

Executive Summary

Purpose

Each year, the Ohio Department of Health (ODH) receives significant funding from the federal Title V Maternal and Child Health (MCH) Services Block Grant. The overriding goal of the MCH Block Grant is to improve the health status of women of childbearing age, infants, and children, including children with special health care needs (CSHCN). In Ohio, the Department of Health (ODH) is the designated state agency responsible for Title V Programs. Within ODH, the Division of Family and Community Health Services (DFCHS) administers programs funded by the MCH Block Grant. Every five years, the Division is required to assess the health needs of the MCH population served by these programs; the MCH Block Grant Application submitted in July 2010 will fulfill this requirement. The needs assessment is the foundation for developing a state MCH plan.

This executive summary

- outlines the needs assessment process,
- identifies the nine critical priorities,
- highlights the ten state performance measures,
- provides an overview of Ohio's Capacity to provide preventive and primary care services, and
- links the nine critical priorities to MCH programs.

Needs Assessment Process

During October-December 2008, ODH convened four day-long meetings to engage stakeholders in discussions around the prioritized health issues within four maternal and child health areas of concern; early childhood (10/31/2008); school-age, adolescents and young adults (11/10/2008); children with special healthcare needs (11/12/2008); and women's health, birth outcomes and newborn health (12/16/2008). Adam Negley, a staff member in the Office of Workforce Development, within The Ohio State University's College of Public Health facilitated the four sessions. Each session included participants from across the State of Ohio representing state agencies, foundations; insurance providers, professional organizations, local public health agencies, and others affiliated organizations. The product from each group discussion was an agreed upon list of prioritized health issues for the sub-population being discussed.

Participants: a broad group of consumers, family members, stakeholders and professionals from across Ohio participated in the needs assessment process. In addition, ODH obtained feedback and input from the Governor's Cabinet and legislators that helped inform the focus groups. Participants were categorized as follows:

1. **Consumers and Family Members:** Through surveys, focus groups, other departmental program needs assessments, consumers were able to express their views on unmet health care needs. The focus groups were composed of adolescents and parents of children from birth to age 14, including CSHCN. Members from the [Parent Advisory Committee \(PAC\)](#) which is composed of parents from

around the state who meet regularly to advise the Bureau for Children with Medical Handicaps (BCMh) regarding care for children with special health care needs were participants. The PAC is chaired by the BCMh employed parent advocate, who is also a parent of a child with special health care needs. The **Young Adult Advisory Committee** composed of youths aged 16 to 24 who are receiving or have received BCMh services offered input into the process. The mission of the YAAC is to advise BCMh of issues facing youth as they transition into adult medical and social services. Key informants and consumers were the primary sources of qualitative data.

2. **ODH Staff and Leadership:** DFCHS formed an internal committee to plan and guide the needs assessment process. This committee consists of ODH staff from within DFCHS and from ODH non-MCH-related programs. Utilizing a voting process, DFCHS Leadership collaboratively selected the final 9 critical priorities.
3. **MCH Council:** Members of the MCH Council, which is an outside advisory committee, served as resources during the process. Representatives from state agencies, foundations, insurance providers, professional organizations, local public health agencies, and other affiliated organizations sit on the council. They also have been instrumental in the important task of prioritizing the health needs; this prioritization drives the objectives for the state plan for the next five years. Members from the [Medical Advisory Council \(MAC\)](#) were participants in the stakeholder groups. MAC sits within BCMh and consists of 21 members appointed by the director of Health. The members represent various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions.
4. **Interested Agencies and Organizations:** Representatives from non-ODH agencies and organizations provided input into the development of a Data Collection Plan. In addition representatives from other state agencies were participants in the focus group process.
5. **Key Informants:** Key informants (local health commissioners, members of the Governor's Cabinet, and legislators) were interviewed to ascertain their opinions on the most pressing health issues for citizens. Key informants and consumers were the primary sources of qualitative data.

Data: The internal committee determined that qualitative as well as quantitative data were needed to assess the health needs of the MCH population. The data items needed and the sources of the data were compiled into a Data Collection Plan. During Phase 1 of the stakeholder engagement process, both quantitative and qualitative data was compiled by sub population. For each sub population, available quantitative data was summarized on data summary sheets. Participants were also provided with a variety of fact sheets that were intended to more fully inform them about many of the issues listed on the data summary sheets.

In addition, participants were provided with a qualitative summary of suggested health care needs provided by Key Informants, Consumers and Family Members, that were surveyed by ODH prior to beginning the needs assessment focus groups. Lastly, meeting participants were provided with a list of external data sources that they could use to determine priorities. Examples include: Ohio Child Fatality

Review Reports, ODH Data Warehouse, 2003 National Survey of Children's Health – Ohio, and the Ohio Family Health Survey.

As indicated above, fact sheets were used to more fully inform participants and were created by sub-population. Based on the sub-population there were anywhere from 16 to 32 fact sheets created per sub-population. The fact sheets highlighted data around the following issues:

- **Early Childhood** (access, asthma, breastfeeding at 6 months, child mortality, insurance status, hearing, immunizations, infant mortality rate, etc.) For this population there were a total of 22 fact sheets shared.
- **School-aged Children, Adolescents and Young Adults** (access to care, birth spacing, violence: harassment or bullying on school property, Chlamydia, child mortality ages 4-12 and 5-9, oral health/dental care, positive youth development, type 2 diabetes, deaths caused by motor vehicle crashes, suicide deaths, etc.) For this population there were a total of 28 fact sheets shared.
- **Children with Special Health Care Needs** (asthma, insurance status, hearing, medical homes, development of birth defects information system in OH, genetic services, etc.). For this population there were a total of 16 fact sheets shared.
- **Women's Health, Birth Outcomes, Newborn Health** (access, prenatal alcohol use, contraception, domestic violence/intimate partner violence, fertility and birth rate, access to family planning services, infant mortality rate, Medicaid and non-Medicaid comparison, obesity, preterm birth, unintended pregnancy, etc.). For this population there were a total of 32 fact sheets shared.

The Needs Assessment process began in November of 2008 and Fact Sheets were drafted for presentation prior to the beginning of focus groups. In order to create the fact sheet, data that was currently available was used; this data does not represent the most current that was submitted in the final Needs Assessment documents. **An example of a "Fact Sheet" can be found on the next page.**



Ohio MCH Fact Sheet

Women's Health, Birth Outcomes, Newborn Health

Infant Mortality* Rate

MCH Block Grant National Outcome Measure

Key Data Summary – Ohio

- In 2006, the overall infant mortality rate in Ohio was 7.8 per 1,000 live births, as shown in the first graph.
- The white infant mortality rate was 6.1 per 1,000 live births in 2006, compared with the black infant mortality rate of 16.7 per 1,000 live births, as shown in the first and second graphs.
- In 2006, the black infant mortality rate was 2.7 times greater than the white infant mortality rate, and 2.1 times greater than the overall infant mortality rate, as shown in the second graph.
- Infant mortality rates are highest among women who give birth between ages 15 and 19 than they are for older women, as shown in the third graph.

Healthy People 2010 Objective 16-1c

- Reduce all infant deaths (within 1 year) to 4.5 per 1,000 live births.

U.S./Ohio Comparison – 2006

- In 2006, the overall infant mortality rate (7.8 per 1,000) in Ohio was higher than the U.S. infant mortality rate (6.7 per 1,000).
- In the United States, as in Ohio, the rate of infant mortality in black infants is higher than any other race.

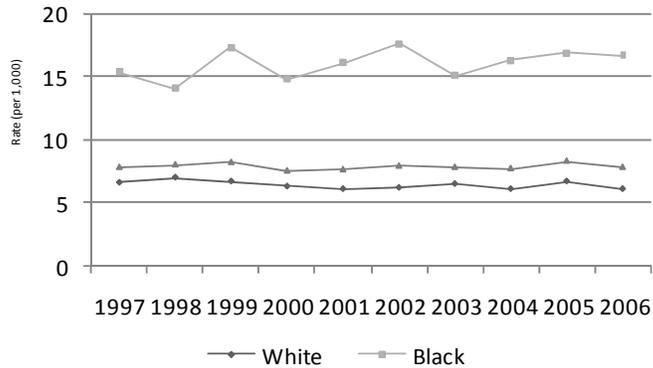
Additional Information

- The top three causes of infant mortality are the same in Ohio as they are for the nation:
 1. Congenital anomalies
 2. Prematurity/low birth weight
 3. Sudden infant death syndrome (SIDS)

Source: Ohio Department of Health Vital Statistics

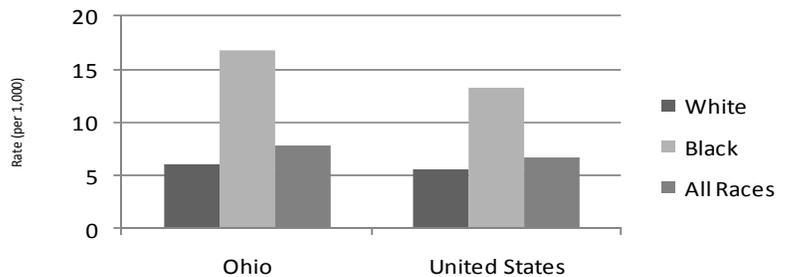
- Infant mortality is used to compare the health and well-being of populations within and across countries.

Infant Mortality Rate per 1,000, by Race Ohio



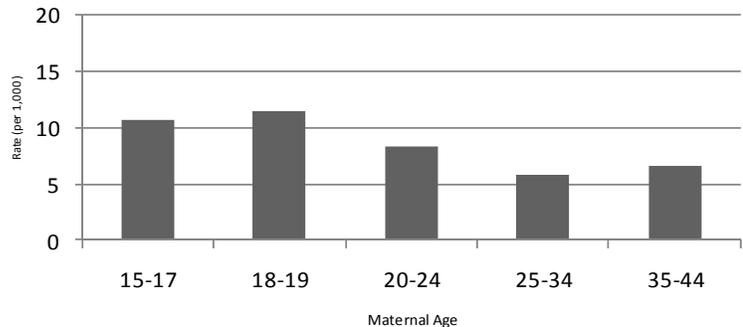
Source: Ohio Department of Health Vital Statistics

Infant Mortality Rate, by Race, 2006



Source: Ohio Department of Health Vital Statistics and National Vital Statistics

Infant Mortality Rate, by Mother's Age, Ohio, 2004



Source: Ohio Department of Health Vital Statistics

*Infant mortality is the death of an infant less than 1 year of age.

Prioritization Methods: In order to arrive at the final nine MCH Priorities, several layers of prioritization occurred. The first layer occurred during Phase I of the Needs Assessment process when participants were asked to individually prioritize a dashboard of suggested MCH health care needs, generated from feedback from the Key Informants and Consumer/Family member survey process. A method called Q-Sort, a technique used for identifying priorities among competing needs, by sorting needs into groups of the most important to the least important was used.

The Q-sort priority setting method allows nine levels of priority. Each individual ranked the issues or indicators of need using this procedure and then all the results were averaged to identify where there was consensus and where there was disagreement. For Phase **1** of the needs assessment process each participant had a list of health issues specific to their MCH Population Group and each health care issue was numbered. Participants were asked to sort each indicator or “need” by priority level and record the number of each need on their Priority Log Sheet. To assist in deciding the level of priority, participants were asked to use the following criteria (or others of their choosing) for each issue/indicator:

- **Impact or Importance** of the issue
 - Size of the problem: Number of people affected; prevalence rates
 - Seriousness of the problem: Effect on morbidity and mortality
 - Size of the discrepancy between what the current status is and what “ought to be”, per standards, national goals, etc.
 - Degree to which the issue is a national and/or state priority
 - Economic impact of the problem
 - Extent that the resolution of a need in this particular area would have a positive effect on a need in another area
 - Community perception of the problem
 - Extent to which there are disparities among populations

Once participants sorted their indicators into priority levels and recorded them (by number) on a log sheet, they were mailed to ODH. ODH staff scored each need/indicator, and generated a mean score for each need. Needs with good agreement were set aside as high, medium, or low. At the conclusion of the scoring process a list of 10 to 15 needs per sub-population was generated. The needs that merited discussion during Phase II were those for which there was **not** good agreement. Phase II was done face to face in a group setting with each member having unique expertise, perspectives and passions concerning maternal and child health at the state or local community level.

The second layer of prioritization occurred during Phase II of the needs assessment process. Each sub-population group was asked to conduct a “Root Cause Analysis” on each of the 10 to 25 identified needs for that population using the following criteria:

- Utilize broad thinking about why a problem is a problem
- Identify contributing factors at various levels
- Use data to verify opinions
- Ask “why” until you can’t ask anymore
- End product: an understanding of the root causes of a problem, “identified health care need”
- Finally, based on the root causes, what interventions can be implemented

After interventions were identified, overall themes were discussed and the top five issues for each sub-population were reprioritized. During Phase II, several groups were combined for efficiency and standardization purposes; the Early Childhood and School-aged Children, Adolescents and Young Adults groups were combined; the Women’s Health, Birth Outcomes, Newborn Health group were combined with the Ohio Task Force on Infant Mortality, since the two groups were addressing similar issues. Below is a list of the final prioritized issues by sub-population group.

Top Health Needs of the MCH Population by Sub-Population

Early Childhood/School-aged Children, Adolescents and Young Adults:

1. Increase access to adequate and culturally appropriate prevention, early identification and treatment services,
2. Prevent unsafe behaviors such as substance use, risky sexual behaviors, violence and the behaviors most likely to cause intentional and unintentional injuries and illness,
3. Provide family-centered services and education to support child/family health and wellbeing,
4. Recognize and reduce the negative impact of social determinants of child and adolescent health,
5. Reduce environmental exposures that contribute to chronic illness, injury and disability.

Children with Special Health Care Needs:

1. Increase the number of standardized medical homes for children with special health care needs,
2. Increase capacity for the medical home to screen, diagnose and access comprehensive medical and non-medical specialty services through the use of evidence based tools,
3. Provide families with the support and networks they need to participate in all aspects of family care,
4. Enhance the system of reimbursement for basic primary care services, and provide incentives for innovative service delivery,
5. Improve capacity to collect and utilize available CSHCN data to drive future decision making.

Women's Health, Birth Outcomes, Newborn Health/Ohio Infant Mortality Task Force:

1. Provide comprehensive reproductive health services and service coordination for all women and children before, during and after pregnancy,
2. Eliminate health disparities and promote health equity to reduce infant mortality,
3. Expand quality improvement initiatives to make measurable improvements in maternal and child health outcomes,
4. Increase public awareness on the effects of preconception health on birth outcomes,
5. Implement health promotion and education to reduce preterm birth.

The third and final layer of prioritization occurred in the fall of 2009, with the Title V leadership reviewing the prioritized issues from the population groups and using those as a starting point in identifying the top ten priority issues for the Ohio MCH program for the coming five years. DFCHS Leadership engaged Bobbie Erlwein, CDC's assignee to Ohio as a Senior Management Official. Her expert facilitation skills and broad knowledge of public health was a perfect match for this next phase of work. Ms. Erlwein guided the leadership through a process to consider other assessment and planning work that had taken place since the last needs assessment (e.g., Director's Task Force on Oral Health, Ohio's Obesity Prevention Plan, Anti-Poverty Task Force, Ohio Health Care Coverage and Quality Initiative) in addition to the recommended priorities from stakeholders, including families.

The leadership further considered the recent successes in the MCH programs, the systems and political challenges that face us in the coming years, and reviewed the updated data regarding the status of the MCH populations at the time. A voting process was utilized to prioritize the 15 top health care needs submitted from the population groups, and those that were identified as the most critical health needs were selected. The facilitation and voting process for this phase of the needs assessment resulted in the identification of 9 priority needs of the MCH population. Those included:

- Increase physical activity and improve nutrition,
- Increase breastfeeding initiation and duration rates,
- Improve early childhood development,
- Decrease rate of smoking for pregnant women, young women and parents,
- Increase the viability of the health care safety net,
- Increase the number of women, children and adolescents with a health home,
- Increase access to evidence based community prevention programs,
- Increase successful transition of special needs children from pediatric/adolescent to adult health care systems,
- Improve the availability of useful and accurate health care data and information (this relates to quality and capacity).

Throughout the needs assessment process, whether it was with population groups, facilitated by Adam Negley, or Leadership sessions facilitated by Bobbie Erlwein, participants considered the breadth and depth of the health issue, the severity of the impact, the potential for affecting the issue, the related political concerns, in their discussions of the health needs of Ohio. Having successfully accomplished this task, Ohio is ready to engage in a planning and implementation process to advance our commitment to meeting the needs of the MCH population, through its Title V programs.

Impact and Monitoring

One of the final steps in drafting the five years Needs Assessment was determining the ten performance measures that would help measure progress in addressing the priorities. The Leadership team accepted responsibility for this task by reviewing the definition sheets for the current state performance measures, and assessing ODH's progress or outstanding issues related to each one. Based on that feedback, and review of the nine critical priorities a decision was made whether or not a past performance measure would be carried forward for consideration in the next 5 year grant period. Those that had been successfully completed and/or were incorporated into other work were dropped, and additional measures were selected. The outcome of that process is outlined below:

MCH State Performance Measures FFY 2006 – 2010

Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes – to continue
Percent of low birth weight black births among all live black births – to continue
Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services – will not continue
Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions – to continue
Percent of 3rd graders who are overweight – to continue
Increase the State's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services – will not continue
Percentage of 3rd grade children with untreated caries – to continue
Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System – will be revised
Increase the proportion of children who receive age-and risk-appropriate screenings for lead, vision, and hearing – will be revised
Integrate ODH Maternal and Child Health Information Systems - will not continue

The 10 FFY 2011 – 2015 MCH State Performance Measures Selected Were:

1. Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.
2. Percentage of low birth weight black births among all live black births.

3. Percent of local health departments that provide health education and/or health services in schools.
4. Degree to which DFCHS programs can incorporate and evaluate culturally appropriate activities and interventions
5. Percent of 3rd graders who are overweight.
6. Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health effects.
7. Percent of 3rd graders with untreated caries.
8. Adolescent deaths (age 10-24) due to intentional and unintentional injuries.
9. Maintenance/enhancement of Ohio Connections for Children with Special Needs (OCCSN) BDIS (birth defect registry) to improve utilization of data of surveillance, referrals to services and prevention activities.
10. Percent of children who receive timely, age-appropriate screening and referral.

To finalize the priorities and state performance measures a cross walk between the selected priorities, national performance measures, state performance measures, state and national outcomes measures, the health systems capacity indicators and health status indicators, was conducted to verify that the priorities were in alignment and could be measured. The crosswalk exercise appears below:

Categories/Priorities	NPM	**SPM	NOM	SOM	HSCI	HSI
A. Improve the health of children and adolescents (e.g., obesity, STD, oral health, decreasing deaths, improving health outcomes).	1-14, 16-18	3-5, 7,8	1-6	1	2,3,7A, 7B,8	1A-4C
1. Increase physical activity and improve nutrition	14	3				
2. Increase breastfeeding initiation and duration rates	11					
3. Improve early childhood development	1,3,12	4, 10				
B. Increase positive pregnancy outcomes and preconception health (e.g., decrease infant mortality and decrease premature births).	8,15,17, 18	1, 2, 6, 9, 10			4	5A,5B
4. Decrease rate of smoking for pregnant women, young women and parents	15	6				
C. System Improvement	3,6	9				
5. Increase the viability of the health care safety net	7, 14	3,4,7				
6. Increase the number of women, children and adolescents with a health home	3					
7. Increase access to evidence based community prevention programs	9	6				
8. Increase successful transition of special needs children from pediatric/adolescent to adult health care systems	6					
9. Improve the availability of useful and accurate health care data and information (this relates to quality and capacity)		6, 9				
Blue shading – Identifies the nine (9) MCH Critical Priorities. *Note 1 – 9 are not ranked in any specific order of importance within and/or among Categories.						
NPM – National Performance Measure						
**SPM – State Performance Measure (represents FFY11 SPM reported in BG)						
NOM – National Outcome Measure (reported in BG)						
SOM – State Outcome Measure (reported in BG)						
HSCI – Health Systems Capacity Indicator (reported in BG)						
HSI – Health Status Indicator (reported in BG)						

A complete list of the NPM’s, NOM’s, SOM, HSCI’s and HIS’s can be found on the following pages.

National Performance Measures (NPM)

1. The percent of screen positive newborns who received timely follow-up to a definitive diagnosis & clinical management for condition(s) mandated by their State-sponsored newborn screening program.

2. The percent of children with special health care needs age 0-18 years whose family's partner in decision making at all levels and are satisfied with the services they receive (CSHCN Survey).
3. The percent of children with special health care needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey).
4. The percent of children with special health care needs age 0-18 whose families have adequate private and/or public insurance to pay for the services they need (CSHCN Survey).
5. Percent of children with special health care needs age 0-18 whose families report the community-based service systems are organized so they can use them easily (CSHCN Survey).
6. The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.
7. Percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 1-14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percent of mothers who breastfeed their infants at 6 months of age.
12. Percentage of newborns that have been screened for hearing before hospital discharge.
13. Percent of children without insurance.
14. Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
15. Percentage of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

National Outcome Measures

The Infant mortality rate per 1,000 live births.
The ratio of the black infant mortality rate to the white infant mortality rate.
The neonatal mortality rate per 1,000 live births.
The post-neonatal mortality rate per 1,000 live births.
The perinatal mortality rate per 1,000 live births plus fetal deaths.
The child death rate per 100,000 children aged 1 through 14.

State Outcome Measures

The adolescent death rate per 100,000 adolescents aged 15-19 years.

Health Systems Capacity Indicators

1	The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 - 493.9) per 10,000 children less than five years of age.
2	The percent Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening.
3	The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
4	The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
5	Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State
6	The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.
6	The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.
7A	Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
7B	The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.
8	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.
09A	General MCH Data Capacity (The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)
09B	Data Capacity - Adolescent Tobacco Use (The Percent of Adolescents in Grade 9 through 12 who Reported Using Tobacco Products in the Past Month)

Health Status Indicators

01A	The percent of live births weighing less than 2,500 grams.
01B	The percent of live singleton births weighing less than 2,500 grams.
02A	The percent of live births weighing less than 1,500 grams.
02B	The percent of live singleton births weighing less than 1,500 grams.
03A	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
03B	The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
03C	The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.
04A	The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
04B	The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
04C	The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
05A	The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.
05B	The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

06A	Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race (Demographics)
06B	Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity (Demographics)
07A	Live births to women (of all ages) enumerated by maternal age and race. (Demographics)
07B	Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)
08A	Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)
08B	Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)
09A	Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)
09B	Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)
10	Geographic living area for all resident children aged 0 through 19 years old. (Demographics)
11	Percent of the State population at various levels of the federal poverty level. (Demographics)
12	Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)

Preventive and Primary Care Services Capacity

Ohio is pleased with the outcomes of the Needs Assessment process and excited about the direction it's heading in regards to MCH programs over the next five years. As plans progress for addressing the MCH Needs Assessment, ODH continues to develop a variety of initiatives and innovative approaches, in cooperation with its stakeholders, to enhance its capacity to promote and protect the health of the MCH population. Some of the exciting new approaches are highlighted below:

Bureau of Early Intervention Services:

The Ohio Early Childhood Cabinet prioritized a review of the Help Me Grow system during the previous biennial budget period (FY 2008-09). At that time, emphasis was given to the administration of the system and redesigning the home visiting (non Part C) portion of the program. In the current fiscal year (FY2010), the Cabinet directed a review of the current Part C/Early Intervention; policies, practices, outcomes and funding to determine the program's future direction. The review was also intended to ensure compliance with federal regulations, leveraging resources, and providing appropriate services to families and their children.

The Cabinet desired a workgroup with broad representation that focused on the key stakeholders in the early intervention system: parents of young children either participating or who had experience with the Part C/Early Intervention (EI) system, state agencies who were involved in the delivery, financing, or planning of services; representatives of local County Boards of Developmental Disabilities; providers of EI services; representatives of Family and Children First Councils, and representatives of Help Me Grow Project Directors. Each of these stakeholders submitted recommendations for membership, and once selected, the members committed to a minimum of five monthly meetings.

The Cabinet also provided guidance on areas that the Workgroup might consider in its deliberations. These areas included:

- Core Services
 - Federal Guidelines
 - State-wide issues
 - Service Model (e.g., trans-disciplinary teaming)
- Funding
 - Cost considerations, local contributions
 - Reimbursement structure
- Other Considerations
 - Target caseloads
 - Specialized services

The diverse workgroup of thirty-seven individuals representing eighteen stakeholder groups in Ohio gathered over seven months (October 2009 – April 2010) and combined their expertise to generate a series of recommendations that will take Ohio's commitment to very young children to a better future.

It is important to note that the Workgroup made a decision to prioritize work on the service recommendations, and not on the financing charge. However, the Workgroup expressed two important points related to funding. First, Ohio must create a *system* of EI services. Families throughout the state must be guaranteed equal and consistent access to early intervention services regardless of where they live. Second, financing of this system should not be constrained by the way services have been organized and funded in the past. The workgroup understood that financing is a threshold issue, and strongly recommended that this be a priority for improvement in the Ohio Part C/EI system.

This resulting paper highlighted the research behind Part C/Early Intervention (EI) for infants and toddlers with developmental delays or disabilities and their families. It presented the guiding principles of the Ohio Part C/EI Workgroup, along with statements that described what they hoped their work would accomplish for young children and families in Ohio. Finally, the paper described eight recommendations to guide the future direction of the Ohio Part C program. In brief, the recommendations were:

- A. All Part C/EI Services will be strength- and relationship-based: Providers of services will listen to families and plan interventions based on conversations about what is already being done, what is working and family priorities; a range of levels of support based on individual need will be available to families.
- B. The Part C lead agency will assure that every family and their child who is eligible for Part C/EI services shall have access to federally mandated, evidence-based EI services through a core team of professionals.
- C. Maximize existing federal, state and local funding, and leverage additional funding to assure access to federally-mandated early intervention services and implement these recommendations.
- D. The Ohio Part C lead agency will create a comprehensive, ongoing workforce development strategy for Part C/EI in partnership with other early childhood efforts in the state.
- E. Given the importance of supporting families in raising their children with disabilities, Ohio's Part C/EI system must assure family support services and the availability of family-to-family support statewide through the Family Information Network (FIN) of Ohio.
- F. Provide consistent materials and messages statewide (child development, making referrals, enhancing social-emotional development, etc.).

- G. Ohio will create a state-level, centralized, dynamic resource (CDR) of early childhood services and supports that are available to families of young children as well as to EI service providers via live staff and the internet.
- H. The Ohio Part C program will develop a statewide system to ensure family accessibility to core team services, regardless of the political subdivision where families reside.

These recommendations are now being implemented by the state, with multiple stakeholders and advisory groups, as well as state agency staff contributing to the work of transforming the Early Intervention system as recommended.

Bureau of Child and Family Health Services:

Child Fatality Review (CFR) in Ohio: A Decade of Success

ODH honors the 10th anniversary of the Ohio CFR program which was established in 2000 in response to the need to better understand why children die. By 2002, CFR boards were organized in all 88 counties and began to review the deaths from all causes to children younger than 18. In 2005, Ohio was among the first states to begin using a national Web-based data system developed by the National Center for Child Death Review. In 2009, the Ohio law was changed to specifically protect the confidentiality of CFR data at the state level, allowing ODH staff access to identifying case information that was previously shielded. This change will greatly enhance ODH ability to improve data quality and provide specific technical assistance to counties regarding their data. As of April, 2010, more than 13,000 Ohio reviews had been entered into the data system. The comprehensive nature of the data system allows detailed analysis of the circumstances and factors related to child deaths, which is included in an annual report submitted to the governor and posted on the Internet. The report has drawn national and international interest. Every year, dozens of local initiatives demonstrate that the multidisciplinary review CFR process results in actions to prevent future deaths. Ten years of successful CFR organization, process, collaborations and partnerships will provide a good foundation for the development of FIMRs, PAMRs and prevention initiatives into the next decade.

New Infant Mortality Consortium

In November 2009 the Ohio Infant Mortality Task Force published its final report containing ten recommendations to lower infant mortality and disparities. The recommendations were developed with input from families and consumers who participated in the task force and provided a large number of comments through an on-line survey. One recommendation was to establish a permanent consortium to carry on with the work. This recommendation resulted in the creation in 2010 of an infant mortality consortium supported by ODH and structured around five workgroups addressing different aspects of the challenge, with oversight by an executive/steering committee. The consortium's work focuses on: Complete and coordinated health care throughout a woman's and child's life; Elimination of disparities in infant mortality and their underlying causes, including racism; Use of evidence-based practice and data to

drive decisions; Public education about infant mortality and ways to decrease it; and Shaping public policy to impact infant mortality and disparities.

Membership consists of a wide array of Ohioans with a high level of interest and expertise in infant and women's health. There exists in the consortium a strong collective will to make changes to significantly improve the health of Ohio's women and infants and reduce the gaps in opportunities for good health between white and black populations. The consortium is off to a good start with the hope and expectation of measurable progress for our citizens in the future.

Transitioning to the Healthy Homes and Lead Poisoning Prevention Program

The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) has made significant gains toward the goal of eliminating childhood lead poisoning in the State of Ohio. In an effort to continue helping Ohio families have safe and healthy homes, the program is currently transitioning into the Ohio Healthy Homes and Lead Poisoning Prevention Program (OHLPPP). With many years of experience completing home environmental assessments and family education, the program is in a strong position to expand its programming to a holistic approach to housing.

Instead of restricting the program's focus to reacting to children who have already been negatively affected by their home environment, OHLPPP has an ever-increasing focus on primary prevention activities. The primary concepts of a healthy home include keeping it dry, clean, safe, well-ventilated, pest-free, contaminant-free and well-maintained. The health issues related to housing can be reduced or eliminated with proper education, home maintenance, and/or testing.

Ohio is moving in a new direction and is leading the way for other states. Ohio coordinated with the Centers for Disease Control and Prevention (CDC) to acquire the Healthy Homes and Lead Poisoning Surveillance System (HHLPPS). The program will be deploying this new web-based surveillance system in the fall of 2010. By looking at the home as a whole system, the OHLPPP will better be able to ensure that all Ohioans have access to a healthy and safe home.

Regional Perinatal Quality Collaborative: Redesigning the Regional Perinatal Center Program (RPC)

ODH has been working with RPCs for several years to address perinatal quality improvement by stimulating the use of data to identify needs and then implement and evaluate interventions based on current evidence. The Ohio Perinatal Quality Collaborative (OPQC) evolved from these efforts and funding from a neonatal transformation grant helped further develop the collaborative, including setting up a data system and supporting optimal systems of care throughout Ohio. The RPC Coordinators served on the executive and steering committees of OPQC; recruited key stakeholders and families; facilitated regional face-to-face meetings; assisted in learning sessions; and reported progress. ODH is now ready to take this approach to the next step and apply the quality improvement science in a broader way.

ODH will build on the successes of OPQC and the training and technical assistance from national experts such as Kay Johnson and Dr. George Little. In order to further advance these and future projects, ODH plans to partner with Medicaid to focus on improving birth outcomes for the Medicaid population, and arranging Medicaid financing to significantly increase the total investment and establish a broader system of regional quality improvement professionals. ODH, Medicaid and the Ohio Colleges of Medicine Government Resource Center will work with medical schools, hospitals, and local public agencies to recruit/sponsor regional quality improvement professionals and support the implementation/evaluation of quality improvement interventions.

Bureau for Children with Medical Handicaps:

There are many innovative and exciting examples of the Bureau for Children with Medical Handicaps (BCMh) contribution to developing, implementing and maintaining an effective and efficient safety net for Ohio's children with special health care needs. BCMh offers many services that are not consistently covered by other healthcare payers, yet offer a significant return on investment from both a fiscal and health status perspective.

BCMh authorizes and provides reimbursement for nutrition consults provided by community dietitians, medication therapy management from a credentialed pharmacist, extended primary care management visits with physicians to support the medical home concept, and public health nurse visits. BCMh's statewide provider network includes hospitals, pharmacies, physicians, allied medical professionals, dentists, durable medical equipment dealers, public health nurses located in the local health departments, disease specific service coordinators located at the tertiary care centers (children's hospitals) and medical supply companies. This list is not exhaustive, but it gives a sense of the breadth of the system of care that BCMh supports for Ohio's children with special health care needs.

Licensed and Registered dietitians provide nutrition consults in the family home. These consults are designed to assess the nutrition status of the child and family and to educate them regarding the role of nutrition in the management of their specific disorder. In the home environment, the dietitian can observe the caregiver mixing a tube feeding, observe the child's eating skills, educate the family on ways to ensure their child receives the optimum nutrition to ensure the child reaches his/her highest levels of development and functioning. The dietitian becomes a key member of the healthcare team. In addition to home visits the dietitian can provide consultative services to the child's school nurse.

BCMh authorizes medication therapy management for clients with a diagnosis of either asthma or diabetes. The specially trained and credentialed pharmacist provides education on the drugs prescribed and any potential interactions, the proper procedures for drug utilization to ensure the client receives the maximum benefit per dose and reviews the pertinent patient history, medication profile (prescription and non-prescription), and recommendations for improving health outcomes and treatment compliance.

In support of the medical home, BCMH pays for extended physician care management care billing codes designed to ensure that physicians are able to spend an appropriate amount of time with children with special health care needs and their caregivers to coordinate needed services. These billing codes afford the physician the opportunity for reimbursement for activities such as extended consultation with other providers, coordination of care among all providers of services and the ability to spend time consulting with the parents, schools or other providers.

Public Health Nurses employed by local health departments serve as a foundation of BCMH's family-centered, community based service coordination model. BCMH pays these nurses to educate families and help them enroll on BCMH, Medicaid, Medicare, CHIP and all other potential health care payers. Additionally, these nurses provide training and education on condition-specific issues, help the family navigate the local care delivery system, identify ancillary services that provide value to the family (specialty transportation, skilled respite-care giver, etc). The public health nurses also work closely with the Service Coordinators and Early Intervention Specialists to address the multi needs of the Part C eligible children. These interactions have proven to be positive for the Early Intervention Specialists, the child's physician and the parents.

Bureau of Community Health Services:

School and Adolescent Health (SAH) Projects

Action Learning Collaborative on Preconception Health for Teens

The Preconception Health and Adolescents Action Learning Collaborative project sponsored by AMCHP in partnership with ASTHO are working to expand state-level preconception health efforts to include adolescents. Ohio is one of six state teams awarded this opportunity to receive technical assistance in creating strategies to implement the Centers for Disease Control and Prevention (CDC)

Recommendations to Improve Preconception Health and Health Care with adolescent populations. ODH is partnering with the ODE to develop an adolescent health framework that can be used across sectors and disciplines to assist health care and education professionals in teaching health literacy to teens in a holistic manner. To view the draft framework go to:

www.amchp.org/groups/Preconception-Health-Adolescents-ALC/Pages/default.aspx

Body Mass Index Surveillance Project

School and Adolescent Health staff have developed a BMI surveillance program that involves obtaining heights and weights of third and seventh graders throughout the state of Ohio. Childhood Obesity is one of the Governor's and Director of Health's top priorities. In addition physical activity and nutrition were the top priorities identified during the needs assessment process this past year. BMI data collection for the third grade population occurs in conjunction with the Oral Health Program's Open Mouth Survey. By combining both surveys into one effort the ODH maximizes resources while limiting intrusion into

schools. In addition to the third grade survey, which collects state and county level data, the School and Adolescent Health Section collects 7th grade BMI data at the state level every other year. The data are used by stakeholders and other ODH programs as a benchmark for evaluating progress and success of interventions targeted to impact childhood obesity. Training and Technical assistance is offered to schools and local public health departments each year to assist in building local data collection efforts.

Nurse Impact SIIS Project

School and Adolescent Health has improved schools' ability to track immunizations using the Ohio Immunization Registry, Impact SIIS, thereby reducing the need for student exclusion from school. School Impact SIIS is a secure Web based, quality assurance tracking tool used by public and private sites in an effort to raise immunization rates and meet healthy people 2010 goals! ORC 3313.671 requires schools to collect satisfactory written evidence of student immunization according to ODH's approved schedule. Students without satisfactory immunization documentation should be excluded after 14 school days until documentation is provided. Recent data from a small sampling of schools indicates that more than 68% of their student population was kept from being excluded for lack of immunization records.

Oral Health Initiatives

ODH was notified in late August that the two HRSA grant applications submitted earlier this year were approved for funding starting September 1, 2010.

1. ODH received *supplemental* funds for the HRSA Workforce Grant initially awarded in Sept. 2009. These additional funds will be used for the same purpose as the current funds in this grant, to further restore funding cuts sustained in 2009 by the Safety Net and dental OPTIONS subgrant programs.
 - [OPTIONS](#) funding will be restored to previous funding levels and some additional funding will be available. This will enable more uninsured Ohioans with low-incomes to receive needed dental care provided by volunteer dentists in their offices.
 - [Safety Net grant](#) funds will be used to provide dental care to additional Ohioans who qualify for dental care through ODH- funded safety nets, primarily the uninsured and those with Medicaid. Safety Net grant applicants must document they are providing care to additional patients to receive an increase in funding from ODH.
2. Additionally, a *new* HRSA Workforce grant will support two new oral health initiatives: expansion of ODH's School-Based Sealant Program (S-BSP) and creation of a dentist loan repayment program.
 - Currently Ohio's [S-BSPs](#) apply sealants to the teeth of about 28,000 children each year, 20,000 of which are served by ODH subgrant programs funded with MCH Block Grant funds (three programs are locally funded). The additional HRSA funds will enable ODH

to expand the S-BSPs to serve approximately 40,000 students in high-risk schools. The S-BSP Expansion Plan includes a three-pronged approach which consists of

- a. Maximizing the reach of the *current* infrastructure of ODH-funded programs by providing local agencies operating S-BSPs with additional funding to include additional eligible schools within their current area and/or to expand their respective service areas.
 - b. Funding *new* agencies to operate S-BSPs in areas, including multi-county, that are not in proximity to existing S-BSPs and have a critical mass of at least 2,000 2nd and 6th grade students enrolled in unserved eligible schools. (see attached map for expansion and areas identified for new programs)
 - c. Developing new approaches to reach schools that the current infrastructure cannot.
- The dentist loan repayment program will be limited to dentists working full-time in federally designated dental Health Professional Shortage Areas (DHPSAs). See map of [dental HPSAs](#). The current Ohio Dentist Loan Repayment Program (ODLRP), funded with a portion of dentist licensure fees, is limited as dentists choose to renew their contracts for 3rd and 4th year funding, allowing a very small number of new applicants to be funded. The timeline for this program is ambitious with dentist contracts starting by 2/1/2011. Additional information will be available on the Oral Health Section's Web page soon <http://www.odh.ohio.gov/odhPrograms/ohs/oral/oral1.aspx>.

Taking into account the new initiatives outlined above, and ODH's existing MCH programs we feel confident that Ohio has adopted priorities that reflect the needs of Ohioans, and aligned those priorities with the most effective state performance measures. ODH's goal is to track program progress related to health status; program or system capacity and utilize continuous quality improvement efforts to improve its programming and ultimately its capacity to serve the MCH population.

Summary

The Ohio Department of Health has a rich and longstanding history of providing comprehensive, community-based maternal child health services across Ohio. ODH's approach has been collaborative and inclusive of consumer/family members, state agencies, private organizations, and other health related entities in the community. The needs assessment process afforded ODH the opportunity to engage a new complement of people and new ways of looking at data information and linking that data to the changing landscape in Ohio. For these reasons, ODH is pleased to submit its FFY 2011 MCH Needs Assessment.

During this period of transformation among state agencies, and in light of health care reform, ODH has committed to a renewed sense of direction for its MCH programs. With limited and often reduced funding

at both the state and federal levels, part of our commitment is directing available resources towards; the funding of essential planned activities that address the state's priorities, staying focused on critical needs such as childhood obesity, the integration of mental health with health, teen pregnancy, eliminating health disparities, and improving well woman care. In the current and necessary climate of doing more with less, the funding received by the Title V MCH Block Grant are vital in Ohio's ability to maintain, enhance, and improve services for the MCH population.

Needs Assessment of the Ohio's Maternal and Child Health Population

2.1. Needs Assessment of the Maternal and Child Health Population

2.1.1 Needs Assessment Process

A. Overview

During 2007 and 2008, in anticipation of the Fiscal Year 2011 Maternal and Child Health Block Grant (MCH BG) application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions and professional judgment from those working in the field. The needs assessment process and resulting priorities are more fully described below and have been used to guide Ohio's MCH BG funded activities and grant application for 2011.

B. Process to Establish Title V FFY2011 MCH Needs Assessment

The 2011 needs assessment process fulfilled goals that had been previously established in the 2006 assessment. The 2006 needs assessment outlined the desire for greater involvement of outside partners and a structured process that would allow for greater collaboration and input statewide.

Leadership Role and Responsibilities:

To determine the most critical needs of the state's maternal and child health population Leadership within the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) Chiefs (division chief, seven bureau chiefs and an external facilitator) collaborated on the most effective way to include partners in a structured prioritization process. Five (5) key areas were identified as being essential for a successful outcome:

- The convening of four (4) day long stakeholder meeting's focused on prioritized health issues,
- Sharing of data that outlined health social indicator status, health and social services access related to the MCH population from an Ohio and national perspective,
- Identifying best, promising or evidence based practices implemented across the state for the MCH population
- Utilizing a drilled down and analysis approach to identifying potential interventions related to the prioritized health issues,
- The incorporation of an evaluation tool at each phase of the process to determine what worked and what didn't.

The primary role and responsibilities of Leadership were to elicit data, information, opinions, and perspectives from key stakeholders, who are well informed and concerned about; 1) the needs of Ohio's maternal and child health (MCH) populations, 2) the existing MCH service system and resources that exists in the state, and/or 3) the existing political context and other environmental factors that affect the implementation of policy and programmatic changes.

Leadership assisted in identifying and recording the health-related issues, of concern to participants. DFCHS Leaders were also asked to interact with participants and obtain their feedback regarding what they believe is working and not working in regards to Title V programs and how they think maternal and child health could be improved.

Division and Bureau Chiefs played a pivotal role in connecting with stakeholders at each level and phase of the needs assessment process, and ensuring that stakeholder questions and concerns were appropriately addressed while adhering to and sharing political and legislative mandates that govern the Ohio Department of Health.

Utilizing break-out sessions represented by the MCH population, participants from across the state representing state agencies, foundations, insurance providers, professional organizations, local public health agencies, and other affiliated organizations drafted agreed upon list of prioritized health issues for the sub-population being discussed. There were several additional face to face and web based meetings that led to the identification of five critical priorities for each MCH population. These rankings were then forwarded to DFCHS Leadership for their use in the final selection of the state's 7 - 10 MCH priorities.

Over the next several months a series of facilitated meetings took place with the DFCHS Leadership to discuss and rank the priorities identified by the stakeholder group. They were able collectively to identify the state's 9 critical MCH priority needs. These 9 critical priorities fall within 3 categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception; and system improvement. The FFY11 Ohio Maternal Child Health Block Grant Priorities are listed below.

Categories/Priorities
D. Improve the health of children and adolescents (e.g., obesity, STD, oral health, decreasing deaths, improving health outcomes).
10. Increase physical activity and improve nutrition
11. Increase breastfeeding initiation and duration rates
12. Improve early childhood development
E. Increase positive pregnancy outcomes and preconception health (e.g., decrease infant mortality and decrease premature births).
13. Decrease rate of smoking for pregnant women, young women and parents
F. System Improvement
14. Increase the viability of the health care safety net
15. Increase the number of women, children and adolescents with a health home
16. Increase access to evidence based community prevention programs
17. Increase successful transition of special needs children from pediatric/adolescent to adult health care systems
18. Improve the availability of useful and accurate health care data and information (this relates to quality and capacity)
*Note 1 – 9 are not ranked in any specific order of importance within and/or among Categories.

FFY11 Ohio MCH BG Priorities

Utilizing the new 9 priorities the next step in this process was for DFCHS Leadership to examine the state and national performance measures in the current MCH BG to determine if they; mapped to the new priorities list; if they were worded in a manner that represented Title V programs; and whether they were still appropriate.

The final step was for DFCHS Leadership to examine each state performance measure for its appropriateness, wording and the data sources that could be used to measure the issue. This process resulted in more than 10 potential new state performance measures being identified. Some were later omitted through a facilitated voting process (after discussing the importance, relevance and the ability of ODH to do something about the measure).

The FFY11 Ohio Maternal Child Health Block Grant State Performance Measures are; 1) Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes; 2) Percentage of low birth weight black births among all live black births; 3) Percent of local health departments that provide health education and/or health services in schools; 4) Degree to which DFCHS programs can incorporate and evaluate culturally appropriate activities and interventions; 5) Percent of 3rd graders who are overweight; 6) Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health effects; 7) Percent of 3rd graders with untreated caries; 8) Adolescent deaths (age 10-24) due to intentional and unintentional injuries; 9) Maintenance/enhancement of Ohio Connections for Children with Special Needs (OCCSN) BDIS (birth defect registry) to improve utilization of data of surveillance, referrals to services and prevention activities; 10) Percent of children who receive timely, age-appropriate screening and referral.

Of the 10 new state performance measures, 1, 2, 4, 5 and 7 are measures being carried forward from the FFY06 MCH Needs Assessment. These issues have been identified by the stakeholders of Ohio as on-going health care concerns. Measures 3, 6 and 8 are completely new and were repeatedly identified as health care concerns for Ohio during the needs assessment process. While, versions of state performance measures 9 and 10 were identified and included in the FFY06 MCH Needs Assessment the new 9 and 10 definitions incorporate quality improvement efforts to expand and extend programming that address the concerns raised during the FFY11 needs assessment process related to these two issues.

With the FFY11 MCH BG Priorities and Performance Measures selected DFCHS Leadership has moved forward in working with staff to develop strategic objectives and action plans; allocate resources; and draft evaluation and quality improvement standards in a manner that best supports the progress and outcomes of Ohio's MCH population.

Model for the Needs Assessment:

Phase 1

During October-December 2008, the DFCHS convened four day-long meetings to engage stakeholders in discussions around the prioritized health issues within four maternal and child health areas of concern: early childhood; school-age, adolescents and young adults; children with special healthcare needs; and women's health, birth outcomes and newborn health. Adam Negley, a staff member in the Office of Workforce Development, within The Ohio State University's College of Public Health, facilitated the four sessions. Each session included participants from across the State of Ohio representing state agencies, foundations, insurance providers, professional organizations, local public health agencies, and other affiliated organizations. The product from each group discussion was an agreed upon list of prioritized health issues for the sub-population being discussed.

DFCHS provided stakeholders participating in the prioritization process with a compilation of quantitative data specific to their population group. The data were primarily organized into topic areas in a fact sheet format. Data sources included state and national Vital Statistics, PRAMS, Youth Risk Behavior Survey (YRBS), www.cdc.gov/nccdphp/dash/yrbs/index.htm, Behavioral Risk Factor Surveillance Survey (BRFSS), www.cdc.gov/brfss/technical_infodata/surveydata.htm, Ohio Family Health Survey (OFHS), <http://grc.osu.edu/ofhs>, Census, Disease Surveillance and ODH program statistics. Prior to each face-to-face meeting, participants were engaged in an individual-level issue prioritization exercise. They were provided with a list of 25 pre-identified health issues for the sub-population they were invited to represent. Individuals then ranked these 25 issues in importance using the "Q-sort" method. Mean rankings and standard deviations for each mean were calculated prior to each face-to-face meeting.

To begin the discussion of health issues, participants reviewed a compiled list of health care issues gathered from a separate stakeholder survey conducted by ODH. This information was sought from practitioners and providers across Ohio and provided a local perspective to the issues for each sub-population. All groups except the early childhood stakeholders generated a

list of recurring themes within these local stakeholder survey results. This list was used as a reference point throughout the issue prioritization phase of the meeting that followed.

