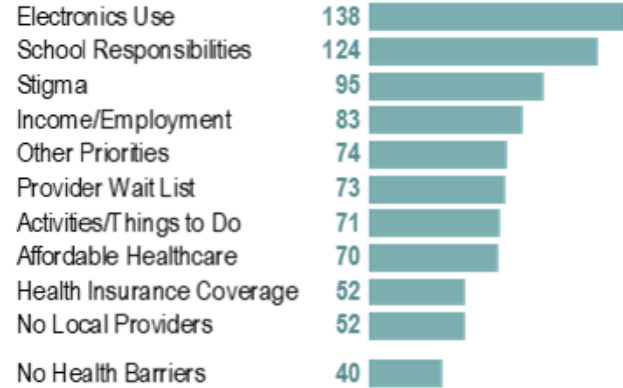
*"I'm in band, so we're a very small family there. We help each other out. We have a leadership team. We care about the other people that are in our band."*



# Mental Health

Definition: Mental health needs, including depression, anxiety, or other conditions.

## Statewide Survey: Mental Health Barriers



## Focus Group Quotes

"A lot of us are under a lot of stress. We have to worry about sports, work, families, school. A lot of us worry about school more than we should." – **Mental Health**

"I always try to be there for my friends. If I notice they're down I'm like hey, we can talk about this if you want to, but if not just know I'm here when you want to." – **Mental Health**

"I think the biggest one for me is school. I think school's overwhelming sometimes." – **Barrier: School Responsibilities**

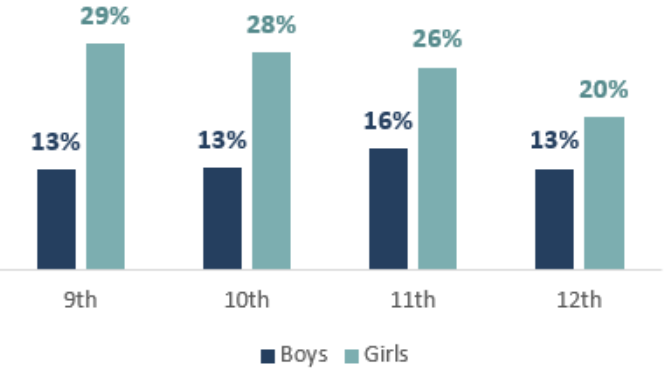
"I feel like a lot of the kids are scared to speak up about [what they need]. In today's generation when you talk about your feelings, people don't actually take into consideration that you have feelings. A lot of people just like to thug it out, but you can't just ignore the fact that you're bothered." – **Barrier: Stigma**

Note: These are the top barriers for respondents that included Mental Health as a need/challenge. Barriers are not exclusive to Mental Health.

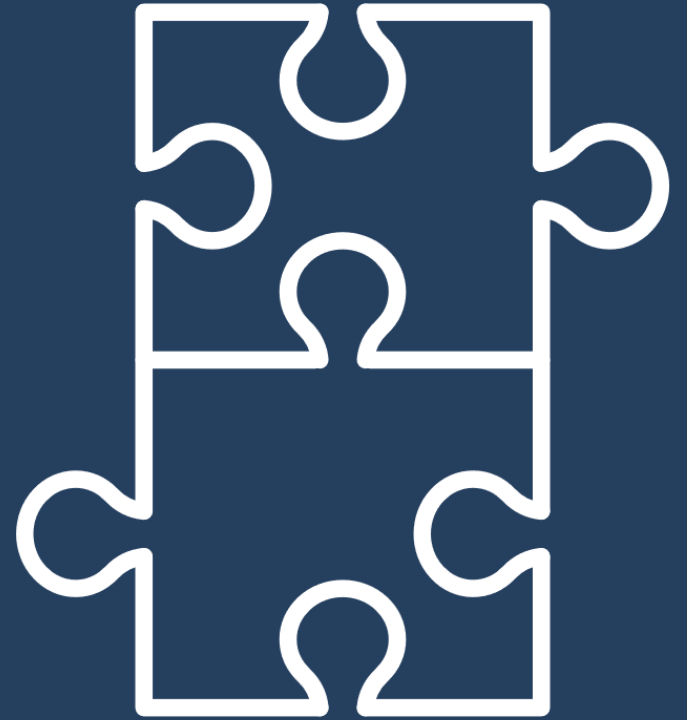
## Quick Facts

- 29%** Of high school students reported feeling sad or hopeless almost every day for two or more weeks in a row (YRBS 2015).
- 39%** Of high school girls reported feeling sad or hopeless almost every day for two or more weeks in a row (YRBS 2015).
- 20%** Of high school students seriously considered attempting suicide (during the 12 months before the YRBS 2015 survey).
- 17%** Of high school students made a plan about how they would attempt suicide (during the 12 months before the YRBS 2015 survey).
- 10%** Of high school students attempted suicide one more more times (during the 12 months before the YRBS 2015 survey).