After reviewing and generating a list of recurring themes from the local stakeholder survey, participants were provided with the results of their Q-sort exercise. After a brief discussion of the results in general, the participants began a discussion of individual issues. At times, groups combined individual issues in order to include more topics within the highest priority issues. At times individual issues were left as stand-alone issues when the groups determined that was more appropriate. A final prioritization of the identified issues produced the final list for each group.

The list of participant-generated themes from local stakeholder surveys as well as each group's final prioritized list of health issues can be found in sections B.4., C.7., D.9., and E.3.

Several of the highest priority health issues cut across more than one sub-population. A few were identified in all four group sessions. These cross cutting issues are:

- **Access to Care** (inclusive of all population groups)
 - Including immunizations
- **Parent education and support** (early childhood, school-age, special needs)
- **Birth outcomes/child mortality** (women's health, early childhood, special needs)
- **Intentional and unintentional injury** (inclusive of all population groups)
- **Early identification through screening** (early childhood, school-age, special needs)
- **Disparities in health outcomes** (women's health, early childhood, special needs)
- **Chronic conditions** (school age, special needs)
 - Including mental illness, diabetes, substance abuse, asthma, obesity/overweight, sensory deficits and developmental delays

The remaining high priority health issues were addressed within work groups focused on the individual sub-populations. Combining the early childhood, school age, adolescent and young adult groups allowed for more consistent interventions for all children as a result of this process. The issues in gray are those that were identified in the first phase of the process, but ranked below the 10th priority.

Population-based Issues:

- **Early Childhood, School-age, Adolescents and Young Adults**
 - Issues to consider:*
 - Risky behaviors including substance use (including tobacco and alcohol), risky sexual behavior, truancy and their consequences
 - Referral to services then diagnosis and treatment (hearing, vision, mental/social-emotional, oral, lead, nutrition, obesity/overweight, early childhood development, asthma, trauma)
 - Inadequate and inappropriate nutrition and physical activity resulting in obesity, overweight and nutritional deficiencies
 - Early care and education (systems approach including all birth to kindergarten services)
 - Health, wellness and social development (life skills) are not identified as a part of school achievement

- Safe and supportive environments (schools, neighborhoods) including environmental exposures
- Breastfeeding sustainment
- **Children with Special Health Care Needs**
 - Issues to consider:*
 - Patient/family centered coordinated care
 - Appropriate insurance coverage to provide needed services to CSHCN aged 0-24
 - Mental, social, behavioral and developmental health issues
 - Transition to all aspects of adult life including adult care
 - Disintegrated administration of the system of care
 - Newborn screening, genetics services
- **Women's Health, Birth Outcomes and Newborn Health**
 - Issues to consider:*
 - Health behaviors (nutrition, physical activity, substance use, oral health, breastfeeding)
 - Well woman care (preconception and interconception care)
 - Sexual behaviors and their consequences (unintended pregnancy, STDS, teen pregnancy, family planning/pregnancy prevention)
 - Pre-natal/post-partum care
 - Neonatal care (1st visit, specialist follow up, car seats, back to sleep/safe sleep, shaken baby)
 - Breastfeeding
 - Mental health
 - Safety (safety belts, abuse/violence, living environment)
 - Chronic disease prevention, treatment and management
 - Educational attainment

Phase 2

During April-June 2009, the Ohio Department of Health convened several web-based and face-to-face meetings to continue stakeholder discussions around the prioritized health issues identified in phase 1 of the MCH needs assessment (November-December 2008). Three stakeholder workgroups were formed as a part of this process. One group dealt with the phase 1 issues that were identified for the early childhood and school-aged sub-populations. Another group dealt with issues involving children with special health care needs. The third group was formed to address the issues involving access to care across all childhood population groups. Adam Negley, a staff member in the Center for Public Health Practice, within The Ohio State University's College of Public Health facilitated the sessions. The participants in phase 2 included representatives from state agencies, foundations, insurance providers, professional organizations, local public health agencies, and other affiliated organizations.

The process for each workgroup began with a web-based meeting. Microsoft Live Meeting and a conference call line were used. The purpose of the first meeting was to introduce participants to each other and the process that we would be using during phase 2. We briefly discussed and clarified the relevant issues identified during phase 1 and shared problem statements that had

been formulated for each issue. The participants were then provided with an overview of root cause analysis and the electronic tool that was developed to help them conduct a root cause analysis for each problem statement. Participants were asked to complete a root cause analysis for each issue on their own after the meeting was over.

The second web based meeting was held 2-3 weeks after the first. The purpose of the second meeting was to review the root cause analysis and discuss the completed tools in more detail. After the second web based meeting, the group of stakeholders working on the access to care issues were asked to rejoin one of the other two groups for the remainder of the process.

On June 16 and 23, 2009, face-to-face meetings were held for the Children's issue group and the Children with Special Healthcare Needs issue group respectively. The purpose of these meetings was to utilize the root-cause analysis results to identify potential interventions related to each priority. After interventions were identified, overall themes were discussed and the top five issues for each population were reprioritized one final time.

A summary of the products from the two face to face meetings follows:

Overall childhood intervention themes:

- Collaboration and coordination among traditional and non-traditional partners
- Best practice identification and data collection (sustaining and expanding successful programs)
- Increasing cultural competency
- Training and workforce development
- Parental behavioral health impact on child health
- Case management/care coordination
- Demonstrating cost effectiveness of prevention
- Messaging and communications
- Disparities
- Connection between environment and health
- Incentives for providers and consumers

a. Final top five Children priorities and suggested interventions:

6. Increase access to adequate and culturally appropriate prevention, early identification and treatment services

Suggested interventions:

- Identify successful prevention programs based on or informed by an existing body of evidence and link programs through a network of partners
- Identify and encourage best practices related to access and utilization of child and adolescent health services
- Identify and promote strategies that seek to increase the supply of providers willing to accept Medicaid/uninsured at state and local levels such as:
 - expanding the scope of practice for mid-level providers
 - more local safety-net clinics

- Identify strategies/incentives to promote multi-disciplinary collaboration and coordination at the local, regional and state levels
 - Conduct outreach to increase enrollment and retention in Medicaid
 - Increase provider training in effective communication during difficult conversations
 - Build the body of Ohio-specific evidence/data for the cost-effectiveness of prevention
 - Create financial and non-financial incentives for patients and providers for preventive care
 - Deliver culturally competent prevention messages and services
 - Increase the focus on prevention in health and related professional training and continuing education programs
7. Prevent unsafe behaviors such as substance use, risky sexual behaviors, violence and the behaviors most likely to cause intentional and unintentional injuries and illness
8. Provide family-centered services and education to support child/family health and wellbeing
- Suggested interventions:**
- Include a case management/care coordination component in appropriate programs to increase patient/family compliance and overall access to appropriate care
 - Sustain and expand high quality parent education through family-centered home-based services
 - Coordinate efforts across sectors and with non-traditional partners to shift towards population based approaches that improve overall health
 - Increase use of social marketing to promote health
 - Promote and increase training in culturally respectful parent education across providers and their staff
 - Increase the use of the full range of communication technologies and strategies to deliver targeted parent education materials
 - Promote the training and use of trusted messengers such as community health workers, lay health workers, patient navigators and child-care workers to deliver parent education.
 - Coordinate parent education activities/messages among not for profit organizations
 - Educate parents on the impact of parental health on child's health and provide links to necessary services
9. Recognize and reduce the negative impact of social determinants of child and adolescent health
- Suggested interventions:**
- Reduce disparities through:

- recruitment of a diverse workforce
- increased cultural competence training
- distribution of health care workforce
- Integrate evaluation of social disparities of health in the process of evaluating and funding environmental programs and projects
- Educate policy-makers on the connections among health disparities, environmental hazards and socio-economic status

10. Reduce environmental exposures that contribute to chronic illness, injury and disability

Suggested interventions:

- Measure and map air and water quality against chronic illness rates in Ohio
- Institutionalize long-range interagency strategic planning with traditional and non-traditional partners focused on the prevention of environmental related illness and injury

Overall themes related to Children with Special Healthcare Needs:

- Family support
- Provider support (education, reimbursement)
- Cross-collaboration (public private, interagency)
- Data collection and analysis
- Prevention (early and continuous screening)
- Innovative tools, technology and models

b. Final top five Children with Special Healthcare Needs priorities and suggested interventions:

1. Increase the number of standardized medical homes for children with special health care needs that include:
 - a. Early and continuous screening
 - b. Care coordination
 - c. Family participation
 - d. Transition

Suggested Interventions:

- Collect and analyze sub-county level data that shows how many CSHCN are living in Ohio and how many are currently left un-served. Hypothyroidism and other genetic screening could be a source of data.
- Institute appropriate reimbursement for assessment/screening, case management and primary care services.
- Enhance education to increase family involvement in the treatment plan
- Work with providers and other stakeholders to create a viable model, including funding, for the medical home that is multidisciplinary (i.e. medical, educational and social services)

- Use existing templates and models to assist providers and families to facilitate the transition of care to appropriate adult providers
2. Increase capacity for the medical home to screen, diagnose and access comprehensive medical and non-medical specialty services through the use of evidence based tools

Suggested Interventions:

 - Collect and analyze data on provider acceptance of insurance coverage including Medicaid in coordination with other state agencies.
 - Facilitate reimbursable digital/telemedicine or face-to-face services in local and low-access communities. This would include diagnostic and therapeutic interventions as well as occupational/physical therapy.
 - Support efforts to streamline paperwork and sharing of appropriate information across programs including examining models where currently records follow patients (military, Kaiser Permanente, role of EMR)
 - Convene a group of consumers on both BCMH and Medicaid to develop recommendations regarding coordination between the two programs
 - Enhance training and education for providers regarding screening services and local referral options
 - Create a system for a referral clearinghouse to link providers and families to local or regional resources
 3. Provide families with the support and networks they need to participate in all aspects of family care

Suggested Interventions:

 - Engage consumer and family advocates to expand and support sustainable patient and family advocate/navigator programs
 - Facilitate networks of family support groups including digital/online methods
 - Seek interagency partnerships to research and deliver appropriate education of risky behavior among high school level students including digital/online/social media strategies.
 - Provide family with support they need to play appropriate role in treatment/therapy
 4. Enhance the system of reimbursement for basic primary care services, and provide incentives for innovative service delivery

Suggested Interventions:

 - Encourage innovative solutions that streamline public and private insurance payee structure for both prevention and care
 - Partner with private entities and other non-traditional partners to leverage expertise in system development
 5. Improve capacity to collect and utilize available CSHCN data to drive future decision making

Suggested Interventions:

- Improve capacity to collect and analyze data regarding birth defect prevention strategies, and other healthcare outcomes

Women’s Health, Birth Outcomes and Newborn Health Recommendations:

During Phase II of the Needs Assessment process the Women’s Health, Birth Outcomes and Newborn Health group was combined with the Ohio Infant Mortality Task Force, given the two groups were addressing many of the same issues. Combining of the two groups would allow for more consistent interventions across this population group.

The Ohio Infant Mortality Task Force was established in early 2009 by ODH at the request of Governor Ted Strickland to 1) take a fresh look at the reasons behind Ohio’s overall infant mortality rate and increasing disparities among different populations; and 2) make both preliminary and long term recommendations to reduce infant mortality and disparities.

A core group of about 30 task force members, co-chaired by Thomas Brietenback, CEO of Premier Health Partners, Inc, and ODH Director Alvin Jackson, MD worked with an additional 40 stakeholders to provide even broader representation and expertise.

The task force formed into maternal health/prematurity, maternal care, newborn care and infant care committees that met separately to work on their areas of concentration and then came together monthly for task force meetings. In addition to establishing a Web site and a Share Point site, ODH- staff members supported the task force by developing and conducting surveys of infant mortality-related research efforts and programs throughout Ohio to provide information for the final report. ODH staff also received technical assistance funding from the MCH BG to engage an expert facilitator to coordinate task force meetings.

Each committee looked at best practices from the public health literature, evidence-based interventions from the medical literature, related indicators for infant mortality and risk factors as they developed their recommendations and strategies.

c. The task force’s recommendations and strategies as they relate to the MCH BG Needs Assessment are:

1. Provide comprehensive reproductive health services and service coordination for all women and children before, during and after pregnancy,

Suggested Intervention:

- a. Many of the causes of infant mortality are best addressed prior to pregnancy. Provide comprehensive medical services and community-based interventions to improve health outcomes.
2. Eliminate health disparities and promote health equity to reduce infant mortality,

Suggested Intervention:

- a. Disparities in infant mortality are longstanding in Ohio and are reflective of the social determinants of health. Focus on disparities that can be geographic, economic, racial, and cultural.
3. Expand quality improvement initiatives to make measurable improvements in maternal and child health outcomes.

Suggested Intervention:

- a. Quality data collection, analysis and interpretation are critical to the success of infant mortality reduction initiatives. Develop and share accessible data products essential to making sound program and policy decisions.
4. Increase public awareness on the effect of preconception health on birth outcomes.

Suggested Intervention:

- a. Many causes of poor birth outcomes may successfully be addressed prior to pregnancy. Invest in culturally competent social marketing and education strategies to lead to improved outcomes.
5. Implement health promotion and education to reduce preterm birth.

Suggested Intervention:

- a. Preterm birth is the number one cause of infant mortality. Decrease infant mortality through education and interventions to reduce risk factors.

2.1.2 Needs Assessment Content

2.1.2.1 Overview of the Maternal and Child Health Population’s Health Status

This section summarizes the qualitative and quantitative information that was presented to the stakeholders who prioritized health issues for the MCH population. This information pertains to health status issues. (See Sections 2.1.2.2 through 2.1.2.5 for data related to health services and systems.) The quantitative information was assembled based on the Data Collection Plan and input/requests from the four stakeholder groups. Information on disparities is provided if it was documented. Racial, age and gender disparities were not reported if disparities were not observed, the numbers were too small to interpret (as was most often the case for Hispanic ethnicity) or the information was not collected. The qualitative information is from surveys and focus groups. (See B.4, C.7, D.9, and E.2 and E.3 in this section.)

A. Demographic

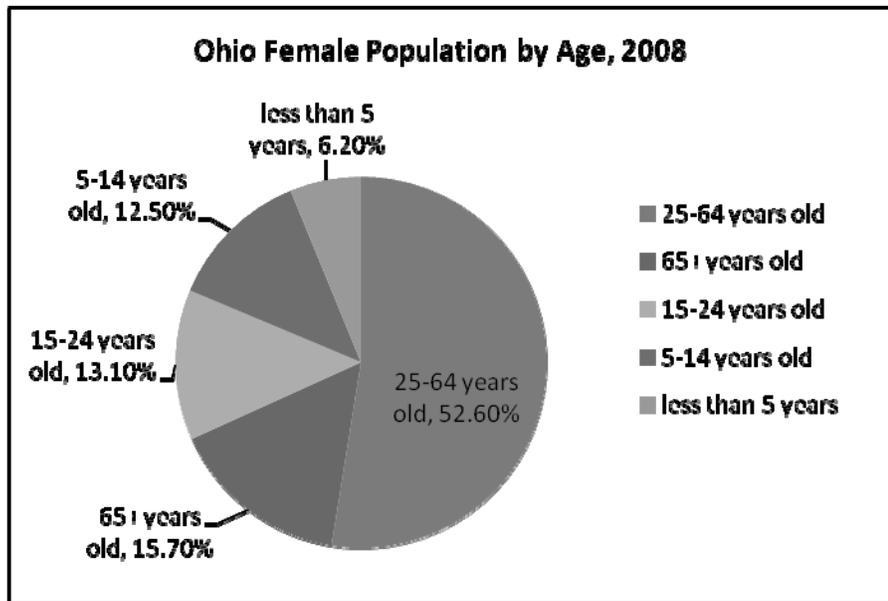
A.1 Geographic Description

Ohio has a land area of 40,953 square miles and is divided into 88 counties. Ohio has no geographical barriers; its accessibility has been perhaps the key factor in its growth. A well-developed interstate highway system interconnects the state: interstate highways 70, 76, 80 and 90 run east and west, and interstate highways 71, 75 and 77 run north and south.

A.2 Population

Overall: The 2009 estimated population of Ohio was 11,542,645¹, giving the state a population density of 281.9 people per square mile. Ohio ranks as the seventh-most populous state among the 50 states and the District of Columbia.² By 2030, Ohio is projected to remain the seventh-most populous state, with an estimated 12.3 million people.³ Between 2000 and 2030, the state expects to gain 254,616 people through migration.⁴

Females in Ohio accounted for 51.2 percent of the total population in 2008. Twenty-five- to 64-year-olds make up 52.6 percent of the female population. Women age 65 years and over comprised 15.7 percent of the female population. Females 15-24 years of age make up 13.1 percent, females 5 to 14 years of age make up 12.5 percent and females younger than 5 make up 6.2 percent of the female population.



Data Source: Estimation Branch, Population Division, U.S. Bureau of the Census

¹ Estimates Branch, Population Division, U.S. Bureau of the Census.

² "Ohio's Population," Ohio Department of Development, Office of Office of Policy, Research, and Strategic Planning, <http://www.development.ohio.gov/research/files/p0006.pdf>.

³ "Projected Population: County Totals," Ohio Department of Development, Office of Strategic Research, 27 January 2004, <http://www.odod.state.oh.us/research/FILES/P200/countytotals.pdf>, 1.

⁴ Ohio Department of Development, Office of Strategic Research (JH), March, 2003.

Geographic Distribution: An estimated 81.1 percent of the population in Ohio resides in metropolitan areas. The 10 counties with the largest populations are Cuyahoga, Franklin, Hamilton, Montgomery, Summit, Lucas, Stark, Butler, Lorain and Lake.⁵ The Ohio Department of Health typically categorizes the 88 counties as metropolitan (11), suburban (16), rural non-Appalachian (29) and Appalachian (32).

Race/Ethnicity: Since 1990, Ohio has had an increase in ethnic minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origin, has seen a 22.4 percent growth since 2000. Likewise, since 2000, the black population has seen a 5.6 percent increase. The three largest groups of Asian populations in Ohio are of Indian, Chinese and Vietnamese origin.⁶

In 2008, 86.6 percent of the population was white, 8.0 percent was black, 0.8 percent was Asian and 1.6 percent was Native American and Alaskan Native.⁷ These groups may also include Hispanics who made up 2.3 percent of the population.⁶

Age: Ohio's age distribution has gone through a fundamental change in the past 10 years. The first half of the baby-boom generation has moved into empty-nester household stage. The 65 and over age group has experienced the slowest growth in three decades due to inclusion of smaller WWII veteran and Great Depression cohorts. Gaining only 3.2 percent growth statewide, growth in the under-18 age group is limited to areas of larger total population growth. Ohio births have declined from the baby boom high of about 243,000 in 1957 to just over 148,000 in 2008.^{6,8}

In 2008, the population of children through age 24 was 3,812,111 representing 33 percent of the total population.⁹ Youth as a percentage of the state population is projected to continue to decrease. This trend is consistent with the national trend.

A.3 Birth Rate

Overall: According to ODH Vital Statistics, there were 148,592 live births to Ohio residents in 2008. By mother's race, births were distributed as follows: white, 75.7%; black, 15.9%; all other races, 8.4%.

The Ohio resident live birth rate decreased over the period 1994 to 2008, from 14.3 births per 1,000 population to 12.9 per 1,000, respectively ($p=0.000$). The white rate followed the same pattern ($p=0.000$), while the black rate declined until 2003 ($p=0.000$), at which point it increased from a low of 16.1 births per 1,000 to 18.1 in 2008 ($p=0.000$). In 2008, Hispanics experienced

⁵ "County Population Estimate", Population Estimates, US Census Bureau, <http://www.census.gov/popest/counties/CO-EST2009-01.html>.

⁶ "Ohio's Population", Population and Housing Division, Ohio Department of Development Office of Policy Research and Strategic Planning. <http://development.ohio.gov/research/PopulationHousing.htm>.

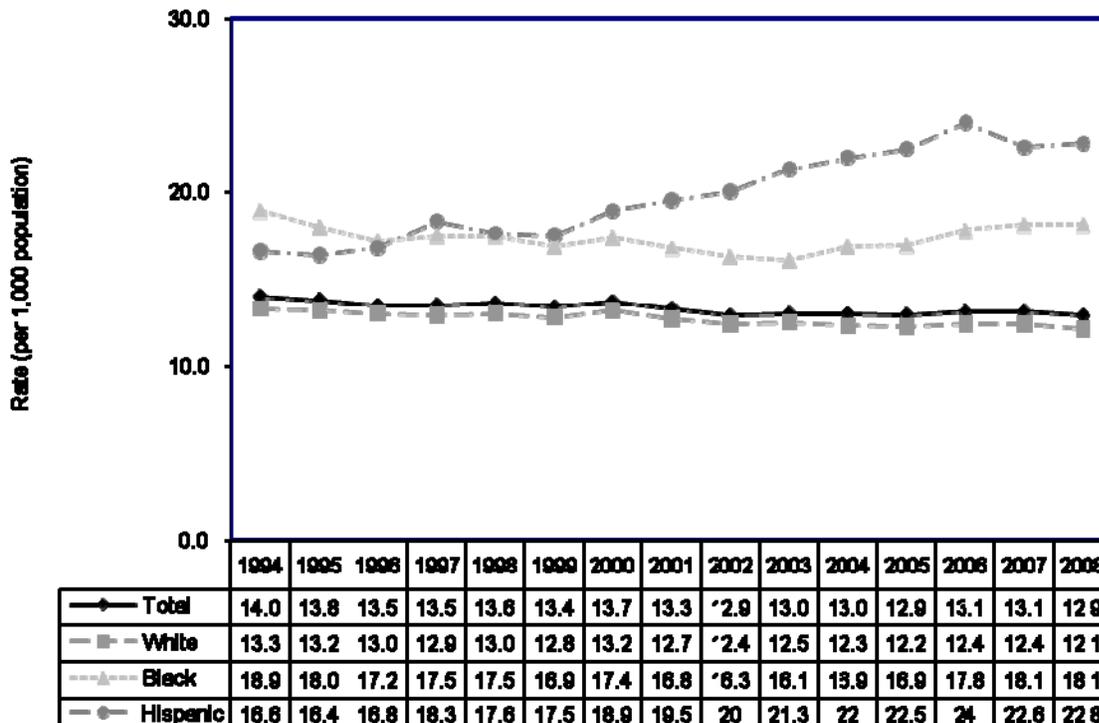
⁷ Population Division, U.S. Census Bureau.

⁸ Ohio Department of Health Information Warehouse, 2008 Live Births

⁹ U.S. Census Bureau, Population Estimates 2008.

the highest live birth rate of all racial/ethnic groups examined, and this was the only group with a marked increase across the period (p=0.000). This finding is consistent with national birth trends.

Implications: Hispanic birth outcomes will exert greater influence on overall Ohio birth outcomes assuming the Hispanic population continues to represent an increasing proportion of Ohio births over time. However, although the proportion of all births that were Hispanic increased 2.7 fold between 1994 and 2008, Hispanics still represented only 4.6 percent of all Ohio live births in 2008.

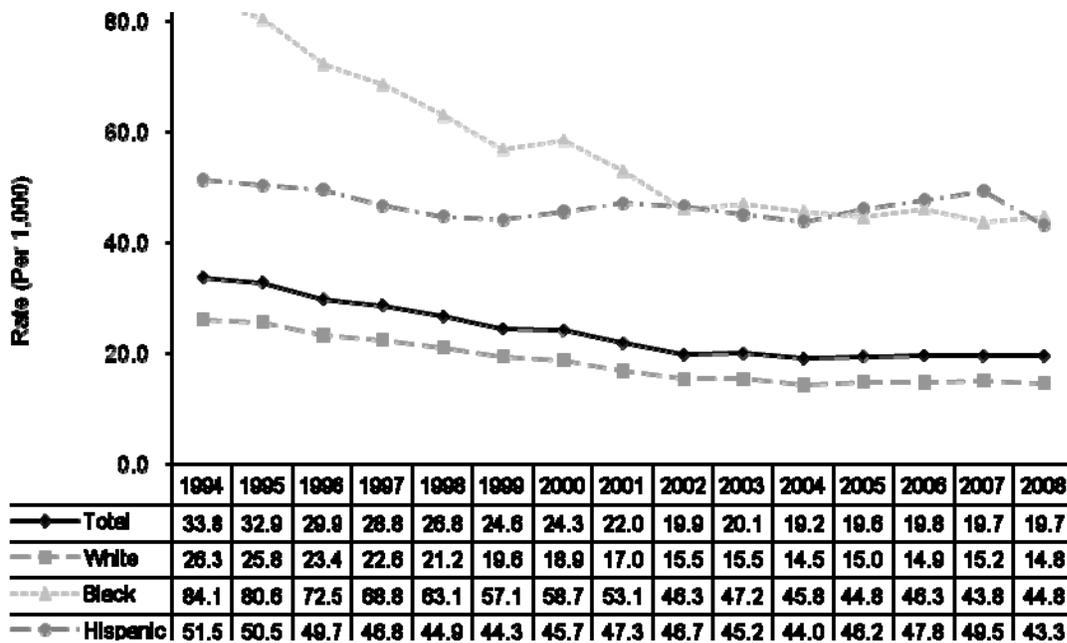


Live Birth Rate, by Race¹ and Hispanic Ethnicity², Ohio Residents, 1994-2008

Data Source: Ohio Vital Statistics

Teen: Ohio teens aged 15 to 17 years had a live birth rate of 19.7 per 1,000 in 2008. The U.S. live birth rate for the same age group in the most recent year available, 2007, was 22.2 per 1,000. In Ohio in 2008, black and Hispanic teens aged 15 through 17 years each experienced a live birth rate about 3 times that of whites (44.8, 43.3, and 14.8 per 1,000, respectively).

A decreasing trend in the overall Ohio live birth rate among 15-17 year-olds was observed from 1994 through 2003 (p=0.000). There was no statistically significant change in the overall rate from 2004 through 2008 (p=0.676). The white teen birth rate declined through 2004 (p=0.000), then leveled off thereafter (p=0.283), while the black teen birth rate declined through 2002 (p=0.000), remaining statistically unchanged beyond that year (p=0.074). The Hispanic rate of live birth among 15-17 year olds remained statistically the same across the period (p=0.109).

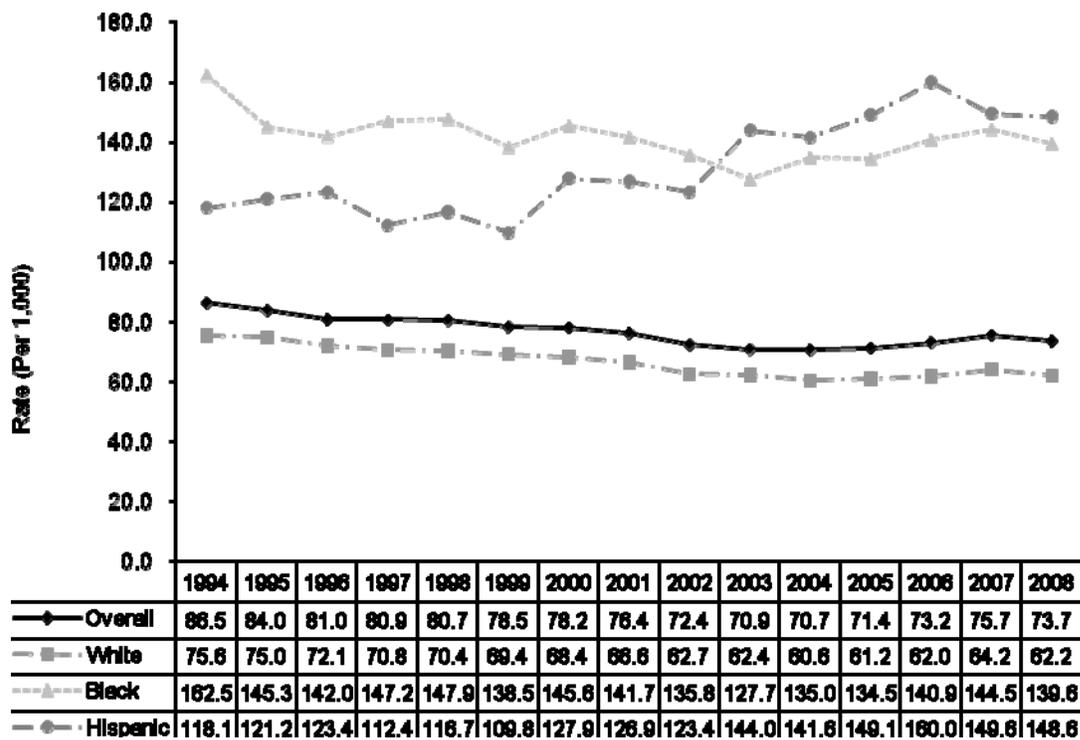


Live Birth Rate Among 15-17 Year Olds, by Race¹ and Hispanic Ethnicity², Ohio Residents, 1994-2008

¹ Race irrespective of ethnicity. ² Ethnicity irrespective of race.

Data Source: Ohio Vital Statistics

Similar to the 15-17 year-old live birth rate, that among 18-19 year-old Ohio residents declined from 1994 through 2004 ($p=0.000$), after which it leveled off ($p=0.107$). The pattern experienced among white 18-19 year olds was the same ($p=0.000$ for 1994-2004 and $p=0.374$ thereafter). The black rate in this age group declined throughout the period ($p=0.022$), while the Hispanic rate was stable from 1994-1999 ($p=0.542$), increasing through 2006 ($p=0.002$), then leveling off again ($p=0.533$). The Hispanic live birth rate overtook that of blacks in 2003 and was the highest of all groups examined in 2008.



Live Birth Rate Among 18-19 Year Olds, by Race and Hispanic Ethnicity, Ohio Residents, 1994-2008

Data Source: Ohio Vital Statistics
 1 Race irrespective of ethnicity. 2 Ethnicity irrespective of race.

A.4 Family Characteristics

Overall: Ohio has 4,508,871 total households. A household consists of all the people who occupy a housing unit. A household may include the related family members and all the unrelated people, if any, such as lodgers, foster children, wards or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. There are two major categories of households, "family" and "non-family." Sixty-five percent of Ohio households are family households; approximately 31.6 percent of family households include children under the age of 18 years. Forty-eight percent of family households are married-couple families; 16.8 percent are single-parent households.¹⁰

¹⁰ U.S. Census Bureau, 2008 American Community Survey ; Subject Tables.

Families Headed by Single Parents: Seventeen percent of all family households in Ohio are single-parent households. Approximately 33.8 percent of these single-parent households are female householders with no husband present. (This excludes single women who live with the child’s father and single teenage moms who live with a parent or other relative). The percentage of births to single mothers has increased from 34.0 in 1997 to 43.2 in 2008.¹¹ The number of single mothers in Ohio has increased 3 times since 1960, to 704,965 in 2008.¹² In Ohio, 78.2 percent of all black births were to single mothers, whereas 36.3 percent of all white births were to single mothers according to 2008 records.¹³

A. 5 Economic Indicators

Geographic: Although not generally considered a minority group, residents of Appalachian counties differ from other Ohioans. Until the 1950s, these regions were isolated, having relatively few roads, telephones or mass communication. A report by the Central Ohio River Valley Association mapped the mortality rates in southern Ohio’s Appalachian counties. These areas showed higher death rates due to all causes compared with overall Ohio rates. Factors contributing to higher rates included poverty, lack of health services, lack of health insurance and possible lifestyles and habits of Appalachian Ohioans.

Labor Force: The percentage of Ohio women who work continues to increase, with 60 percent of the female civilian population over age 16 participating in the labor force in 2008, up from 58 percent in 1994. The percent of women in the labor force is projected to continue to increase over the next 10 years.

Ohio Labor Force Estimates*: 1994, 2004, 2014				
	Civilian Noninstitutional Population 16 and Over	Civilian Labor Force	Labor Force Participation Rate	Share
1994				
Total	8,435,000	5,548,000	65.8%	100.0%
Male	3,977,000	2,981,000	75.0%	53.7%
Female	4,458,000	2,567,000	57.6%	46.3%
2004				
Total	8,828,000	5,884,000	66.6%	100.0%
Male	4,225,000	3,105,000	73.5%	52.8%
Female	4,603,000	2,778,000	60.4%	47.2%
2014				
Total	9,197,000	6,128,000	66.6%	100.0%
Male	4,446,000	3,216,000	72.3%	52.5%
Female	4,751,000	2,912,000	61.3%	47.5%

*Data for 1994 and 2004 are from the Geographic Profile of Employment and Unemployment. Data for 2014 are from the Ohio Bureau of Labor Market Information

¹¹ Ohio Vital Statistics, Information Warehouse

¹² U.S. Census Bureau; 2008 American Community Survey; “Ohio 2000 Demographic Profile: Charting the Change, May 2001”; U.S Census Bureau, Census 2000.

¹³ Ohio Vital Statistics, Information Warehouse

Education: Ohio Asian women lead in pursuing higher education with 31 percent of those 25 years and older holding at least a bachelor's degree, compared with 15.6 percent of non-Hispanic white women, 9.6 percent of black women and 11.3 percent of Hispanic women¹⁴. In 2008, for those 25 years and older, the educational levels of women are lower than men. Roughly 28.8 percent of women in this age group have completed college compared with 30.1 percent of men.¹⁵

Poverty Levels: The poverty rate for the total population decreased from 1994 (14.2 percent) through 2008 (13.4 percent). This is similar to the national rate of 13.2 percent. The poverty level; however, varies greatly by county. The five counties with the highest poverty rates were all Appalachian counties: Athens (29.6 percent), Vinton (23.0 percent), Adams (21.9 percent), Morgan (21.1 percent) and Jackson (20.7 percent). The five counties with the lowest poverty rates were Delaware (4.9 percent), Medina (5.8 percent), Warren (6.6 percent), Geauga (6.9 percent), and Union (7.1 percent).¹⁶

Within metropolitan areas, the average poverty rate for Ohio cities was 18.9 percent, compared to 6.5 percent for areas outside of the central cities. Eight central cities had poverty rates greater than 20 percent: Cleveland (26.3 percent), Bowling Green (25.3 percent), Kent (25.2 percent), Youngstown (24.8 percent), Dayton (23.0 percent), Lima (22.7 percent), Cincinnati (21.9 percent) and Steubenville (20.4 percent). Two-thirds of Ohio's poor are white, yet this racial group has the lowest poverty rate—10.8 percent in 2008. The poverty rate was 29.3 percent for blacks, 12.3 percent for Asian and 24.8 percent for Hispanics.

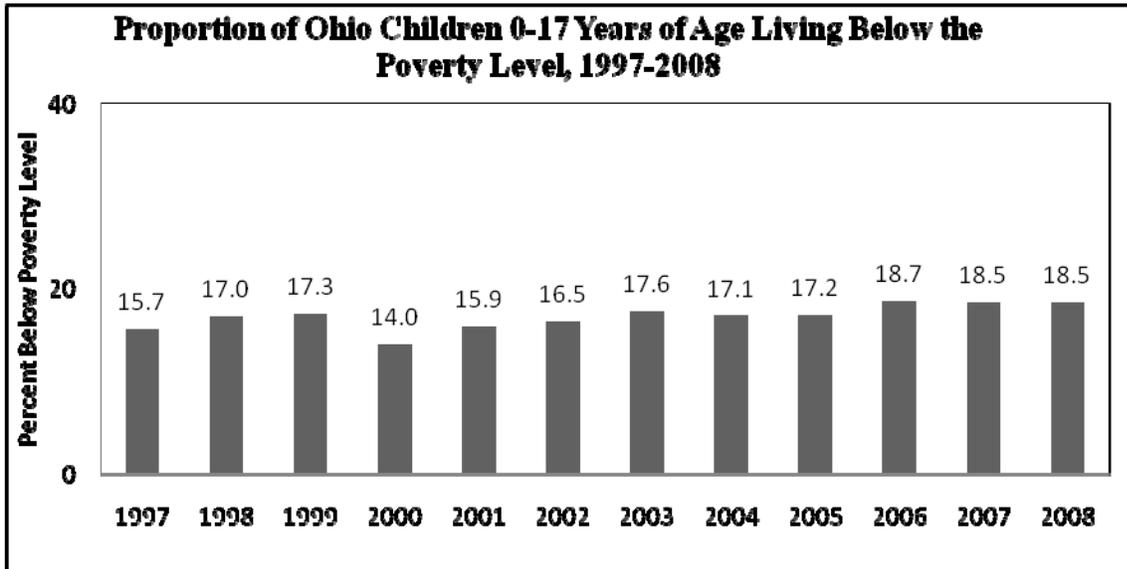
Children are the poorest people in Ohio: 18.5 percent of children under 18 years old lived below the poverty level in 2008. The rate for children under 18 years decreased from 1994 (20.9 percent) to 2008. Among families, the risk of poverty varies by the type of household in which people live and whether they have children. Families with children are at greater risk of being poor than families with no children. Of the 2,936,172 families currently estimated to be below the poverty level, 48.5 percent of those families have related children younger than 18 years of age. The risk of poverty is greater among families headed by a woman with no spouse present. There were 389,259 families with female heads of household that fell below the federal poverty level in 2008. Approximately 68.5 percent of families with female heads of household had related children 18 years of age and younger.¹⁷ Those with at least one child had poverty rates only three to ten times higher than the rates of those with no children. The higher poverty rate for children may be partly explained by the larger proportion of one-parent families.

¹⁴ Census. American Community Survey 2008.

¹⁵ National Center for Education Statistics <http://nces.ed.gov/help/sitemap.asp>.

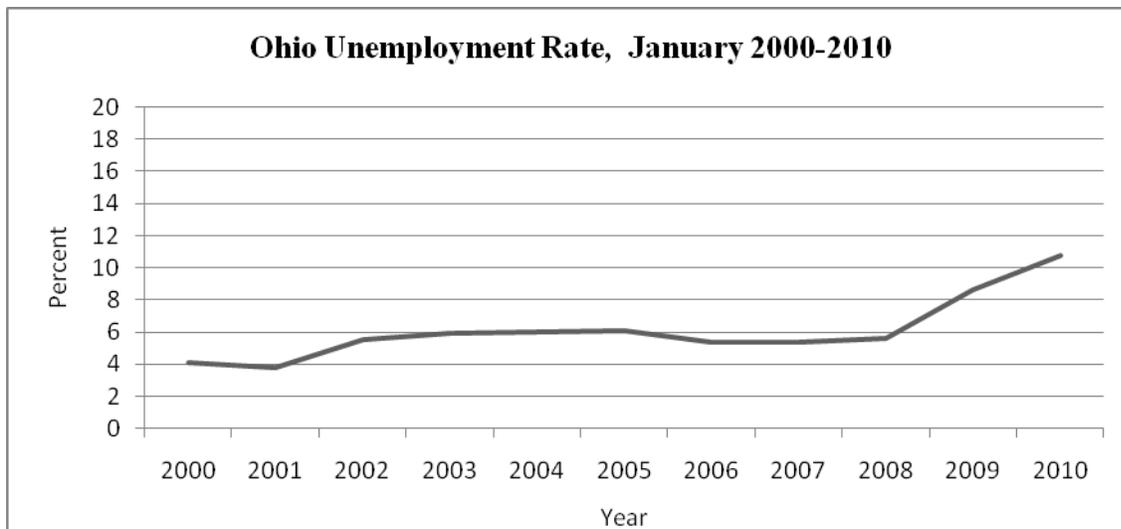
¹⁶ U.S. Census Bureau, Small Area Income and Poverty Estimates; Estimates for Ohio Counties, 2008.

¹⁷ U.S. Census Bureau, American Community Survey, Subject Tables; 2008.



Data Source: U.S. Census

Unemployment: The unemployment rate in Ohio was 10.8 percent in January 2010, which was higher than the national average of 9.7 percent for the period. Since January 2006, Ohio's unemployment rate has risen drastically, which is consistent with the national trend.¹⁸



¹⁸ United States Department of Labor: Bureau of Labor Statistics; Local Area Unemployment Statistics, Ohio and United States.

Food Stamp Recipients: In 2008, Ohio had 526,800 family households participating in SNAP (Supplemental Nutritional Assistance Program). The total annual issuance of food stamp benefits was \$1,494,661,229.¹⁹ Approximately 49 percent of participating family households had children and 34 percent were single parent households. The distribution of participating households by poverty status based on gross countable income as a percentage of the poverty guideline was: 37.8 percent of participating households had a poverty status of 50 percent or below, 50.8 percent had a poverty status of 51 percent to 100 percent and 11.4 percent of the households were classified as having a poverty status of 101 percent or more. The number of white Ohio households receiving food stamps in 2006 was 302,000 or 65 percent of all recipients of food stamps; black households receiving food stamps in 2006 was 142,000 or 30.6 percent; and Hispanic households receiving food stamps was 9,000, or 2 percent. The distribution of participants by age for 2007 was: 17 percent preschool age children, 30.2 percent school age children, 45.3 percent non-elderly adults and 7.5 percent elderly adults. In 2007, the average monthly number of recipients receiving food stamps was nearly 1,038,000. The average monthly issuance was \$99.73.²⁰

Welfare Recipients: In 1996, the U.S. Congress eliminated the Aid to Families with Dependent Children program and replaced it with the federal Temporary Assistance for Needy Families (TANF) program. Ohio created two separate programs from within TANF: Ohio Works First (OWF) and Prevention, Retention and Contingency (PRC). OWF is a state-supervised, county-administered program that provides time-limited cash assistance to needy families with (or expecting) children. This assistance provides work, training and other support services they need to attain permanent self-sufficiency while meeting the family's ongoing needs. PRC is a county-administered, state-supervised program that provides ongoing services and non-recurring short-term benefits to promote self-sufficiency.²¹

As of June 2006, there were more than 175,000 individual TANF recipients in the State of Ohio. Of these recipients, Ohio averaged about 180,000 OWF cash assistance participants per month, of which 42,825 were child-only cases. Medicaid eligibility is aligned with OWF eligibility so all participants have access to quality health care.²²

Children and Adults on Public Insurance: In 2008, children and adults in Ohio relied primarily on employment-based insurance for health services access. About 53.3 percent of Ohio children and 61.7 percent of adults received coverage through a present or former employer or through a relation with job-based coverage. The uninsured in Ohio are primarily adults. Approximately 17 percent of Ohio adults aged 18-64 years lack health insurance. Among children under the age of 18 years however, about 4 percent, or fewer than 200,000 individuals, lacked health insurance in 2008. This was a decrease from 2004 when approximately 5.4 percent lacked coverage.

¹⁹ United States Department of Agriculture Food and Nutrition Services Supplemental Nutrition Assistance Program (SNAP), 2008.

²⁰ Mathematica Policy Research, Inc. "Characteristics of Food Stamp Households".

²¹ Temporary Assistance to Needy Families (TANF) Program State Title IV-A Plan, Ohio Department of Job and Family Services, October 1, 2004.

²² <http://www.jfs.ohio.gov/0001infocenter.stm#reports/>.

However, this change represents a decrease in children covered by job-based insurance and an increase in children covered by Medicaid.²³ In 2007, Ohio Medicaid covered approximately 1 million low-income or disabled children, or 39 percent of all children in Ohio. These numbers include approximately 34,000 children with disabilities.²⁴

Racial disparities in source of coverage are apparent among children. Hispanic children were 3.3 times more likely to be uninsured. Although not significantly more likely than white children to be uninsured, more than half of black children rely on Medicaid coverage, compared to just over 20 percent of white children. White children are twice as likely as black children to be covered by job-based insurance. Job-based coverage for children increases and Medicaid coverage declines with age of the child. Medicaid covers one-third of all newborns, while that coverage declines to less than one-fourth of 13-17 year-olds.²⁵

See further discussion of Health Insurance Coverage issues Section 2.1.3.1, A.1

Ohio Medicaid Enrollees as a Percentage of Total Population, State Fiscal Year 2007				
	Enrollees	Population		Percent
Population	2,170,311	11,466,917		19.0%
0-4	364,467	736,416		49.0%
5-19	823,701	2,328,240		35.0%
20-64	799,174	6,857,176		12.0%
65-84	136,539	1,323,262		10.0%
85+	46,430	221,823		21.0%
By Sex				
Male	915,142	5,591,161		16.0%
Female	1,255,169	5,875,756		21.0%
By Race				
White	1,497,793	9,730,889		15.0%
Black	634,748	1,377,629		46.0%
Other	37,770	358,399		11.0%
By Ethnicity				
Hispanic	69,378	283,755		24.0%
Non Hispanic	2,100,933	11,183,162		19.0%

Data Source: <http://www.jfs.ohio.gov/OHP/reports/documents/2007OhioMedicaidRptCntyPrfls.pdf>

B. Maternal and Infant Health Status

B.1 Mortality

Infant Mortality

Description: Infant mortality is the death of an infant under 1 year of age. The leading causes of infant death nationally in 2007 were congenital malformations, (one-fifth of all infant deaths),

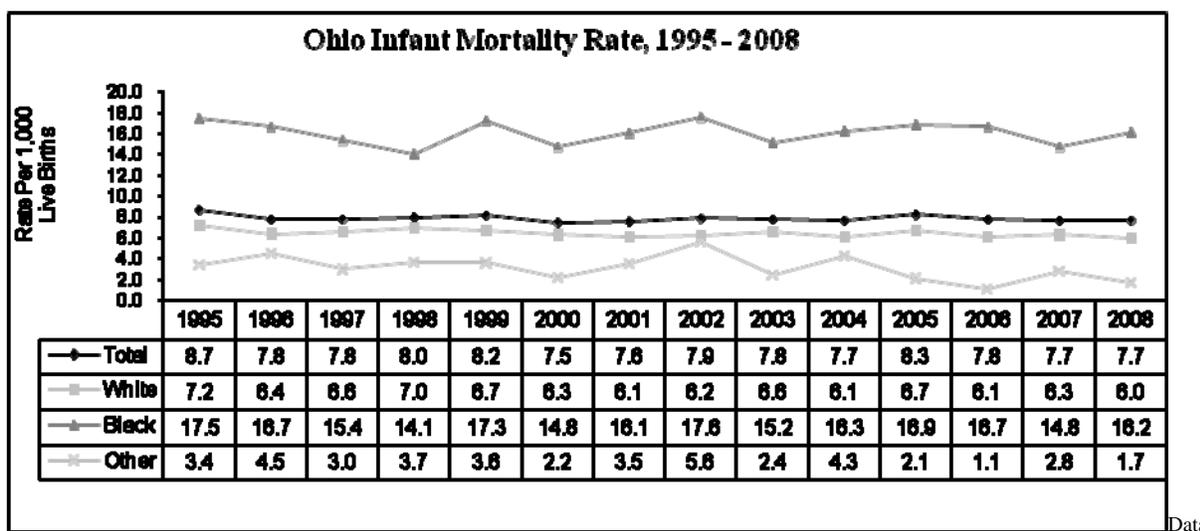
²³ http://ckm.osu.edu/sitetool/sites/ofhspublic/documents/OFHS_Brief_Simpson.pdf

²⁴ <http://jfs.ohio.gov/OHP/reports/documents/2007OhioMedicaidRptCntyPrfls.pdf>

²⁵ <http://jfs.ohio.gov/OHP/reports/documents/2007OhioMedicaidRptCntyPrfls.pdf>

disorders related to short gestation and low birth weight, and sudden infant death syndrome (SIDS).²⁶

Quantitative Data: The infant mortality rate (IMR) is the number of deaths per 1,000 live births in a given year. In 2008, 1,144 infants in Ohio died before they reached their 1st birthday. This represents an IMR of 7.7, which was higher than the national rate of 6.75 in 2007 (provisional). In 2005, Ohio had the 8th highest IMR among states. The Ohio rate is higher than the Healthy People 2010 target rate of 5.0. From 1990 to 1997 there was a significant decrease in mortality that averaged 3 percent a year. However, from 1997 to 2008 there has been no significant change in Ohio's IMR. According to the 2009 Ohio Child Fatality Review, Prematurity and congenital anomalies account for 70 percent (658) of all infant deaths from medical causes and 61 percent of infant deaths from all causes.²⁷



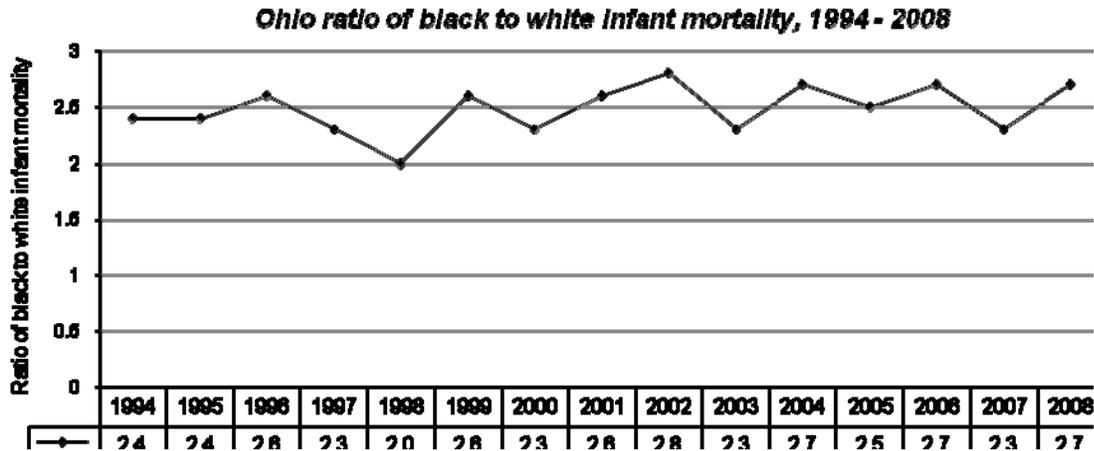
Source: Ohio Vital Statistics

For Ohio counties with 20 or more infant deaths during 2006-2008, the highest overall IMR (8.5 per 1,000 or greater) were in the following counties: Hamilton, Cuyahoga, Franklin, Union, Ashtabula, and Scioto (see maps). The county with at least 20 deaths with the lowest overall IMR (less than 4.5) was Delaware.

Racial/Ethnic Disparities: The 2006-8 combined IMR for black infants was 15.9 compared to 6.1 for white infants. A black infant born in Ohio is about 2 and one half times as likely to die in the first year of life compared to a white, and the ratio has stayed in that range for the past decade. Ohio's ratio is similar to the national, which were 2.4 in 2007. The 2006-8 combined IMR for Hispanic infants was 6.2 compared to 7.8 for non-Hispanic infants (not shown). Nationally, the Hispanic IMR was 5.7 in 2007.

²⁶ http://ckm.osu.edu/sitetool/sites/ofhspublic/documents/OFHS_Brief_Simpson.pdf

²⁷ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>

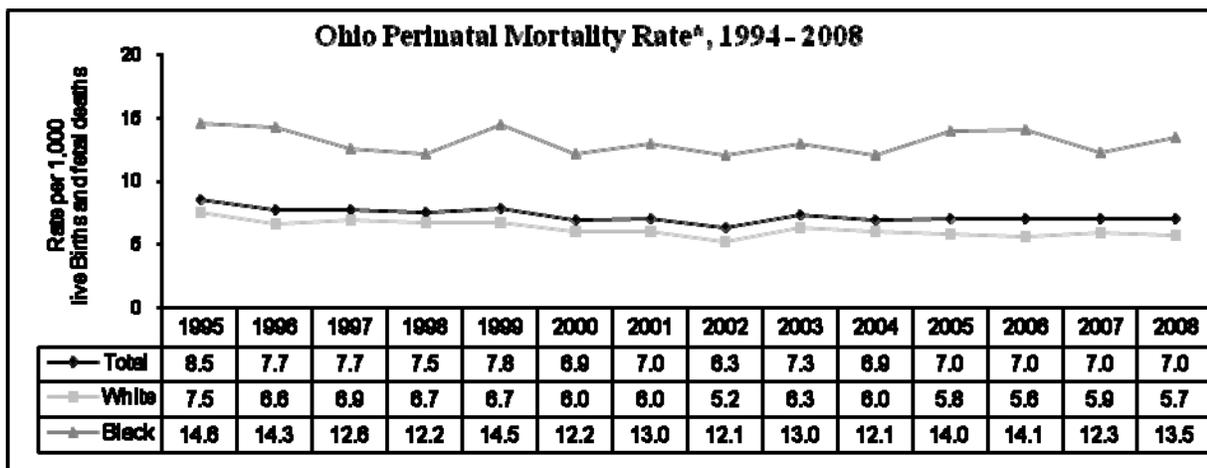


Data Source: Ohio Vital Statistics

Perinatal Mortality

Description: Perinatal mortality refers to deaths that occur around the time of delivery. Both fetal deaths of at least 28 weeks of gestation, and early infant (neonatal) deaths before seven days after birth are included. Groups at higher risk for fetal mortality include non-Hispanic black women, teens, women aged 35 years and greater, unmarried women, and multiple deliveries. Risk factors for perinatal death include pre-pregnancy obesity, prenatal smoking, severe/uncontrolled hypertension or diabetes, infections, placental/cord problems, intrauterine growth retardation, and previous perinatal death.

Quantitative Data: In Ohio, fetal death is defined as death of a product of conception of at least 20 weeks gestation prior to its complete expulsion or extraction from its mother. The perinatal mortality rate is the number of fetuses and infants who die during the perinatal period per 1,000 live births and fetal deaths in a given year. The Healthy People 2010 (HP2010) target is 4.5 and the national rate was 6.6 in 2005²⁸. In 2008, Ohio's perinatal mortality rate was 7.0.²⁹

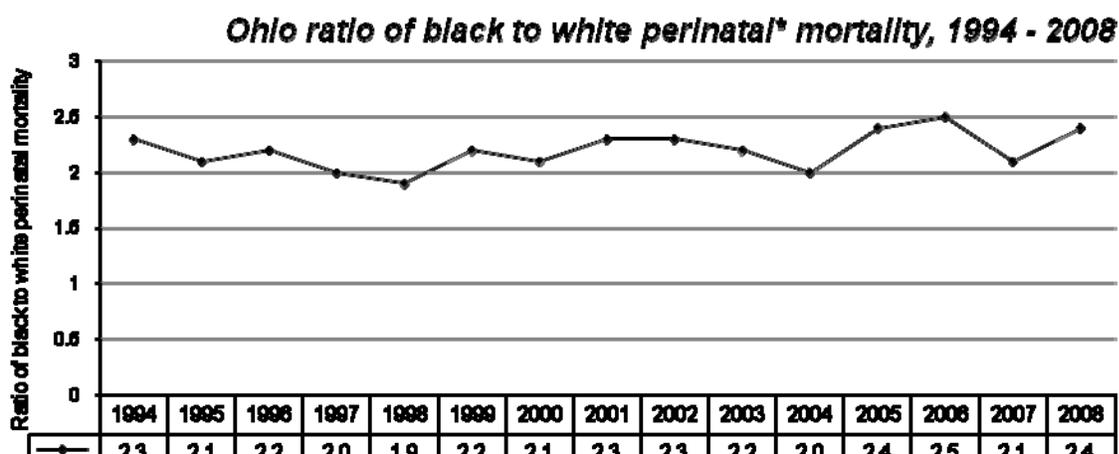


²⁸ MacDorman MF, Kirmeyer S. Fetal and perinatal mortality, United States, 2005. National vital statistics reports; vol 57 no 8. Hyattsville, MD: National Center for Health Statistics. 2009.

²⁹ Ohio Vital Statistics.

* Infant deaths of less than 7 days and fetal deaths with gestation of 28 weeks or more, per 1,000 live births and fetal deaths.
Data Source: Ohio Vital Statistics

Racial/Ethnic Disparities: The ratio of the black to the white perinatal mortality rate has remained in the range of 1.9 to 2.5 from 1994 through 2008. This compares closely to a 2005 ratio of 2.3 for the nation (note: interpret with caution given definition differences). However, the Healthy People 2010 goal of a ratio of 1 between black and white perinatal mortality rates has not been met.³⁰



* Infant deaths of less than 7 days and fetal deaths with gestation of 28 weeks or more, per 1,000 live births and fetal deaths.
Data Source: Ohio Vital Statistics

Neonatal Mortality

Description: Neonatal mortality is the death of an infant under the age of 28 days. Nearly two-thirds of all infant deaths occur during the neonatal period. The leading causes of neonatal deaths are disorders related to short gestation and low birth weight (LBW). Other causes include complications of pregnancy, complications involving the placenta, umbilical cord and membranes, and asphyxia.

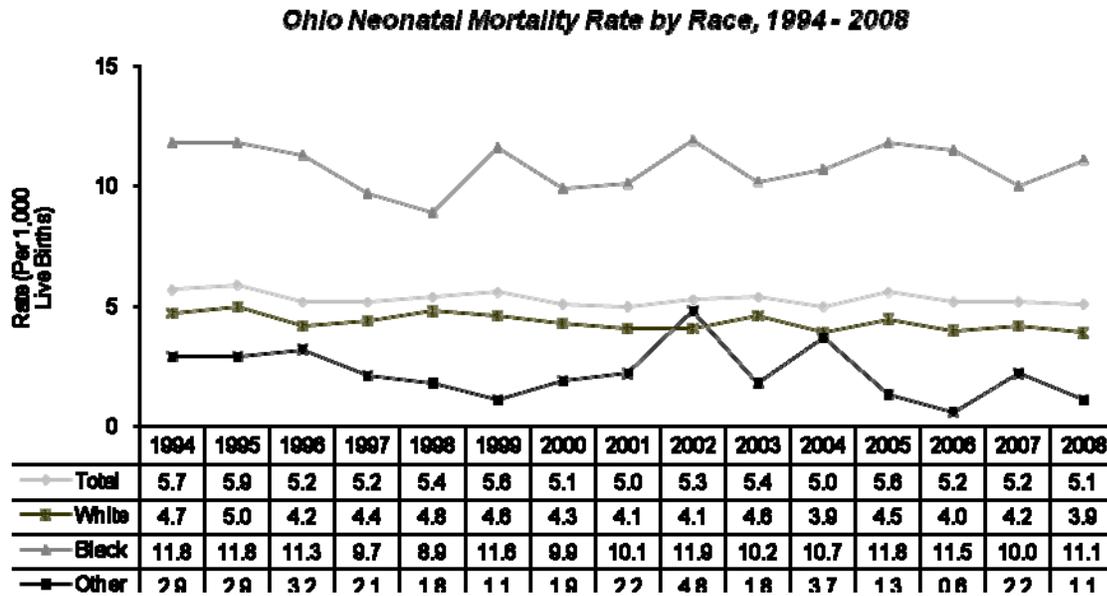
Racial/Ethnic Disparities: The 2008 NMR for black infants was nearly three times the rate for white infants (11.1 compared to 3.9 respectively). The national ratio was 2.3 in 2007 (8.65 compared to 3.70). The Ohio 2006-8 combined NMR for Hispanic infants was 4.0 compared to 5.2 for non-Hispanic infants (not shown).

Quantitative Data: The neonatal mortality rate (NMR) is the number of infants who die during the neonatal period per 1,000 live births in a given year. In 2008, there were 755 neonatal deaths in Ohio. The 2008 NMR was 5.1, and three-year average rate was 5.2 for 2006-8, both of which were higher than the 2007 national rate of 4.4. The Healthy People 2010 target rate of 3.3 has not

³⁰ Ohio Vital Statistics.

been met. Prematurity and congenital anomalies account for 78 percent (575) of the deaths to infants 0-28 days old.³¹

For Ohio counties with 20 or more neonatal deaths during 2006-2008, the highest overall neonatal mortality rates (6 per 1,000 or greater) were in the following counties: Hamilton, Cuyahoga, Franklin, Butler, and Scioto (see maps). The only Ohio County with at least 20 deaths which met the Healthy People 2010 Objective of 2.9 was Delaware.



Data Source: Ohio Vital Statistics

Postneonatal Mortality

Description: Postneonatal mortality is the death of an infant from age 28 days to less than 1 year old. One-third of infant deaths occur during the postneonatal period. After the first month, SIDS is the leading cause of infant mortality, accounting for about one-third of all deaths during the postneonatal period. The causes of SIDS are unknown, but risk factors include sleep position, maternal smoking, prematurity, and lack of breastfeeding.

Quantitative Data: The postneonatal mortality rate (PMR) is the number of infants who die during the postneonatal period per 1,000 live births in a given year. In Ohio, 389 postneonatal deaths occurred in 2008. Ohio's 2007 PMR and 2006-7 combined PMR were both 2.6,³² higher than the 2007 national rate of 2.3 and higher than the Healthy People 2010 goal of 1.2. Nationally, the PMR increased significantly from 2006 to 2007. According to the 2009 Ohio CFR, sleep-related deaths accounted for 45 percent (159) of the reviewed deaths to infants 29

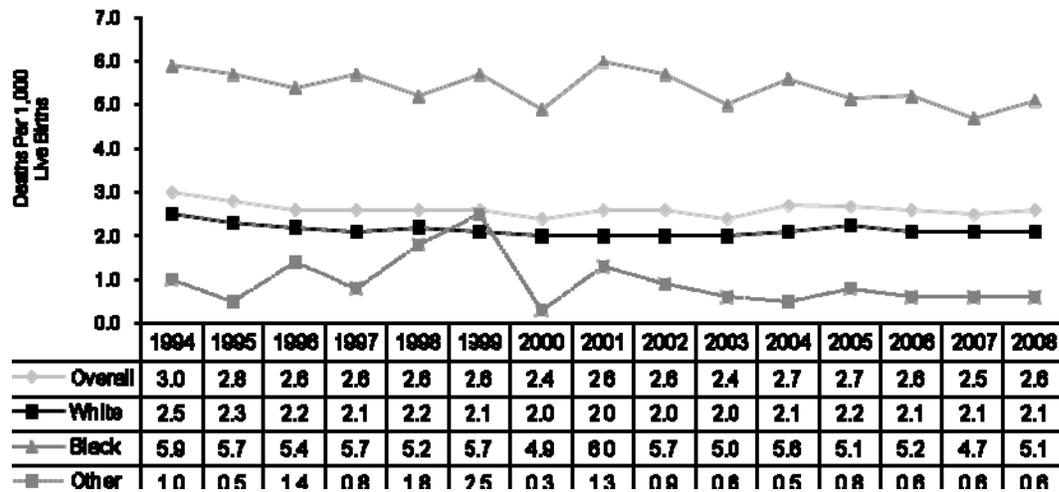
³¹ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>.

³² Ohio Vital Statistics.

days to 1 year old³³. The numbers of postneonatal deaths from 2006-8 were not great enough to make any meaningful county comparisons.

Racial/Ethnic Disparities: The 2008 PMR for black infants was 5.1 compared to 2.1 for white infants (a ratio of 2.4). This compares closely to a 2007 U.S. PMR among blacks of 4.59 and 1.94 among whites. The Ohio 2006-8 combined PMR for Hispanic infants was 2.2 compared to 2.6 for non-Hispanic infants (not shown).

Ohio Postneonatal Mortality Rate by Race, 1994 - 2008



Data Source: Ohio Vital Statistics

Maternal Mortality

Description: The effect of pregnancy and childbirth is an important indicator of women’s health and access to reproductive health care. While the numbers are small, maternal mortality remains significant because a high proportion of these deaths are preventable.

A pregnancy-related death is a death to a woman while pregnant or within 1 year of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. A maternal death is a pregnancy-related death that occurs within 42 days of the termination of pregnancy.

Risk factors for pregnancy-related morbidity include ectopic pregnancy, preeclampsia, eclampsia, premature rupture of placenta, and placenta previa. Many risk factors can be mitigated or prevented with good preconception and prenatal care. Prenatal care is especially important for women at increased risk of poor outcomes (teens, black women, and low-income women).

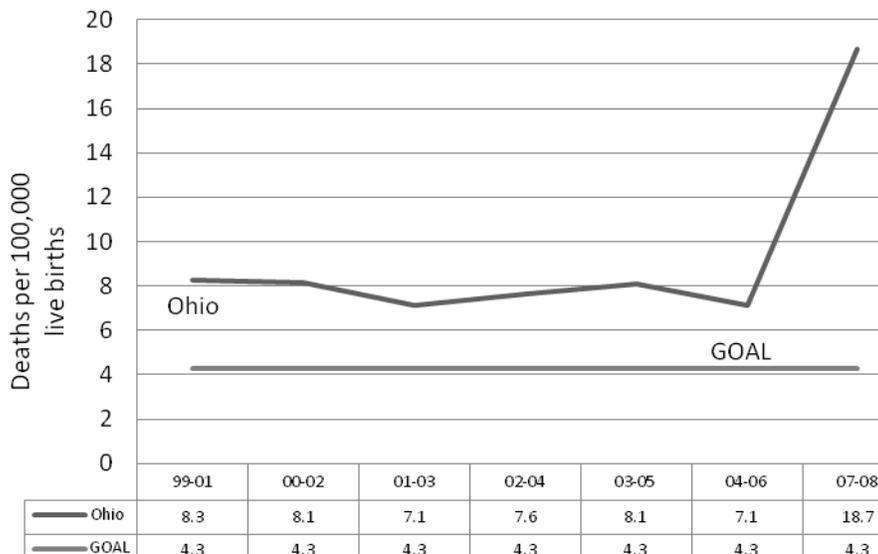
Quantitative Data: Ohio reported 23 maternal deaths in 2008 for a maternal mortality rate of 15.5/100,000 live births. This is higher than the Healthy People 2010 target rate of 4.3. Maternal and late maternal deaths were determined using ICD-10 codes in the “O” range of the cause of

³³ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>.

death fields on death certificates. However, death certificate information captures only a portion of pregnancy-related deaths. This information should be combined with linking vital records, surveillance, investigation of other data sources, and expert review of records to capture additional pregnancy-associated deaths and to determine which of these deaths are actually pregnancy-related (Source: CDC).

Beginning in 2007, Ohio adopted the 2003 NCHS death certificate and collects information about whether a female decedent was pregnant at time of death or in the year preceding through a check box. This expanded information enables coders to assign a more specific (pregnancy-related) condition for deaths occurring 2007 and later and likely accounts for the dramatic increase in reported maternal mortality. Ohio currently has no expert maternal mortality review team; however a grant has been awarded to develop a statewide review team and will allow for further examination and understanding of the data.

Pregnancy-Related^a Death Rates (per 100,000 live births) Using Maternal and Late Maternal Deaths as Defined by ICD-10 Codes on Death Certificates, Ohio 1999-2008



Data Sources: Ohio Vital Statistics

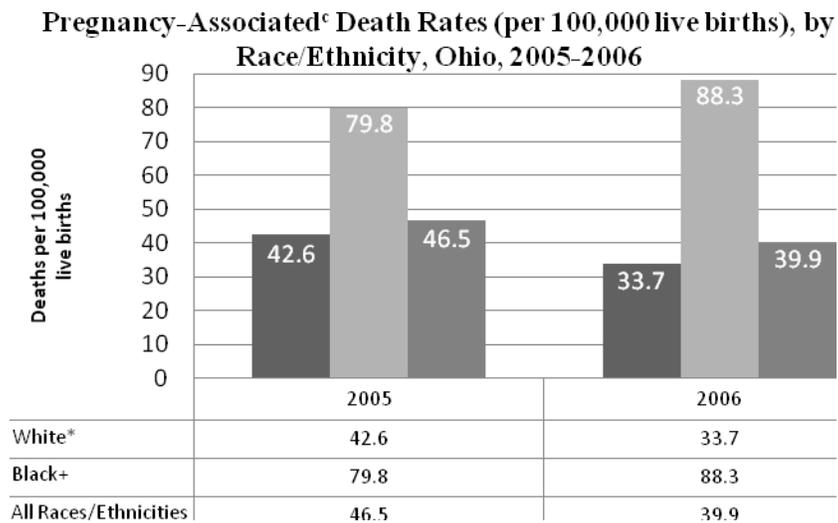
*In 2007, Ohio adopted the 2003 NCHS death certificate

^aA **pregnancy-related death** refers to the death of a woman while pregnant or within 1 year of termination of pregnancy, irrespective of duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes.

Using a check box on the death certificate, the following numbers of deaths were found:

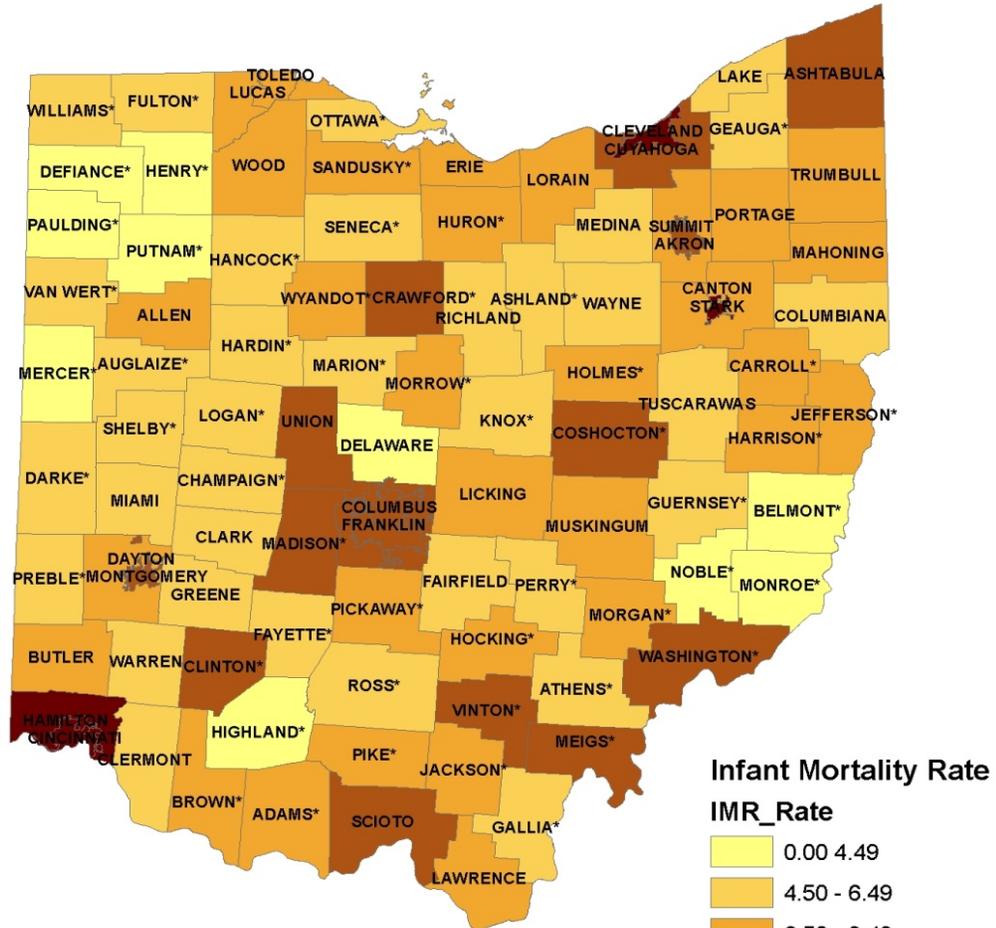
	2007	2008
Pregnant at time of death	28	34
Not pregnant, but pregnant within 42 day of death	11	7
Not pregnant, but pregnant 43 days to 1 year before death	15	23

Racial/Ethnic/Age Disparities: In Ohio in 2005 and 2006, the pregnancy-associated death rate for non-Hispanic black women was between 2 and 2.5 times that of non-Hispanic white women.



*White, non-Hispanic, +Black, non-Hispanic ^cA **pregnancy-associated death** is defined as the death of a woman while pregnant or within 1 year of termination of pregnancy, irrespective of cause. Data Source: Ohio Vital Statistics

Infant Mortality Rate** by County and Selected Cities of Ohio, 2006-2008

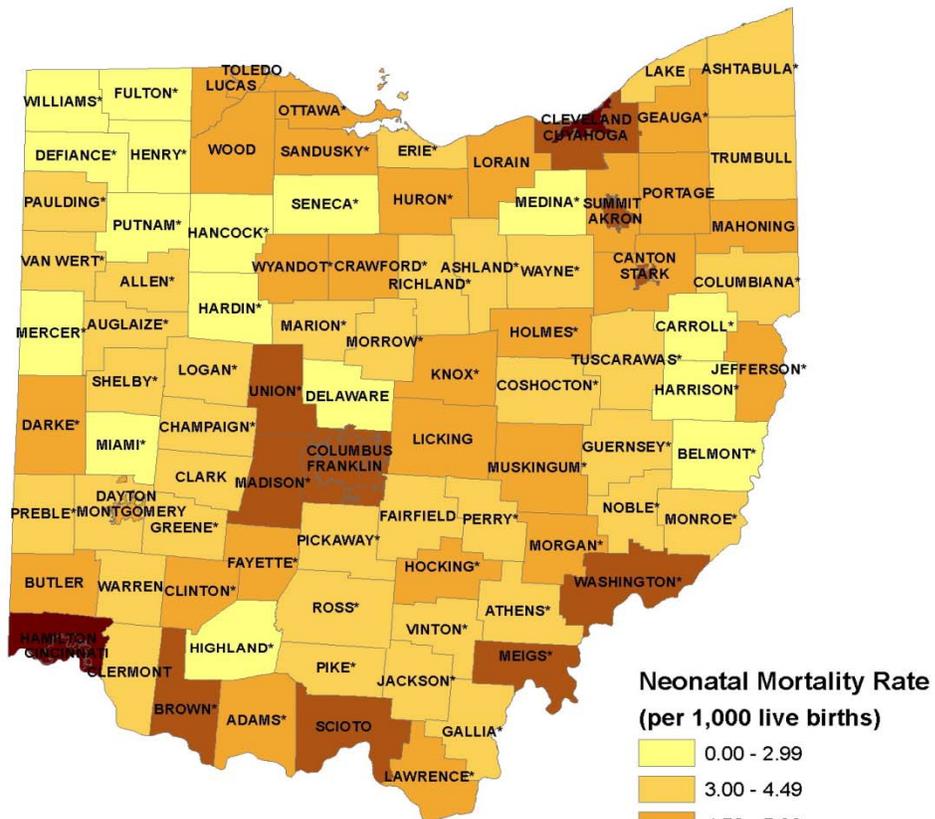


* Rates based on less than 20 observations may be unstable.

** County rate is aggregated for the entire population of the county (includes city counts).

Healthy People 2020 Goal:
Infant Mortality Rate for Ohio 2006-2008: 7.64/1,000
Source: Ohio Vital Statistics

Neonatal Mortality Rate** by County and Selected Cities of Ohio, 2006-2008



* Rates based on less than 20 observations may be unstable.

** County rate is aggregated for the entire population of the county (includes city counts).

Healthy People 2020 Goal:
Neonatal Mortality Rate for Ohio 2006-2008: 5.10/1,000
Source: Ohio Vital Statistics

B.2 Other Birth Outcomes

Low Birth Weight (LBW)

Description: Low birth weight (LBW) is defined as a weight of less than 2,500 grams (about 5.5 pounds) at birth, and is closely associated with neonatal mortality. Infants with LBW are also more likely to experience long-term disabilities or to die during the first year of life than are infants of normal birth weight. Disabilities include cerebral palsy, autism, developmental delay, vision and hearing impairments and other developmental disabilities. Expenditures for the care of LBW infants total more than half of the cost incurred for all newborns.

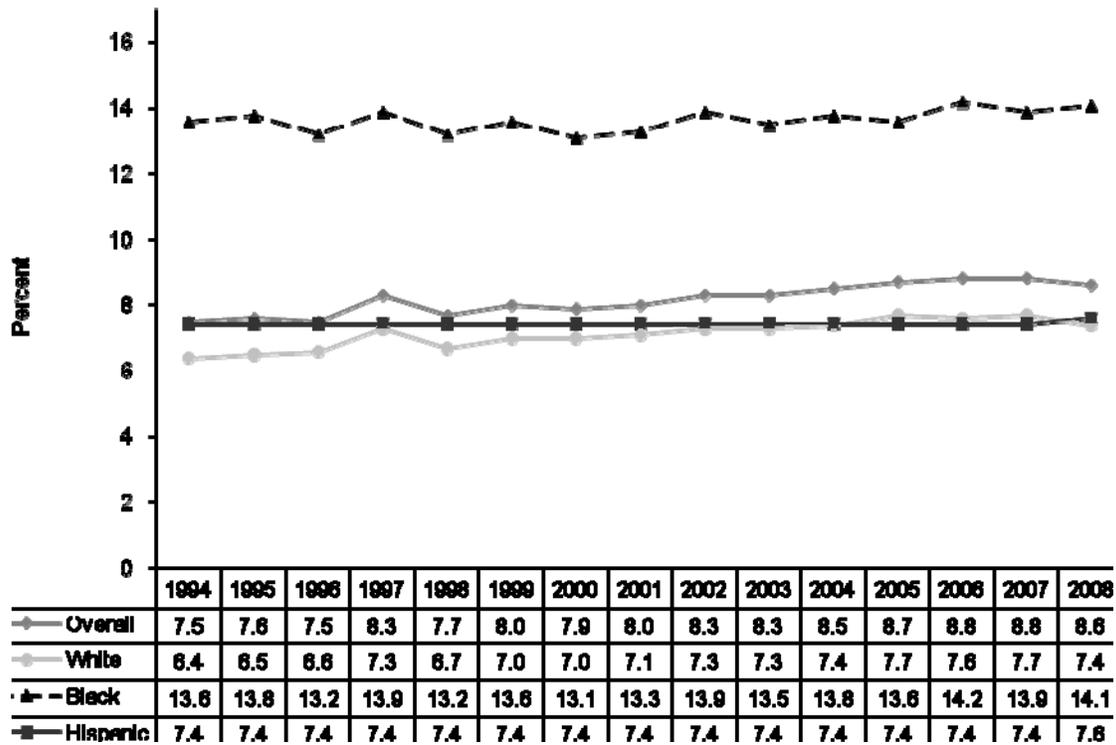
Maternal Risk Factors: Factors associated with increased risk of LBW include: minority status, age, poverty, low level of educational attainment, parity, previous pregnancy outcome, inadequate weight gain in pregnancy, multiple birth, infection, stress, smoking, other substance abuse and chronic health problems.

Quantitative Data: The LBW rate is usually expressed as the percentage of infants born in a given year with birth weight less than 2,500 grams. In Ohio in 2008, the LBW rate was 8.6 percent, higher than the national percentage of 8.2 in 2007.³⁴ The Healthy People 2010 target of 5.0 percent has not been met. Ohio's overall LBW rate increased from 7.5% in 1994 to 8.8% in 2006 (p=0.000), with no statistically significant change thereafter (p=0.410).

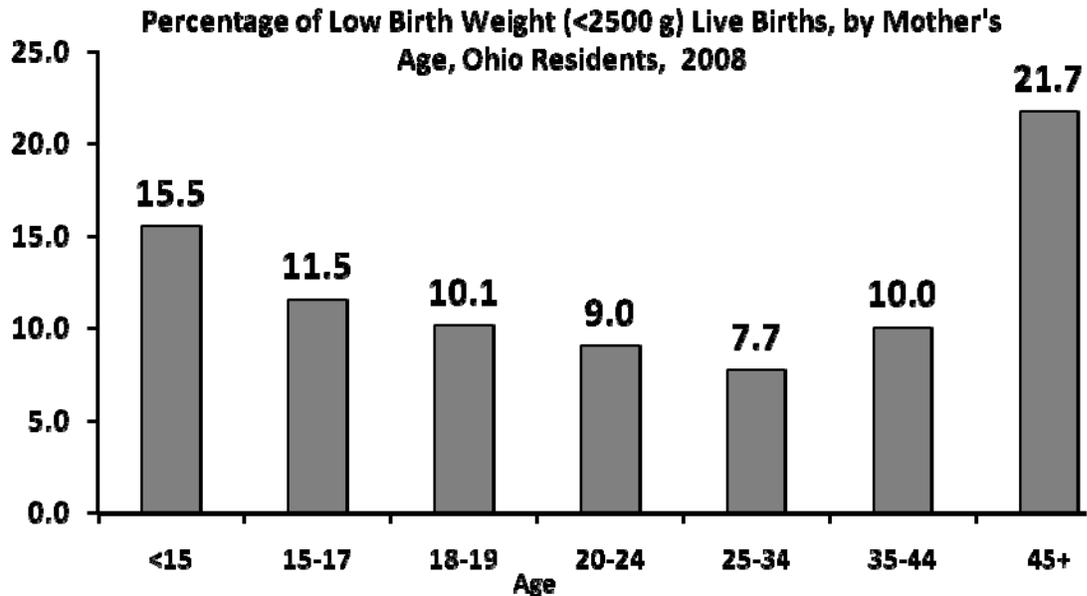
Racial/Ethnic Disparities: The Ohio white LBW percentage increased from 6.4 in 1994 to 7.6 in 2006 (p=0.000), but did not increase or decrease from that time through 2008 (p=0.236). The LBW percentage among blacks showed a statistically significant increase throughout the period 1994 through 2008 (p=0.031). The crude relative prevalence of LBW among blacks when compared to whites was 1.9 in 2008, which paralleled national data. The Ohio Hispanic LBW percentage did not change over the period (p=0.377) and was similar to that of whites in 2008.

Age Disparities: In 2008, prevalence of LBW in Ohio showed a clear relationship with mother's age, decreasing from 15.5% among mothers aged less than 15 years to a low of 7.7 percent among mothers aged 25-34 years, thereafter increasing monotonically with mother's age. Women aged 45 years and over were 2.8 times more likely to have a live born LBW infant when compared to women aged 25-34 years (21.7 versus 7.7 percent).

Percentage of Low Birth Weight (<2500 g) Live Births, by Mother's Race and Ethnicity, Ohio Residents, 1994 - 2008

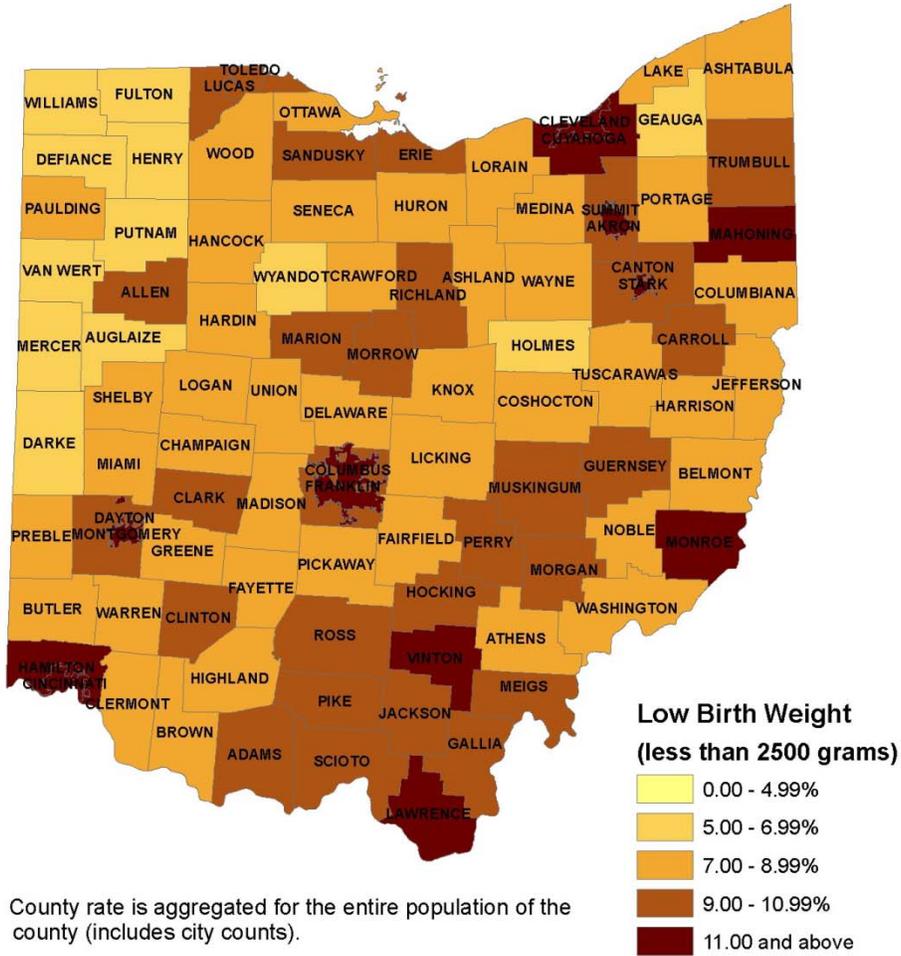


Data Source: Ohio Vital Statistics



Data Source: Ohio Vital Statistics

Percentage of Low Birth Weight Births* by County and Selected Cities of Ohio, 2006-2008



Healthy People 2020 Goal:
 Percentage of Low Birth Weight Births for Ohio 2006-2008: 9.60%
 Source: Ohio Vital Statistics

Very Low Birth Weight (VLBW)

Description: VLBW is a weight of less than 1,500 grams (about 3.3 pounds) at birth. Although infants weighing less than 1,500 grams comprise a small percentage of births, they account for up to half of the deaths of newborns. Nearly 90 percent of the very smallest infants (less than 500 grams) die within the first year of life. VLBW infants who survive are at significantly increased risk of severe problems including physical and visual difficulties, developmental delays and cognitive impairment. These conditions all require increased levels of medical, educational and parental care.

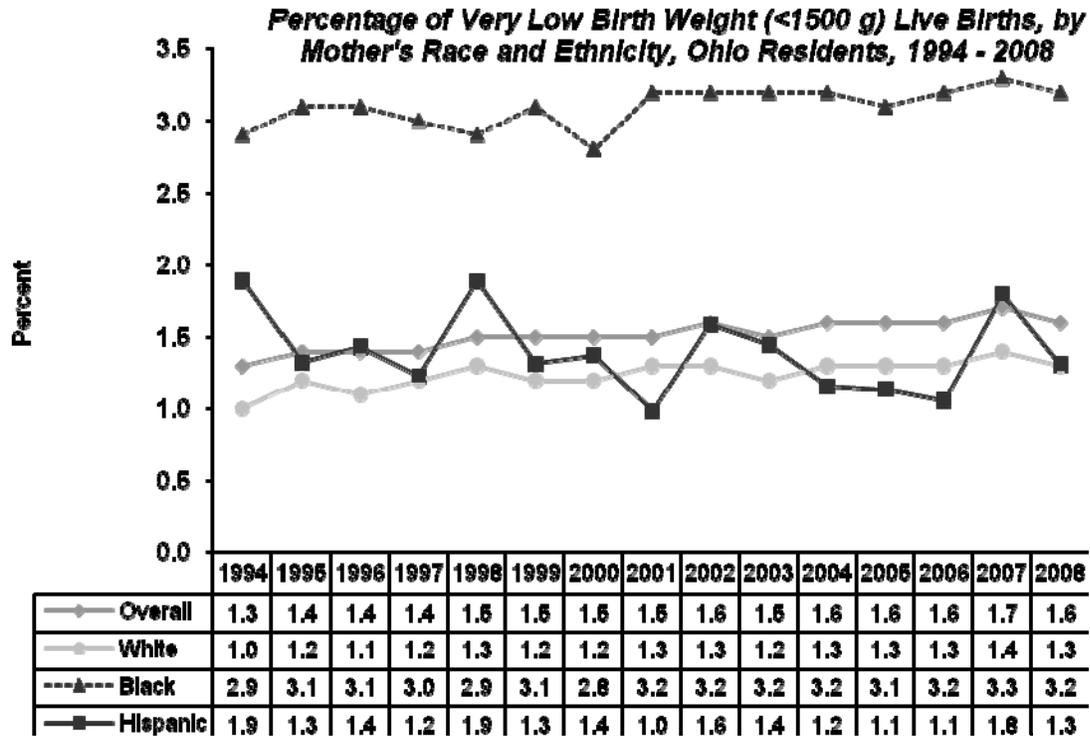
Maternal Risk Factors: VLBW is usually associated with preterm birth. Primary known risk factors for preterm birth include prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight and cigarette smoking during pregnancy. However, these risk factors account for only one-third of all preterm births. Substance use during pregnancy also may increase the risk of preterm birth. Risk of VLBW may be lessened with good pre-conception and prenatal care.

Quantitative Data: The VLBW rate is the percentage of infants born with birth weight less than 1,500 grams in a given year. In 2008, the overall Ohio VLBW rate was 1.6 percent³⁵. This was higher than the national rate of 1.5 in 2007 and higher than the HP 2010 target rate of 1.0 percent. A statistically significant increasing trend in VLBW percentage was observed in Ohio from 1994 through 2008 (p=0.000).

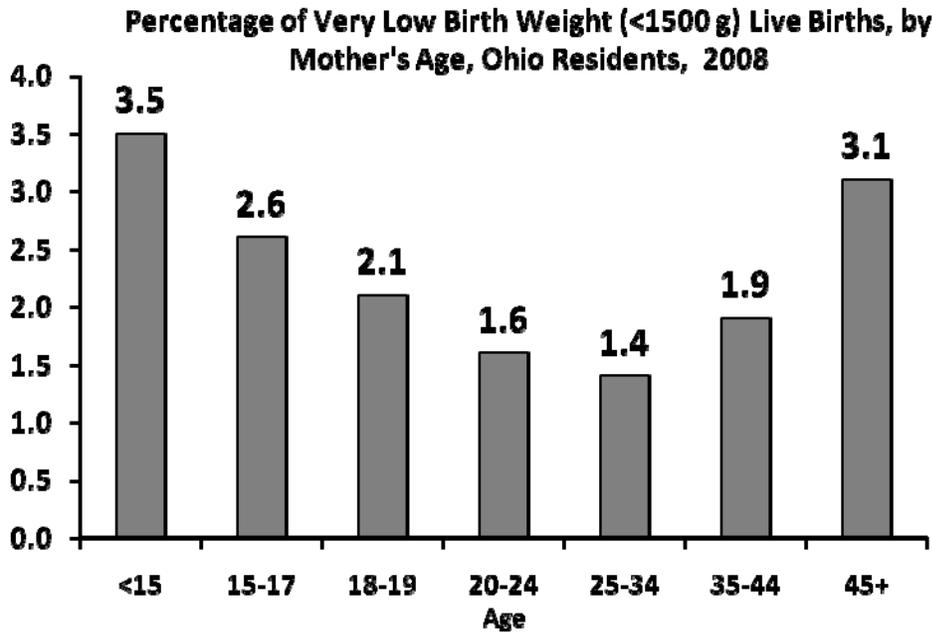
Racial/Ethnic Disparities: The white VLBW rate showed an increasing trend from 1994 through 2008 (p=0.000), as did that of blacks (p=0.010). In 2008, the crude relative prevalence of VLBW was 2.5 in blacks when compared to whites. Due to a relatively small numbers of births among Hispanics, greater variation in the VLBW rate from one year to the next was observed. However, the change in the percentage of Hispanic VLBW births over the period 2004-2008 was not statistically significant (p=0.429).

Age Disparities: VLBW by mother's age exhibited a U-shaped distribution similar to that of LBW, although mother's less than 15 years had the highest rate of VLBW (3.5%). Mothers aged 25-34 years experienced the lowest VLBW rate (1.4%).

³⁵ Ohio Vital Statistics.



Data Source: Ohio Vital Statistics



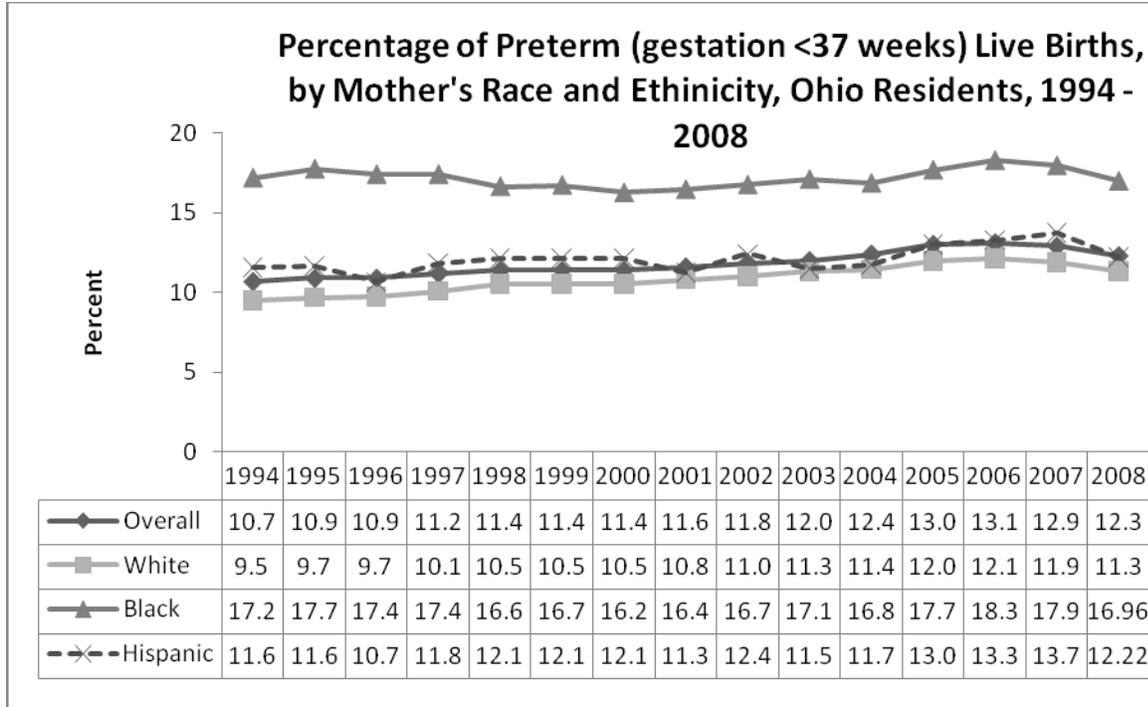
Data Source: Ohio Vital Statistics

Preterm Births

Description: Preterm birth is defined as a live birth that occurs before 37 completed weeks of gestation. It is common to classify preterm births into moderately preterm (32-36 weeks) and very preterm (<32 weeks). These classifications are useful because they often correspond to clinical characteristics of increasing morbidities or illnesses with decreasing gestational age. Babies born too soon are often born too small. While the causes of preterm birth and LBW may be different in some cases, there is significant overlap within these populations of infants.

Quantitative Data: In 2008, 10.7 percent of Ohio live births were classified as preterm.³⁶ This is higher than the HP target of 7.6 percent. The overall rate of Ohio preterm births increased between 1994 and 2002 ($p=0.000$) and between 2002 and 2006 ($p=0.009$). The rate of increase was steeper in the latter period (2002-2006) than in the previous one (1994-2002). The observed decrease from 2006 through 2008 was not statistically significant ($p=0.085$).