A larger percent of **high school girls** seriously considered attempting suicide (in the 12 months before the survey) compared to **high school boys**.



# Annual Application



# Title V Requirements

## ► State Priorities (7-10 total)

- *Broad goals and overarching themes*

## ► National Performance Measures

*(1 per population domain)*

- *Evidence-based Strategy Measures (ESMs) must support and provide additional ways to measure progress of NPMs; this allows us some flexibility for these broad categories.*
- *Each NPM belongs to a predesignated population health domain.*

## ► State Performance Measures

*(freedom to create if needed)*



NPM	Description
1	Well-Woman Visit
2	Low-Risk Cesarean Delivery
3	Risk-Appropriate Perinatal Care
4	Breastfeeding
5	Safe Sleep
6	Developmental Screening
7.1/7.2	Injury Hospitalization (0-9 & 10-19)
8.1/8.2	Physical Activity (6-11 & 12 -17)
9	Bullying
10	Adolescent Well-Visit
11	Medical Home
12	Transition
13.1/13.2	Preventive Dental Visits (pregnancy & child)
14.1/14.2	Smoking (pregnancy & household)
15	Adequate Insurance

# Noteworthy

- ▶ **Priorities/NPMs/SPMs stay in place from 2020-2025.**
- ▶ **Strategies, the work we do, and how we do it can change during this time period.**
- ▶ **We will continue to assess the needs of Indiana's MCH population instead of waiting until 2024.**



**IN IT TOGETHER**

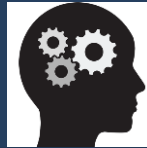
Indiana Title V Needs Assessment

# Indiana Priorities: 2020 – 2025

**Reduce Preventable Deaths** in the MCH population with a focus on reduction and elimination of inequities in mortality rates



**Strengthen Mental, Social, and Emotional Wellbeing** through partnerships and programs that build capacity and reduce stigma



**Promote Physical Activity** through policy improvements and changes to the built environment



**Access to High-quality, Family-centered, Trusted Care** is available to all Hoosiers



**Prevent Substance Use** including alcohol, tobacco, and other drugs among pregnant women and youth



**Engage Families and Youth** with diverse life experiences to inform and improve MCH services



**Reduce Health Disparities and Inequities** in internal programs, policies, and practices to improve maternal and child health



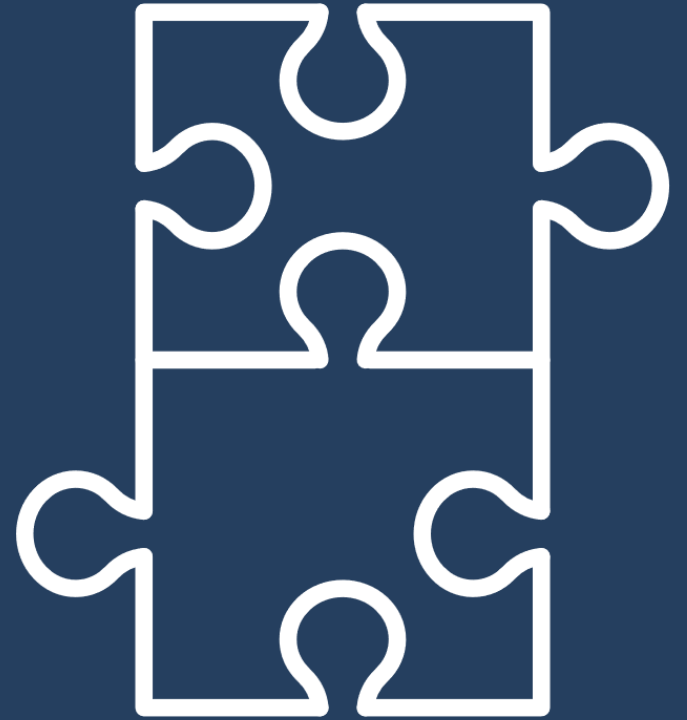
**Ensure Frequent Surveillance, Assessment, and Evaluation** of data drives funding, programming, and system change





# State Priority Measures

*by population domain*



**Women/Maternal**

## **NPM 1: Well-Woman visit**

- **PRAMS participation**
- **Postpartum care**
- **Home-visiting/ OB Navigation**

## **SPM1: Reduce maternal mortality and disparities**

- **AIM bundle implementation**
- **MMRC findings**
- **Implicit bias training/analysis**

## **SPM2: Prevent substance use among pregnant women**

- **PSU hospital collaborative**
- **Plans of safe care**
- **Tobacco cessation programs**
- **Alcohol screening**

**Perinatal/Infant**

## **NPM 3: Risk-appropriate Perinatal Care**

- **LBW/Pre-term birth**
- **Levels of care**
- **Perinatal centers**

## **SPM3: Reduce disparities in infant mortality**

- **Fetal Infant Mortality review (FIMR)**
- **Breastfeeding**
- **Safe sleep**
- **Group prenatal care**