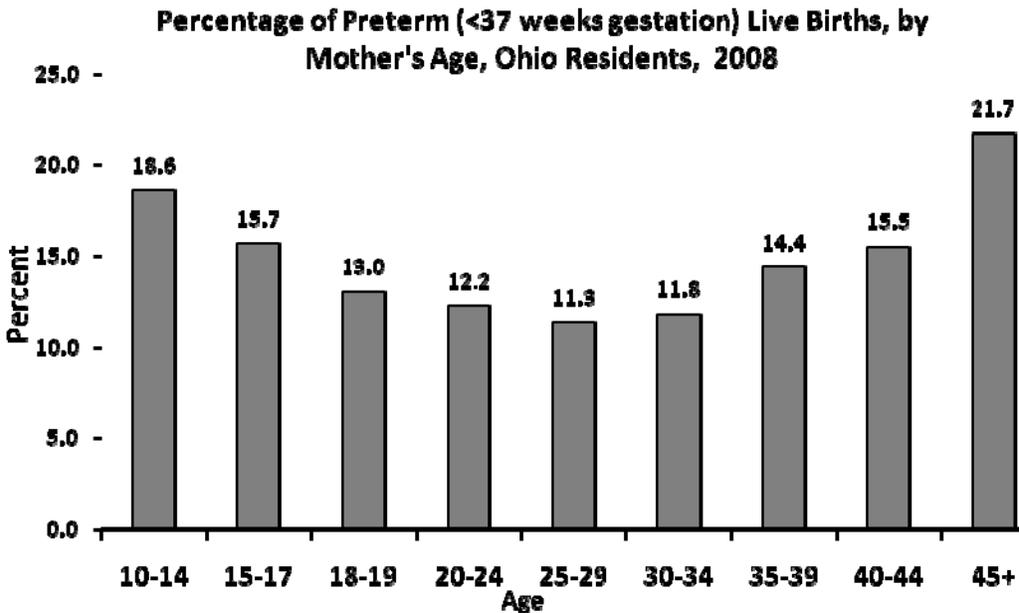
Racial/Ethnic Disparities: The pattern among whites was similar to the state preterm birth trend, with a significant increase observed until 2006 ($p=0.000$), and no statistically significant change thereafter ($p=0.196$). In blacks, the percentage of preterm births decreased between 1994 and 2001 ($p=0.016$) but then increased from 2001 through 2006 ($p=0.039$), after which it leveled off ($p=0.293$). The Hispanic preterm birth rate increased throughout the period 1994-2008 ($p=0.010$). It is not clear to what extent the change in birth certificate format (occurring in 2006) impacted these trends. In any given year, blacks experienced the highest preterm birth rate of all groups examined while that of Hispanics was slightly elevated over the white rate.



Data Source: Ohio Vital Statistics

³⁶ Ohio Vital Statistics.

Age Disparities: Maternal age is a risk factor for preterm births, with higher preterm birth rates found among the youngest and oldest mothers in the United States. In Ohio, mothers aged 45 years old had the highest preterm birth rate (21.7 percent), with the next highest rate among 10-14 year olds (18.6 percent). Those aged 25-29 experienced the lowest preterm birth rate (11.3 percent).



Data Source: Ohio Vital Statistics

Neural Tube Defects

Description: A neural tube defect (NTD) is the defective closure of the neural tube during early growth and development of the embryo. Spina bifida is the most frequently reported NTD, occurring twice as often as anencephaly. About 50 percent of NTDs may be prevented if women receive adequate doses of folic acid before and during pregnancy.

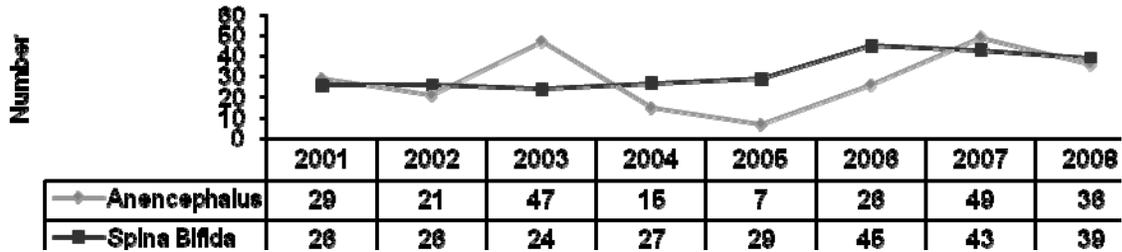
Quantitative Data: After a significant increase in the overall spina bifida rate in the United States from 1992 to 1995, there was a significant decline from 1995 to 1999, after which the rate leveled off through 2002. The overall rate for spina bifida in the United States in 2002 was 20.1 per 100,000 live births.

After a decline in the early part of the decade the overall United States anencephalus rate was stable during the mid-1990s (1994-97). The overall United States rate of anencephalus in 2002 was 9.6 per 100,000 live births, significantly lower than in 1997.

The decline in NTD is attributed in part to a 1996 Food and Drug Administration mandate requiring all breads and grains sold in the United States be fortified with folic acid by January 1998.

In Ohio in 2008, 39 spina bifida cases were recorded on resident birth certificates, while 36 cases of anencephalus. The quality of the birth certificate for providing accurate birth defects case counts is known to be poor.

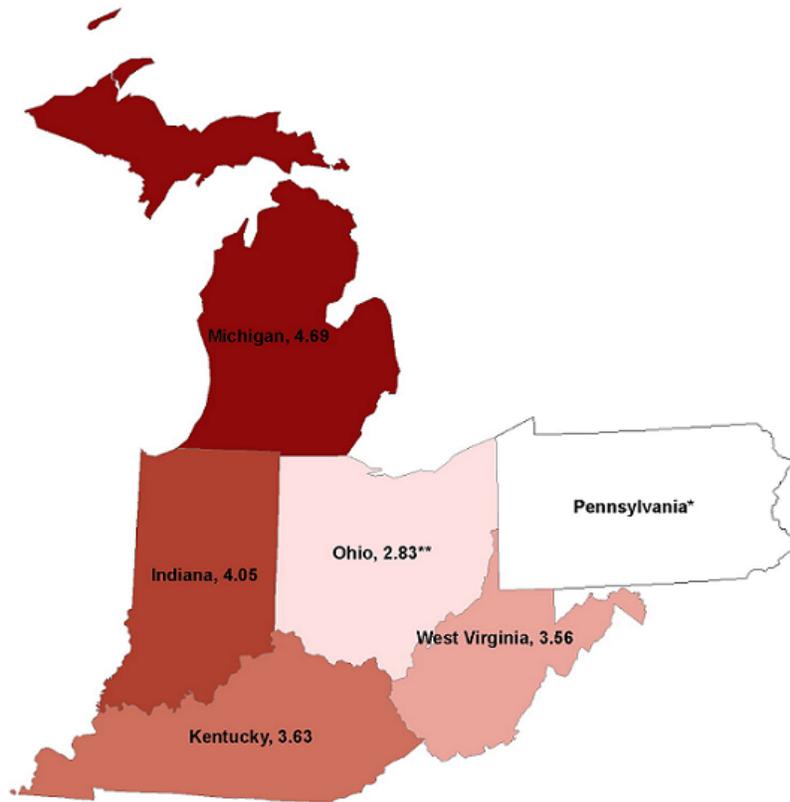
Ohio Neural Tube Defects, 2000 - 2008



Data Source: Ohio Vital Statistics

Spina Bifida Rates

Data from National Birth Defects Prevention Network (NBDPN)† and
Ohio Connections for Children with Special Needs (OCCSN),
Ohio Department of Health



Rates reported are per 10,000 live births.

* = Not Reporting to NBDPN.

** = Preliminary data, 2008.

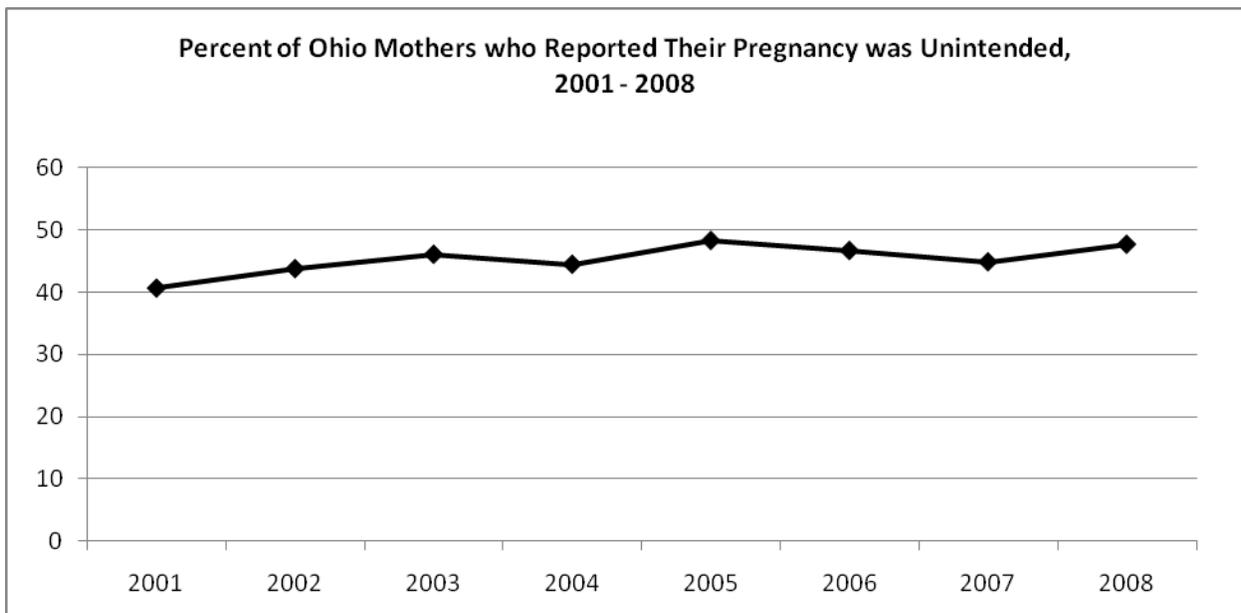
† = Data requested from 1/1/2002 through 12/31/2006.

B. 3 Contributing Factors

Unintended Pregnancy

Description: Unintended pregnancies include births that were not wanted at the time of conception (mistimed), births that were not wanted at all at conception and abortions. Unintended pregnancies resulting in live births are associated with delayed entry into prenatal care, poor maternal nutrition, cigarette smoking and alcohol and other drug use. Some unhealthy behaviors such as delayed entry into prenatal care may be related to the time frame in which women discovered the pregnancy.

Quantitative Data: Among Ohio mothers giving birth in 2008, 47.7 percent reported that their pregnancy was unintended which has increased from 40.7 percent in 2001.³⁷ In 2008, 35.1 percent reported their pregnancy as mistimed and 12.6 percent reported that their pregnancy was unwanted.



Data Source: Ohio PRAMS

Racial/Ethnic Disparities: In 2008, Black mothers reported a significantly higher prevalence of unintended pregnancy (66.3%) than White mothers (43.5%) or mothers of other races (50.8%).

Age Disparities: In Ohio in 2008, mothers under 20 years reported the highest prevalence of unintended pregnancy at 71.4 percent which was more than twice the prevalence for mothers over 35 years at 34.2 percent.

³⁷ Ohio Pregnancy Risk Assessment Monitoring System (PRAMS).

Cigarette Smoking During Pregnancy

Description: Cigarette smoking during pregnancy has been shown to increase the risk of spontaneous abortion, bleeding during pregnancy, other pregnancy complications and LBW. In addition, smoking during pregnancy has been associated with SIDS and other negative effects on child health and development. One major concern with accurate interpretation of this type of data is underreporting of smoking behavior.

Quantitative Data: In 2008, nearly 19.3 percent of Ohio mothers smoked during pregnancy. Ohio ranks among the 10 states with the highest rates of smoking during pregnancy. In Ohio, rates of smoking during pregnancy are highest among younger women and among women with less education. These trends are similar to those found in the United States overall. Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) data showed that in 2007, 28.5 percent of mothers smoked in the three months prior to pregnancy, 18.0 percent smoked during the last three months of pregnancy and 22.9 percent were smoking in the early post-partum period.³⁸ From 2000-2005 Ohio had increases in the rates for smoking before, during, and after pregnancy.³⁹ Among pregnant women participating in the WIC program, 22.1% reported smoking in the last 3 months of pregnancy.⁴⁰

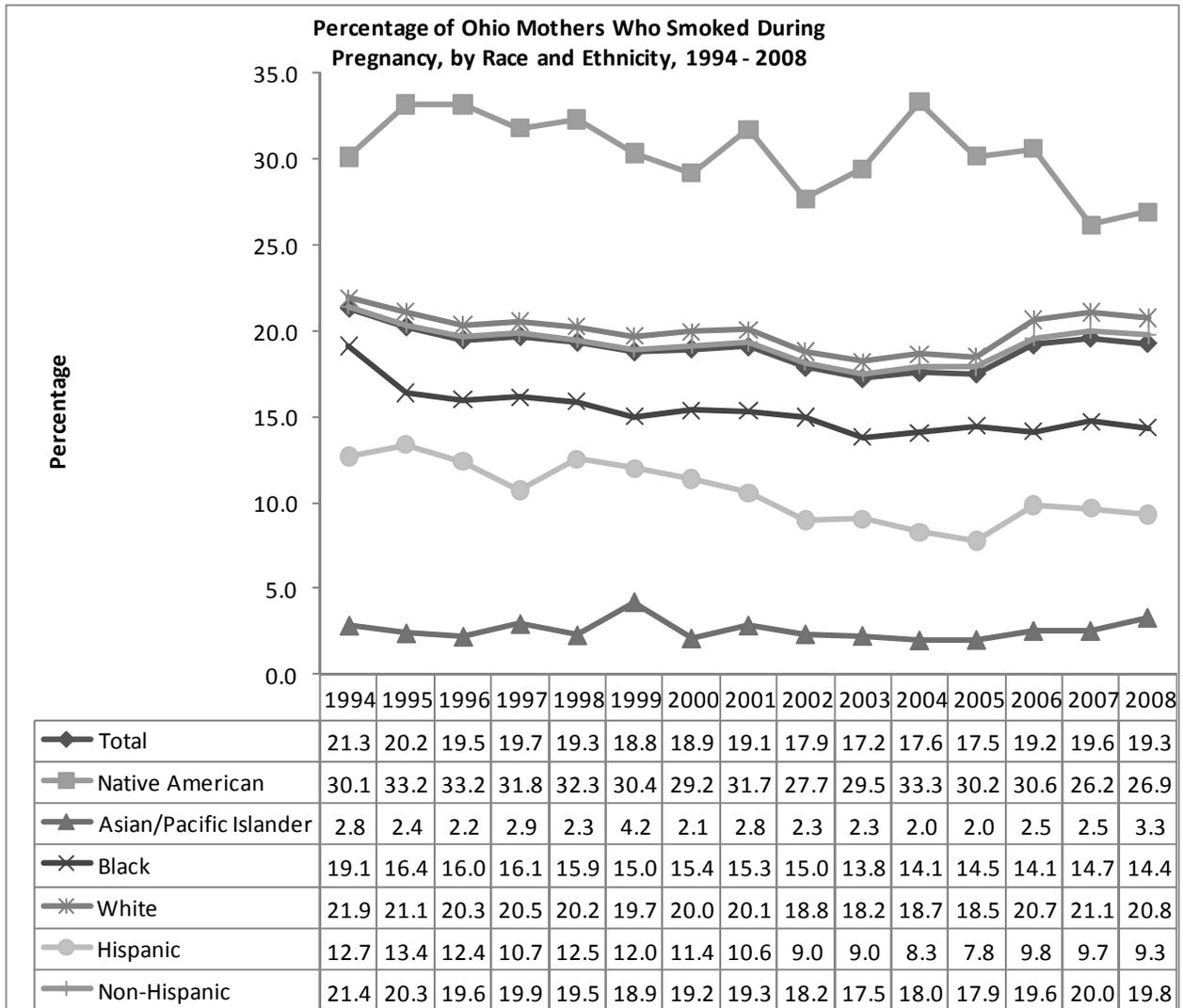
Racial/Ethnic Disparities:

The overall percentage of smoking during pregnancy in Ohio in 2008 was 19.3 percent. This is lower than the percentage observed in 1994 (21.3%) but higher than that in 2003 (17.2%). Women with the highest prevalence of smoking during pregnancy were of Native American decent (26.9% in 2008), followed by white women (20.8% in 2008). Those with lowest rates included Asians (3.3% in 2008) and Hispanics (9.3% in 2008).

³⁸ CDC PRAMS CPONDER online data center <http://www.cdc.gov/PRAMS/CPONDER.htm>.

³⁹ <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5804a1.htm>.

⁴⁰ Ohio Pregnancy Nutrition Surveillance System (PNSS), <http://www.odh.ohio.gov/healthStats/data/pnss/PNSS.aspx>



Data Source: Ohio Vital Statistics

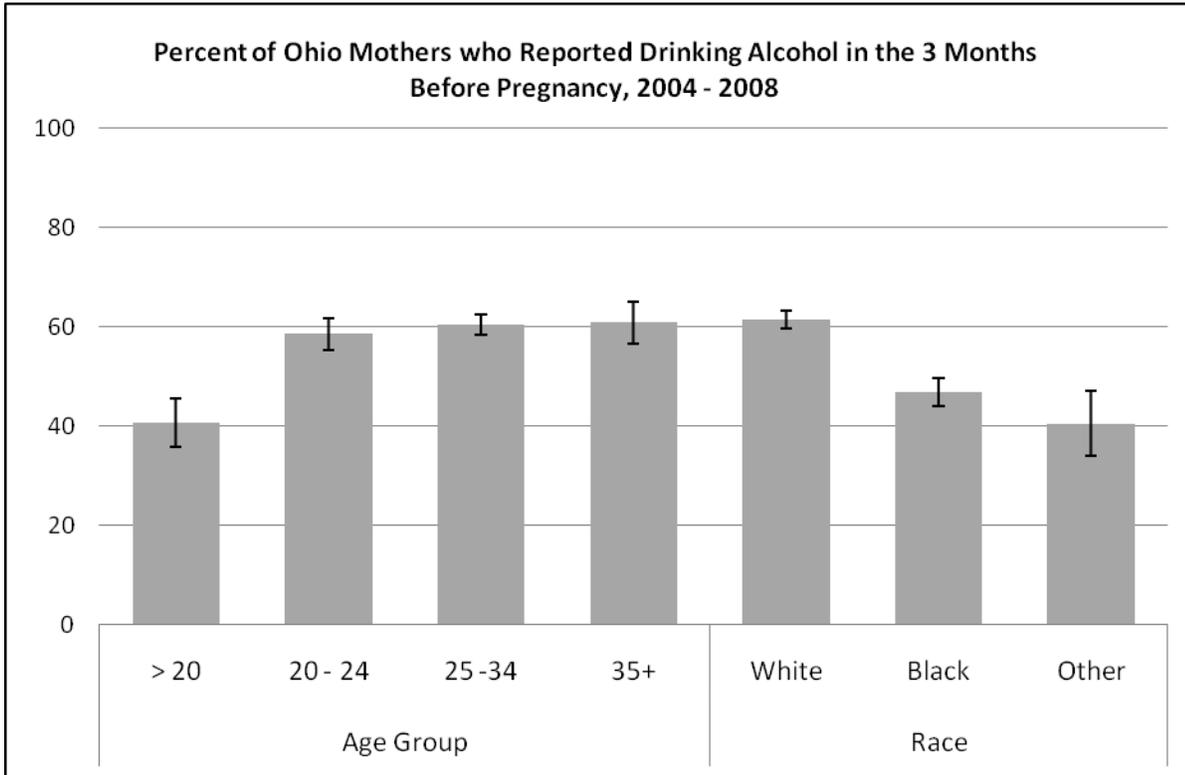
Alcohol Use During Pregnancy

Description: The use of alcohol during pregnancy is a leading cause of preventable defects and developmental disabilities. Heavy alcohol use during pregnancy is a risk factor for poor fetal alcohol spectrum disorders (FASD), which consist of growth abnormalities, central nervous system function abnormalities and facial characteristic abnormalities. Fetal alcohol effects consist of less severe effects in the same three areas. One major concern with accurate interpretation of these types of data is underreporting of alcohol use during pregnancy.

Quantitative Data: The Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) collects information on alcohol use in the 3 months prior to pregnancy. Because pregnancy confirmation often does not occur until several weeks into pregnancy, alcohol use during the earliest stages of pregnancy is likely to be captured by reported alcohol use during the 3 months before conception. PRAMS also assesses alcohol use during the last 3 months of pregnancy. In 2008, 60 percent of mothers of live born infants reported drinking alcohol during the 3 months before

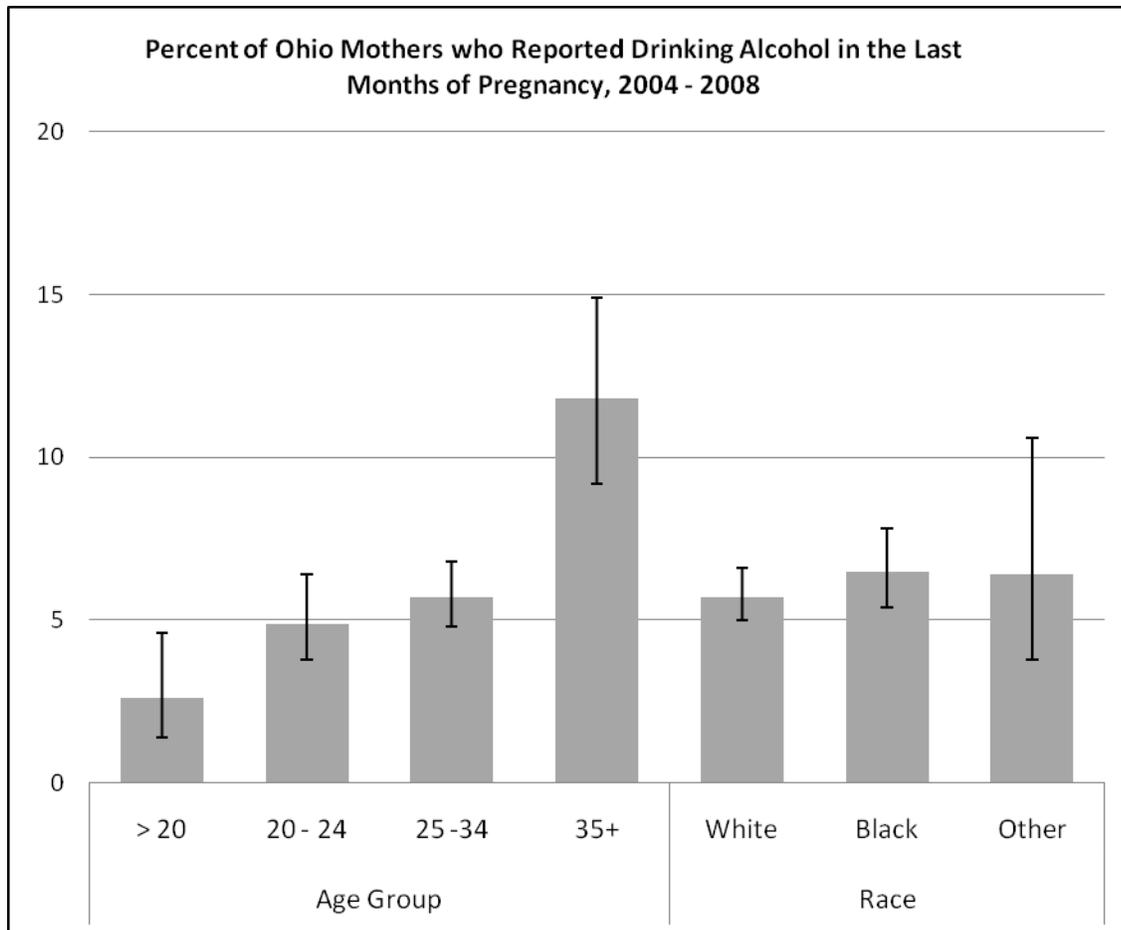
they got pregnant while 6 percent reported drinking any alcohol during the last 3 months of pregnancy.

Racial/Ethnic and Age Disparities before Pregnancy: In the 3 months before conception, women under 20 years of age reported the lowest prevalence of alcohol use. White women reported the highest prevalence of using alcohol in this period.



Data Source: Ohio PRAMS

Racial/Ethnic and Age Disparities during Pregnancy: Mothers over the age of 35 years reported a significantly higher prevalence of drinking alcohol during the last three months of pregnancy than any other age group. There were no significant differences among the races for alcohol use during the last three months of pregnancy.



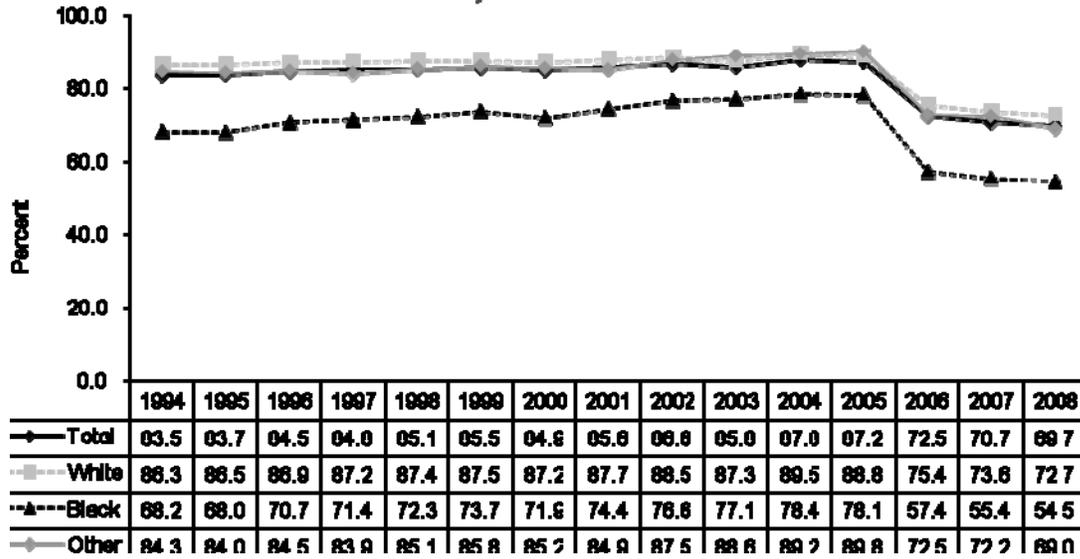
Data Source: Ohio PRAMS

Prenatal Care

Description: Early and high-quality prenatal care can help to prevent poor birth outcomes, especially by impacting high risk maternal behaviors such as alcohol, tobacco and other drug use.

Quantitative Data: First Trimester Prenatal Care: The rate of first trimester prenatal care is defined as the percentage of all births for which the mother began prenatal care in the first trimester. In each year examined, the percentage of black women with first trimester prenatal care was below that for white women. However, the quality of this information from the Ohio birth file is considered low since the percentage of missing data exceeds 20% and varies by race and hospital of birth. Trends tests were also not applied since information from the pre-2006 period was not comparable to that collected in 2006 and beyond. This was due to Ohio's adoption of the 2003 NCHS birth certificate format in 2006.

Ohio Women Receiving First Trimester Prenatal Care by Race, 1994 - 2008

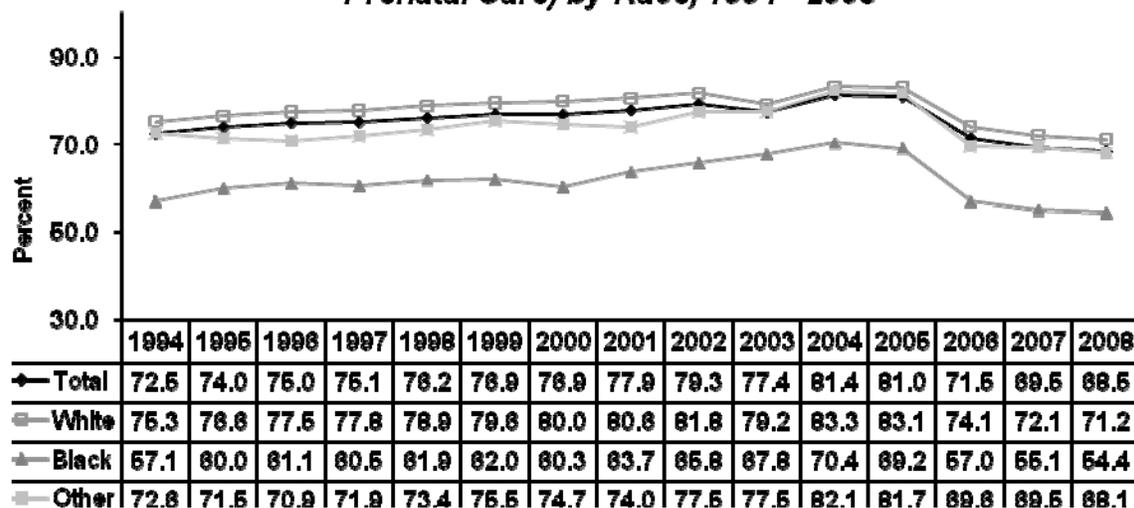


Data Source: Ohio Vital Statistics

Adequacy of Care: The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization Index, is an index of prenatal care based upon month of entry, number of prenatal visits and gestational age of an infant at birth. The following four levels comprise the index: Inadequate (0 through 49 percent of expected visits), Intermediate (50 through 79 percent), Adequate (80 through 109 percent) and Adequate Plus or Intensive (110 percent or greater). This index does not assess the quality of the prenatal care that is delivered, but rather its utilization.

In each year examined, the percentage of black women with adequate or better prenatal care was below that for white women. As with prenatal care timing, the quality of this information from the Ohio birth file is considered low since the percentage of missing data on prenatal care timing exceeds 20% and varies by race and hospital of birth. Trends tests were not applied to this measure since information from the pre-2006 period was not comparable to that collected in 2006 and beyond. This was due to Ohio's adoption of the 2003 NCHS birth certificate format in 2006.

Ohio Kotelchuck Index (Adequate and Adequate Plus Prenatal Care) by Race, 1994 - 2008



Birth Spacing

Description: Birth intervals of less than 18 months are associated with adverse maternal and child outcomes. A relationship exists between short birth intervals and preterm births, VLBW, LBW and small size for gestational age. Birth/pregnancy intervals are measured in three ways: 1) Birth-to-birth interval – the period between two consecutive live births, from birth date to birth date; 2) Birth-to-conception interval – the period between a live birth or stillbirth and the conception of the next pregnancy; and 3) Interpregnancy interval – the period from conception of the first child to conception of the next. The birth spacing statistics below do not include twin births or births with missing date information needed to calculate the interval between live births. The statistics also omit primiparous women.

Quantitative Data: In 2008, 87,381 births were preceded by a previous live birth, representing 59.7 percent of all live births⁴¹. Birth spacing was calculated by number of months between the month of current birth and the month of last live birth. Of these 87,381 births, 13.4 percent of Ohio infants were born less than 18 months after their mother’s previous live birth.

Racial/Ethnic Disparities: In 2008, 18.7 percent of black mothers had births that were preceded by a previous live birth of less than 18 months. 12.7 percent of white mothers had births that were preceded by a previous live birth in less than 18 months.

Age Disparities: Teen mothers are the least likely age group to have had a previous live birth. But teen multiparous women are the most likely to have experienced birth intervals of less than 18 months. In 2008, 37.1 percent of Ohio mothers 10 to 19 years of age had births that were preceded by a previous live birth of less than 18 months. 11.5 percent of mothers 20 to 34 years of age had births that were preceded by a previous live birth in less than 18 months. Only 6.0

⁴¹ Ohio Vital Statistics.

percent of women 35 years and older who gave birth in 2008 had births that were preceded by a previous live birth in less than 18 months.

Prepregnancy BMI and Gestational Weight Gain

Description: Body mass index (BMI) is a measure of weight in relation to height, expressed as wt (kg) / ht² (m). BMI criteria developed by the World Health Organization (WHO) are commonly used to classify adults as underweight, normal weight, overweight, and obese.

- *Underweight* is defined as BMI below 18.5. The lower a woman’s BMI the more likely she is to be undernourished. Women who are underweight prior to pregnancy are at higher risk for poor birth outcomes including, low birth weight, fetal growth problems, perinatal mortality, and other pregnancy complications.⁴²
- *Normal weight* is defined as a BMI between 18.5 and 24.9.
- *Overweight:* is defined as a BMI of 25.0 up to 29.9. Being overweight prior to pregnancy is a risk factor for postpartum weight retention.⁴³
- *Obese* is defined as a BMI greater than 30.0. Obese women are at greater risk of delivering an infant much larger than normal weight for their developmental age, and experiencing shoulder dystocia and other complications.⁴⁴ Obese women are also more likely to develop gestational diabetes.

Maternal (or gestational) weight gain refers to the weight change during the period from conception to delivery. The 2009 Institute of Medicine (IOM) recommendations for singleton pregnancy weight gain are as follows.

Weight	Pre-Pregnancy BMI	Recommended Total Weight Gain (lb)
Underweight	<18.5	28–40
Normal weight	18.5 – 24.9	25–35
Overweight	25.0 – 29.9	15–25
Obese	>30.0	11-20

Data Source: IOM 2009

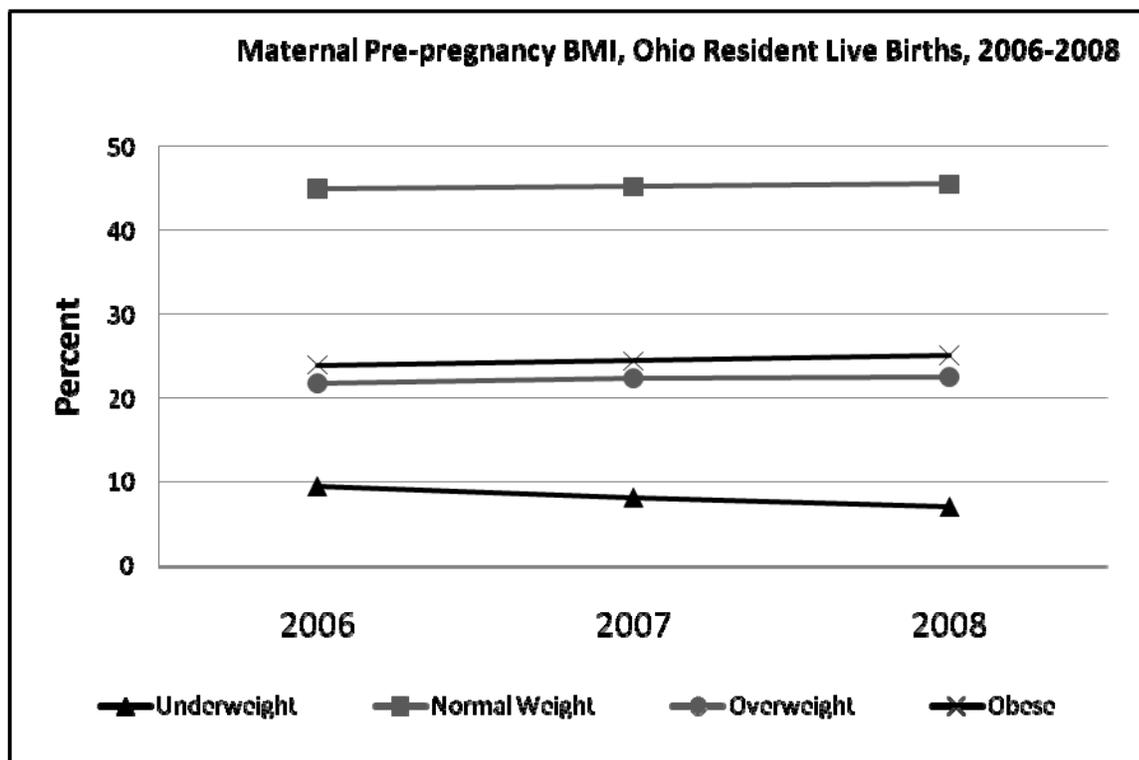
Quantitative Data: The Ohio birth certificate began collecting mothers’ height in 2006, along with pre-pregnancy and delivery weight, allowing for the calculation of pre-pregnancy BMI and adequacy of weight gain for all Ohio mothers of live born infants.

Because there are only three years of available data, trends tests were not carried out.

⁴² Institute of Medicine 2009, <http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx>.

⁴³ Institute of Medicine 2009, <http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx>

⁴⁴ Institute of Medicine 2009, <http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx>



Data Source: Ohio Vital Statistics

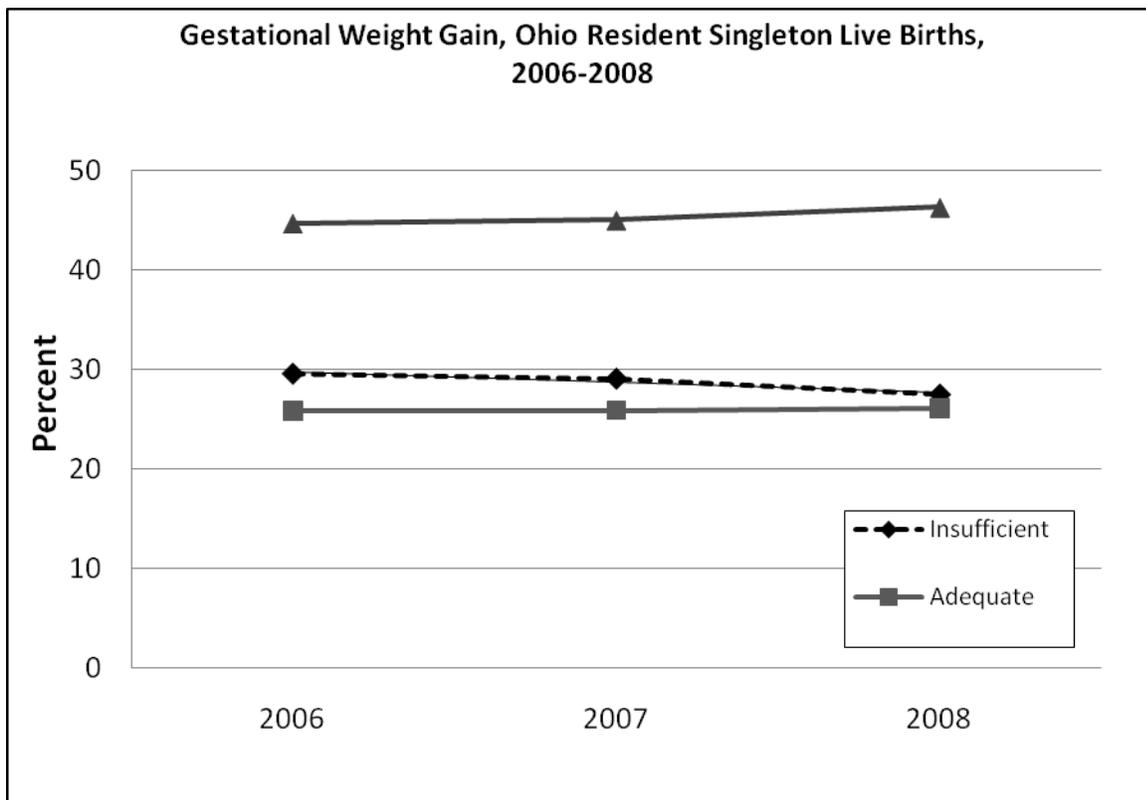
Quantitative Data: In 2007, 23.5 percent of Ohio mothers were classified as obese before they became pregnant.⁴⁵ In 2008, black women were more frequently classified as obese prior to pregnancy than women of other racial groups. Hispanic women were more frequently classified as underweight than those of other groups.

Pre-pregnancy BMI of Ohio Mothers by Race, 2008

	Underweight (%)	Normal Weight (%)	Overweight (%)	Obese (%)
White	7.0	47.0	22.2	23.8
Black	6.2	36.3	24.6	32.9
Asian	12.1	63.1	15.8	9.1
Native American	7.1	44.4	22.0	26.5
Hispanic	15.1	38.5	22.2	24.1

Data Source: Ohio Vital Statistics

⁴⁵ Ohio Pregnancy Risk Assessment Monitoring System (PRAMS).



Data Source: Ohio Vital Statistics

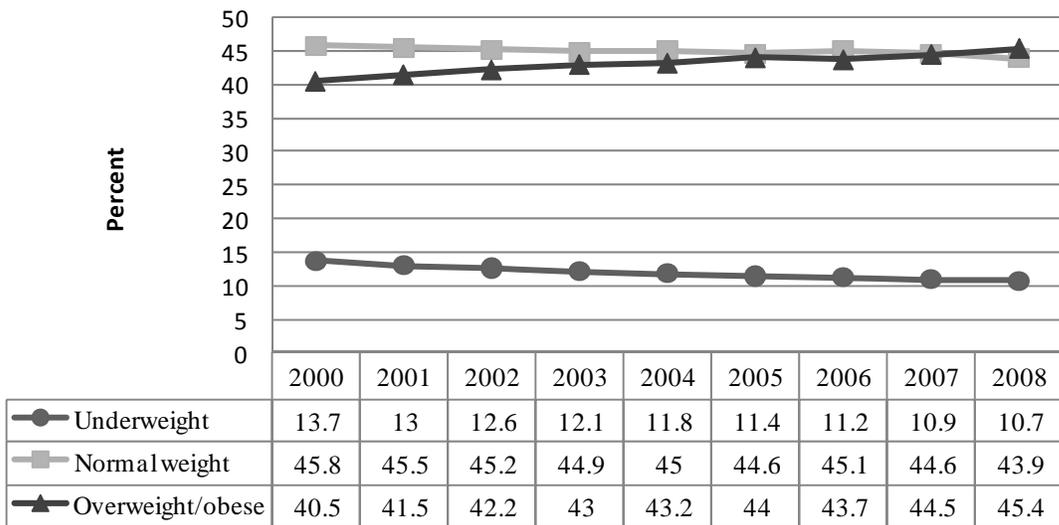
In 2008, black women were most likely of groups examined to gain insufficient weight during pregnancy, while white mothers were most likely to exceed weight gain recommendations. Asian and Hispanic women were the most likely to exhibit appropriate weight gain.

Gestational Weight Gain, By Race, Ohio Resident Singleton Live Births, 2008

	Insufficient (%)	Adequate (%)	Excessive (%)
White	25.9	26.7	47.4
Black	34.5	22.4	43.1
Asian	32.3	35.1	32.6
Native American	30.0	24.7	45.3
Hispanic	26.1	35.3	38.6

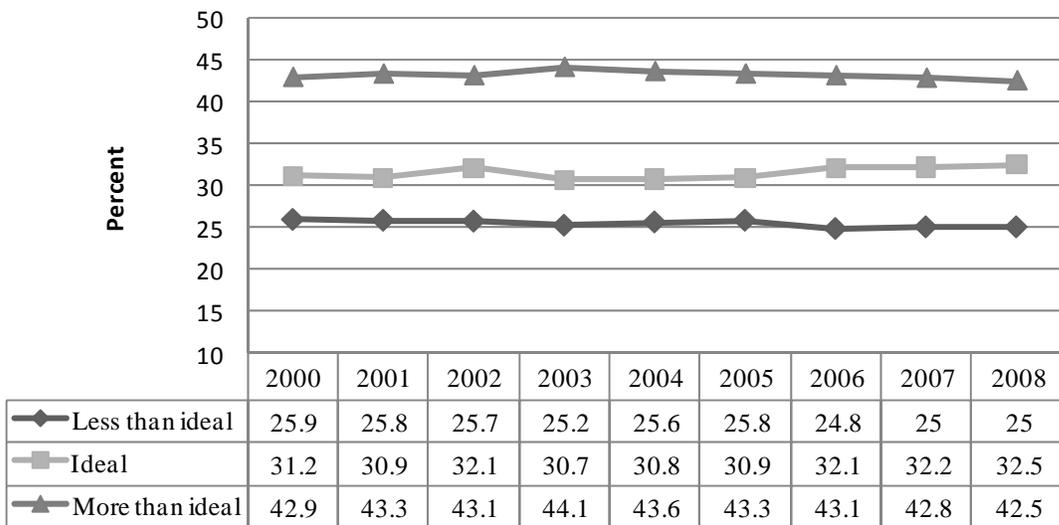
Source: Ohio Vital Statistics

Prepregnancy BMI of Mothers with Live-born Infants Participating in the WIC Program, Ohio 2000-2008



Data Source: CDC PDNSS

Weight Gain During Pregnancy Among Women with Live Births Participating in the WIC Program, Ohio 2000-2008

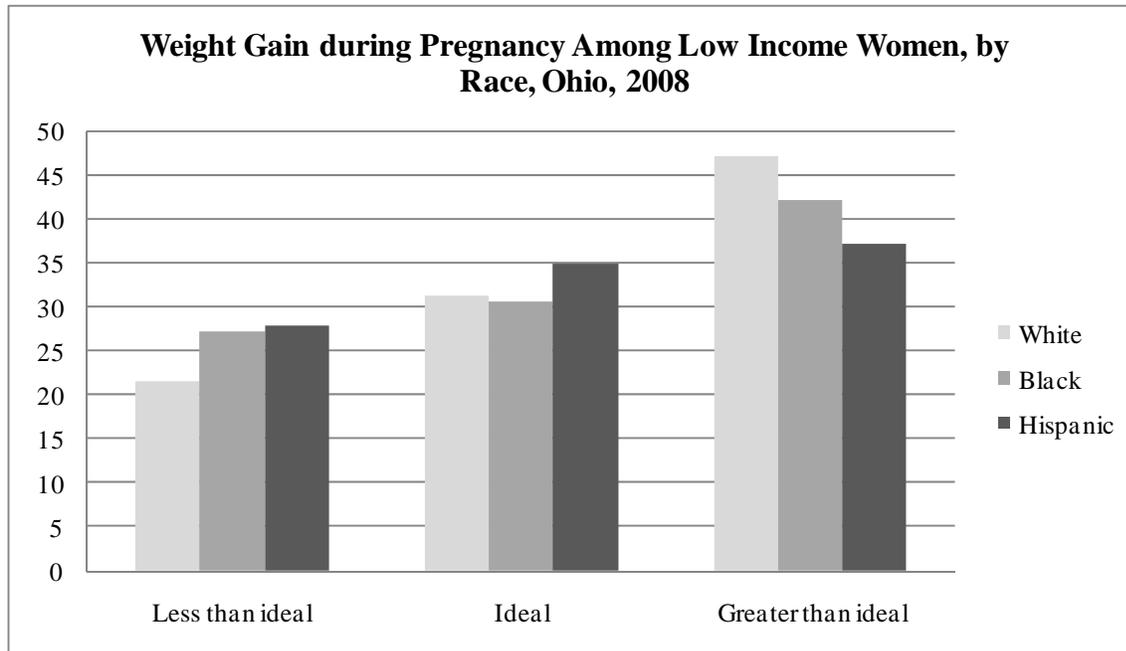


Data Source: CDC PDNSS

Among low-income pregnant and postpartum women enrolled in WIC, 44 percent were of normal weight before pregnancy.⁴⁶ Thirty percent of all Ohio women enrolled in WIC with live births were obese; 15 percent were overweight and 11 percent were underweight. Among women

⁴⁶ Pregnancy Nutrition Surveillance System (PNSS), <http://www.odh.ohio.gov/healthStats/data/pnss/PNSS.aspx>

enrolled in WIC with live births in 2008 32.5 percent had ideal maternal weight, 25 percent had less than ideal maternal weight gain, and 42.5 percent greater than ideal weight gain.



Data Source: CDC PNSS

Violence, Abuse and Stress

Percentage of Ohio Mothers Experiencing Violence, Abuse, or Stress Before or During Pregnancy, Ohio, 2008		
	% of Black Mothers (95% CI)	% of White Mothers (95% CI)
Argued more than usual with partner	42.4 (37.4 - 47.5)	27.8 (24.2 - 31.7)
Was in a physical fight	13.7 (10.5 - 17.7)	3.4 (2.2 - 5.3)
Woman or partner went to jail	13.3 (10.1 - 17.2)	5.3 (3.6 - 7.7)
Physical abuse BEFORE pregnancy - husband or partner	8.3 (5.9-11.7)	2.6* (1.6 - 4.3)
Physical abuse BEFORE pregnancy - ex-husband or ex-partner	11.2 (8.3 - 14.9)	4.7 (3.2 - 6.9)
Physical abuse DURING pregnancy - husband or partner	6.7* (4.5 - 9.9)	1.7* (0.9 - 3.3)
Physical abuse DURING pregnancy - ex-husband or ex-partner	7.8 (5.4 - 11.1)	2.4* (1.4 - 4.3)

Sexually Transmitted Infections and Perinatal Transmission of HIV

Description: Sexually transmitted infections are risk factors for adverse perinatal outcomes such as miscarriage, ectopic pregnancy, stillbirths, preterm delivery, newborn illness and death. Women with a sexually transmitted infection are two to five times more likely to acquire HIV infection if they are exposed through sexual contact.⁴⁷ Perinatal transmission of HIV accounts for 91 percent of all AIDS cases among children under the age of thirteen in the United States and 100 percent of all AIDS cases among children under the age of thirteen in Ohio.⁴⁸

Reported Ohio Perinatal HIV Transmissions by Year of Birth

Year of birth	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
No.	4	4	7	4	3	4	1	5	4	6

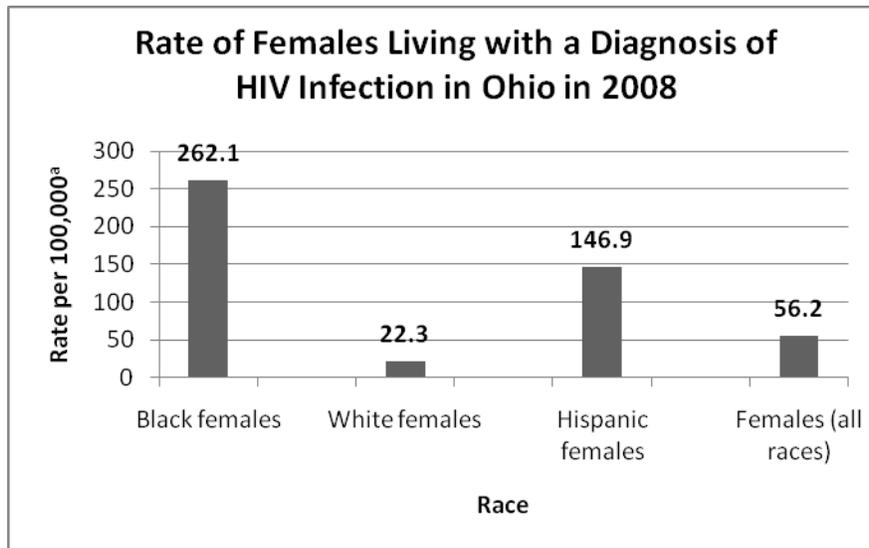
Source: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through June 30, 2009.

The widespread use of antiretroviral therapy during pregnancy has greatly reduced the number of children born with HIV infection. However reports of perinatal HIV transmission are underestimated. Reasons for this include women not seeking adequate prenatal care, lack of routine testing at physicians’ offices, and a significant number of women (nearly one in four according to the Centers for Disease Control and Prevention) who are unaware of their HIV status. In addition, children born to mothers who are HIV positive are known to be under-reported, making the number of children in Ohio exposed to HIV perinatally difficult to quantify. Two methods of screening pregnant women for HIV infection exist. The opt-in method requires either the mother or the healthcare provider to request a HIV test and written consent must be obtained.⁴⁹ In the opt-out method all patients are notified that they will be screened for HIV infection along with other routine prenatal tests. The test is performed unless the patient specifically declines. Rates of testing are much higher when the opt-out method is utilized, and women have reported feeling less anxiety about the HIV screening when it was included with other routine prenatal tests.⁴⁹ The CDC recommends that states adopt the opt-out policy.⁴⁹ Several states have adopted this policy; however Ohio currently employs opt-in screening for pregnant women.

Quantitative Data: The rate of Chlamydia among women of all ages in Ohio in 2008 was 406.6 cases per 100,000 women, compared to an overall rate of 401.3 cases per 100,000 women in the United States. In 2008, the rate of gonorrhea among women in Ohio was greater than the national rate, 143.6 and 111.6 per 100,000 women, respectively. The rate of syphilis among women in Ohio was greater than the national average rate, 6.7 and 4.5 cases per 100,000 women respectively. The Ohio 2008 rate of congenital syphilis was lower than the national average. Ohio’s 2008 average rate of cases per 100,000 live births was 1.3 compared to the overall rate of 10.1 cases of congenital syphilis per 100,000 live births in the United States.⁴⁷ The rate of women living with a diagnosis of HIV infection in Ohio in 2008 is 56.2 per 100,000 Ohioans.⁴⁸

The number of women living with a diagnosis of HIV infection in Ohio increased 26 percent between 2004 and 2008.⁴⁸

Racial/Ethnic Disparities: Significant racial disparities are evident when examining the effect of HIV on women in Ohio. Black women have been hardest hit by the HIV epidemic. In 2008, black females made up 6 percent of Ohio’s population, yet accounted for 13 percent of all reported persons diagnosed with HIV infection in Ohio. The rate of black women living with a diagnosis of HIV infection in Ohio is 12 times higher than white women. The rate for Hispanic women living with a diagnosis of HIV infection is 7 times higher than white females.⁴⁸



^a The rate is the number of persons living with HIV/AIDS per 100,000 population calculated using 2000 census data. Source: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through Dec. 31, 2008.

References

⁴⁷ Ohio data: Ohio Department of Health Sexually Transmitted Disease Data; National Data: CDC STD Surveillance Data.

⁴⁸ Ohio Department of Health: HIV/AIDS Surveillance Program. <http://www.odh.ohio.gov/healthStats/disease/hivdata/hivcov.aspx>.

⁴⁹ The Centers for Disease Control and Prevention. MMWR. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-care Settings. September 22, 2006. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

B.4. Priority Issues for Maternal and Infant Health

MCH Stakeholder-identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the Maternal and Infant Health group. A list of group members can be found at the end of this report.

Group Rank	Health Issue
1	Disparities in health outcomes
2	Health behaviors (e.g., nutrition, physical activity, substance use smoking, alcohol, drug use, oral health, breastfeeding)
3	Access to care/Insurance coverage (e.g., women, infants, coordination of social and community resources/services)
4	Well woman care (e.g., preconception and inter-conception care, immunizations)
5	Sexual behaviors and their consequences (e.g., unintended Pregnancy, STDS, teen pregnancy, family planning/pregnancy prevention)
6	Pre-natal/Post-partum care (e.g., childbirth education, abuse/violence)
7	Birth outcomes (fetal/neonatal mortality, pre-term, low birth weight, birth defects)
8	Neonatal care (e.g., 1 st visit, immunizations, specialist follow up, car seats, back to sleep/safe sleep, shaken baby)
9	Breastfeeding
10	Mental health
11	Safety (e.g., safety belts, abuse/violence, living environment)
12	Chronic disease prevention, treatment and management
13	Educational attainment

Local Agency-identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects, WIC projects, practitioners and providers across Ohio requesting feedback in regard to the top 10 priorities identified in the last Maternal and Child Health Needs Assessment. Health care issues gathered from the survey provided a local perspective to the issues for each sub-population group.

Women’s Health, Birth Outcomes and Newborn Health Stakeholders Group identified themes from local stakeholder survey:

- Nutrition
 - Breastfeeding
 - Obesity
 - Healthy eating
- Physical activity
- Parenting skills
 - Breastfeeding
- Access to care
 - Lack of insurance
 - Appropriate care
 - Prenatal/preterm/low birth weight
- General education
- Health literacy
 - Provider’s role
 - Parent’s role
- Substance abuse
- Unplanned pregnancy
- Infections
 - STD/MRSA/Immunization
- Safety
 - Violence
- Pre-natal care
 - Low birth weight/premature delivery
 - Poor outcomes
- Mental health
- Social support
 - Transportation
 - Physical environment
- Poverty
- Infant mortality
- Chronic disease
- Birth control

C. Early Childhood Health Status

C.1 Mortality

Overall Mortality Ages 1 through 4

Description: Nationally, the 2008 mortality rate for children ages 1-4 was 28.4 per 100,000 children in that age group. Injuries were the leading cause of death, accounting for 43 percent of deaths.⁴⁷ Unintentional injury, specifically, continued to be the leading cause of death among 1-4-year olds, accounting for 35 percent and 37 percent of all deaths, respectively. The next leading cause of death was congenital anomalies (birth defects), followed by malignant

⁴⁷ <http://mchb.hrsa.gov/mchirc/chusa>.

neoplasms (cancer), homicide, and diseases of the heart.⁴⁸

Quantitative Data: The overall death rate for children aged 1-4 years in Ohio in 2002 was 30.4, similar to the national rate of 28.4 but higher than the Healthy People 2010 goal of 25. The mortality rate for this age group has declined since 1994, when the rate was 40.9.

Racial/Ethnic Disparities: Black early childhood mortality has remained much higher than for white children. In 2008 the mortality rate for black children aged 1-4 years was 44.0, while the rate for white children was 28.4.⁴⁹



Data Source: Ohio Vital Statistics

Mortality Due to Motor Vehicle Crashes

Description: Injury is the leading cause of death in children. Motor vehicle (MV) crashes are the leading cause of mortality from injury, accounting for about 30 percent of all injury deaths among 1–4 year-olds.

Quantitative Data: Children aged 1 through 4: In 2005-7 MV accident mortality rate for Ohio was 2.0.⁵⁰ In 2007, children aged 1 through 4 had a mortality rate for MV accidents of 2.4, lower than the national 2008 rate of 2.9, and higher than the HP 2010 target rate of 2.1.⁵¹

Racial/Ethnic Disparities: Black children are somewhat more likely to die in MV accidents compared to white children with rates of 3.0 and 2.3, respectively.

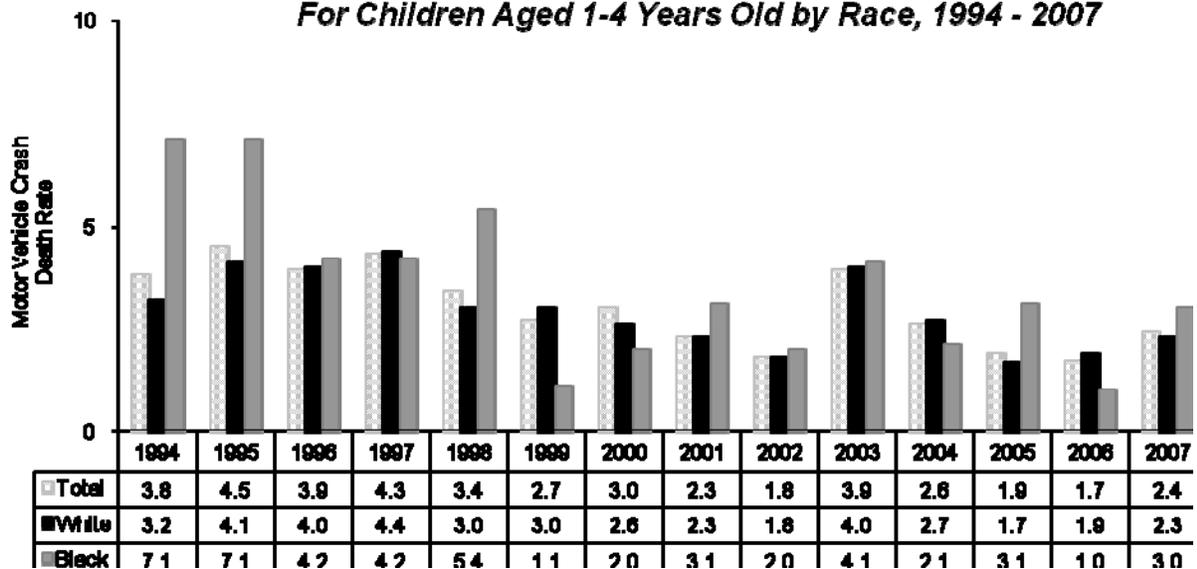
⁴⁸ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Apr 12, 2010.

⁴⁹ Ohio Vital Statistics.

⁵⁰ Ohio Vital Statistics.

⁵¹ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Jun 4, 2010.

**Ohio Motor Vehicle Crash Death Rates (per 100,000 population)
For Children Aged 1-4 Years Old by Race, 1994 - 2007**

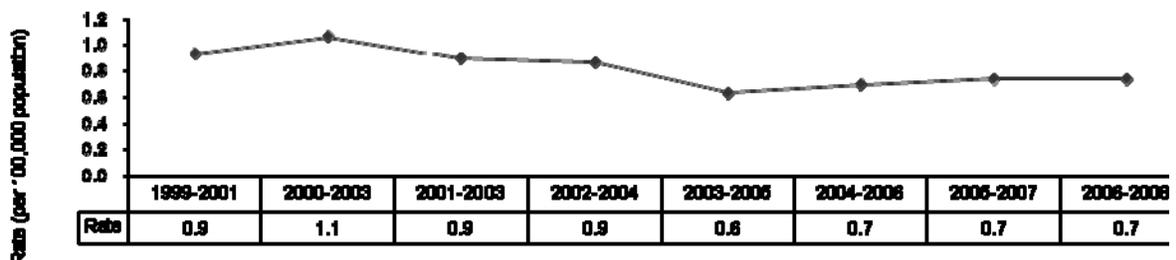


Data Source: Ohio Vital Statistics

Mortality Due to Child Abuse

The death rate for children ages 1 – 4 years due to child abuse decreased slightly between 1999 and 2008. Rates should be interpreted with caution due to the low numbers which can produce unstable estimates. There were four deaths in 2006, six deaths in 2007, and three deaths in 2008.

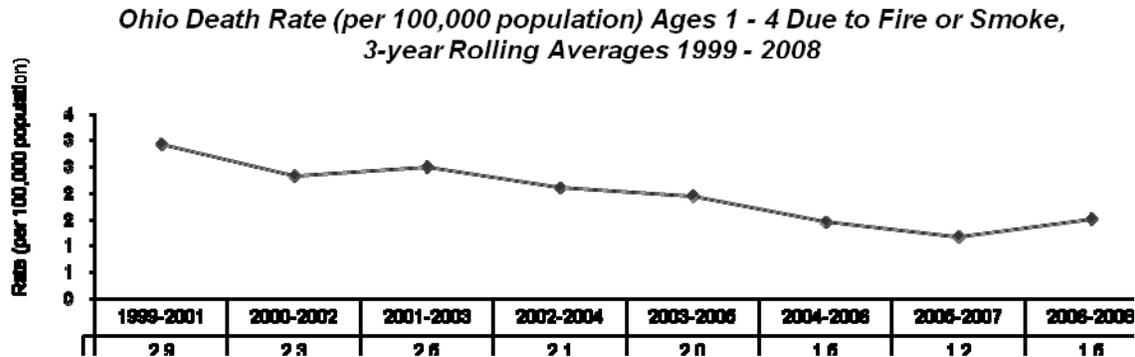
**Ohio Death Rate (per 100,000 population) Ages 1-4 Due to Child Abuse,
Rolling 3-year averages, 1999-2008**



Data Source: Ohio Vital Statistics

Mortality Due to Fire and Smoke

Deaths due to fire and smoke among children 1 – 4 years of age decreased slightly between 1999 and 2008. There were 9 deaths in 2006, 7 in 2007, 21 in 2001 and 11 in 2008.



Data Source: Ohio Vital Statistics

C. 2 Environmental - Morbidity

Elevated Blood Lead Levels

Description: High blood lead levels are among the most prevalent childhood conditions and the most prevalent environmental threat to the health of children. An elevated blood lead level is defined as greater than or equal to 10 micrograms per deciliter. Childhood lead poisoning is totally preventable. However, the amount of lead in paint, dust and soil has been reduced to only a limited extent. Lead in the home environment is the major remaining source of human lead exposure. Health effects of high levels of lead include coma, convulsions, developmental delay, seizures and death. Lower levels of exposure can result in chronic impairment of the central nervous system, including decreased cognitive development, reduced IQ and growth deficiency. Children between 0 and 6 years of age are at highest risk for the negative physiological effects of lead poisoning.

Quantitative Data: In Ohio in 2008, 1.7 percent of all children aged 0-72 months screened for elevated blood lead levels were found to have levels in excess of 10 micrograms per deciliter. This continued a trend of decline in percentage of screened children with high levels, down from 1.9 percent in 2007, 2.3 percent in 2006 and 2.8 percent in 2005.⁵²

Asthma

Description: Asthma is a chronic inflammatory disorder of the airways characterized by variable airflow obstruction and airway hyper-responsiveness in which prominent clinical manifestations include wheezing and shortness of breath. It is a multi-factorial disease that has been associated with familial, infectious, allergenic, socioeconomic, psychosocial and environmental factors. Asthma is one of the most common chronic diseases in the United States, and it has increased in importance during the preceding 20 years. Despite its importance, no comprehensive

⁵² "Childhood Lead Poisoning," Ohio Department of Health, http://www.odh.ohio.gov/Data/Lead_Poison/lead1.htm.

surveillance system has been established that measures asthma trends in children at the state or local level.

Quantitative Data: The rate of asthma prevalence among U.S. children less than 18 years old is 9.3 per 100,000 children and asthma attack prevalence is 5.5 per 100,000 children.⁵³ The highest rates for primary diagnosis of asthma hospital discharges are for children under age 5 (39.5 per 100,000 residents), 56.7 percent higher than the next nearest age group in 2003.⁵⁴

Children in households with annual incomes of less than \$25,000 were more likely than those with higher annual household incomes to have more than one emergency department visit for asthma. Parents who reported a child having asthma are significantly more likely to face a variety of health care-access issues than parents who do not have a child with asthma. Male children are significantly more likely to be told that they have asthma. Of Ohio boys, 15.1 percent have been told they have asthma, compared with 11.5 percent of girls.

Racial/Ethnic Disparities: African-American children were the most likely to have asthma; nearly one-fifth (19.5 percent) were reported to have asthma, a significant difference from white children. In comparison, 12.2 percent of whites, 9.5 percent of Asians and 16.0 percent of Hispanic children were reported to have asthma.⁵⁵

Second Hand Smoke

Description: Exposure to secondhand smoke increases the chances that children will suffer from smoke-caused coughs and wheezing, bronchitis, asthma, pneumonia, potentially fatal lower respiratory tract infections, eye and ear problems or injury or death from cigarette-caused fires. Children who breathe secondhand smoke are more likely to get colds, allergies, asthma, and ear infections.

Quantitative Data: Secondhand smoke causes 300,000 cases of pneumonia and bronchitis in children every year in the United States. Babies of parents who smoke are twice as likely to die from sudden infant death syndrome.⁵⁶ In 2007, 7 percent of mothers reported their baby spent time in a room with someone who is smoking⁵⁷. Among children 0-17 years of age, 16.3 percent are exposed to smoking in the home; this is twice as high as and statistically significantly greater than the U.S. exposure rate of 7.6%.⁵⁸

C. 3 Infectious Diseases - Morbidity

Vaccine-preventable Diseases

Description: Widespread vaccination of children has resulted in decreases in morbidity and

⁵³ CDC Health Data Interactive <http://www.cdc.gov/nchs/hdi.htm>.

⁵⁴ "Hospital Discharges for Asthma in Ohio, 1999-2003". Ohio Department of Health, Asthma program.

⁵⁵ "The Burden of Asthma in Ohio" Asthma program; Indoor Environments Section, Ohio Department of Health.

⁵⁶ "Secondhand Smoke- Environmental Tobacco Smoke (ETS) Fact Sheet"- Ohio Department of Health Tobacco Use and Cessation program.

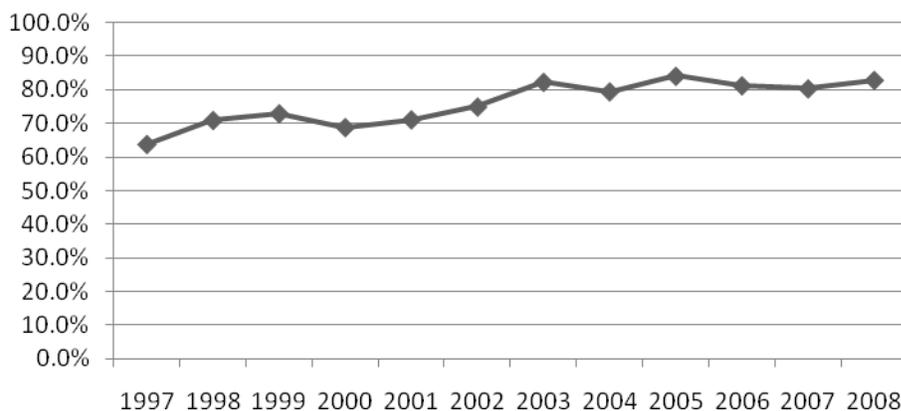
⁵⁷ Ohio PRAMS.

⁵⁸ Child and Adolescent Health Measurement Initiative. 2007 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. www.nschdata.org.

mortality due to vaccine-preventable diseases. An HP 2010 objective for vaccine-preventable diseases is the elimination of congenital rubella syndrome, diphtheria, measles, mumps, polio, rubella, tetanus and invasive disease caused by *Haemophilis influenza* type b (Hib).

Quantitative Data: In Ohio in 2008, 82.9 percent of children aged 19 to 35 months had received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, *H. influenza* and hepatitis B (series 4:3:1:3:3)⁵⁹. This is comparable to the national rate of 76.1 percent, but below the HP 2010 goal of 90 percent. In 2008, there were 517 cases of pertussis reported in children 0 – 19 in Ohio, with 32 percent occurring in children less than 4 years of age. In addition, there were 26 cases of *H. influenza*, 11 cases of mumps and zero cases of measles reported in 2008.⁶⁰

**Immunization Coverage (series 4:3:1:3:3)
Children Ages 19-35 Months Ohio 1997-2008**



Source: Ohio Department of Health: Current Rates of Immunization

C. 4 Injuries - Morbidity

Nonfatal Motor Vehicle Injuries in Children

Description: MV crashes are a major cause of injuries in early childhood.

Quantitative Data: Children aged 1-5: In 2008, the rate of nonfatal injuries due to transport accidents was 192/100,000 nationally.⁶¹ In Ohio, the rate was 403/100,000.⁶²

⁵⁹ Ohio Department of Health: Current Rates of Immunization, <http://www.odh.ohio.gov/odhprograms/ids/immunize/immform.aspx>.

⁶⁰ <http://www.odh.ohio.gov/healthStats/disease/idann/idsum08/08idsun1.aspx>.

⁶¹ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁶² Calculated from ODP (Ohio Department of Public Safety) data with number of injury by age group divided by population estimates available through www.factfinder.census.gov.

Child Abuse and Neglect

Description: Child abuse is any mistreatment or neglect of a child that results in non-accidental harm or injury and that cannot be reasonably explained. Child abuse can include physical abuse, emotional abuse, sexual abuse and neglect. In about three-quarters of all child abuse cases the perpetrator is the child's own parent. Contributing factors to child abuse include immaturity of parents, lack of parenting skills, unrealistic expectations, prior abuse of parent, social isolation and problems with alcohol or illicit drugs. Violent and abusive behaviors continue to be major causes of death, injury and stress in the United States. Child abuse and neglect has increased more than 85 percent since 1987. Children who have been maltreated are more likely to be involved in delinquent and violent behaviors during adolescence.

Quantitative Data: According to *Child Maltreatment 2008*, published by the Administration for Children and Families in the U.S. Department of Health and Human Services, 23.7 percent of cases were substantiated incidences of child maltreatment in the United States. Ohio came in at 18.8 percent, lower than the national rate. In Ohio, almost half of the victims of child maltreatment (46 percent) suffered from neglect, while 31.6 percent were victims of physical abuse and 17.5 percent suffered sexual abuse (2008 data). Males and females suffer abuse at roughly the same rates, with females accounting for 51.3 percent of victims in 2008 (U.S. data). Younger children are more frequently the victims of maltreatment, with the rate of victimization of children 0-1 in the United States in 2008 at 21.7/1,000 and decreasing in every older age group.⁶³

The same source reports 2.71/100,000 fatalities as a result of child maltreatment in Ohio in 2008, compared with 2.33/100,000 nationally.⁶⁴

Racial/Ethnic Disparities: White children have the highest rate of abuse in Ohio at 55.3/1,000 (2008 data). Black children come in second at 23.2/1000, followed by the unknown race category 18.5/1,000. The Hispanic rate was 2.6.⁶⁵

C. 5 Nutrition - Morbidity

Overweight in Children Younger than 5 Years

Description: High body mass index (BMI) for age in children is defined based on the 2000 Centers for Disease Control and Prevention sex-specific BMI-for-age growth charts. Specifically, overweight is defined as BMI-for-age between the 85th and 95th percentiles and obesity as BMI-for-age at or above the 95th percentile.⁶⁶ The health problems associated with childhood overweight/obesity include high blood pressure, high cholesterol, glucose intolerance, orthopedic disorders, and psychosocial disorders. In addition, longitudinal studies show that overweight/obesity in childhood is often associated with overweight/obesity in adulthood, further

⁶³ "Child Maltreatment 2008; Administration of Youth and Families, <http://www.acf.hhs.gov/programs/cb/pubs/cm08/cm08.pdf>.

⁶⁴ Ibid.

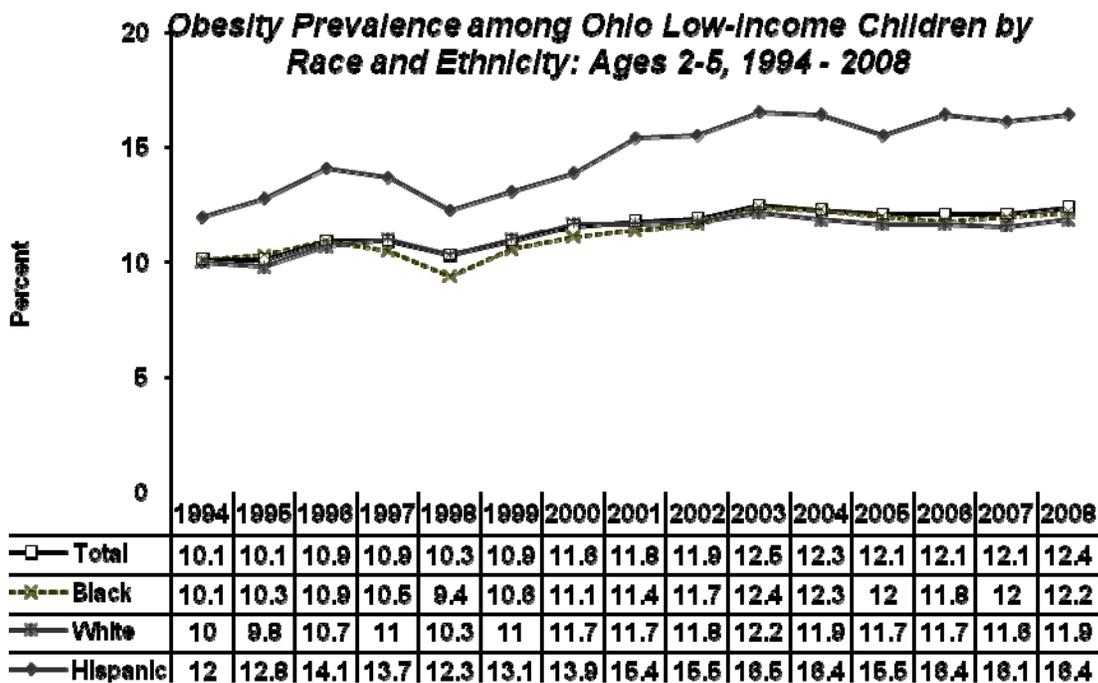
⁶⁵ Ibid.

⁶⁶ Krebs NF, et al. Assessment of child and adolescent overweight and obesity. *Pediatrics*. 2007; 120 (suppl 4): S193-S228.

increasing risk of chronic conditions such as diabetes, cardiovascular disease, and certain cancers. Contributing factors to overweight/obesity in children include high BMI of parents, low family income, poor quality nutrition intake, and decreased physical activity.

Quantitative Data: According to the 2008 Pediatric Nutrition Surveillance System (CDC), which assesses children aged 0 to 5 years in families who are at less than 185 percent of the federal poverty level and who receive WIC benefits, 12.4 percent of low-income Ohio children enrolled in WIC were obese, slightly lower than the national rate of 14.1 percent. Among children aged 2-5 years, 15.8 percent of low-income Ohio children enrolled in WIC were overweight, and 12.2 percent were obese, slightly lower than the national rates of 16.5 percent and 14.8 percent, respectively.⁶⁷ Ohio does not collect population-based data on childhood overweight in children younger than 5 years.

Racial/ethnic disparities: Hispanic children are more likely than white or black children to be overweight or obese.



Data Source: PedNSS

Anemia

Description: Anemia, defined by a low hemoglobin concentration or a low hematocrit level, is often used as an indicator of iron deficiency, the most common nutritional deficiency in the world. Iron deficiency is associated with developmental delays and behavioral disturbances in children. In addition to iron deficiency, anemia can be caused by other nutritional deficiencies (e.g., folate or vitamin B12 deficiency); hereditary defects in red blood cell production (e.g.,

⁶⁷ “2008 Pediatric Nutrition Surveillance, National, Table 16D” CDC, http://www.cdc.gov/pednss/pednss_tables/pdf/national_table16.pdf.

thalassemia and sickle cell disease); recent or current infection; and chronic inflammation. Anemia is declining among low-income children as a result of increased iron intake during infancy; therefore, anemia is becoming less predictive of iron deficiency and more strongly associated with other underlying illnesses.

Quantitative Data: As reported in the 2008 Pediatric Nutrition Surveillance System (CDC), 14.9 percent of low-income U.S. children less than 5 years old receiving benefits from WIC had anemia as defined by low hemoglobin/low hematocrit⁶⁸ compared with 41.1 percent of Ohio children.⁶⁹

Racial/Ethnic Disparities: Nationally, blacks had a higher rate of anemia (22.8 percent) than whites (11.5 percent).⁷⁰ The racial disparity in Ohio is similar to national data.⁷¹

Age Trends: Ohio children less than 11 months old have the highest rates of anemia at 18.6 percent. The rate falls slowly over each successive one-year period, with children 48-59 months having the lowest rate of 87.6 percent.⁷²

C. 6 Nutrition - Contributing Factors

Breastfeeding

Description: Breastfeeding provides a wide range of benefits to the mother, child, and community. Not breastfeeding increases risks of infection, developmental problems, mortality, and long-term ailments such as diabetes and cancers for mother and child. In support of the evidence, the American Academy of Pediatrics, American College of Obstetrics and Gynecology, the American Public Health Association, the World Health Organization, and many other medical and health professional organizations recommend that infants consume only mother's milk (exclusive breastfeeding) for at least the first 6 months of life, followed by continued breastfeeding. The American Academy of Pediatrics recommends exclusive breastfeeding to age 6 months and continued breastfeeding for at least the first year of life (1). The *Healthy People 2010* (HP2010) targets (16-19a-c) for initiating breastfeeding, breastfeeding to age 6 months, and breastfeeding to age 12 months, are 75%, 50%, and 25%, respectively.

Quantitative Data: Of infants born in 2006, the percentage who were ever breastfed was 58.5 (± 7.3), 15 percentage points lower than the national percentage of 73.9 ($\pm 1.1^*$). At 6 months of age, 29.7 (± 6.2) percent were breastfed (compared to a national rate of 43.4 ± 1.3) and at 12 months of age, 12.0 (± 3.9) were breastfed (compared to a national rate of 22.7 ± 1.1). Ever breastfeeding rates have not changed from 2000-2006. Ohio meets none of the HP2010 objectives on breastfeeding and in 2006 had the 4th lowest prevalence of ever breastfeeding in the country.

⁶⁸ 2008 Pediatric Nutrition Surveillance, National, CDC, http://www.cdc.gov/pednss/pdfs/PedNSS_2008.pdf.

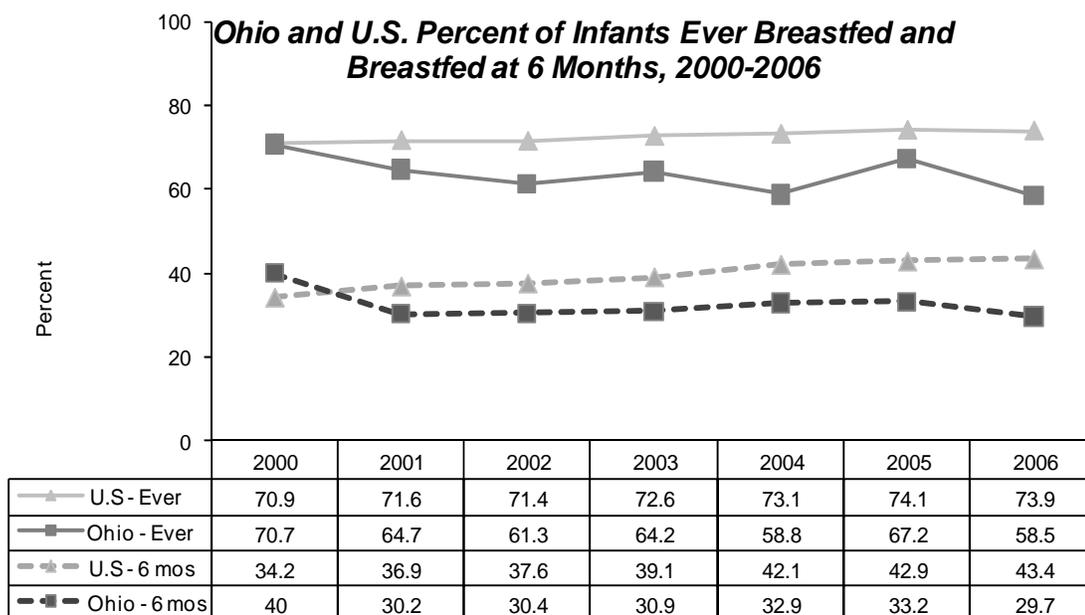
⁶⁹ Ohio Department of Health 2008 Pediatric Nutrition Surveillance, Ohio. <http://www.odh.ohio.gov/healthStats/data/pednss/pednss.aspx>.

⁷⁰ 2008 Pediatric Nutrition Surveillance, National, CDC, http://www.cdc.gov/pednss/pdfs/PedNSS_2008.pdf.

⁷¹ Ohio Department of Health 2008 Pediatric Nutrition Surveillance, Ohio. <http://www.odh.ohio.gov/healthStats/data/pednss/pednss.aspx>.

⁷² Ibid.

Racial/Ethnic Disparities: National disparities in breastfeeding rates are mirrored in Ohio. However, while the prevalence of ever breastfeeding among non-Hispanic black infants in Ohio is similar to the national rate, non-Hispanic white infants in Ohio breastfeed at a lower rate than the national average. For infants born from 2004-6, white children had the highest percentage of ever breastfeeding, at 64.7 percent, followed by Hispanics at 61.3 percent and blacks at 54.1 percent.⁷³ Ohio's breastfeeding rate among white infants is about 10 percentage points lower than the national (74.3) but among black infants is similar (54.4% nationally). Prevalence of breastfeeding at 6 months was 23.4% and 33.4%, and at 12 months was 9.5% and 14.7%, among black and white infants respectively. All black vs. white differences were statistically significant.



⁷³National Immunization Survey http://www.cdc.gov/breastfeeding/data/NIS_data/.

* +/- half 95% Confidence Interval.

C.7. Priority Issues for Early Childhood

MCH Stakeholder Identified Issues: Through a series of individual and group prioritization by community stakeholders, the needs listed below (in priority order) were identified as priority issues within the early childhood group. A list of group members can be found at the end of this report.

During Phase II of the Needs Assessment process The early childhood, school age, adolescent and young adult groups were combined to allow for more consistent interventions for all children as a result of this process.

Group Rank	Health Issue
1	Access to Care (Providers, Insurance)
2	Early Identification through Health/Developmental Screenings (hearing, vision, mental/social-emotional, oral, lead, nutrition, obesity/overweight, early childhood development, immunization, asthma, trauma)
3	Referral to Services then Diagnosis and Treatment (hearing, vision, mental/social-emotional, oral, lead, nutrition, obesity/overweight, early childhood development, asthma, trauma)
4	Support and Education for Parents and Families
5	Early Care and Education (systems approach including all birth to kindergarten services)
6	Immunizations
7	Disparities in Health Outcomes (cultural competency)
8	Maltreatment/Neglect/Abuse/Violence/Injury-Intentional
9	Environmental Exposures
10	Postneonatal and Child Mortality
11	Injury – Unintentional
12	Breastfeeding Sustainment
13	Neighborhood Safety and Support

Local Agency-identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects, WIC projects, practitioners and providers across Ohio requesting feedback in regard to the top 10 priorities identified in the last Maternal and Child Health Needs Assessment. Health care issues gathered from the survey provided a local perspective to the issues for each sub-population group.

School-age, Adolescents and Young Adults Stakeholders

- Obesity
- Access to primary care
- Nutrition- breastfeeding
- Exercise
- Depression/mental health needs
- Access-lack of providers
- Early identification and referral

Group identified themes from local stakeholder survey:

- Developmental disorders/ADHD
- Parent education, awareness and support
- Appropriate insurance
- Disparities in health outcomes
- Immunizations

D. School Aged Children and Adolescent Health Status

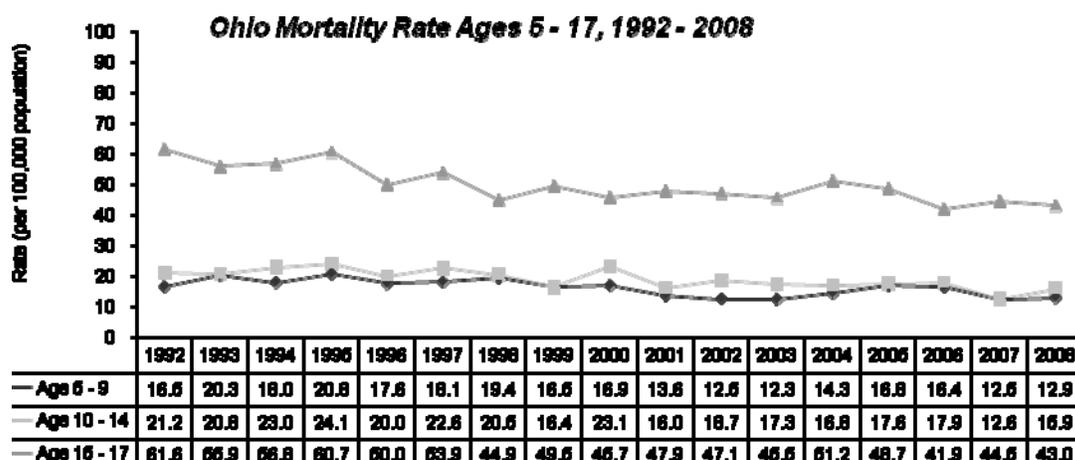
D.1 Mortality

Overall Mortality, Ages 5 through 14

Description: In 2006, the national mortality rate for children in this age group was 15.2 per 100,000, and injuries accounted for 37 percent of all deaths in children ages 5 through 14 in 2006.⁷⁴ The second leading cause of death was malignant neoplasms, followed by homicide and congenital anomalies.⁷⁵

Quantitative Data: The overall death rate for children aged 5 through 14 in Ohio in 2008 was 14.4 per 100,000 and was lower than the national rate. Ohio achieved the HP 2010 targets for children aged 5-9 (Ohio rate: 12.9; HP 2010 target 14.3), and aged 10-14 (Ohio rate: 15.9; HP 2010 target 16.8).

Unintentional injuries accounted for 33.1 percent of all mortality in this age group in the years 2005-2007.⁷⁶ MV crashes were by far the leading cause of death from accidental injury, accounting for 48 percent of fatalities, followed by accidental exposure to smoke, fire and flames; accidental drowning and submersion; and other and unspecified, non-transport accidents.



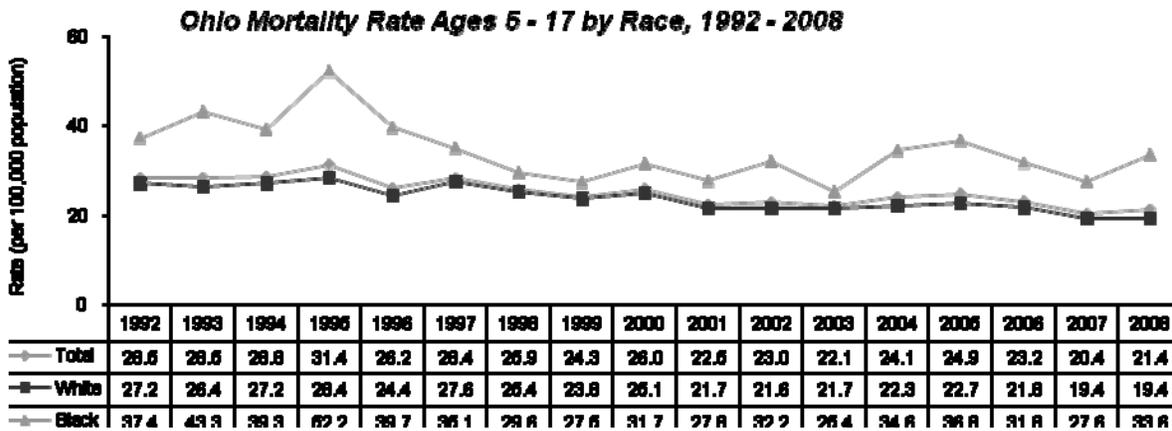
Data Source: Ohio Vital Statistics

⁷⁴ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Apr 12, 2010.

⁷⁵ Child Health USA, <http://www.mchb.hrsa.gov/chusa08/pdfs/c08.pdf>.

⁷⁶ Ohio Vital Statistics.

Racial/Ethnic Disparities: In Ohio, black children aged 5-14 years have a higher mortality rate than white children. The rates for other races are not shown because they are unstable due to low numbers.⁷⁷



Data Source: Ohio Vital Statistics

Overall Mortality, Ages 15 through 19

Description: In 2006, the national mortality rate for adolescents in this age group was 64.4 per 100,000. Injury, both intentional (homicide and suicide) and unintentional (accidental), was the leading cause of death, accounting for 74.9 percent of all deaths in that age group (note: the data reported are for 15-24-year-olds).⁷⁸ In Ohio, 72.1 percent of all deaths of 15-24-year-olds from 2005-2007 resulted from unintentional injury, homicide or suicide. Other leading causes of death in this age group are malignant neoplasm followed by diseases of the heart.⁷⁹

Quantitative Data: The overall mortality rate for the 15-24 year age group in Ohio was 75.1 per 100,000 in 2007. This rate has remained fairly stable since 1994.⁸⁰

Racial/Ethnic/Gender Disparities: There is a striking gender disparity in death rates among this age cohort; the national death rate for males 15-24 was 119.3 in 2006, while for females the rate was 42.8.⁸¹ As is true for each of the other age groups mentioned in this report, black rates were much higher than whites, especially among males. For instance, in 2006 the death rate for black males 15-24 was 171.3, compared with 111.8 for white males. Disparities, while present, were less striking among females, with the death rate for black females 51.3, compared with 41.7 for white females. Blacks have the highest death rates of all races/ethnicities and Asian Americans the lowest.⁸²

⁷⁷ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfc-icd10.html> on Apr 12, 2010.

⁷⁸ Ibid.

⁷⁹ Ohio Vital Statistics.

⁸⁰ Ibid.

⁸¹ CDC NCHS chart book, [http://www.cdc.gov/nchs/data/09.pdf#listtables](http://www.cdc.gov/nchs/data/hus/09.pdf#listtables), Table 35.

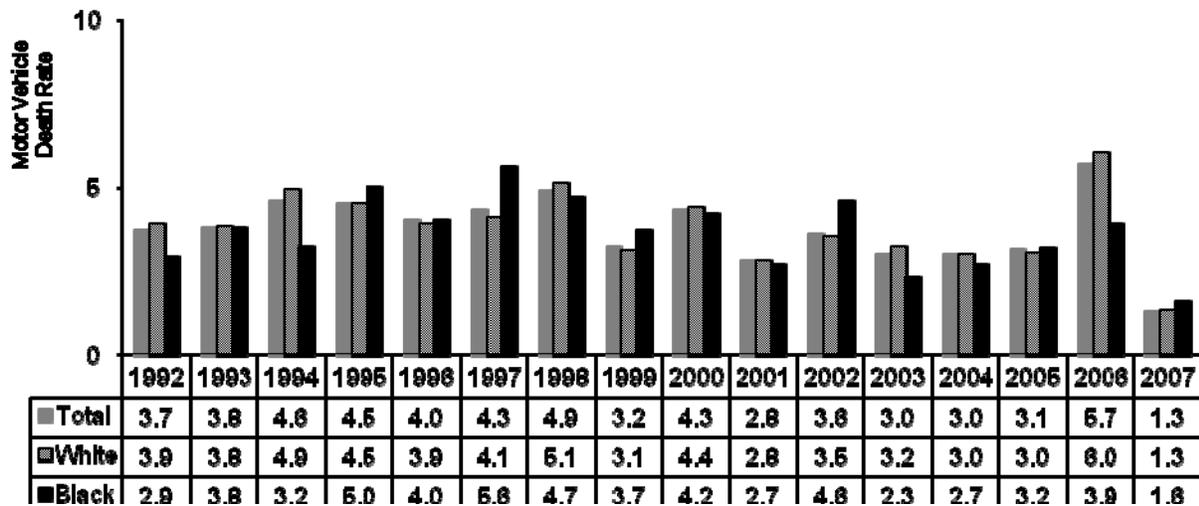
⁸² Ibid.

Mortality Due to Motor Vehicle Crashes

Description: MV crashes are the leading cause of mortality from accidental injury, accounting for 50 percent of all accidental injury deaths among children age 5-14 and 62 percent of accidental injury deaths for 15-24-year-olds in 2005-2007.

Quantitative Data: *Children aged 5 through 14:* In Ohio in 2007, the MV mortality rate was 1.3 for this age group, slightly lower than the national rate of 3.0 and lower than the Healthy People 2010 target rate of 2.1.⁸³

**Ohio Motor Vehicle Crash Death Rates (per 100,000 population)
For Children Aged 5-14-years-old by Race, 1992 - 2007**



Data Source: Ohio Vital Statistics

Youth ages 15-19: In 2006, the mortality rate for MV accidents in children aged 15-19 was 18.5/100,000. This rate is lower than the national rate of 23.3 and higher than the HP 2010 target of 9.0.⁸⁴

Racial/Ethnic/Gender Disparities: In 2006, there was a gender disparity in rates of death by MV accident in the 15-19-year-old group, with males (25.6) double the rate of females (10.4).⁸⁵ Racial and ethnic disparities are less apparent for this cause of death.

⁸³ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Jun 4, 2010

⁸⁴ Ibid.; CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hs/hs04trend.pdf#035>.

⁸⁵ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

Suicide Deaths and Suicide Attempts

Description: In Ohio in the years 2005-2007, 15 percent of deaths in the 15-24-year-old age group were due to suicide.⁸⁶

Quantitative Data: Suicide deaths: In 2006, the rate of suicide deaths in 15-19-year-olds in Ohio was 8.8 /100,000. This rate is higher than the national rate of 7.3 for this age group and the HP 2010 target rate of 6.0/100,000.⁸⁷

Suicide attempts: According to the 2007 Ohio Youth Risk Behavior Survey (YRBS), 7 percent of teens in grades nine through 12 reported that they had attempted suicide one or more times in the past 12 months,⁸⁸ very close to the 6.9 percent reported in the national 2007 YRBS data.⁸⁹

Racial/Ethnic/Gender Disparities: In the 15-19-year-old age group, suicide rates were higher for whites (9.6/100,000) than blacks (5.8) in Ohio in 2004-2006. The rates for males were much higher than for females (14.1 vs. 3.7).⁹⁰ More females (9.4 percent) than males (4.9 percent) in Ohio reported attempted suicide in 2007.⁹¹

D. 2 Infectious Diseases—Morbidity

Chlamydia in Adolescents Ages 15 through 19

Description: Chlamydia is the most common sexually transmitted disease (STD). STD rates are highest among the teenage population, especially females. Ohio ranked eleventh (first=highest) out of all states in cases of Chlamydia, according to 2008 data.⁹²

Quantitative Data: The rate of Chlamydia in adolescents aged 15-19 years old in Ohio has risen steadily from 1,181/100,000 in 1996 to 2,370 in 2008. However, this prevalence of 2.4 percent is lower than the HP 2010 objective of 3 percent.