**Children**

## **NPM 7.1: Nonfatal injury hospitalization, ages 0-9**

- **Child Fatality Review (CFR)**
- **Car seat safety**

## **NPM 8.1: Physical activity, ages 6-11**

- **School policies and staff training**
- **CATCH curriculum**
- **Youth and Physical Activity Grant**
- **Tactical urbanism/built environment**
- **Active Living Workshops**

## **SPM 5: Promotion of optimal health, development, and wellbeing**

- **System building and coordination**
- **Increase marketing and education materials**
- **NBS materials and training**
- **Oral health care improvement**

# **Children with Special Health Care Needs**



**NPM 11: Medical home,  
ages 0-17**

- **Care coordination**
- **Newborn screening follow-up care**

**NPM 12: Transition to adult  
health care,  
ages 12-17**

- **Provider training**
- **School-based clinic coordination for future planning**

**SPM 5: Promotion of optimal  
health, development, and  
wellbeing**

- **System building and coordination**
- **Increase marketing and education materials**
- **NBS materials and training**
- **Oral health care improvement**

**Teen / Young Adult**

**NPM 7.2: Nonfatal injury hospitalization, ages 10-19**

- YRBS data
- Youth suicide prevention
- Depression screenings

**NPM 8.2: Physical activity, ages 12-17**

- School policies and staff training
- Tactical urbanism/built environment

**NPM 10: Adolescent well visit**

- Adolescent Champion Model
- Teen-friendly health clinics/medical home

**SPM 4: Positive youth development**

- Youth advisory board
- LifeSkills and Teen Café Model

# Cross-Cutting

# Collaboration Required

**Strengthen mental, social, & emotional health to build capacity & reduce stigma**

**MCH data are used and shared to inform MCH programming at the state and for partners**

**Engage family & youth voices to share a diverse perspective & experience**

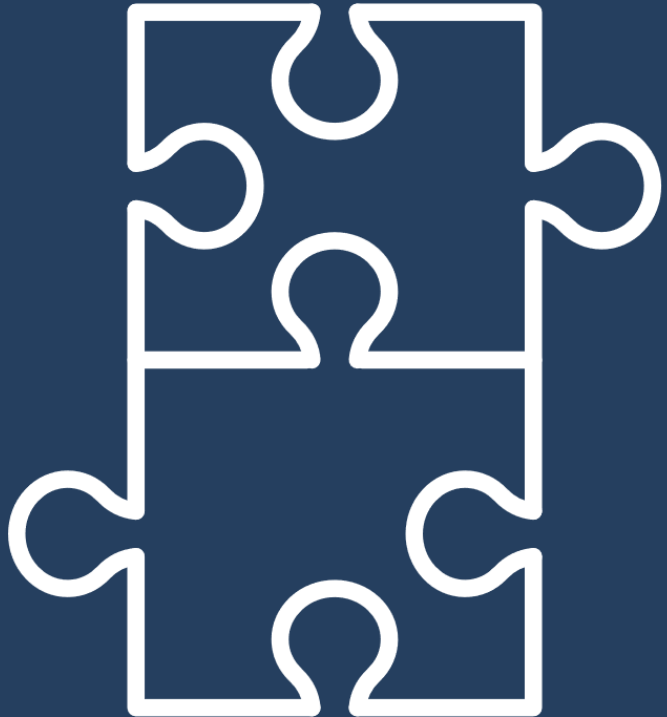
**Reduce health disparities in internal programs, policies, & practices to improve maternal & child health**

*Of note:*

*All cross-cutting measures were selected due to need and our commitment to collaboration with others to positively impact the health of Hoosier families.*



# Next Steps



# Stay Engaged:

## ▶ Next week:

- Slides, recording, & fact sheets online
- <https://www.in.gov/isdh/28508.htm>

## ▶ Public Input Survey

- Open for your comments next week
- <https://forms.office.com/Pages/ResponsePage.aspx?id=ur-ZIQmkE0-wxBi0WTPYjYpdIsEQF-RDngu4JrnJNIIUMVc3Mks1NTUwREdLTVBFMDIWRUVWRUxaWS4u>

## ▶ Cross Cutting Collaboration

- Mental health, data sharing, family engagement, & racial equity sign up options
- <https://www.signupgenius.com/go/60B044AA9AD29A5F58-title>

# **Future Funding Opportunity Announcement**

- ▶ **Save the Date: NOFO Webinar**
  - **Tuesday, February 16, 2021 11 am – 12 pm EST**
- ▶ **Initial proposals: March 2021**
- ▶ **Proposal presentations: April 2021**
- ▶ **Funding will start October 2021**





## **IN IT TOGETHER**

Indiana Title V Needs Assessment

# Questions?

Indiana's Title V  
Block Grant & Needs Assessment

**Kate Schedel**

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