Racial/Ethnic/Gender Disparities: Reported rates among females are much higher than males because women are more likely to be symptomatic and seek treatment. In 2008, the rate of Chlamydia in female's ages 15-19 years old was 3,843/100,000, compared with 847/100,000 for

⁸⁶ Ohio Vital Statistics.

⁸⁷ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁸⁸ Ohio Youth Risk Behavior Survey 2007.

⁸⁹ CDC Youth Risk Behavior Surveillance-United States, 2007, <http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?ByVar=CI&cat=1&quest=Q26&loc=XX&year=2007>.

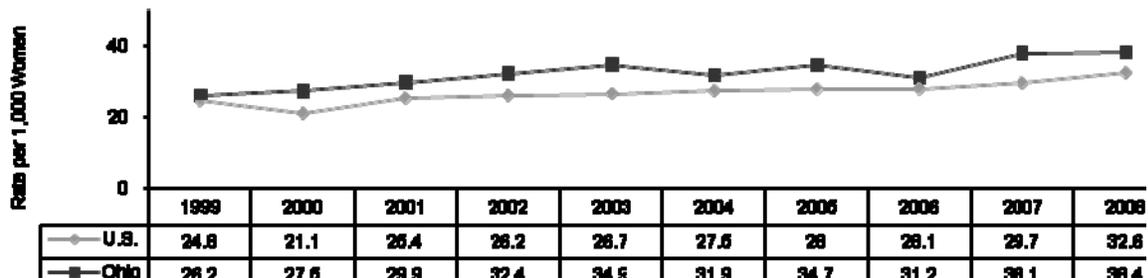
⁹⁰ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁹¹ Ohio Youth Risk Behavior Survey 2007.

⁹² US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention (NCHSTP), Division of STD/HIV Prevention, Sexually Transmitted Disease Morbidity for selected STDs by age, race/ethnicity and gender 1996-2008, CDC WONDER On-line Database, November 2009. Accessed at <http://wonder.cdc.gov/std-std-v2008-race-age.html> on Apr 14, 2010 10:42:37 AM

males. Chlamydia rates are more than ten times higher for black teens (6,281/100,000) than for white teens (569/100,000).⁹³

Chlamydia Rate (per 1,000 Women) Ages 15 - 19 U.S. and Ohio, 1999 - 2008



Data Source: Ohio Vital Statistics, CDC

HIV/AIDS

Description: The majority of HIV/AIDS diagnoses among young persons (10-24) occurred to those ages 20-24 years (68% for females and 76% for males) and males (71%). Among youths aged 10--14 years, more diagnoses were received by females (70%) than males (30%).⁹⁴

Quantitative Data: As of December 31, 2007 there were 508 young person's 15-24 years of age living with HIV/AIDS in Ohio, a rate of 32.3/100,000. This population accounts for 3 percent of all diagnosed HIV/AIDS cases in Ohio. Seventy-nine percent of persons living with HIV/AIDS were male.⁹⁵

Racial/Ethnic/Gender Disparities: HIV/AIDS rates are higher among males than females and higher in blacks than in whites. The rate of HIV/AIDS among Hispanics is higher than in whites, but lower than in blacks.

D. 3 Infectious Diseases - Contributing Factors

Teen Sexual Intercourse

Description: Sexual intercourse is defined as heterosexual vaginal intercourse. Sexual experience, and particularly age at first intercourse, represents a critical risk factor for pregnancy

⁹³ US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention (NCHSTP), Division of STD/HIV Prevention, Sexually Transmitted Disease Morbidity for selected STDs by age, race/ethnicity and gender 1996-2008, CDC WONDER On-line Database, November 2009. Accessed at <http://wonder.cdc.gov/std-std-v2008-race-age.html> on Apr 14, 2010 11:29:14 AM.

⁹⁴ CDC, Cases of HIV Infection and AIDS in the United States and Dependent Areas, by Race/Ethnicity, 2003–2007, HIV/AIDS Surveillance Supplemental Report - Volume 14, Number 2.

⁹⁵ "Reported persons living with HIV/AIDS as of Dec. 31, 2007, by current disease status and selected characteristics," Ohio Department of Health, <http://www.odh.ohio.gov/ASSETS/3E0A21CF1A814032B75A66E8582B28A4/Ohio.pdf>.

and sexually transmitted infections including HIV/AIDS. Youths who begin having sex at younger ages are exposed to these risks over a longer time. Research has shown that youths who have early sexual experiences are more likely at later ages to have more sexual partners and more frequent intercourse.

Quantitative Data: The data for this health issue comes from the Ohio YRBS. In 2007, 45 percent of teenagers in grades nine through 12 reported ever having sexual intercourse, down from 55 percent in 1993. Similarly, the number reporting first sexual intercourse before age 13 decreased to 6 percent in 2007, down from 11 percent in 1993.⁹⁶

Racial/Ethnic/Gender Disparities: In 2007 in Ohio, black teens (59.5 percent) and Hispanic teens (50.3 percent) were more likely to report ever having intercourse than whites (41.7 percent). Roughly equal numbers of males and females reported intercourse in the later grades.⁹⁷

Age Disparities: In Ohio, a greater percentage of older adolescents report having had sexual intercourse than younger adolescents. In 2003, 27 percent of ninth graders reported ever having sexual intercourse, while 62 percent of 12th graders reported having intercourse.

D. 4 Injuries - Morbidity

Nonfatal Motor Vehicle Injuries

Description: MV crashes are a major cause of injuries in children and youth.

Quantitative Data: Children aged 5 - 14: In 2008, the rate of nonfatal injuries due to transport accidents was 1,191/100,000 nationally.⁹⁸ In Ohio in 2008, 10,256 children 0-15 were involved in nonfatal motor vehicle injuries.⁹⁹

Youth aged 15 through 24: In 2008, the national rate of nonfatal injuries due to transport accidents was 2,561/100,000.¹⁰⁰ In Ohio in 2008, 17,468 young person's ages 16-20 were involved in nonfatal motor vehicle injuries. The young person was the driver of the vehicle in 66 percent of cases.¹⁰¹

Racial/Ethnic/Age Disparities: The rate of MV-related injuries is similar for males and females (3,034 for males and 2,965 for females). Blacks have a higher injury rate than whites, 3,132 compared to 2,422.¹⁰² In Ohio, the age group with the highest number of injuries is 16-20 years,

⁹⁶ "2007 Ohio Youth Risk Behavior Survey, Sexual Behaviors, <http://www.odh.ohio.gov/ASSETS/BEC0EE39B2324D62B96D91CC9A6067B5/Behaviors-Activity.pdf>.

⁹⁷ "2007 Ohio Youth Risk Behavior Survey, Sexual Behaviors, <http://www.odh.ohio.gov/ASSETS/BEC0EE39B2324D62B96D91CC9A6067B5/Behaviors-Activity.pdf>.

⁹⁸ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁹⁹ <http://www.publicsafety.ohio.gov/links/HSY7606-2008.pdf>.

¹⁰⁰ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

¹⁰¹ <http://www.publicsafety.ohio.gov/links/HSY7606-2008.pdf>.

¹⁰² WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

with a rate of 2,045/100,000, compared with 1,703 for 21-25-year-olds and 936 for children aged 0-15.¹⁰³

D. 5 Nutrition - Morbidity

Overweight

Description: High body mass index (BMI) for school aged children is defined based on the 2000 Centers for Disease Control and Prevention sex-specific BMI-for-age growth charts. Specifically, overweight is defined as BMI-for-age between the 85th and 95th percentiles and obesity as BMI-for-age at or above the 95th percentile.¹⁰⁴ The health problems associated with childhood overweight/obesity include high blood pressure, high cholesterol, glucose intolerance, orthopedic disorders, and psychosocial disorders. In addition, longitudinal studies show that overweight/obesity in childhood is often associated with overweight/obesity in adulthood, further increasing risk of chronic conditions such as diabetes, cardiovascular disease, and certain cancers. Contributing factors to overweight/obesity in children include high BMI of parents, low family income, poor quality nutrition intake, and decreased physical activity.

Quantitative Data: In 2007-2008, 35.5 percent of U.S. children aged 6-11 years and 34.2 percent of children aged 12-19 years were overweight/obese. No significant differences in BMI were found between 1999-2000 and 2007-2008. However, among boys aged 6-19 years, there was a significant increase in the prevalence at the highest BMI cut point (BMI-for-age at or above 97th percentile).¹⁰⁵

Since the 2004-2005 school year, Ohio has been measuring height and weight among 3rd grade children. In 2008-2009, the combined prevalence of overweight/obesity was 35.9 percent, with 17.4 percent being overweight and 18.5 percent being obese. There were no statistical differences in the proportions of 3rd graders who were overweight, obese, or at the highest BMI cut point between survey years.

Ohio also collects population-based, self-reported height and weight data on adolescents in grades 9-12 through the Youth Risk Behavior Survey (YRBS). According to these self-reports, 12.4 percent of students were obese in 2007, in addition to 15.0 percent overweight. There were no significant differences in overweight or obesity between 1999 and 2007. Adolescents tend to underreport weight and over report height, leading to underestimations of overweight/obesity prevalence in this population.¹⁰⁶

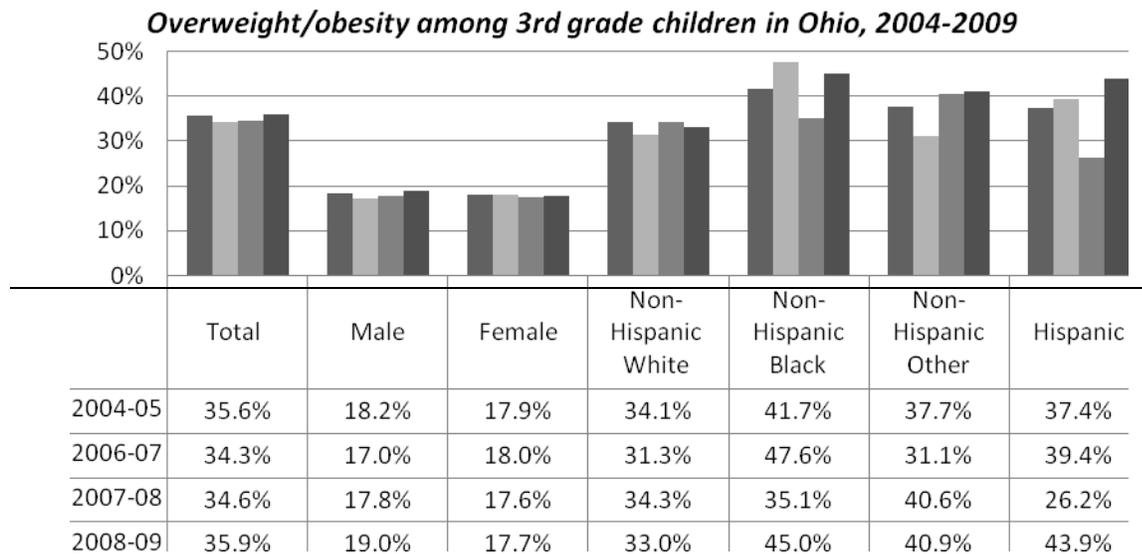
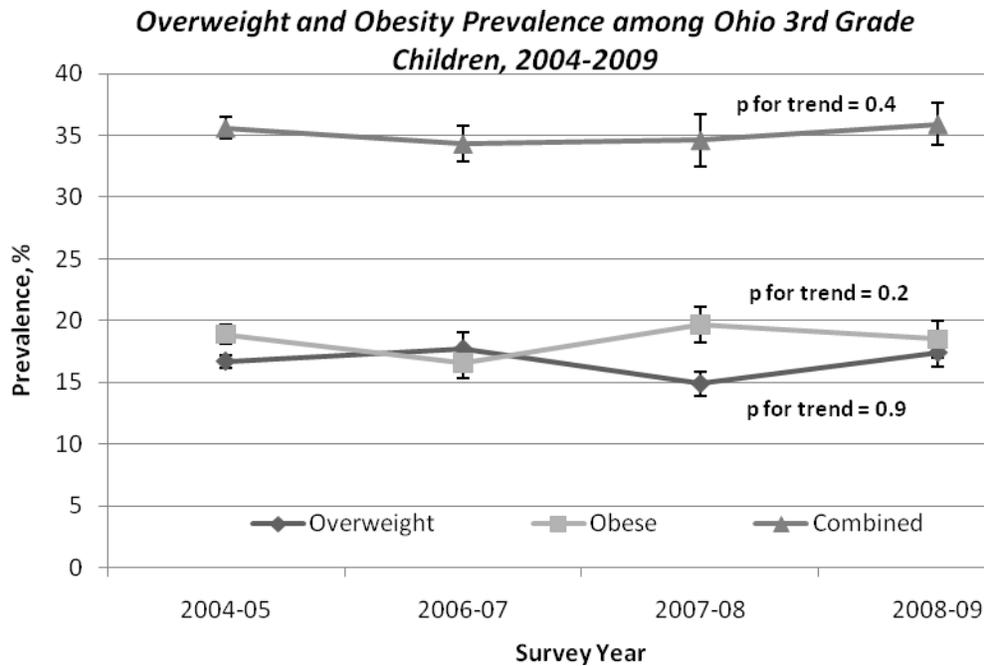
¹⁰³ Calculated from ODP data available at <http://www.publicsafety.ohio.gov/publicat/HSY7606/HSY7606-2003.PDF> with number of injury by age group divided by population estimates available at <http://www.census.gov/popest/states/asrh/tables/SC-EST2003-02/SC-EST2003-02-39.pdf>.

¹⁰⁴ Krebs NF, et al. Assessment of child and adolescent overweight and obesity. *Pediatrics*. 2007; 120 (suppl. 4): S193-S228.

¹⁰⁵ Ogden CL, et al. Prevalence of high body mass index in U.S. children and adolescents, 2007-2008. *JAMA*. 2010; 303(3): 242-249.

¹⁰⁶ Brener ND, et al. Reliability and Validity of Self-reported Height and Weight among High School Students. *Journal of Adolescent Health*. 2003;32:281-287

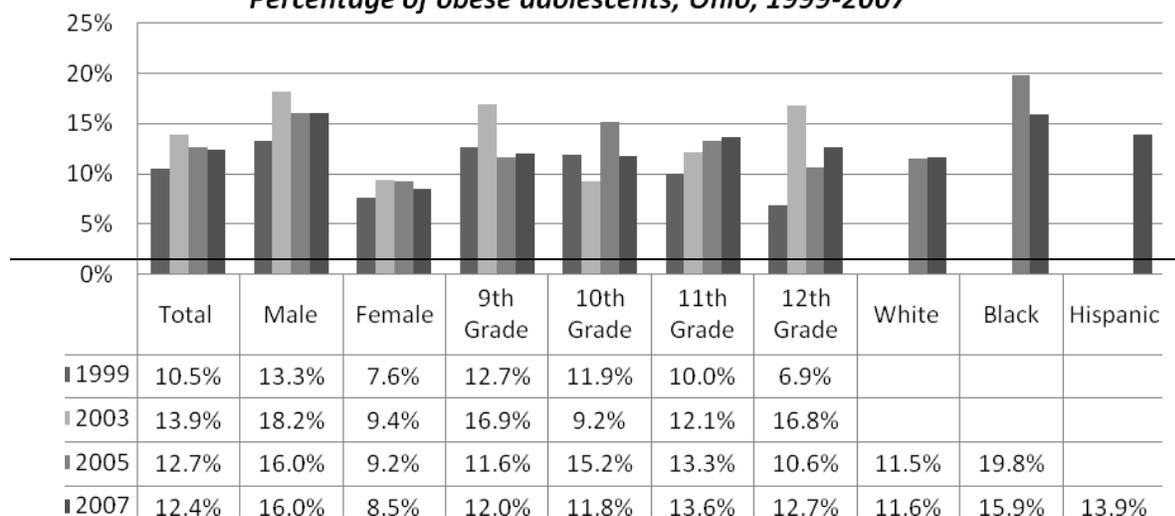
Racial/Ethnic Disparities: Nationally, prevalence of overweight/obesity was highest among Hispanic 6-11 and 12-19 year olds (42.6 percent and 41.2 percent, respectively), followed by non-Hispanic blacks and whites.¹⁰⁷ Ohio data among 3rd grade children and adolescents in grades 9-12 showed a similar prevalence among blacks and Hispanics.



Data Source: 3rd grade oral health and BMI survey

¹⁰⁷ Ogden CL, et al. Prevalence of high body mass index in U.S. children and adolescents, 2007-2008. *JAMA*. 2010; 303(3): 242-249.

Percentage of obese adolescents, Ohio, 1999-2007



Data Source: Youth Risk Factor Surveillance Survey (YRBS)

D. 6 Oral Health Morbidity

Dental Caries

Description: Dental caries is described by disease attack and untreated disease. Untreated disease indicates the lifetime history of tooth decay, counting previously decayed (filled) teeth as well as currently decayed (untreated) teeth. Disease attack reflects the extent to which factors that cause decay (such as diet) balance against preventive factors (such as exposure to fluorides and sealants). Dental caries (tooth decay) is the most common infectious disease of U.S. children. Dental caries has affected 52 percent of children ages 6 through 8. The percentage increases to 84 by the time children have graduated from high school. Unless arrested in the earliest stages, dental caries becomes irreversible, progressing to large cavities and abscesses.

Quantitative Data: In Ohio, 55 percent of third grade students had an observable history of dental caries in 2004-2005.¹⁰⁸ This rate is higher than the HP 2010 goal of 42 percent.

Racial/Ethnic Disparities: In the Ohio Sentinel Schools study in 2007-2008, a lower percentage of black students had a history of dental caries than white students.¹⁰⁹

Socioeconomic Disparities: In the 2007-2008 Ohio Sentinel Schools Study, a higher percentage of children from lower-income families, as determined by eligibility for school lunch programs, had a history of dental caries than children not eligible for the school lunch program.¹¹⁰

¹⁰⁸ "A Survey of the Oral Health of Ohio Schoolchildren, 2004-2005," Ohio Department of Health, <http://www.odh.ohio.gov/ASSETS/318CE478E2784B088377359F69F6A075/FinalOHSreport.pdf>.

¹⁰⁹ Sentinel Oral Health Surveys of Ohio Schoolchildren, <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20tatewide%20Trends08.pdf>.

¹¹⁰ Ibid.

Untreated Dental Caries

Description: Untreated dental caries (tooth decay) can result in needless pain and suffering, difficulty speaking and chewing, increased cost of care and loss of self-esteem. Dental caries afflicts more persons than any other single disease in the United States and is amenable to early intervention.

Quantitative Data: In 2004-2005, 26 percent of Ohio third graders had untreated dental caries.¹¹¹ Ohio's rate is higher than the HP 2010 target of 21 percent.

Racial/Ethnic Disparities: In 2007-2008, white children in Ohio had slightly higher rates of untreated dental caries than black children.¹¹²

Socioeconomic Disparities: In 2007-2008, untreated dental caries were more prevalent in Ohio children eligible for free lunch programs compared to children ineligible for free lunch programs.¹¹³

D. 7 Oral Health - Contributing Factors

Protective Sealants in Third Grade Children

Description: Dental sealants are the most effective method of preventing tooth decay in the surfaces that are most susceptible.

Quantitative Data: In Ohio in 2004-2005, 43 percent of third grade students had received protective sealants on at least one permanent molar tooth.¹¹⁴ This is higher than the national rate of 26 percent but slightly below the HP 2010 target of 50 percent.¹¹⁵

Racial/Ethnic Disparities: In national data, there are large disparities in protective dental sealants between black, Hispanic and white children. Thirty-one percent of non-Hispanic white children had dental sealants, compared to 13 percent of non-Hispanic blacks and 17 percent of Mexican children aged 8-10.¹¹⁶ In Ohio, a higher percentage of black third graders had sealants than white third graders.¹¹⁷

¹¹¹ "A Survey of the Oral Health of Ohio Schoolchildren, 2004-2005," Ohio Department of Health, <http://www.odh.ohio.gov/ASSETS/318CE478E2784B088377359F69F6A075/FinalOHSreport.pdf>.

¹¹² "Sentinel Oral Health Surveys of Ohio Schoolchildren", <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20Statewide%20Trends08.pdf>.

¹¹³ Ibid.

¹¹⁴ "A Survey of the Oral Health of Ohio Schoolchildren, 2004-2005," Ohio Department of Health, <http://www.odh.ohio.gov/ASSETS/318CE478E2784B088377359F69F6A075/FinalOHSreport.pdf>.

¹¹⁵ "Table 2.11, Children and adolescents with dental sealants by age group and selected demographic characteristics," The Third National Health and Nutrition Examination Survey (NHANES III) 1988-1994, National Center for Health Statistics, CDC, http://drc.nidcr.nih.gov/report/alltables.htm#2_1_1.

¹¹⁶ Ibid.

¹¹⁷ "Sentinel Oral Health Surveys of Ohio Schoolchildren", <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20Statewide%20Trends08.pdf>.

Socioeconomic Disparities: In Ohio in 2007-2008, a higher percentage of third-graders eligible for school lunch programs received sealants than those who were not eligible for school lunch programs.¹¹⁸

Ability to Get Wanted Dental Care

Description: Many children do not receive dental care because their parents or caregivers do not seek care for them. Some of the barriers to dental care include the following: the perception that dental care is required only for a swollen face and painful tooth, inability to find a dentist who accepts Medicaid, lack of insurance and cost.

Quantitative Data: Nationally, 74.3 percent of children aged 2-17 had at least one dental visit in the past 12 months.¹¹⁹ Ohio rates compare favorably with national rates, with 78 percent of third graders reporting a dental visit in the past year.¹²⁰

Racial/Ethnic Disparities: In national data, Hispanics aged 2-17 were the least likely to have visited a dentist in the past year (62 percent) followed by blacks (70 percent) and non-Hispanic whites (79 percent).¹²¹ In Ohio, white third graders were more likely than black third graders to report a dental visit within the last year.¹²²

Socioeconomic Disparities: Persons at or above the FPL (all ages) were more likely (71 percent) to report a visit to the dentist in the past year than those who were less than the FPL (51 percent).¹²³ In Ohio, children not eligible for school lunch program were more likely to report a dental visit in the past year than children who were eligible for school lunch program.¹²⁴

¹¹⁸ “Sentinel Oral Health Surveys of Ohio Schoolchildren”, <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20Statewide%20Trends08.pdf>.

¹¹⁹ Table 79, CDC, <http://www.cdc.gov/nchs/data/hus/04trend.pdf#079>.
http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹²⁰ “A Survey of the Oral Health of Ohio Schoolchildren, 2004-2005,” Ohio Department of Health, <http://www.odh.ohio.gov/ASSETS/318CE478E2784B088377359F69F6A075/FinalOHSreport.pdf>.

¹²¹ “Table 7.1.1. Visits to a dentist during the past year among those aged 2 years and older,” CDC, http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹²² “Sentinel Oral Health Surveys of Ohio Schoolchildren”, <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20Statewide%20Trends08.pdf>.

¹²³ “Table 7.1.1. Visits to a dentist during the past year among those aged 2 years and older,” CDC, http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹²⁴ “Sentinel Oral Health Surveys of Ohio Schoolchildren”, <http://www.odh.ohio.gov/ASSETS/AEF424E54D9145D2B9210FFB95CC0B0C/Sentinel%20School%20Data%20Statewide%20Trends08.pdf>.

D. 8 Substance and Tobacco Use - Contributing Factors

Tobacco Use

Description: Tobacco use (smoking cigarettes and/or using smokeless products) is the chief preventable cause of death in the United States. It is responsible for approximately one of every five deaths.

Quantitative Data: In 2007, 22 percent of Ohio adolescents in the ninth through 12th grade reported that they smoked one or more cigarettes in the 30 days preceding the survey¹²⁵. This is the close to the rate reported nationally (20 percent)¹²⁶ and represents a significant decrease since 1999, when 40 percent of students reported use of cigarettes within the past 30 days.¹²⁷ The Ohio rate falls short of the HP 2010 goal of 16 percent.

Racial/Ethnic Disparities: In Ohio, a higher percentage of white adolescents smoked (22 percent) than black adolescents (12 percent).¹²⁸ In the national YRBS, a higher percentage of white adolescents smoked cigarettes (23 percent) than black adolescents (12 percent).¹²⁹

Gender Disparities: There was not a significant difference in the percentages of Ohio males and females who smoked.¹³⁰

¹²⁵ Ohio YRBS, <http://www.odh.ohio.gov/ASSETS/F8FD479547B84C1CAF639F8FE834E123/Tobacco-Drugs.pdf>.

¹²⁶ “YRBSS, Youth Online: Comprehensive Results”, 2007.

¹²⁷ Ohio YRBS, <http://www.odh.ohio.gov/ODHPrograms/YouthRsk/Survey/tobacco.pdf>.

¹²⁸ Ohio YRBS, <http://www.odh.ohio.gov/ASSETS/F8FD479547B84C1CAF639F8FE834E123/Tobacco-Drugs.pdf>.

¹²⁹ “YRBSS, Youth Online: Comprehensive Results”, 2007.

¹³⁰ Ohio YRBS, <http://www.odh.ohio.gov/ASSETS/F8FD479547B84C1CAF639F8FE834E123/Tobacco-Drugs.pdf>.

D. 9 Priority Issues for School-Aged and Adolescent Health

MCH Stakeholder-identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the school aged and adolescent health group. A list of group members can be found at the end of this report.

During Phase II of the Needs Assessment process the early childhood, school age, adolescent and young adult groups were combined to allow for more consistent interventions for all children as a result of this process.

Group Rank	Health Issue
1	Risky behaviors including substance use (including tobacco and alcohol), risky sexual behavior, truancy and their consequences
2	Access to appropriate and affordable family-centered health care (combined with disparities, medical home, insurance, specialty)
3	Early identification as defined in Bright Futures and referral to proper diagnostic and treatment services (Screenings for: vision, hearing, oral health, mental health, BMI, immunization, nutrition)
4	Inadequate and inappropriate nutrition and physical activity resulting in obesity, overweight and nutritional deficiencies
5	Intentional and unintentional injury/trauma resulting in physical and/or psychological morbidity and mortality (e.g. homicide, suicide, child abuse, sexual assault, bullying, motor vehicle and other causes of injuries. Also includes attempted.)
6	Chronic conditions including mental illness, diabetes, substance abuse, asthma, obesity, sensory deficits and developmental delays
7	Safe and supportive schools and neighborhoods (including environmentally safe)
8	Health, wellness and social development (life skills) are not identified as a part of school achievement
9	Lack of teacher and/or parent/guardian education, awareness and support to provide an environment conducive to wellness for the child

Local Agency-identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects, WIC projects, practitioners and providers across Ohio requesting feedback in regard to the top 10 priorities identified in the last Maternal and Child Health Needs Assessment. Health care issues gathered from the survey provided a local perspective to the issues for each sub-population group.

School-age, Adolescents and Young Adults Stakeholders

Group identified themes from local stakeholder survey:

- Obesity
- Risky behavior, drugs, sex, STD
- Nutrition
- Exercise
- Depression/mental health needs
- Access-lack of providers
- Lack of medical home
- Dental care
- Developmental disorders/ADHD

- Parent education, awareness and support
- Tobacco
- Violence/abuse (domestic and bullying)
- Life skills for kids

E. Children With Special Health Care Needs Health Status

E. 1 Morbidity

Prevalence of Children with Special Health Care Needs (CSHCN)

Description: CSHCN are children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions that require health and related services of a type or amount beyond that generally required by children.¹³¹

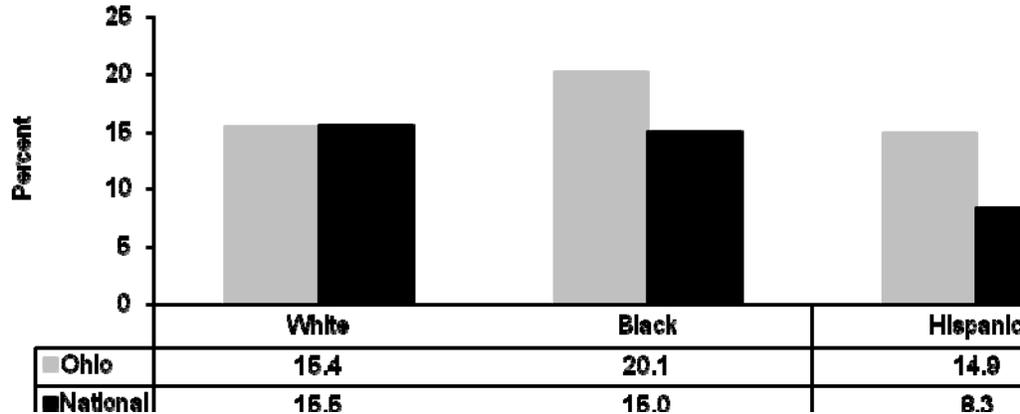
Quantitative Data: Ohio has approximately 445,205 CSHCN age 0-17 years. They comprise 16.2 percent of all Ohio children compared with 13.9 percent in the nation. A greater proportion of CSHCN are in the older ages, reflecting an increased identification or development of special health needs as the child grows. There are more males with special health care needs compared to females. Children in households below the federal poverty level were more likely to have special health care needs than those above the poverty level.¹³² In State Fiscal Year 2008, the Bureau for Children with Medical Handicaps (BCMh) provided funding for services to approximately 36,000 clients with medically handicapping conditions. BCMh provided funding for diagnostic evaluations for 10,000 children at a cost of \$2,100,000; treatment services for 24,500 children at a cost of \$18,200,000 and service coordination for 1,750 children at a cost of \$703,000.

Racial Disparities: Non-Hispanic black children are somewhat more likely to have a special health care need compared to white children: white 15.4 percent and black 20.1 percent, Hispanic 14.9 percent.

¹³¹ Definition from Maternal and Child Health Bureau, U.S. Dept. Health and Human Services, and American Academy of Pediatrics.

¹³² The National Survey of Children with Special Health Care Needs, Chartbook 2005-2006, <http://mchb.hrsa.gov/cshcn05/SD/ohio.htm>.

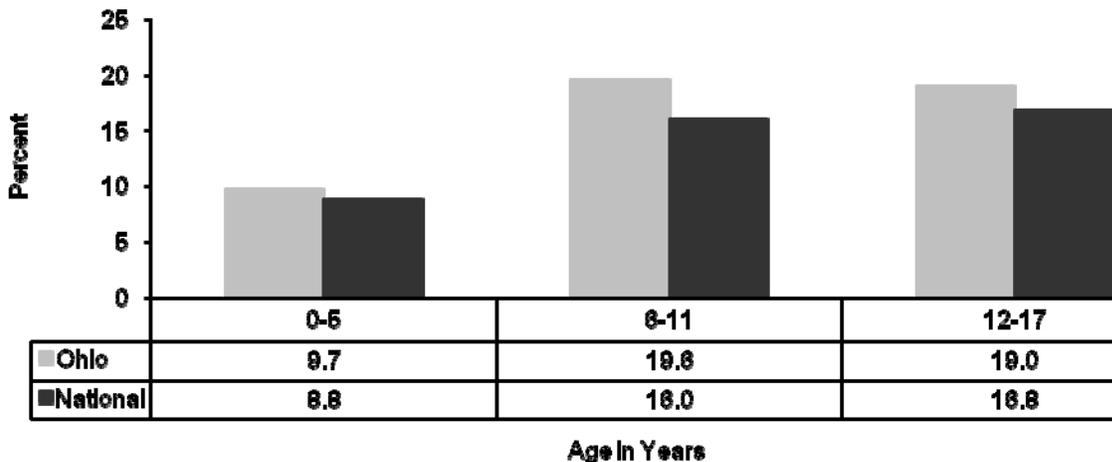
**Ohio and U.S. Children with Special Health Care Needs
Prevalence By Race/Ethnicity, 2005-2006**



Data Source: National Survey of CSHCN, 2005-2006

Age Disparities: Prevalence of CSHCN is disproportionately distributed among older age groups: children 0-5 years, 9.7 percent; children 6-11 years, 19.6 percent; children ages 12-17, 19 percent.

**Ohio and U.S. Children with Special Health Care Needs
Prevalence by Age, 2005-2006**



Data Source: National Survey of CSHCN, 2005-2006

Severity: As of 2007, 84 percent of Ohio CSHCN had at least one functional difficulty.¹³³ Forty-three percent of Ohio CSHCN had one or more moderate or severe chronic conditions. Thirty-five percent of children were able to manage their condition(s) primarily through prescription medication.¹³⁴

¹³³ Child and Adolescent Health Measurement Initiative. 2007 *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved from www.nschdata.org

¹³⁴ Ibid.

According to the 2007 National Survey of Children's Health, 12 percent of Ohio children ages 0 to 17 years currently have asthma. This compares to 9 percent for the nation. Fifty-seven percent of Ohio CSHCN currently has asthma.¹³⁵

Mental/Behavioral/Emotional Disorders among Children and Youth with Special Health Care Needs (CYSHCN): In Ohio, 7 percent of CYSHCN qualified on the CSCHN screener criteria for having ongoing emotional, developmental or behavioral conditions that require treatment or counseling. Six percent of parents/caregivers reported that a doctor or health professional had ever told them that their CYSHCN aged 2-17 years had depression. Eleven percent of children aged 6-17 consistently exhibited problematic social behaviors. This is not statistically significantly different from the nation.¹³⁶

Medical Home: Fifty-nine percent of Ohio CYSHCN ages 0-17 years receive health care that meets the AAP definition of medical home, compared with 50 percent for the nation.¹³⁷ One component of medical home is having a usual place for sick and well care; 93 percent of Ohio CYSHCN ages 0-17 have a usual place for sick and well care, similar to the national prevalence.

E.2. Priority Issues for Children with Special Health Care Needs (CSHCN)

MCH Stakeholder-identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the CSHCN Group. A list of group members can be found at the end of this report.

Group Rank	Health Issue
1	Access to primary care with early and continuous screening
2	Access to comprehensive treatment and specialty services
3	Patient/family centered coordinated care
4	Early identification and referral to services through medical and non-medical sources
5	Parent and family support
6	Chronic health conditions (e.g. obesity/overweight, diabetes, asthma and appropriate interventions including nutrition and physical activity)
7	Appropriate insurance coverage to provide needed services to CSHCN aged 0-24
8	Mental, social, behavioral and developmental health issues
9	Transition to all aspects of adult life including adult care
10	Birth defects surveillance and prevention
11	Disparities in health outcomes and access
12	Disintegrated administration of the system of care
13	Newborn screening, genetics services
14	Injury prevention

¹³⁵ Ibid.

¹³⁶ Ibid.

¹³⁷ Ibid.

Local Agency-identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects, WIC projects, practitioners and providers across Ohio requesting feedback in regard to the top 10 priorities identified in the last Maternal and Child Health Needs Assessment. Health care issues gathered from the survey provided a local perspective to the issues for each sub-population group.

**Children with Special Health Care Needs Stakeholders
Group identified themes from local stakeholder survey:**

- Funding for services
- Access to services or lack of services, providers
- Transportation (rural)
- Family support (respite care)
- Insurance/payment sources
- Eligible but don't apply (additional outreach)
- Diverse needs
 - Metro-Homeless/immigrant/access
 - Rural-Access/local agency funding
- Prevention issues
- Finding resources/navigating the system
- Financing the system
- Case management/coordination
 - Patient navigation/1:1 relationship
- Lack of family-based coverage/support\
- Mental health/stress
- Simplification [of the system of care]

2.1.3 Needs Assessment MCH Program Capacity by Pyramid Level

2.1.3.1 Overview of the Maternal, Infant, Child and Adolescent Health - Direct Care and Enabling Services

The balance between the state's involvement in direct health care services and enabling services is a dynamic process that responds to changes in the economy (e.g., willingness of providers to treat Medicaid patients, health care benefits associated with employment) and public policy (e.g., Medicaid/State Children's Health Insurance Program (SCHIP) expansions, impact of managed care). ODH sets its strategic priorities based on annual assessments of needs, wants and resources. With significant reductions in state public health funding combined with potential or proposed cuts in federal funding this process is producing significant shifts in current and planned funding for maternal and child health.

ODH Title V and other federally funded initiatives have supported efforts to transform funded projects from direct care to other efforts designed to strengthen community resources for treatment including local needs assessments, linkages with safety net providers and targeting of health care provider placement programs. The Ohio General Assembly has proposed a study commission to address the need for a comprehensive, long-term funding solution to support treatment services for CSHCN.

Because the state's role in assuring access via enabling services is so closely linked to the availability of direct services and the factors discussed above, the two are considered together in this section. This section is structured as follows:

- The first part (**A**) examines the barriers that face the MCH and CSHCN populations and the systems or programs that seek to provide the capacity to meet the needs of the MCH population and address the barriers.
- The second part (**B**) discusses CSHCN-enabling services. While the issues for the maternal, infant, child and adolescent population may be similar, those for CSHCN often have their own character.
- The third and final part (**C**) concludes with a list of priority concerns regarding access.

A. Barriers and System/Programs to Address Them

Most health care is provided by private providers and institutions. However, many Ohioans face barriers to accessing care in the private sector. Barriers can relate to *finances* (lack of financial resources, previous medical bills, deductibles, cost); *availability of providers* (distance to providers by miles and/or time, availability of transportation, availability of Medicaid providers or other safety net providers who use a sliding fee scale based on 200 percent of the Federal Poverty Level); or *societal/acceptability issues* (language, poverty, cultural differences, discrimination).

A.1 Financial Barriers

Health Insurance Coverage

A major determinant of access to health care is the ability of a family to pay for care. Private and public health insurance are significant enabling factors. The 2008 Ohio Family Health Survey of over 50,000 households revealed that 14.1% percent (1.2 million) of Ohio residents 18 years of age or older had no health insurance. From 1998 to 2008 the uninsured rate for children ages 0 through 17 declined significantly from 9.8 percent (280,000) to 4 percent (111,255), largely due to eligibility expansions in Ohio's Medicaid program. However, 12 percent of Ohio's Hispanic children and 33% of children <100% FPL were uninsured in 2008. Children in rural counties had the highest uninsured rate (4.9% for rural non-Appalachian counties and 4.8% Appalachian counties). For supplemental services not always covered under a regular health insurance plan, children had the highest reported rate of no coverage for vision care (22.3%), followed by dental care (18.3%), and prescription medications (6.9%).¹³⁸ The child uninsured rate in Ohio is substantially lower than the 2008 national average of 9.9 percent for this age group,¹³⁹ but higher than the HP 2010 target rate of 0 percent. Among Ohio CSHCN, 2.1 percent were uninsured. The uninsured rate for Ohio women ages 18 through 64 was 15 percent in 2008.¹⁴⁰

The uninsured rate for working age adults 18 to 64 increased from 15.0% in 2004 to 17.9% in 2008, increasing from as estimated 1,055,651 uninsured 18-to-64-year-olds in 2004 to 1,220,895 uninsured 18-to-64-year-olds in 2008. A key explanation for this increase in the uninsured rate is the decline in job-based coverage, which has fallen from 63.5% in 2004 to 61.7% in 2008. One

¹³⁸ 2008 Ohio Family Health Survey.

¹³⁹ Income, Poverty, and Health Insurance Coverage in the United States: 2008, U.S. Census Bureau.

¹⁴⁰ The National Survey of Children with Special Health Care Needs, Chartbook 2005-2006, <http://mchb.hrsa.gov/cshcn05/SD/ohio.htm>.

reason for this decline in employer-based coverage is a large increase in the number of people not working. Disparities exist among the working age uninsured. For working age adults 18 to 64, the uninsured rate has increased since 2004 for whites, blacks, and Hispanics. However, the increase is particularly significant for Hispanics from 27.2% to 39.1%. Blacks aged 18 to 64 were 1.8 times more likely to be uninsured than whites.¹⁴¹

Ohio Medicaid

In Ohio, Medicaid is administered by the Ohio Department of Job and Family Services (ODJFS) through six state agencies, 88 county departments of job and family services, 88 county boards of mental retardation and developmental disabilities (MR/DD), 56 behavioral health boards, eight managed care organizations, and 64,389 health care providers. Medicaid accounts for 3.0% of Ohio's economy and 23% of total state government spending. Ohio spends more on Medicaid (\$13 billion in 2008) than any other program, including the \$12.9 billion spent on primary, secondary and higher education combined (it should be noted that here is no federal match for education spending, it is all state dollars, and the state share of Medicaid spending is \$5.2 billion). Medicaid is not only Ohio's largest governmental program it is growing faster than most other state programs. As a result, Medicaid policy receives considerable attention when the Governor and Ohio General Assembly put together the State's two-year operating budget.

Ohio Medicaid covered 2.2 million Ohioans in 2008 (total annual non-duplicated enrollment). However, because people enter and exit the program throughout the year, Medicaid covered, on average, 1.7 million Ohioans each month. Some low-income areas of the state depend on Medicaid more than others. In Ohio's urban centers, 20-30% of the population is covered by Medicaid. Along the Ohio River, there are ten counties where more than 30% of the population is covered by Medicaid — and 20 counties where Medicaid covers more than 65% of all children under age five. More than half of all Medicaid-eligible Ohioans (57%) are nondisabled children. Children and families make up 78.2% of the Ohio Medicaid population but consume only 30.2% of Medicaid spending.

Each month, Medicaid covers: • 992,000 children (1 out of 3), including 34,000 children with disabilities; • 340,000 parents; • 108,000 seniors; and • 259,000 people with disabilities, including children. Ohio Medicaid's health coverage for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 200% of poverty are eligible for Healthy Start (Governor Strickland has proposed increasing eligibility to 300% in his 2010-2011 budget). Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year regardless of family income. If a child's parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty.

Governor Strickland's goals for health care coverage in Ohio include reducing the number of uninsured Ohioans to 500,000 by 2011 (about half the current number) and increasing the number of small businesses that are able to offer health coverage to their workers. The Governor focused first on seeking to expand Medicaid coverage for children, requested and received federal permission to increase Ohio's Medicaid/SCHIP income test from 200% to 300% of

¹⁴¹ 2008 Ohio Family Health Survey

poverty, and included the expansion in his 2010-2011 budget proposal. Ohio recently accepted Secretary Sebelius' challenge to states to enroll all potentially eligible children into the Medicaid program. Ohio recently implemented both presumptive eligibility and continuous eligibility for children, and there are plans to implement express lane eligibility as well.

Children's Buy-In (CBI) Program

CBI provides another option for Ohio's uninsured children in families with income above 300% of federal poverty guidelines (\$63,600 annually for a family of four). CBI allows working families who have uninsured children with special health needs or high monthly premiums to purchase public health coverage (Medicaid Healthy Start) for their children. Children must be uninsured for six months prior to enrolling and must meet additional criteria in order to qualify. The CBI program began April 2008 and, despite early estimates that 5,000 uninsured Ohio children would obtain coverage, only two children were enrolled in CBI as of November 2008.

Delivery System

Ohio Medicaid provides primary and acute care services through a fee-for service system and managed care plans. Both delivery systems provide medically necessary primary care, specialty and emergency care services, and preventive services. Ohio Medicaid also provides home and community-based and facility based long-term care services, exclusively through the fee-for-service system.

Fee-For-Service

The Ohio Medicaid program has a network of 64,389 providers, including hospitals, family practice doctors, pharmacies and durable medical equipment companies. These providers are permitted to provide health care services to Medicaid consumers and to bill Medicaid for those services. Medicaid uses a pre-set schedule of payment, called fee-for-service (FFS), to determine how much to pay the provider for a particular service.

The FFS system operates statewide. A Medicaid consumer may go to any Ohio Medicaid provider. However, a provider's participation in the Medicaid program is voluntary, and consumers need to ask the provider if they accept Medicaid before scheduling an appointment.

Managed Care

Ohio's Medicaid managed care program was created in 1978 and continues today as a strategy to ensure access to services, provide quality care, and manage Medicaid costs. The 2006-2007 budget more than doubled the size of Ohio's program, from 529,000 enrollees in 15 counties in June 2005 to 1.3 million enrollees in all 88 counties in January 2009. In most counties, Medicaid managed care enrollees have a choice of three health plans. Statewide, seven health plans serve Medicaid beneficiaries. As a result of the managed care expansion, almost all Medicaid-eligible children and parents (1.2 million people as of January 2009, receive Medicaid services through a managed care organization. In addition, some people with disabilities, 86,722 people as of January 2009) are enrolled in managed care. Most Medicaid-eligible seniors and people with disabilities (76%) are excluded from the managed care expansion and continue to receive Medicaid services through the fee-for-service program, including children under age 21 with disabilities, residents of institutions, recipients of Medicaid waiver services, and persons eligible for Medicare or who "spend down" their assets in order to qualify for Medicaid. Despite these

medically-complicated, high-cost groups being ideal candidates for care coordination, Ohio law currently prohibits them from enrolling in Medicaid managed care.

Executive Medicaid Management Administration (EMMA)

In December 2007, Governor Strickland established EMMA by executive order to serve as the central coordinating body to manage the Ohio Medicaid Program across all state agencies. The purpose of EMMA is to facilitate program and operational efficiency, eliminate duplication, facilitate compliance with federal Medicaid laws, avoid conflicting policy decisions, and maximize federal funding. An executive director manages the cabinet level office, which includes a council of directors from the Departments of Alcohol and Drug Addiction Services, Aging, Budget and Management, Health, Job and Family Services, Mental Retardation and Developmental Disabilities, Mental Health, and the Superintendent of Public Instruction. The Ohio Department of Job and Family Services remains the single state Medicaid agency. Health care reform is among the highest priorities on state and federal policy agendas. Health system problems, politics, and policies seem to be converging — creating a window of opportunity for reform. So far, much of the debate (in Ohio and nationally) has focused on coverage for the uninsured. Ohio fares well in terms of coverage — only 14 states do a better job covering uninsured citizens. However, according to the Commonwealth Fund, Ohio ranks very low in terms of quality — 37th in avoidable hospitalizations, for example, and 41st in terms of healthy living. Coverage is important, but reform must also drive toward better health outcomes. With careful oversight and policy formation, Medicaid has the potential to fill gaps in coverage but also improve quality and contain costs, strengthening the foundation for broader health system reform.

A.2 Lack of Availability of Providers

A lack of availability of health care resources, particularly for vulnerable populations, often results from geographic barriers and barriers within the very systems created to fill gaps (i.e., Medicaid). Although they have limitations, federally designated health professional shortage areas (HPSAs) are a proxy for summarizing the availability of mostly private providers. Safety net resources attempt to fill the gaps in the private system.

Data Sources and Limitations

Like other states, Ohio suffers from a shortage of primary care, dental care and mental health care providers in a number of communities and counties. Attempts at enumerating shortage areas center on those that have gone through the process of being designated a federal HPSA. These data; however, do not present the whole picture because many areas that might qualify as HPSAs do not apply. In addition, limited ODH staff resources do not have the capacity to identify all areas that may meet the federal criteria for designation. While raw numbers of providers to population at the county level offer a gross indication of geographic shortage areas, they do not tell the story of communities, usually urban, in which poverty is concentrated in proximity to wealth. These areas may have a large number of providers, but a relatively small number serve the poor and near-poor populations. The true need in the state is therefore under-represented by the numbers that follow.

ODH has some data on advanced practice nurses and public health nutritionists by county. However, there are no standards against which to measure their availability. ODH does not have

information on medical social workers, audiologists, occupational therapists, physical therapists and speech-language therapists.

The number of HPSAs can vary based upon when you check and what designation status is being used. Typically HPSAs have 4 designation statuses: 1) designated, 2) no data, 3) proposed for withdrawal, and 4) withdrawn. All are considered “active” except for those with the status of “withdrawn”.

Primary Care HPSAs

Ohio has 127 federally designated primary care HPSAs distributed within 51 of its 88 counties. This often times creates a difference in the numbers. They include much of rural Ohio and parts of every major city in Ohio (Cleveland, Cincinnati, Toledo, Columbus, Dayton, Youngstown, Akron and Canton). The counties with the largest metropolitan areas (Cuyahoga [Cleveland], Franklin [Columbus] and Hamilton [Cincinnati]) have many primary care HPSAs, but they also have many Title V and non-Title V clinics to act as safety net providers. In the rural underserved areas of Ohio, the safety net varies from none, in counties such as Meigs and Morrow, to significant, in counties such as Pike and Lawrence.

Dental HPSAs

As with primary care HPSAs, dental HPSAs represent only those that have applied. Other areas would likely qualify if they applied. The map references a total of 98 dental HPSAs: 1 whole county, 3 geographic areas, 57 population groups and 37 facilities. The 57 population group HPSAs indicates that the majority of the Dental HPSAs are for low-income groups in both rural and urban areas.

Mental Health HPSAs

The same caveats on using HPSA data as a proxy for shortage areas apply to mental health care providers. Ohio has 65 mental health HPSAs; 7 whole county, 12 geographic areas, 4 special population, and 42 facilities. Thirteen geographic designations indicate a need for 19 psychiatrists to serve a population of more than 907,000 Ohioans. Of the 19 counties within these geographic designated areas, 12 are in the Appalachian region. The remaining three mental health HPSAs have been designated for facilities (one state prison and two state psychiatric hospitals).

Ohio Primary Care Health Professional Shortage Areas (HPSAs)



This output may contain proprietary data obtained from Claritas, Inc. (Census boundary files: 2000; MSA boundary files: 2000, 2002)

Health Professional Shortage Areas (Primary Care) - Point		HRSA Data		Health Professional Shortage Areas (Primary Care)	
◆ Alaskan Native Tribal Population	◆ Federally Qualified Health Center Look A Like	◆ Geographical Area	◆ Single County	◆ States	◆ Counties
◆ Comprehensive Health Center (cont)	◆ Indian Health Service Facility	◆ Population Group (cont)			
	◆ Native American Tribal Population				
	◆ Rural Health Clinic				

Map prepared by:

HRSA Geospatial Data Warehouse
datawarehouse.hrsa.gov

Ohio Mental Health Professional Shortage Areas (HPSAs)



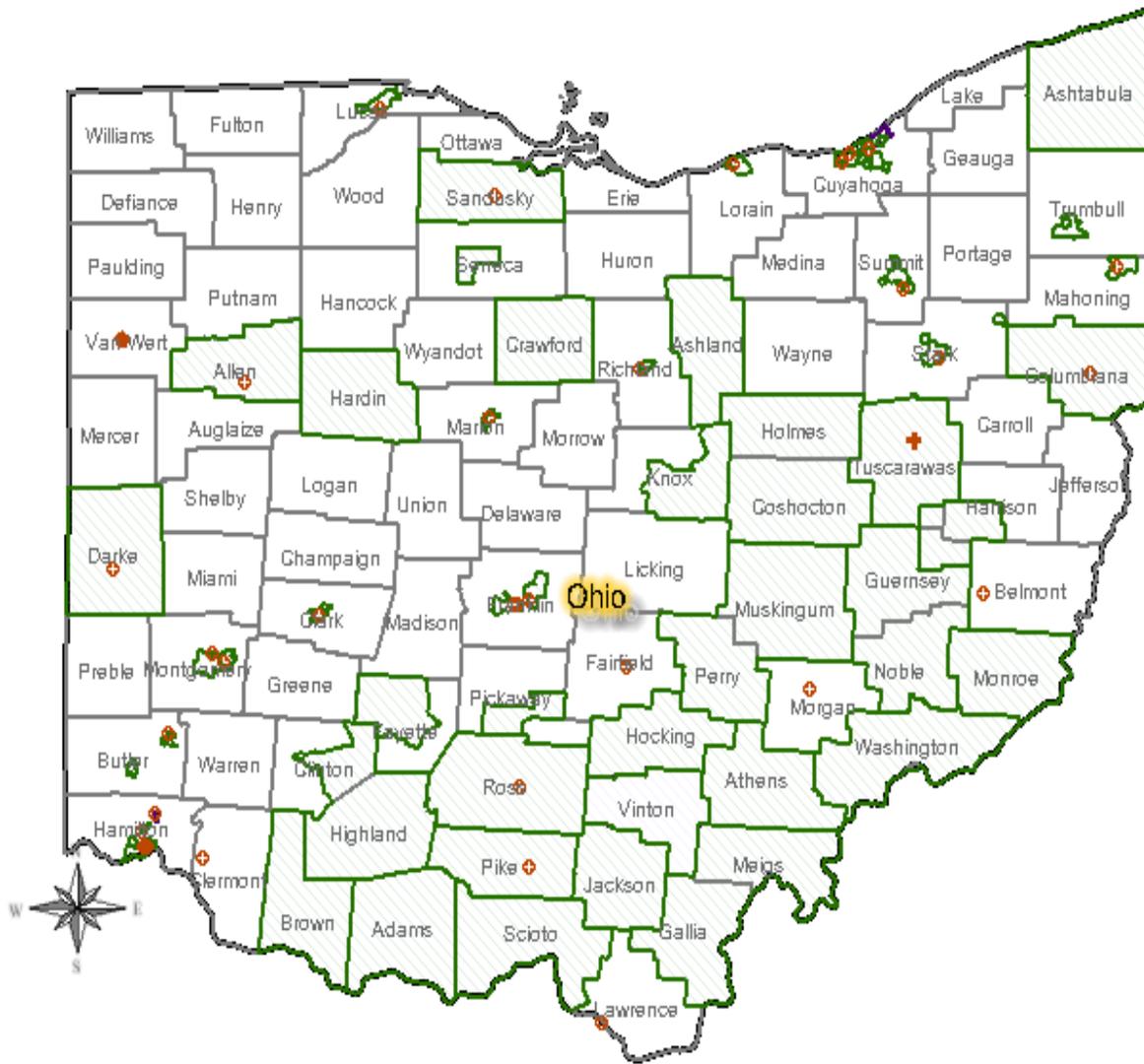
This output may contain proprietary data obtained from Claritas, Inc. (Census boundary files: 2000; MSA boundary files: 2000, 2002)

Health Professional Shortage Areas (Mental Health) - Point		HRSA Data		Health Professional Shortage Areas (Mental Health)	
◆ Alaskan Native Tribal Population	◆ Federally Qualified Health Center Look A Like	◆ Geographical Area	▨ Single County	▨ States	
◆ Comprehensive Health Center (cont)	▣ Indian Health Service Facility	▨ Population Group (cont)	▨ Counties		
	▣ Native American Tribal Population				
	◆ Rural Health Clinic				

Map prepared by:

HRSA Geospatial Data Warehouse
datawarehouse.hrsa.gov

Ohio Dental Health Professional Shortage Areas (HPSAs)



This output may contain proprietary data obtained from Claritas, Inc. (Census boundary files: 2000; MSA boundary files: 2000, 2002)

- | | | | |
|---|---|--|--|
| <p>Health Professional Shortage Areas (Dental Care) - Point</p> <ul style="list-style-type: none"> ◇ Alaskan Native Tribal Population ◇ Comprehensive Health Center (cont) | <p>HRSA Data</p> <ul style="list-style-type: none"> ◆ Federally Qualified Health Center Look A Like ■ Indian Health Service Facility ▭ Native American Tribal Population + Rural Health Clinic | <p>Health Professional Shortage Areas (Dental Care)</p> <ul style="list-style-type: none"> Geographical Area Population Group (cont) | <ul style="list-style-type: none"> Single County States Counties |
|---|---|--|--|

Map prepared by:
HRSA Geospatial Data Warehouse
datawarehouse.hrsa.gov

A.3 MCH Programs that Address Capacity Barriers

The Safety Net of Health Care Services

Even when people have Medicaid coverage, they still may have difficulty finding a private health care provider to serve them. Programs that serve as a safety net for vulnerable women and children are found in a variety of settings (e.g., local health departments, community health centers, hospitals and other community agencies). Some safety net programs receive funding through DFCHS, sometimes originating from Title V. ODH provides subsidies to FQHCs for uninsured care for children and pregnant women. ODH also sends dollars to FQHCs from tobacco funding for uninsured pregnant women and children to receive care. For many pregnant women and children who are low income, eligible for Medicaid and uninsured or underinsured, programs administered by DFCHS serve as an important part of the safety net by providing enabling services or direct health care services. The most notable systems are the CFHS Program, The Ohio Infant Mortality Reduction Initiative (OIMRI), specialty clinics and dental care clinics. Enabling service is also provided by the Help Me Grow program and the WIC program. A description of each follows.

Child and Family Health Services Program (CFHS) is a community based program that uses a combination of federal/state/local monies to provide public health programs/services, including safety net clinical services to low income un/underinsured families/children in Ohio. The program is designed to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants/children. Currently 71 agencies in 73 counties (local health departments/hospitals/community action agencies/other nonprofit agencies) hold CFHS grants.

There are 5 components in the CFHS Program: Community Health Assessment (CHA) (required); Child Health; Family Planning; Prenatal Health; OIMRI. Applicant agencies are limited to strategies that address the MCH BG priority topics. Applicant agencies must develop strategies based on best practices research with clear, measurable benchmarks for each strategy. CFHS projects have been asked to re-evaluate their need to provide direct care services. CFHS expanded use of the Integrated Perinatal Health Information System (IPHIS) data to include all CFHS perinatal care providers. CFHS clinics are piloting screening tools for environmental risks to women of childbearing years. CFHS is developing a plan to expand the environmental risk initiative.

CFHS projects use their CFHS grant dollars to provide infrastructure, population-based, enabling and direct care programs and services. The maximum funding a county can apply for will be determined by a formula similar to the one used to allocate funds for the MCH Block Grant. CFHS projects have been asked to re-evaluate their need to provide direct care services. In 2010 the CFHS program is being redesigned to reflect the national and state performance measures outlined in the MCHBG.

The Ohio Infant Mortality Reduction Initiative (OIMRI) is a targeted perinatal service coordination program. OIMRI is an enabling service that will be incorporated into the CFHS program for FY 2006 as described above. Currently, the program funds 13 OIMRI projects that target those census tracts or neighborhoods with high-risk, low-income pregnant women for first

trimester prenatal care. The OIMRI program utilizes the community care coordination model to empower communities to eliminate disparities. The community care coordination model supports employing individuals from the community as trained advocates (community care coordinators (CCC) who empower individuals to access resources. The services focus on achieving success in health, education and self-sufficiency. The CCC makes home visits on a regular basis during pregnancy and through the baby's second year of life; identifies and reinforces risk reduction behaviors; and collaborates with other agencies in making appropriate referrals when necessary to assure positive pregnancy and infant health outcomes. While Ohio has a safety net system of healthcare for un/underinsured and Medicaid consumers, significant barriers to pregnant women and children accessing those services remain. The OIMRI program addresses the barriers (e.g., financial, geographic, cultural) that women and children experience and improves their access and utilization of health care services.

The focus of OIMRI changed in 2006 to address disparity in infant mortality in Ohio's African American community. ODH completed the data needs assessment and began work on identifying an appropriate data collection system. The Ohio Infant Mortality Task Force, provided recommendations and strategies in the Preventing Infant Mortality in Ohio: Task Force Report 2009. To continue the work of the Task Force ODH is establishing an ongoing consortium to implement and monitor the recommendations. In 2010, ODH program staff collaborated with Columbus Public Health on the Infant Mortality and Racism Action Learning Collaborative.

Specialty Medical Services Program (SMSP): the SMSP provides pediatric hearing/vision specialty services in 36 counties and facilitates services for cardiac/orthopedic pediatric specialty clinics in 8 counties. These clinics improve access for low-income children to pediatric specialists in medically underserved areas. Both diagnosis and treatment services are provided through these itinerant clinics, these "safety net" clinics supplement the private practice system in providing access points for patients. The clinical services are provided through a contractual arrangement with providers and ODH. The itinerant clinics are based primarily in local health departments through a contractual agreement.

Local Public Health Nurses assist families in applying for Medicaid and the Bureau for Children with Medical Handicaps (BCMh) help families make follow-up appointments for other testing and surgery. The majority of the clinics are provided in Rural-Appalachian counties located in the Southeast region of the state due to the lack of specialty providers. A total of 3,253 children were served from July 1, 2008 through June 30, 2009; there was a decrease in clinics due to local H1N1 activities. ODH is pleased to participate as a key partner in one of the five pilot state programs of the MCHB National Universal Vision Screening for Young Children Coordinating Center. The programs are developing and implementing a uniform statewide strategy for universal vision screening by age 4 and determining a mechanism for uniform data collection, reporting, and establishing a state Title V performance measure for vision screening.

Safety Net Dental Care Clinics provide diagnostic, preventive and treatment services primarily for people who cannot or will not access the private system, usually for reasons relating to payment. While the numbers often fluctuate, Ohio's 113 safety net primary dental care clinics currently include the following:

- Two dental schools (plus seven of their clinics and two mobile programs for special populations).
- Twelve city and county health department clinics.
- Twenty-two hospital-based/linked programs.
- Forty-three FQHC clinics.
- Twenty-seven other programs (e.g., United Way agencies, Community Action Agencies, homeless programs, church-affiliated and other volunteer programs).

The capacity of safety net dental clinics, in terms of the services they provide and the populations they serve, varies widely. The largest programs tend to be dental schools or hospitals, where Medicaid is accepted, but sliding-fee schedules are rare. About half of safety net dental care programs have waiting lists to get initial appointments. Waits are typically one to three months, but some exceed six months.

All of the state's 21 subgrantees receive Title V funds from ODH. ODH also combines Title V and state dollars to fund the OPTIONS program of referral coordinators (case managers) linking low-income and/or disabled individuals with dentists willing to provide discounted or donated care.

The Help Me Grow (HMG) program provides information, services and support to pregnant women, new parents, infants and toddlers at risk for or with developmental disabilities and their families. ODH is the lead agency for Ohio's Part C Early Intervention Program, which has been integrated into the HMG Program that includes home visitation services for families, infants, toddlers at greatest risk of poor health or social outcomes and provides important information on prenatal/ infant care development, positive parenting, safety and abuse prevention. While funding for HMG comes from sources other than the MCH BG, the program works collaboratively with Title V-funded programs to improve the health of infants, young children and their families. In SFY2009, HMG provided visits to over 29,000 newborns and their families and provided supports/services to over 27,000 infants, toddlers with developmental delays and disabilities as well as over 35,000 infants/toddlers at-risk for developmental delays.

The USDA-funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), (Farmer's Market Nutrition program), provides highly nutritious foods, nutrition and breastfeeding education/support, immunization screening and health care referral through local agencies to eligible individuals. WIC is administered through 75 local agencies with 220 clinics throughout Ohio's 88 counties. Ohio has the 7 largest WIC programs in the U.S. that provide enabling services of nutritional help during critical times of growth and development to prevent health problems and improve health status of eligible individuals. WIC has partnered with ODH lead testing, smoking cessation & immunization screening programs to promote maternal and child wellness.

A.4 Qualitative Data on Health Services (Related to Maternal, Infant, Child and Adolescent Issues)

In addition to health status issues, health services issues were frequently mentioned by participants in surveys and focus groups. Below is a summary of perceived needs to maternal, infant, child and adolescent health services issues.

In 2009, Ohio Department of Health Director Dr. Alvin Jackson convened the Task Force on Oral Health and Access to Dental Care for the purpose of prioritizing oral health and dental care needs related to underserved Ohioans. Through a series of regional meetings, the group identified the following dominant themes:

1. Achieving oral health is a complex challenge with many interdependent variables, where control and influence over the variables is widely distributed among many parts that do not interact or, when they do, the process is cumbersome and colored by missing, inaccurate or confusing information.
2. While personal and community-based prevention activities were mentioned during each meeting, there was little discussion about evidence-based community approaches to dental disease prevention (i.e., water fluoridation and school-based dental sealant programs). The dominant focus of the regional meetings was barriers to Ohio's most vulnerable populations receiving dental care.
3. Despite the limited focus on prevention, it was clear that community-based prevention is seen as an essential and critical strategy, but one that is labor intensive, misunderstood, underfunded and hindered by the fact that documenting the results is long term proposition that is not being invested in any systematic way.
4. Achieving oral health and accessing dental care were discussed primarily as economic challenges rather than health challenges.
5. Patients, consumers and advocates tend to see dental care as unaffordable and programs that are intended to help make them affordable are underfunded, hard to get to and complicated to participate in.
6. Providers tend to see access to dental care in terms of insufficient reimbursement rates, cumbersome paperwork and difficult patients.
7. Medicaid and Medicaid Managed Care are seen by all as a mixed blessing. They are essential to getting people services, but seen as complicated, cumbersome and inconsistent in how they assess and meet people's needs.
8. At the same time, the growing number of people with no insurance is seen as serious problem for those who need care and those who want to provide it but have to build and maintain sustainable business models to survive.
9. Most people believe that the resources allocated to public oral health and dental care is insufficient for the challenge. They also believe that there is considerable waste in the system.
10. The current economic conditions are increasing the demand on this fragile system.
11. There was a significant focus on increasing the number and variety of providers and care givers, as well as the variety of setting in which the work is done.
12. Consumers tend to think of clinics as somewhat more accessible than private practice dentists, but worry that the quality of care is lower at a clinic.
13. While there are many barriers to access, there are examples of tools and strategies that are working or could work.
14. Community partnerships seem to provide many examples of actual and potential success. However, the demands on the system and its parts are so great and the linkages among the parts so weak, it takes considerable focus, will and persistence to build the kind of relationships that support authentic collaboration.

15. As the number of people, who are uninsured, underinsured or Medicaid eligible grows, there are people with special needs who face additional challenges. People with developmental disabilities, who are elderly, children, the homeless, people for whom English is not their primary language and other cultural and ethnic groups were among the groups identified as especially vulnerable.

16. While quality of care is an undercurrent in much of what was said at the meetings, it was not addressed explicitly in any significant way.

17. There is overwhelming agreement that a major problem is that the general public does not see oral health as being a significant aspect of overall health, undervalues it and has built systems that undervalue oral health. As much as people want more resources for oral health services, they also see a need for massive public education.

The task force primarily made three types of recommendations: 1) those that relate to initiatives in place; 2) those that can/should be addressed in the short-term future and require little or no additional investment of scarce resources; and 3) those that are more long term, requiring investment in identifying leadership, building relationships and other resources. One important recommendation calls for convening an inclusive statewide oral health advocacy and action group to continue to carry on with the director's charge and to bring focus and continuity to Ohio's oral health agenda. This plan will be a road map for the group when it is convened. This group is likely to play such an important role in implementing the plan; the task force did not provide implementation details for the entire plan. Nevertheless, this document includes limited recommendations plan that highlights the programs that are in place and short-term strategies. As the advocacy and action group is formed and the economy improves, the long-term strategies will become actionable.

In 2008, as part of the Ohio Department of Health Family Planning Needs Assessment, key informant interviews were conducted with health commissioners and directors of nursing in 19 Ohio counties without any state-funded family planning services. The goal was to identify barriers to providing care, current capacity to provide family planning services and the need for provision of family planning. The interviews yielded the following recommendations:

- 1) Review/revise incentives designed to recruit and retain health care providers to rural counties. Physicians tend to relocate from rural communities upon completion of their JN1 program. Recommendations include but are not limited to:
 - a. Extended JN1 Program Contracts;
 - b. Incentives to complete higher/more specialized education while working in the rural communities;
 - c. Incentives to recruit family practitioners to offer preventive care and specialists who offer the most extensive treatment options; and
 - d. Incentives to recruit diverse health care providers to include gender, lifestyle, cultural and religious beliefs.
- 2) Partner with other government agencies and health care providers to improve the Medicaid programs and processes that will ultimately eliminate the unfavorable perceptions associated with managing patients covered by the health insurance program.

- 3) Key informants agreed that to offer low cost family planning services, the organization must be very creative with the name, branding and marketing of the location. Using the name “family planning” in the counties included in the assessment would likely create community outrage, protests and possibly a change in the laws. Names such as “Women’s Health Center”, “Health Services for Women and Children” and “Crossroads Health Complex” are more appealing. In addition, it is very important to offer a variety of healthcare and family planning services at each facility during most business hours to eliminate the stigma of visiting the “free clinic” during the “testing” hours.
- 4) Continue to offer counseling related to abstinence, pregnancy, reproductive health care, prescription contraception, sexually transmitted diseases (STD) and sexual health to counties that have high rates of teen pregnancies and increased occurrences of STDs.
- 5) Continue to distribute culturally competent literature to promote reproductive cancer screenings and treatment options in counties included in the assessment.
- 6) Expand programming that offers support services to women in need of publicly funded contraceptive services and supplies including transportation, counseling, pre-natal support and co-payments.
- 7) In addition to facilities, providers, funding and staffing, create easier access to resources and equity for smaller, rural counties. Examples include but are not limited to:
 - a. Grant systems and databases that are user friendly and accessible from any computer with an internet connection;
 - b. Offer block grants to allow smaller counties to provide specific family planning services needed in their counties;
 - c. Relax long term sustainability requirements. Doing so will allow smaller health districts to help some residents in the short term as opposed to not helping any in the long term. In addition, the strongest programs ultimately change behaviors and may eliminate the need for sustainability.
 - d. Create opportunities for counties with newly awarded family planning grants to learn best practices from other counties with well designed family planning programs.
 - e. Apply diversity training requirements to counties with greater populations of diverse residents. The counties included in the assessment have smaller minority populations than the state average. The training requirements for the smaller counties constrain resources with little immediate perceived value to the health care providers and/or administrators.
 - f. Relax grant writing documentation requirements. Smaller counties have fewer employees who are typically trained as health care providers, not grant writers. The explanations, data entry, delivery processes and redundancy may discourage smaller counties from applying for much needed funding.
 - g. Scale grant award requirements based on the population of the county and the percentage of women in need of publicly funded contraceptive services and supplies. Smaller counties are not able to complete with the total number of women in need of publicly funded contraceptive services and supplies in the metropolitan areas.

At the final stakeholder meeting, an action plan for each priority was developed by consensus. This included a concise problem statement, identification of the target population, development of broad strategies and accompanying, detailed activities as interventions, and identification of resources and barriers. Each intervention was ranked in order of priority by the stakeholders. Keeping current Office of Population Affairs (OPA) Program Priorities in mind, the ODH staff refined each intervention by developing work plans and evaluation strategies to reflect the priorities identified. In summary, the priority areas identified by external stakeholders were merged into a final list of five areas of need:

1. In Ohio in 2006, the number of women of reproductive age in Ohio who needed publicly supported contraceptive services and supplies was 645,540 women.
2. Nearly 53% of Ohio newly delivered mothers that had an unintended pregnancy was not using contraception at the time of conception in 2005.
3. The cervical cancer rate for the Title X service area (7.9/100,000) was higher than the rate for the state of Ohio overall (7.4/100,000).
4. The percentage of adult women in Ohio who are obese (body mass index greater than 30) has gradually increased to nearly 27% in 2007.
5. Only 72.7% of Ohio women began prenatal care in the first trimester and the overall short inter-pregnancy interval (defined as less than 18 months) was 14% in 2005.

The need area identified by stakeholders with the highest priority was access to family planning services. For this needs assessment process, the ODH and its stakeholders looked at access to services in a broad fashion. The components of access include fiscal considerations, appointment availability, cultural acceptability, method choice availability, and geographic proximity. Most of the other need areas have related access issues. We looked at many components to access in this need assessment. In particular, attention was paid to increasing services to teens and young adults. As fiscal considerations permit, those counties currently without services will require technical assistance to develop fundable grant applications. In addition, services to clients will be expanded to encompass a broader range of reproductive services and outreach conducted to reach more clients through existing sub-grantees.¹⁴²

B. Direct Care and Enabling Services for CSHCN

B.1 Coordination of the CSHCN Program

The state CSHCN program, coordinated by BMCH, is shifting the mixture of services provided from funding of direct health care to enabling services.

Public health nurses (PHN) and the following individuals coordinate enabling services. The medical review nurses stationed in the Columbus office of BCMH are responsible for case management. These nurses communicate with the BCMH field nursing consultant, medical center staff, the child's family, the physician and the PHN. The specialty team service coordinator is a clinical nurse specialist or social worker located in the tertiary medical center. The child's managing physician is responsible for maintaining a medical home and developing a medical treatment plan, coordinating the request of services needed by the child, and submitting the necessary reports to BCMH. BCMH works closely with the local PHN and local health

¹⁴² FY 2009 Federal Title X Family Planning Grant Application

department to assure CSHCNs and their families have access to the local service coordination they need.

Families require varying degrees of assistance in negotiating the increasingly complex systems of care and assistance (both public and private). For some, the help may come from another parent. For others, the PHN or a service coordinator from Early Intervention is appropriate. Many families need special assistance in negotiating the county department of human services system and support in completing the Medicaid application process—and indeed, in reapplying. PHNs have been especially helpful in educating families about what they need to do and, at times, advocating on their behalf with human services agencies.

The Ohio Legislature formed a Funding Commission to look at future funding for the Title V CSHCN Program. In 2008 the Title V CSHCN program achieved stable funding in the recommendations for the Biennium Budget and as a result increased enrollment of children. With stable funding the BCMH is considering revisions and additions to its program as recommended by the Legislative Funding Commission. The Legislative Funding Commission's report has been published & the recommendations are being reviewed & where possible implemented. However, the current recession is placing funding stress on the CSHCN program while at the same time increasing the program's case load.

B.2 Systems Issues

Serving Children on Supplemental Security Income (SSI) children who receive SSI have some disabling condition and live in families with modest incomes. Disabling conditions are more likely to be mental (65 percent) than physical, although children may have secondary medical problems. The predominant disabling condition is mental retardation (37 percent), followed by diseases of the nervous system and sense organs (12 percent).

Uninsured CSHCN Served by Title V a percentage of the children enrolled on the BCMH treatment program have no other source of health care coverage for the entire year. BCMH continues to closely monitor these children and assist them in any way possible to obtain other third-party coverage. Counties having the highest numbers of uninsured children receiving BCMH treatment services are, in rank order, Geauga, Franklin, Hamilton, Holmes, Cuyahoga, Trumbull and Summit.

Medical Home every child with a special health care need should have an identifiable medical home. According to the AAP, a medical home has the following components: accessible care, family-centered care, continuing care, comprehensive care, coordinated care, compassionate care and culturally competent care. In addition, the managing physician of a medical home is a trusted, well-trained pediatrician or other physician who can manage and facilitate all aspects of pediatric care.

BCMh continues to support the Medical Home for all children and especially children and youth with special health care needs (C&YSHCN) and closely networks with Medicaid and Early Intervention programs. BCMH and the Bureau for Managed Health Care co-sponsored six regional meetings with emphasis on; Transition Issues, Medical Home, and CSHCN Survey results. Youth advisory councils have been developed in three locations around the state to

advise the program on issues around transition from being a youth with special needs to the adult world. To support and assist these efforts BCMH has implemented an electronic medical record system which will greatly improve its ability to match C&YSHCN with the services they need.

BCMH continues to work closely with the Ohio Chapter of the AAP on all medical home issues. BCMH is in the process of developing a Web-based educational tool on The Medical Home for CSHCN for Ohio Physicians. BCMH is working with the Cincinnati Children's Hospital to support a state-wide "Special Needs Resource Directory for CSHCN." The Web address is <http://www.cincinnatichildrens.org/special-needs>.

Family Participation in the CSHCN Program: BCMH is committed to being accountable to the customers of its services. BCMH has increased consumer participation significantly through the appointment of a full-time parent consultant. The parent consultant is involved in key workgroups and in establishing a Parent Advisory Council. Parent focus groups conducted as part of this needs assessment will serve as the basis for a continuing dialogue with families in their communities.

The focus groups pointed out the need for families to feel that they have meaningful input into the programs that serve them or that those programs are responsive to their expressed needs. While BCMH has made significant progress in increasing family participation, BCMH recognizes that it needs to continue improvement in its relationship with families. Currently, BCMH is conducting a customer satisfaction survey, and developing methods to measure the impact of policy and procedure changes on families and is asking individual families what services they need that neither BCMH nor any other program supplies. BCMH has formed regional Young Adult Councils throughout the state to meet with and assist young adults as they transition to the adult health care system. There have been three meetings in four areas of the state and quarterly meetings are planned.

Genetic Evaluation and Counseling Services

Ohio has been divided into six perinatal regions based on the adoption of the State Perinatal Guidelines in response to the national recommendations outlined in *Toward Improving the Outcome of Pregnancy*. ODH determined that at least one entity would be available within each region to serve as a hub for the Regional Perinatal Centers (RPC) Program.

This population based RPC Program is designed to promote access to evidence-based and risk-appropriate perinatal care to women and their infants through regional activities with the goal of reducing perinatal mortality and morbidity. The program has moved from outreach education toward data driven performance monitoring and quality improvement. The program is using the perinatal Data Use Consortium approach (based on CityMatCH and CDC) to engage health professionals from medicine and public health into a regional team to advance data-driven projects and activities. All maternity, newborn care hospitals, local health departments and other public health entities are assisted by the RPC program.

ODH has an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative. Most of this support will be provided by RPC programs facilitating local access for quality initiatives. The Bureau of Children & Family Health Services (BCFHS) funds six

RPC Programs. Other ODH systems that collect data related to genetics include the following: electronic birth certificates, which include data collection of some specific birth defects; the Behavioral Risk Factor Surveillance System, which asks women of childbearing age about their knowledge of the use of folic acid and the prevention of neural tube defects; and PRAMS, which collects data on what women of childbearing age know about folic acid and the prevention of NTDs, history of birth defects in women of childbearing age and alcohol use during pregnancy.

In addition, ODH has developed a comprehensive birth defects information system that will include reported data collection on children with birth defects, as well as referrals to services to assure that children are linked to medical and other support systems. As genomic medicine becomes more mainstream, the ODH Genetics program continues to integrate a genetics component in other public health programs such as cancer, cardiovascular health, universal newborn hearing screening, expanded newborn metabolic screening and promoting preconception health in family planning and prenatal programs.

C. Priority Access Concerns – Strengthens and Weaknesses

The state has identified the following concerns regarding access to MCH health care and health-related services. The needs assessment process incorporated data required to measure the MCH Block Grant performance and outcome measures and the health status indicators that were being developed by the federal MCH Bureau. The priority areas of greatest concern are organized below by the four levels of the pyramid, and the overall programming strengths and weakness for each population group are outlined at the end of each section.

C.1 Concerns for the Maternal and Infant Population

For the following identified items, the concern relates to deficits in the specified item.

Direct Health Care Services

1. Access for low-income women and adolescents to perinatal and family planning safety net services.
2. Providers accepting Medicaid.
3. Access to preconceptional and interconceptional care.
4. Access to mental health services.
5. Access to genetics services.

Enabling Services

1. Assistance in the enrollment process for available health insurance plans.
2. Targeted outreach efforts to bring high-risk women into early prenatal care.
3. Culturally appropriate family planning materials.
4. Prenatal smoking cessation programs.
5. Programs that employ community health workers to improve access to care through culturally competent care coordination.
6. Programs to provide nutrition services for those who are overweight and obese.

Population-based Services

1. Awareness of the public about reproductive health and family planning services.

2. Awareness among low-income women about the importance of early and continual prenatal care.
3. Understanding among pregnant women of the harmful effects on the fetus from smoking during pregnancy.
4. Public awareness about the following:
 - a. Postponement of teen sexual activity.
 - b. Mental and behavioral health issues in the MCH population.

Infrastructure Building Services

1. Information and training for providers on the following:
 - a. Factors contributing to low and very low birth weight.
 - b. Culturally competent practices.
 - c. Identifying populations at risk for poor birth outcomes.
 - d. Identifying populations at risk for mental and behavioral health problems.
 - e. Adult obesity.
2. Quality data and information for policy development and program planning on the following:
 - a. Smoking among pregnant women.
 - b. Access to early prenatal care, including high risk.
 - c. Adequacy of prenatal care.
 - d. Effective outreach strategies.
 - e. Education needs of prenatal providers.
 - f. Availability of high-risk prenatal services.
3. Understanding among prenatal service providers of the barriers to care that pregnant women face.

Strengths and Weaknesses

Currently, Ohio's economy has played a major role in the deficits associated with women and infant health and birth outcomes. The diminishing financial support and revenue sources have helped to erode local program funding or prevented programming from expanding state-wide. Diminished financial support has also contributed to a lack of adequate prenatal care providers. Another weakness has been the lack of available contraceptive services for teens due to the expense of the newer contraceptive methods, and resistance in Ohio for schools to fully address use of contraceptives. In regards to an overall perspective, some of the trends surrounding programming activities have not been fully investigated in order to identify impact, strengths or weaknesses.

Although, programming weaknesses can be found, Ohio has numerous strengths that have aided MCH programs in weathering the current economic environment. ODH continues to strengthen its collaborative efforts with other state agencies, which promotes the sharing of data, information, and the combining of resources. Additional supplemental funds from Title X have helped to strengthen ODH's capacity to meet MCH needs. In 2009 the charge was given to ODH to create the Ohio Infant Mortality Task Force to address disparities in infant mortality in Ohio's African American community. In 2010, ODH collaborated with Columbus Public Health on the

Infant Mortality and Racism Action Learning Collaborative. Additional strengths for women and infant health, is that Ohio has a single breastfeeding coalition and adoption of breastfeeding in the workplace by the Ohio Obesity Plan. In alignment with national performance measure 18, Medicaid has a mandated performance indicator that addresses access to prenatal care for women in their first trimester.

C.2 Concerns for the Early Childhood, Adolescent and Young Adult Population

Direct Health Care Services

1. Health insurance coverage and access to care.
2. Access for low-income children and adolescents to dental care (including dental sealants).
3. Access to comprehensive services including immunization, oral health, vision, hearing, lead screening, behavioral and mental health screening.
4. Adolescent and family planning safety net services.
5. Providers accepting Medicaid (including dental care providers).
6. Access for low-income children and adolescents to specialty providers.

Enabling Services

1. Assistance in the enrollment process for available health insurance plans.
2. Effective community-based outreach and enrollment strategies to ensure that children receive needed health care services through Medicaid/SCHIP.
3. Programs to provide nutrition services for those who are overweight.

Population-Based Services

1. Public awareness about the following:
 - a. Overweight children and healthy eating and exercise.
 - b. Community-based fluoride promotion.
 - c. Smoking and substance abuse.
 - d. Health effects of childhood lead poisoning.
 - e. Importance of oral health and issues relating to access to dental care.
 - f. Importance of early professional vision care for children.
 - g. Importance of immunization schedule.
 - h. Postponement of teen sexual activity.
 - i. Proper use of safety devices to decrease motor vehicle deaths in children and
 - j. adolescents.
 - k. Navigation of the health care system.
 - l. Adolescent asset building models.
 - m. Risk factors for adolescent suicide.

Infrastructure Building Services

1. Information and training for providers on the following:
 - a. Pediatric overweight.
 - b. Oral health status, oral health resources and access to dental care.
 - c. Blood lead screening policy.

- d. Vision assessment.
 - e. Screening and referral.
 - f. Immunization schedule.
 - g. Adolescent risk assessment inventories.
 - h. Adolescent skill building and decision making models.
 - i. Promotion of motor vehicle safety.
 - j. Healthy Start/SCHIP information.
 - k. Risk factors for adolescent suicide.
 - l. Smoking and substance abuse.
 - m. Suicide prevention initiatives.
 - n. Behavioral and mental health issues.
2. Capacity among local public health agencies to conduct a community health assessment and planning process.
 3. Quality data and information for policy development and program planning on the following:
 - a. Childhood lead poisoning prevention.
 - b. Effective immunization outreach strategies.
 - c. Contributing factors for teen pregnancy and LBW.
 - d. Motor vehicle crashes.
 - e. Rate of uninsured children served through safety net health care programs.
 - f. Medicaid provider recruitment, training and reimbursement.
 - g. Uninsured rates for children.
 - h. Medicaid-eligible children receiving services.
 - i. Barriers to Medicaid enrollment.
 - j. Childhood overweight.
 - k. School nurse manpower levels and services.
 - l. Adolescent health risk behaviors.
 4. Coordination/collaboration with ODHS regarding blood lead screening for Medicaid eligible children.
 5. Collaboration among public and private agencies to coordinate immunization planning efforts.
 6. Information for legislators, policy makers, and MCH stakeholders regarding contributing factors related to teen birth rates
 7. Information for legislators, policy makers and MCH stakeholders regarding childhood overweight and surveillance of child BMI status.

Strengths and Weaknesses

In 2008, 28% of low-income Ohio children aged 2 to 5 years had a BMI at or above the 85th percentile, while 12% were considered to be obese with a BMI at or greater than the 95th percentile. In addition during 2008-2009 18.5% of third graders were obese and 17.4% of third graders were overweight. The data associated with these percentages suggest that low-income Hispanic and Non-Hispanic black 3rd graders were significantly likely to be overweight or obese than non-Hispanic or white children. Although, Ohio is experiencing weaknesses in regards to obesity of its school age children, for its 0 – 3 age group Ohio's Home Visiting program curricula has had successes with its healthy nutrition programs.

Another area of concern for Ohio is that black and Hispanic children are less likely than white children to have private health insurance. ODH has attempted to convene staff from multiple state agencies to discuss this issue, but was not successful in FFY09. This continues to be an ongoing issue in FFY10, as well as the lack of health insurance coverage for adolescent and young adults transitioning to the adult system for their on-going medical needs.

At the same time, Ohio continues to improve in its capacity to serve the MCH population through efforts like implementing and evaluating programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy. Working with Healthy Child Care Ohio in regards to their efforts to increased child care providers competency to manage children's chronic health care needs. Additional strengths include the increase in social and emotional screenings for children in child care, combined with the fact that the overall death rate for students considering suicide have decreased.

Other infrastructure level strategies that strengthen MCH programs are accomplished by working with AMCHP and collaborating with the Ohio Department of Education in an Action Learning Collaborative on: establishing health education in Ohio public schools; distributing supplemental funds to subgrantees to purchase long-acting reversible contraceptives; monitoring funded subgrantees to assure that they utilize best practices; promoting community outreach activities, and assuring that culturally, age, and education-level appropriate information is available to patients, partners and community members; and collaborating with WIC to use a mobile van to provide pregnancy testing, STI testing, treatment and contraception.

Ohio has demonstrated strength in its capacity to meet the needs of the MCH population through its campaign to increase public and professional awareness of early hearing detection and intervention (EHDI) and distributing educational materials to physicians; preparing and disseminating reports for legislators and others; identifying potential areas for collaboration and working with Au.D. programs and medical schools to incorporate EHDI into curriculums. The Infant Hearing Program and the Genetics Program staff continued to explore ways to collaborate. In the Fall of 2009 the staff began to revise the UNHS Follow-up Hearing Evaluation Reporting form and genetics referral was included. A Genetics Counselor regularly attends Help Me Grow (HMG) training to provide an overview of and literature on genetics.

C.3 Concerns for the CSHCN Population

The major concern of families with CSHCN is their access to the medical care and treatment services they need. These concerns are outlined below.

Direct Health Care Services

1. Health care services—direct funding of those portions that are not covered by other funding sources. These services include physical, occupational, speech, behavioral, art, music, equestrian and aquatic therapies.
2. Special equipment (educational, medical, and adaptive) and medical supplies. Parents need to be trained to use medical devices and equipment, and trained with educational material to help the child's development.

3. Home health care.
4. Mental health services.
5. Respite care.
6. Specialized day care. This is needed particularly for children with behavioral needs.
7. Nutrition services. These include evaluation, education, and supplements.
8. Medical homes. Concerns about respectful and caring treatment by primary and specialty care physicians should be incorporated in the strategy for assuring a medical home for CSHCN.

Enabling Services

1. Lack of Information, families want more and better information regarding available services, eligibility requirements, particular conditions and latest medical developments.
 1. Assistance with navigating benefits systems. Families want help with the following: getting on the Medicaid waiver program; intervention with an insurance carrier to get a service approved or to request an out-of-network provider; requesting benefit exceptions; determining which payment source should cover a particular medical bill; and helping a family understand a denial and whether the denial should be reconsidered.
 2. Distance to specialty care. This is a special concern for Appalachian families.

Infrastructure Building Services

1. Coordination among complex government programs. Families must deal with redundant eligibility processes, complex requirements and high reading levels of materials.
2. Access to providers. Many providers will not accept the Medicaid card, particularly dentists, therapists in rural areas, optical providers and pharmacies in some areas.
3. Continuity of care with the child's established provider. Continuity of care is either difficult or not possible when multiple sources are involved.
4. Establishment of a network of providers in both urban and rural areas who are needed to diagnose and treat asthma and pervasive developmental disorder (PDD). These are two qualitatively different problems. Because these problems have both primary and specialty care components and cross the boundaries of different state agencies, the strategy is essentially that of infrastructure development through collaboration. Provision of direct and enabling services may be necessary to some extent to support infrastructure changes.
5. Availability of community PHN services. This is still uneven across the state.
6. Comprehensive population-based data on CSHCN. Data are needed on the numbers and types of CSHCN, the extent to which their care needs are being met and what public systems of care serve them.

Strengths and Weaknesses

Ohio's capacity is often challenged when it comes to serving children with special health care needs, due to the complexity and specialized nature of the illness. Providers and parents of this population are often dealing with data systems that are not yet integrated. This is a particular weakness for newborn screening labs and other ODH genetics and sickle cell partners. Children's hospitals do not have access to vital statistics Integrated Public Health Information System (IPHIS) to report screening and paper reports are sent to ODH for data entry.

Timelines for reporting this information is specified in regulations so there is often reliance on goodwill and education to improve the timeliness. However, timeliness of reporting; poor coordination and understanding of IPHIS access at the hospital level; a lack of emphasis on comprehensive accurate reporting and self monitoring create an inability of systems to integrate data.

Ohio currently lacks adequately trained pediatric providers in some geographic areas. Due to reduced funding in recent years it has become increasingly harder to recruit and retain clinicians, especially in specific areas such as Appalachia. The lack of family and provider resources not only in Appalachia but rural and inner city areas lends itself to inadequate or decreased trained pediatric providers or require extensive travel. Adding to this is also the lack of central resources (manpower) to provide more outreach and education to audiologist, primary care providers and for general coordination and troubleshooting.

While these issues exist and can appear to be significant, Ohio has developed numerous strengths in meeting the needs of the CSHCN population. ODH staff monitors the reporting that comes in and can identify specific concerns for outreach and education. In addition, ODH approves hospital protocols to ensure compliance with standards, and uniformity across the state and can offer technical assistance to help generate system integration.

Statewide, there are approximately 130 hospitals or birthing facilities that are reporting on the number of infants who have received hearing screens before discharge. To assist with provider shortage issues, via the Help Me Grow website a Pediatric provider directory has been posted and is updated regularly.

Health Child Care Ohio has increased their social and emotional screenings for children in child care, while collaborations between Ohio's Chapter of the American Academy of Pediatrics (AAP) and ODH has resulted in increased screening for developmental and social-emotional delays in young children. There continues to be a big push to promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN. Some areas of success can be found in working with key stakeholders in expansion of Medicaid for Children/SCHIP and Children's Buy-In Program; the training of local health departments, hospital based services coordinators on state and federal changes; the family voice continues to be heard regarding how to maintain CSHCN data capacity by including questions in the Ohio Family Health Survey relative to CSHCN; and ODH provides educational material regarding impact of federal health care reform for CSHCN on its web-site.

2.1.4.2 Maternal Child Health Population-Based Services

An overview of the MCH Population-based services is outlined below, those services center on screening, immunization, community water fluoridation and outreach/education.

A. Screening

The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) is CDC-supported OCLPPP is a comprehensive population based lead poisoning prevention program. OCLPPP is the collection point for all blood lead (BL) analysis performed on Ohio residents. The data are reported weekly in an electronic format and either held in the childhood program or the adult (ABLES) program (Surveillance). The OCLPPP is required by statute to complete public health lead investigations on all children in its jurisdiction who have a confirmed BL level of 10 mcg/dl of whole blood or greater.

The OCLPPP provides lead poisoning prevention education to medical and public health providers through the Pediatric Lead Assessment Network Education Training program. The OCLPPP funds its four Regional Resource Centers by using Title V funds for TA to local providers and families on the importance of screening, public awareness and maintenance of local collaboratives to prevent lead poisoning of children. The OCLPPP funds five local jurisdictions to facilitate comprehensive Childhood Lead Programs in their local communities.

Vision: Save Our Sight Program (SOS): the population based SOS Program is a state statute to ensure that children in Ohio have good vision and healthy eyes. The SOS Fund was created with the purpose of providing funding, technical assistance and support to 501(c) organizations delivering children's vision services in all Ohio counties. The funds are generated by voluntary contributions by citizens of Ohio registering their motor vehicle and/or renewing their license plate(s) and administered by ODH.

These funds support organizations to provide training, certification and equipment for voluntary children's vision screeners; provide protective eyewear for youth sports and school activities; develop and provide eye health and safety programs in schools; implement an Amblyope Registry. The competitive grant application in SFY 2009 was streamlined to match Ohio Revised Code with emphasis on the importance of ongoing evaluation, measuring impact of current SOS eye health and safety programs in Ohio, and strengthening outcome measures and reporting requirements.

Hearing: the Ohio Revised Code mandates that all newborns in hospital nurseries be assessed for risk for hearing loss and referred for hearing testing when identified with risk factors. In July 2004, as part of the Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program, the birthing hospital's in Ohio began screening all newborns for hearing loss prior to hospital discharge. Every newborn is screened using a physiologic test; results are reported to the parents and newborn's primary care provider. Babies who do not pass the two-part screen are referred to the regional infant hearing program (9 regional projects) for follow-up and referral to the Help Me Grow (HMG) program if a hearing loss is confirmed. Ohio anticipates that about 400-500 infants with hearing loss will be identified each year. In calendar year 2008, 181 UNHS-

identified infants were diagnosed with a hearing loss; 61 non-UNHS infants were diagnosed with a hearing loss (provisional data). In 2009 UNHS implemented a comprehensive electronic database for tracking all newborn hearing screenings, follow-up and EI enrollment.

B. Population-based Preventive Services

Immunization Coverage Through Age 2: In Ohio, children entering regulated child day care centers, Head Start or kindergarten are required to be fully immunized against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. Children entering kindergarten must receive hepatitis B immunizations. Students must have a second MMR vaccine before entering seventh grade. Head Start also requires immunization against hepatitis B and HIB. The percent of 19-35 month olds who received a full schedule of age appropriate immunizations in Ohio was 80.4% for 2007 per CDC's National Immunizations Survey. This strategy was accomplished by ODH collaborating with the ODJFS Immunization Advisory group; other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services. Of the 71 subgrantees funded by the CFHS Grant, 47 percent have included immunization strategies in their program plan.

Lead Screening: local health departments collaborated with neighborhood groups, housing agencies and Community Action Agencies to increase awareness of childhood lead poisoning in targeted neighborhoods (including supplies/instructions for cleaning). Each local agency receives a list of locations participating in the HEPA Vacuum loaner program; families are provided with an instructional video tape with the vacuum. In-services to staff and lead screenings of children enrolled in Head Start programs were done in many communities.

Community Water Fluoridation: Due to Ohio's fluoridation law as of 2008, 93 percent of Ohioans on community water systems receive optimally fluoridated water. Children who drink fluoridated water from birth will have a 20-40 percent reduction in tooth decay in their lifetime. The benefits of fewer cavities, less tooth loss, better nutrition, and improved self-image continue throughout adulthood. Efforts to bring fluoridated water to the remaining 7 percent of Ohio communities are ongoing, but successes are relatively few and far between.

C. Community Outreach/Education

Help Me Grow program promotes early identification and intervention services for young children. Most of the programs are funded through sources other than the MCH BG, such as state General Revenue Funds, U.S. Department of Education, and other federal grants from U.S. Department of Health and Human Services. ODH is the lead agency for Ohio's Part C Early Intervention Program, and includes home visitation services for families and their infants and toddlers who are at the greatest risk of poor health or social outcomes. The program provides important information on prenatal and infant care development, positive parenting, safety, and abuse prevention.

HMG also administers a birth to 3 program serving pregnant women, newborns, infants, toddlers and their families. HMG includes enabling and population based services that include home

visits to pregnant women, first time teen moms, infants and toddlers at risk for or with Developmental Disabilities.

Help Me Grow is providing federal American Recovery and Reinvestment Act (ARRA) funds to County Family and Children First Councils to be used for programs under Part C of the Individuals with Disabilities Education Act (IDEA). The Part C ARRA funds are to be used to preserve and/or create jobs for Part C service coordination and/or child find and to assist in stabilizing HMG budgets, in order to minimize and avoid reductions in essential Part C services.

Motor Vehicle Safety: DFCHS collaborates with the Division of Prevention on car seat safety interventions. They exchange information on new recommendations, standards of practice and press releases from the Consumer Product Safety Commission with appropriate BCFHS staff; facilitate local collaboration among DFCHS-funded agencies; participate in Ohio Safe Kids car seat safety events; and provide technical assistance to DFCHS-funded agencies that provide child passenger safety activities. Materials for education on the proper use of safety devices was provided through the Newborn Home Visiting program in HMG, through the Child and Family Health Services clinics in MCH and through various programs in Injury Prevention.

Shaken Baby Syndrome Education Program: S.B. 144 signed into law by Governor Strickland in November, 2007 (Claire's Law). The law carried no funding. The development of the Shaken Baby Syndrome program was assigned to BCFHS with help from BEIS. ODH was required to establish a Shaken Baby Syndrome education program by developing materials that are readily comprehensible and by making the materials available in an easily accessible format on the ODH web site.

ODH convened a work group for advice in developing the materials. The work group included: Child abuse prevention advocates; Help Me Grow staff; Experts in infant care; Maternity Unit directors; Parenting skills educators; Child care facilities; BCFHS staff.

The work group met three times during May, June and July, 2008. Group members shared information on programs currently being conducted and recommendations for materials to be included on the ODH web site and evaluation strategies. The ODH Shaken Baby Syndrome web site debuted on February 27, 2009. The materials on the web site are intended to be distributed to parents and expectant parents by child birth educators, pediatrician and obstetrician offices, hospitals and birthing centers, Help Me Grow staff, and child care facilities (to their staff).

Sudden Infant Death Program (SID): the SID Program supports population based activities that assure compliance with an Ohio statute related to reporting of SIDs and the provision of support and bereavement services. Through a grant, ODH partners with the SID Network of Ohio to be the state's agent for the SID program. The SID Network is responsible for receiving from coroners the Notification of Infant Death. The SID Network notifies the local health district; mails a packet of SID information and bereavement resources to the family; notifies the local network support affiliate; provides training to public health nurses on making a home visit to families; and serves as a resource for SID risk reduction information for local health departments, other agencies and individuals.

Since 2002 the SID Network of Ohio has implemented a community-based African American outreach campaign to reduce the risk of SID in the minority population. Per a SID program evaluation in 2007, the SID Risk Reduction component was removed from the competitive grant. ODH is currently exploring options related to meeting the requirements of the Ohio statute. These include retaining the grant program, moving to contract-based implementation or assuming the responsibilities in-house.

2.1.4.3 Maternal Child Health Infrastructure Building Services

Infrastructure building services, the base of the MCH pyramid, are largely the assessment and policy development core functions identified by the IOM in 1988. These functions are built on coordination and collaboration at all levels of government, and with the private and non-profit sectors.

A. Community Assessment and Planning

CFHS Program Plan is a community based program that uses a combination of federal, state, and local monies to provide public health programs and services, including safety net clinical services to low income un/underinsured families and children in Ohio. The program is designed to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants and children.

Currently 71 agencies in 73 counties (local health departments, hospitals, community action agencies, other nonprofit agencies) hold CFHS grants. There are five components in the CFHS Program: 1) Community Health Assessment (CHA) (required); 2) Child Health; 3) Family Planning; 4) Prenatal Health; 5) OIMRI.

Applicant agencies must develop strategies based on best practices research with clear, measurable benchmarks for each strategy. Applicant agencies are limited to strategies that address the MCH BG priority topics. CFHS projects have been asked to re-evaluate their need to provide direct care services. CFHS expanded use of the Integrated Public Health Information System (IPHIS) data system to include all CFHS perinatal care providers. CFHS clinics are piloting screening tools for environmental risks to women of childbearing years. CFHS is developing a plan to expand the environmental risk initiative.

Oral Health Survey: In 2004-05, the Bureau of Community Health Services (BCHS) conducted its second county-level oral health survey to make oral health status and access data available to local planners. In collaboration with CDC and the Association of State and Territorial Dental Directors, BCHS led the development of a model for conducting local surveys which is used to train interested communities in Ohio.

Summary of Survey Findings:

Dental disease remains a common condition among Ohio's children, with 55 percent of children experiencing tooth decay by the time they are in the third grade. More than one-quarter of the children surveyed had cavities that had not been treated, and 10 percent of all children had suffered from a toothache during the previous six months. More than 25 percent of the children had cavities or other dental problems that required they see a dentist.

Less than half of children surveyed (43 percent) had one or more dental sealants, even though sealants are the most effective way of preventing the most common type of tooth decay. While most children had reportedly visited a dentist during the past year, nearly one-quarter (22 percent) had not. The most common reasons for not receiving desired dental care was that the family couldn't afford to go to the dentist or because the family didn't have dental insurance.

The overall oral health of Ohio's children is not improving dramatically. The findings from the 2004-05 survey remains consistent with findings from the previous survey conducted in 1998-99, and fall short of national targets for oral health. The only indicator of oral health that has shown substantial improvement is the prevalence of dental sealants, which has increased from 34 percent in 1998-99 to 43 percent in 2004-05. This may be due to the expansion of public health dental sealant programs in Ohio's schools.

During the 2009-2010 school year, ODH, with the support of the Ohio Department of Education, conducted a statewide oral health survey of third grade students in 399 elementary schools in Ohio. The purpose of the survey was to measure the prevalence of tooth decay, dental sealants and other oral conditions and to collect information on parents' ability to obtain dental care for their children. With parental consent, children in selected schools in each Ohio county were screened by dentists and dental hygienists. The data from the survey will be analyzed over the coming months and a final report is expected by the end of 2010.

Child Fatality Review (CFR) Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent another. Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July, 2000, mandating Child Fatality Review (CFR) Boards in each of Ohio's counties (or regions) to review the deaths of children under eighteen years of age.

The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will: 1) Promote cooperation, collaboration and communication between all groups that serve families and children; 2) Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths; 3) Recommend and develop plans for implementing local service and program changes; and advise the department of health of aggregate data, trends and patterns found in child deaths.

The Ohio CFR project promoted partnerships at the local and state levels to enhance the exchange of information about CFR and their findings. The CFR Advisory Committee members reflect members of local CFR boards, state agencies and other organizations. CFR information and findings have been shared with Children's Trust Fund, SID Network of Ohio and other ODH staff in CFHS-funded programs. CFR staff has promoted the exchange of information by participation on MCH Block Grant Strategy groups and Emergency Medical Services for Children group. A Motor Vehicle Death subgroup and a SIDS/Sleep-related Death subgroup have been formed with members from ODH, Public Safety, law enforcement, child care

advocates, coroners groups and other interested parties to share information and develop prevention strategies.

B. Coordination and Collaborative Relationships

Coordination of State Activities with Programs Implemented Under Title V and Related Federal Grant Programs the Division of Family and Community Health Services (DFCHS) was established for the purpose of ensuring the provision of MCH programs at the state/local level. DFCHS is also responsible for implementation of the following state statutes that impact the Title V program:

(1) The Bureau of Child and Family Health Services (BCFHS) administers the CDC Childhood Lead Poisoning Prevention Program; the Title X program; and services for women of childbearing age, infants and children, particularly those who are low income or lack access to health care.

(2) The Bureau of Community Health Services (BCHS) administers the Primary Care and Rural Health Services Section, which identifies underserved areas of the state and attempts to place health care practitioners in those areas; the Black Lung Program; the SEARCH program that recruits health care provider students to work in underserved areas and the Ryan White Title II Program which provides funding for health care, medications and support systems to approximately 7,500 HIV positive Ohioans; develops and implements programs to prevent oral diseases and to improve access to primary dental care for underserved Ohioans; the Development of the Abstinence and Adoption Education Guidelines were created as a result of SFY 08/09 biennial budget. The budget bill redirected funds that were used exclusively on a sexual abstinence-only message to include more comprehensive sexuality education information. The project's purpose is to create guidelines for the development of abstinence and adoption education programs with the purpose of decreasing unplanned pregnancies and abortion.

(3) The Bureau for Children with Medical Handicaps (BCMh) administers diagnostic, treatment and service coordination services for CSHCN, and the state's Genetic Services Program, Sickle Cell Services Program, Metabolic Formula and Birth Defects Information System (BDIS).

(4) The Bureau of Early Intervention Services (BEIS) administers several programs serving young children (primarily birth to 3) and their families. The HMG program provides information, services and supports to pregnant women, new parents and to infants and toddlers at risk for or with developmental disabilities and their families. BEIS also administers the Healthy Child Care Ohio grant for health consultation by registered nurses to child care providers; the Newborn Infant Hearing Program; and the State Early Childhood Comprehensive Systems Grant.

(5) The Bureau of Nutrition Services (BNS) administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); and the Farmers Market Nutrition Program.

Title V and Title XIX Intergovernmental Collaboration

The Ohio Title V Program, administered within the ODH, has strong collaborative relationships with other state agencies, local health departments (LHD), local public health agencies, academic programs/professional associations to improve the health of the MCH and CSHCN population. The interagency agreement between ODH Title V and ODJFS Title XIX is in place and is updated every two years. The DFCHS medical director sits on the Medicaid Medical Advisory Committee for the ODHS and on the Executive Committee for that group.

Intergovernmental and Interorganizational Collaboration

Ohio Family and Children First (OFCF): OFCF is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. The partnership is critical because no single state system has the resources or capacity to meet this goal alone.

Oversight of the initiative is provided by the OFCF Cabinet Council which include agency directors of; Ohio Department of Education (ODE), Ohio Department of Alcohol and Drug Addiction Services (ODADAS), Office of Budget Management (OBM), Ohio Department of Health (ODH), Ohio Department of Jobs and Family Services (ODJFS), Ohio Department of Mental Health (ODMH), Ohio Department of Developmental Disabilities (DODD), ODA, and Ohio Department of Youth Services (ODYS). The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities.

DFCHS data staff serves on the OFCF Data Committee to develop a set of child well-being indicators. Each of Ohio's 88 counties has created an OFCF Council. Local council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness and to address a shared commitment to child well-being which include: expectant parents and newborns thrive, infants and toddlers thrive, children are ready for school, children and youth succeed in school, youth choose healthy behaviors, and youth successfully transition into adulthood.

Medicaid Collaboration

Governor Strickland at the outset of his administration set clear expectations for state agencies to coordinate and collaborate to achieve efficiencies and to increase the impact of programs and services for all Ohioans. In addition, Governor Strickland's Administration has demonstrated a strong commitment to strengthening the wellbeing of children and improving the reach and quality of children's health services – even as Ohio experiences difficult times. The Administration and state leaders have made the health care of Ohio's children a top priority and have begun major initiatives with bipartisan support including: making changes to the governance of early childhood services; convening the Infant Mortality Task Force; and refocusing programs, eligibility and services. The six child-serving state agencies, Health, Mental Health, Developmental Disabilities, Medicaid, Alcohol and Drug Addiction Services, and Education have engaged in unprecedented coordination and collaboration to improve systems that serve women of childbearing age, pregnant women, children, children with special health care needs and their families.

Several recent initiatives clearly illustrate the strength of the partnerships that have evolved. A CMS Transformation grant to improve neonatal outcomes, a Commonwealth-funded State Quality Institute which form the Ohio Coverage and Quality Improvement Council, and a National Academy of State Health Policy (NASHP) Assuring Better Child Development (ABCD) award; supporting QI collaborative in childhood obesity and early childhood development; establishing a Section on Children's Health within Medicaid; initiating Medicaid funding for children in schools; and prioritizing child health even when other parts of the state budget were being cut. In addition to taking a leadership role in these Governor's initiatives, Ohio's Title V MCH Program has established an unprecedented, strong working partnership with Ohio Medicaid to directly advance the quality of child health care through grants awarded to Medicaid such as a CMS Transformation grant to improve perinatal and neonatal outcomes.

BEACON

Ohio's Medicaid leadership has joined with the Ohio's Title V MCH Program to convene children's health care partners to form the BEACON Council. The aim of the **B**est **E**vidence for **A**dvancing **C**hildhealth in **O**hio **N**OW (**BEACON**) initiative is to achieve transformational change in health outcomes for children by improving the quality of each child's healthcare. Through the systematic and reliable application of established improvement science methods and by building strong partnerships with key stakeholders, Ohio's statewide collaboration will achieve unprecedented results for birth and developmental/behavioral health outcomes and safe hospital care for children. Simultaneously, BEACON will establish a sustainable infrastructure for improvement capability.

The BEACON Council is building on strong support from the Governor, state agencies, state and national professional organizations, health providers, advocacy groups, the business and insurance community, and other stakeholders. It is also building on a robust, but early existing infrastructure of inter-related collaborative networks and relationships across provider-based models (including children's hospitals, perinatal providers, primary care practices), state agencies professional organizations, family and child advocates, and university based researchers. The design is to apply strong theoretical and evidence-based proven approaches of quality improvement science across all settings to reliably achieve processes that improve child health outcomes. Early successes include the rate of scheduled births between 36.1 and 38.6 weeks, without a documented medical indication, declined from 25% to below 5%. Birth certificates from member sites recorded fewer inductions without a listed indication, declining from a 12 month mean of 13% to 8%. Fewer infants born at 36-38 weeks went to a neonatal intensive care unit (NICU). In the developmental and autism screening project, over 800 providers have been trained and are using the evidence based screening tools at the appropriate stages of development. Enough screenings are happening that Medicaid claims data now are showing the increase among the Medicaid eligible population. The BEACON Council meets regularly and will be identifying ways to maximize the further spread of the improvement science to affect continued improvement in perinatal and child health outcomes.

The Ohio Infant Mortality Task Force in 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force, co-chaired by Thomas G. Breitenback, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. Membership

represented a wide range of public and private health providers, businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. In November 2009, the **Ohio Infant Mortality Task Force** issued its final report which provided extensive background information and included ten recommendations. The complete task force report, including involved organizations is available at <http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx>

The task force recommended the creation of an ongoing consortium to continue its work, and the ODH DFCHS (Karen Hughes is Chief) is facilitating the development of this consortium. A small executive/steering committee is now being formed to develop the leadership and committee structure as well as bylaws. Later, members will be recruited for specialized committees. Once organized, the yet-to-be-named consortium will likely create a plan to promote implementation of the recommendations, search for funding, and prepare annual progress reports for the Governor.

ODJFS participates with ODH Perinatal Data Use Consortium. ODH entered into an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative (OPQC). Most support is provided by the Regional Perinatal Center Program facilitating local access for quality improvement initiatives. ODH in collaboration with ODJFS are addressing poor pregnancy outcomes through a CMS sponsored transformation effort involving a partnership of state agencies, neonatal/obstetrical providers, professional organizations and a center with expertise in quality improvement.

This effort has already demonstrated substantial improvements in perinatal outcomes. OPQC's first obstetrics project achieved a statistically significant 70% reduction (12.5% to 4%) in the rate of scheduled late preterm deliveries without medical indication, and a reduction in NICU-associated, bacterial, bloodstream infections in preterm infants 22-29 weeks gestational age by 40% (20% to 12%).

Executive Council of the Cleveland Healthy Family/Healthy Start Project the DFCHS Chief and BCFHS Chief serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB.

FQHCs, and the growth of the National Health Service Corps (NHSC) the Primary Care/Rural Health (PCRH) program has taken the lead for 2 Presidential Initiatives in Ohio: development/expansion of FQHCs, and growth of the National Health Service Corps (NHSC). A coordinated effort is underway with Ohio Association of Community Health Centers (OACHC) to develop FQHCs in medically underserved areas. NHSC Scholarship and Loan Repayment Programs assist in staffing Ohio FQHCs as well as other safety net provider sites located in underserved areas. Ohio Rural Development Partnership (ORDP) developed a 501c3 organization, Ohio Rural Partners (ORP), which is able to apply for and receive federal/foundation/other funding.

With the passage of the current biennial budget in July 2009, the administration of the OPDP Advisory Committee was transferred successfully from the Ohio Board of Regents to ODH. The BCMH Chief is the governor's appointed representative of ODH and Chair on the Ohio Physician Loan Repayment advisory committee which selects applicants who are practicing in underserved parts of Ohio to receive loan repayments funded with money collected with medical license renewals.

BCHS School and Adolescent Health (SAH) program helps ODE improve nutrition messages for school aged children/families/teachers with the expertise of a public health nutritionist funded by the MCH BG. The SAH program works with randomly selected local school districts to administer the YRBS. In collaboration with the Ohio Chapter of the American Cancer Society, SAH administers the Governor's Buckeye Best School awards program which recognizes schools for achievements in the areas of increasing physical activity, improving nutrition and preventing tobacco use.

The school nursing supervisor in SAH worked collaboratively with ODE special education services to revise rules for providing clinical services to students with special health care needs. SAH collaborated with ODE to write a grant application to CDC that funds support for YRBS, Coordinated School Health and HIV education. The SAH is working with the ODE on implementing the CDC Coordinated School Health (CSH) grant. The CSH grant has resulted in an MOU with ODE which funds one full time equivalent (FTE) to function as the project coordinator for ODH. SAH is providing technical assistance and training to school districts and ODH funded agencies promoting school health using the CSH framework. The SAH program works collaboratively to promote school healthy with the Ohio School Based Health Center Association and Ohio Action for Healthy Children by participating on the Board of Directors of both agencies.

The Bureau of Early Intervention Services (BEIS) collaborates with the ODJFS Bureau of Child Care and the Child Care Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health and safety information to licensed child care providers. The ODH Healthy Child Care Ohio coordinator serves as an ex-officio member on the ODJFS Day Care Advisory Council, a legislatively mandated body that advises ODJFS on child care policy and implementation of child care law.

Other Intergovernmental Collaboration: DFCHS has developed agreements and cooperative arrangements with many state agencies including the departments of Mental Retardation and Developmental Disabilities, Alcohol and Drug Addiction Services, Rehabilitation and Corrections, Job and Family Services and Education. DFCHS also has forged links with the University Affiliated Programs, the Cincinnati Center for Developmental Disorders (CCDD) and the Nisonger Center. CCDD and the Nisonger Center also house the MCH Bureau funded (Title V) Interdisciplinary Leadership Education Excellence in caring for Children with Neurodevelopmental and Related Disabilities training programs, which have close ties to DFCHS.

The DFCHS also collaborates with Ohio's two MCHB-funded Healthy Start Projects in Cleveland and Columbus.

C. Collaboration with the Medical Community and Social Service Organizations

DFCHS programs provide many opportunities for collaboration and coordination with major providers of health and health-related services. Examples of collaborations include the following:

- 1) The BCMH Medical Advisory Committee works with the Ohio Chapter of the AAP (OC/AAP) on the Children with Disabilities Subcommittee. This subcommittee is made up of members from the private sector and several state agencies and deals with social and educational issues of CSHCN in addition to medical issues. The ODH DFCHS participates with the OC/AAP in the development of a long-term strategic plan targeting mental health concerns for children and adolescents. The DFCHS medical director chairs the physician group which advises ODH on the recruitment of providers to participate in the statewide immunization registry. She also serves as liaison between ODH and the OC/AAP in regard to the immunization education program for physicians and nurses.
- 2) The BCFHS bureau chief attends Ohio Section of ACOG quarterly meetings to share information from ODH and to assure that pregnant women have early and adequate prenatal care.
- 3) MCH BG funds support regional perinatal teams that are housed in tertiary medical centers and provide technical assistance to local hospitals. In addition, children's hospitals, March of Dimes, Ohio Hospital Association and Children's Defense Funds are represented on the MCH Council.

Ohio Hospital Association (OHA): OHA is the membership/advocacy organization for Ohio's hospitals. OHA has developed a strong interest in its small/and rural hospitals, and has created a Small/ Rural Hospital Committee. In addition, OHA partnered with the State Office of Rural Health (SORH) in the development/implementation of the State Rural Hospital Flexibility Grant Program that enabled Ohio to designate Critical Access Hospitals (CAHs). Early in the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the OACHC, the Ohio State Health Network, Division of EMS, ORDP, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly; since its inception this meeting has been hosted by OHA. A total of 34 small rural hospitals have achieved CAH designation in Ohio.

A memorandum of understanding for data sharing between ODH and OHA was signed in 2003. ODH developed an agency agenda for data needed from OHA for research/reporting purposes and has received and analyzed OHA data. ODH staff is currently analyzing hospitalization data dealing with ambulatory sensitive conditions to determine potential access to care issues across Ohio.

Ohio Association of Children's Hospitals (OACH): BCMH collaborates closely with OACH. The Association is a key member of the MCH Advisory Counsel, the Birth Defects Advisory Council, and serves on other advisory groups as requested. OACH is a key partner/advocate for health care issues for all children, especially CSHCN.

Ohio Chapter/American Academy of Pediatrics (OC/AAP): OC/AAP shares the Children with Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. The DFCHS participates with the OC/AAP in development of a long term strategic plan targeting mental health concerns for children/adolescents. The BCHS works with OC/AAP and American Council of Family Practitioners to develop oral health training for physicians/ pediatricians.

Ohio Section of ACOG: The BCFHS Bureau Chief attends Ohio ACOG quarterly meetings to share information from ODH. Ohio ACOG and other diverse groups are members of the Family Planning (FP) Advisory Council. An ACOG representative actively participates on the ODH facilitated Action Learning Lab for Prenatal Smoking Cessation. The Ohio ACOG representative is an invited member of the ODH FP Advisory Council and the FP State-Wide Needs Assessment Stakeholders Workgroup Ohio Rural Development Partnership: See discussion under "Collaborations with FQHCs.

Ohio Dental Association (ODA): BCHS partners with ODA to administer a statewide volunteer dental care program called Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services). This dental referral/case management program matches clients with dentists who provide discounted or donated care in their offices.

Ohio Head Start Association, Inc. (OHSAI): BNS has an interagency agreement with OHSAI for the purpose of program coordination. BCHS collaborates closely with the OHSAI and convenes the Head Start Oral Health Steering Committee on a regular basis. Among other agencies/organizations on this group are ODJFS, ODH BEIS, State Head Start Collaboration Office, Ohio Academy of Pediatric Dentistry, ODA, and numerous local groups.

Collaboration with Local Health Agencies ODH continues to provide greater support to local health agencies as funding of direct health services lessens. Fortunately, BCMH had the foresight to create a Futures Committee as a forum for representatives of local health agencies to voice concerns about local and state policy as they impact families and communities. The local health agencies will require communication, training, technical assistance and innovative funding as they conduct public awareness campaigns, provide direct services to families and work to coordinate local systems for the benefit of families. The BCMH field nursing consultant for each region is a key component of the program's ongoing infrastructure commitment.

Many local health departments are subgrantee agencies for county WIC programs. Due to this internal relationship, many health departments collaborate from within by referring participants to programs they administer. Collaborations include home health care, family planning, prenatal, well child and immunization. If the WIC program is housed in the same building with other health department programs, one-stop shopping for participants is an additional benefit. Outreach efforts between the WIC program and the health department are common. Community events such as health and county fairs offer an opportunity to inform residents of available services that include the WIC program.

BCHS works with local health departments as requested. Collaboration usually centers on water fluoridation or local access program development.

ODH (BCFHS) will partner with the department of obstetrics and gynecology at The Ohio State University College of Medicine (OSU-COM), which has been named as a recipient of Agency for Healthcare Research and Quality funds, to develop a state-wide Pregnancy Associated Mortality Review (PAMR) system in Ohio. Pregnancy-associated mortality review (PAMR) is a perfect illustration of a process where a focus on patient safety and prevention of adverse events would lead to improvements in both healthcare system operations and clinical care. This would, in turn, decrease the potential for medical liability claims.

Ohio is one of 5 states that will work with the National Universal Vision Screening for Young Children Coordinating Center. This National Center will promote and ensure a continuum of eye care for young children within the healthcare system. Ohio Coalition members include the Ohio Departments of Education and Job and Family Services (Medicaid) as well as professional organizations such as the Ohio Chapter of the American Academy of Pediatrics, Ohio Academy of Family Physicians and National Association of Pediatric Nurse Practitioners. ODH is a co-chair of this Coalition and the ODH Title V Director is serving on the national advisory panel as the title V representative for this project.

Collaboration with The Ohio State University School of Public Health: BCFHS collaborated with the OSU School of Public Health and the National Association of City and County Health Officials (NACCHO) to provide regional strategic decision making process workshops for CFHS projects. Title V staff have also provided formal internships to students enrolled in the School of Public Health. Various Title V staff has assisted in teaching didactic components of classes within several colleges at OSU.

Three other public health programs have developed within Ohio: The Consortium of Eastern Ohio (four universities); a consortium of northwestern Ohio (three universities) and Case Western Reserve University. Title V staff are working with these institutions.

D. Provider Education

The ODH uses Title V funds to support many programs that sponsor numerous training activities and continuing education opportunities on various MCH topics. Some of these programs include the following:

Vision: The Specialty Medical Clinic program worked to improve and increase training on vision assessment and referral for primary physicians. Preschool vision screening reference materials were distributed to physicians. Vision assessment information was presented at four regional conferences. A vision screening videotape was produced with the emphasis on school age children and distributed to participants of ODH vision screening training. Nursing programs were offered the opportunity for workshops and vision trainings.

Lead Poisoning Prevention: The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) funded four Lead Regional Resource Centers (Seneca County, Cincinnati, Cleveland

and Mahoning County) that provided education on nutrition, assisted in outreach initiatives and coordinated screening efforts. The Statewide Lead Education Committee met quarterly to plan and develop program strategies to educate/increase awareness and improve physician compliance with screening/follow-up. OCLPPP provided promotional ideas/technical assistance to sub-grantees during Lead Awareness Week.

Prenatal Smoking Cessation: The “5 A’s” (Ask, Advise, Assess, Assist and Arrange) are considered best practice for treatment of tobacco use and dependence. The Prenatal Smoking Cessation Program has provided training to more than 500 prenatal care providers.

Ohio Partners for Smoke-Free Families is currently working with 60 Ohio Special Supplemental Nutrition Program for Women, Infants and Children WIC sites to ensure that health care systems are in place to screen all women of reproductive age, including pregnant women for tobacco use and all reproductive-aged women and pregnant smokers receive best practice cessation intervention. Health care providers who work with women of reproductive age including pregnant women, are given the tools, training and technical assistance needed to treat smokers effectively. Expansion efforts are being designed for Family Planning and Child & Family Health Services programs.

School Nursing Consultation: DFCHS school nurse consultants provide continuing education opportunities through annual and regional statewide conferences for the population of approximately 1,200 school nurses throughout the state. Regional trainings to Ohio school nurses are provided on topics such as Health Insurance Portability and Accountability Act (HIPAA), bioterrorism, SARS and current school-based mental health programs. Additional technical assistance and training is delivered to school nurses through the development of Web-based continuing education modules. ODH “Guidelines on BMI for Age” were developed to help local health departments and schools collect this information accurately. DFCHS collaborated with the ODH Homeland Security Program and has received funds to develop school-based training for emergency preparedness in schools. Through these school nurses, the information provided in the conferences has the potential to reach and affect all 2 million Ohio school children and their families.

2.2 State Priority Needs and Relationship to Outcomes & Performance Measures

2.2.1 Priority Needs Assessment Summary

Ohio’s Title V MCH Program embodies the states mission, and fully embraces the charge of improving healthcare for the populations it serves as exemplified by the nine priorities that have been selected. To determine the most critical needs of the state's maternal and child health population Leadership within the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) Chiefs (division chief, seven bureau chiefs and an external facilitator) collaborated on the most effective way to include partners in a structured prioritization process. Five (5) key areas were identified as being essential for a successful outcome: The convening of four (4) day long stakeholder meeting's focused on prioritized health issues; Sharing of data that outlined health social indicator status, health and social services access related to the MCH population from an Ohio and national perspective; Identifying best, promising or evidence based practices implemented across the state for the MCH population;

Utilizing a drilled down and analysis approach to identifying potential interventions related to the prioritized health issues.

Over several months a series of facilitated meetings took place by the DFCHS Leadership to discuss and rank the priorities identified by the stakeholder group. They were able to collectively identify the state's 9 critical MCH priority needs. These 9 critical priorities fall within 3 categories: Category A. Improve the health of children and adolescents (e.g., obesity, STD, oral health, decreasing deaths, improving health outcomes). The priorities under category A are: 1) Increase physical activity and improve nutrition; 2) Increase breastfeeding initiation and duration rates; 3) Improve early childhood development. Category B. Increase positive pregnancy outcomes and preconception health (e.g., decrease infant mortality and decrease premature births). One priority falls under category B, 4) Decrease rate of smoking for pregnant women, young women and parents. Category C. System Improvement. The majority priorities fall under category C, 5) Increase the viability of the health care safety net; 6) Increase the number of women, children and adolescents with a health home; 7) Increase access to evidence based community prevention programs; 8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems; 9) Improve the availability of useful and accurate health care data and information (this relates to quality and capacity).

Many of the needs that were high priority in the last Needs Assessment continue to be priorities, and are reflected in the new state performance measures however, most have been replaced with broader needs statements. Priorities such as "enhance social/emotional strengths of families" and "Promote collaboration and coordination of programs through partnerships and data integration" continue to be addresses as filters that run through all the priorities, performance measures and programming activities. The new areas that have emerged as priorities were identified across all population groups as a critical need such as access to care and overall healthcare, appropriate insurance coverage.

Therefore, priorities that assure quality screening; identification, intervention, care coordination, medical homes, and access to comprehensive and preventive treatment services for individuals, and families, including CSHCN emerged as the focus during this Needs Assessment. In addition all stakeholder groups emphasized the importance of reducing disparities, and this need will be addressed within an on-going state performance measure. The Categories and 9 critical priorities support and provide overarching themes for the federal and state outcomes and performance measures. The Ohio MCH Title V program has begun active planning and implementation to address the needs raised during this Five Year Needs Assessment.

A. Outcome Measures – Federal and State

This section describes the National and State Outcomes Measures and their collective positive impact on the Title V population and connections to achieving the 9 MCH Priorities.

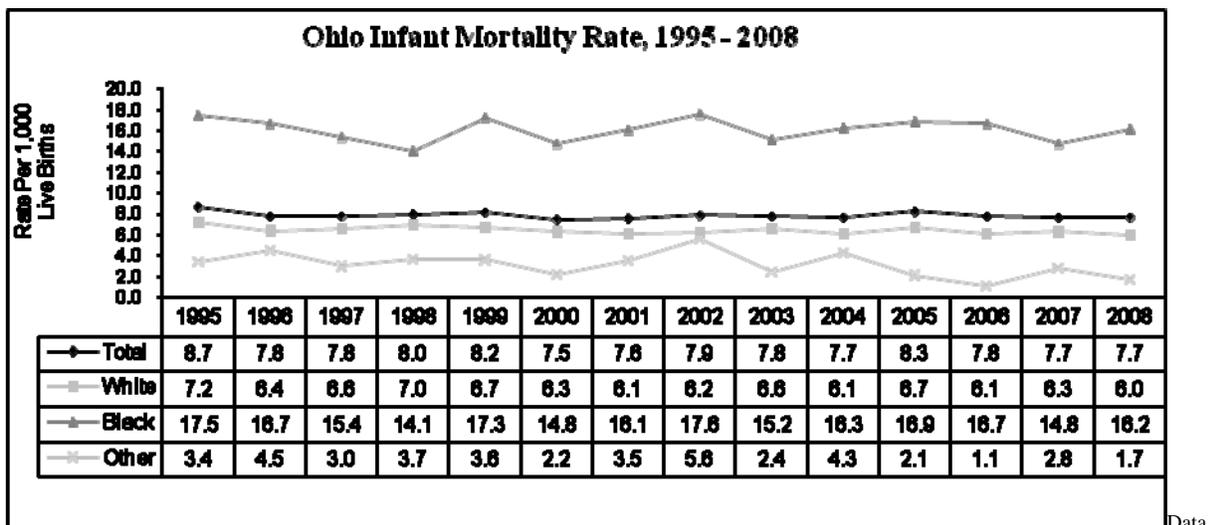
The status of Ohio's six national and one state outcome measures are described below.

NOM01: The leading causes of infant death nationally in 2007 were congenital malformations, (one-fifth of all infant deaths), disorders related to short gestation and low birth weight, and

sudden infant death syndrome (SIDS).¹⁴³ In 2008, 1,144 infants in Ohio died before they reached their 1st birthday. This represents an IMR of 7.7, which was higher than the national rate of 6.75 in 2007 (provisional).

In 2005, Ohio had the 8th highest IMR among states. The Ohio rate is higher than the Healthy People 2010 target rate of 5.0. From 1990 to 1997 there was a significant decrease in mortality that averaged 3 percent a year. However, from 1997 to 2008 there has been no significant change in Ohio’s IMR. According to the 2009 Ohio Child Fatality Review, Prematurity and congenital anomalies account for 70 percent (658) of all infant deaths from medical causes and 61 percent of infant deaths from all causes.¹⁴⁴

Racial/Ethnic Disparities: The 2006-8 combined IMR for black infants was 15.9 compared to 6.1 for white infants. A black infant born in Ohio is about 2 and one half times as likely to die in the first year of life compared to a white, and the ratio has stayed in that range for the past decade. Ohio’s ratio is similar to the national, which were 2.4 in 2007. The 2006-8 combined IMR for Hispanic infants was 6.2 compared to 7.8 for non-Hispanic infants (not shown). Nationally, the Hispanic IMR was 5.7 in 2007.



Source: Ohio Vital Statistics

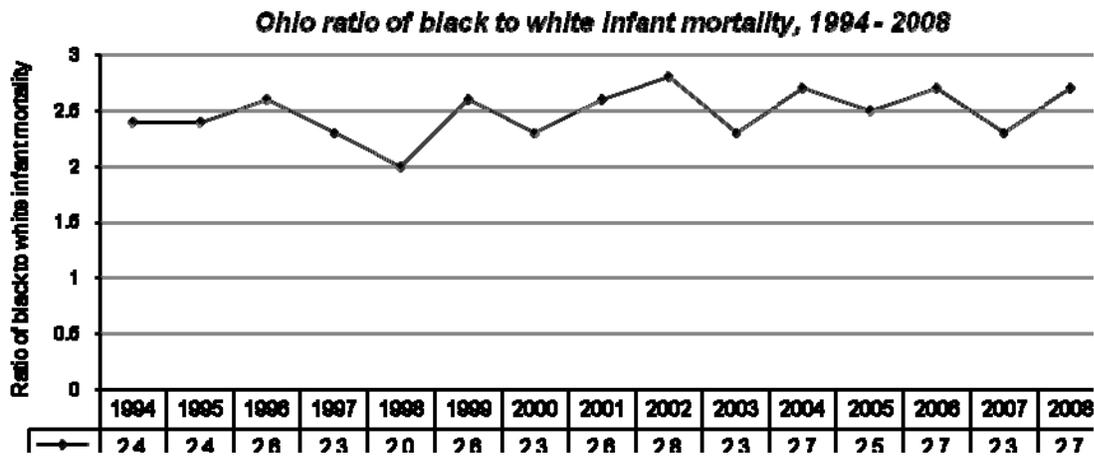
For Ohio counties with 20 or more infant deaths during 2006-2008, the highest overall IMR (8.5 per 1,000 or greater) were in the following counties: Hamilton, Cuyahoga, Franklin, Union, Ashtabula, and Scioto (see maps). The county with at least 20 deaths with the lowest overall IMR (less than 4.5) was Delaware.

NOM 02: The 2006-8 combined IMR for black infants was 15.9 compared to 6.1 for white infants. A black infant born in Ohio is about 2 and one half times as likely to die in the first year of life compared to a white, and the ratio has stayed in that range for the past decade. Ohio’s ratio is similar to the national, which were 2.4 in 2007. The 2006-8 combined IMR for Hispanic

¹⁴³ http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf

¹⁴⁴ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>

infants was 6.2 compared to 7.8 for non-Hispanic infants (not shown). Nationally, the Hispanic IMR was 5.7 in 2007.



Data Source: Ohio Vital Statistics

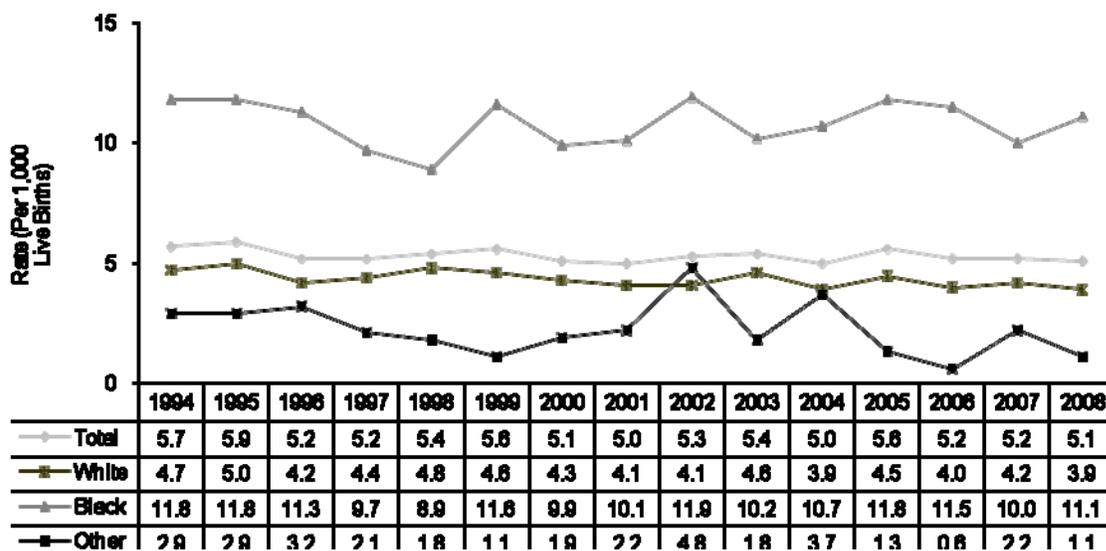
NOM 03: The neonatal mortality rate (NMR) is the number of infants who die during the neonatal period per 1,000 live births in a given year. In 2008, there were 755 neonatal deaths in Ohio. The 2008 NMR was 5.1, and three-year average rate was 5.2 for 2006-8, both of which were higher than the 2007 national rate of 4.4. The Healthy People 2010 target rate of 3.3 has not been met. Prematurity and congenital anomalies account for 78 percent (575) of the deaths to infants 0-28 days old.¹⁴⁵

For Ohio counties with 20 or more neonatal deaths during 2006-2008, the highest overall neonatal mortality rates (6 per 1,000 or greater) were in the following counties: Hamilton, Cuyahoga, Franklin, Butler, and Scioto (see maps). The only Ohio county with at least 20 deaths which met the Healthy People 2010 Objective of 2.9 was Delaware.

Racial/Ethnic Disparities: The 2008 NMR for black infants was nearly three times the rate for white infants (11.1 compared to 3.9 respectively). The national ratio was 2.3 in 2007 (8.65 compared to 3.70). The Ohio 2006-8 combined NMR for Hispanic infants was 4.0 compared to 5.2 for non-Hispanic infants (not shown).

¹⁴⁵ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>.

Ohio Neonatal Death Rate by Race, 1994 - 2008



Data Source: Ohio Vital Statistics

NOM 04: One-third of infant deaths occur during the postneonatal period. After the first month, SIDS is the leading cause of infant mortality, accounting for about one-third of all deaths during the postneonatal period. The causes of SIDS are unknown, but risk factors include sleep position, maternal smoking, prematurity, and lack of breastfeeding.

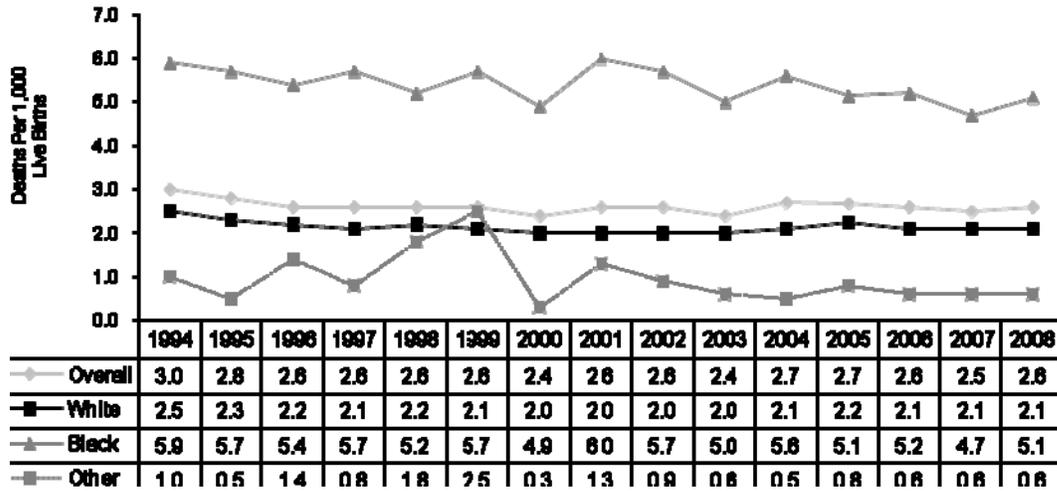
In Ohio, 389 postneonatal deaths occurred in 2008. Ohio’s 2007 PMR and 2006-7 combined PMR were 2.6,¹⁴⁶ higher than the 2007 national rate of 2.3 and higher than the Healthy People 2010 goal of 1.2. Nationally, the PMR increased significantly from 2006 to 2007. According to the 2009 Ohio CFR, sleep-related deaths accounted for 45 percent (159) of the reviewed deaths to infants 29 days to 1 year old¹⁴⁷. The numbers of Postneonatal deaths from 2006-8 were not great enough to make any meaningful county comparisons.

Racial/Ethnic Disparities: The 2008 PMR for black infants was 5.1 compared to 2.1 for white infants (a ratio of 2.4). This compares closely to a 2007 U.S. PMR among blacks of 4.59 and 1.94 among whites. The Ohio 2006-8 combined PMR for Hispanic infants was 2.2 compared to 2.6 for non-Hispanic infants (not shown).

¹⁴⁶ Ohio Vital Statistics.

¹⁴⁷ Ohio Child Fatality Review, <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>.

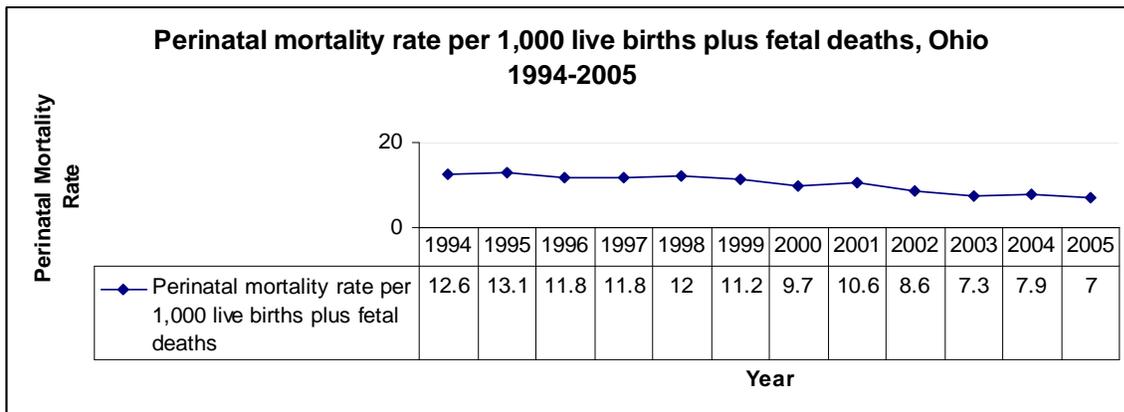
Ohio Postneonatal Mortality Rate by Race, 1994 - 2008



Data Source: Ohio Vital Statistics

NOM 05: Perinatal mortality is the death of a fetus/infant during the perinatal period (20 weeks gestation to seven days after birth). Fetal deaths can be associated with complications of pregnancy such as maternal blood disorders and problems with amniotic fluid levels. Substance use during pregnancy increases the risk for fetal deaths: the rate is 33 percent greater in women who smoke and 77 percent greater in women who use alcohol.

In Ohio, the perinatal mortality rate is the number of fetuses and infants who die during the perinatal period per 1,000 live births and fetal deaths in a given year. This definition is different from the national definition and the Healthy People 2010 (HP2010) definition, making comparisons difficult. In Ohio, fetal death is defined as death of a product of conception of at least 20 weeks gestation prior to its complete expulsion or extraction from its mother (including induced abortions). In 2005, the perinatal mortality rate was 7.0.¹⁴⁸



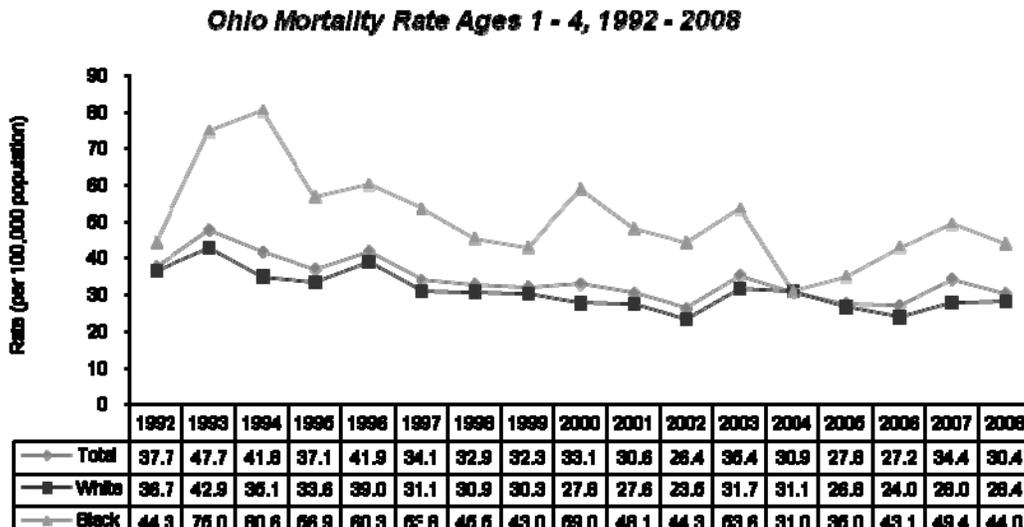
Data Source: Ohio Vital Statistics

¹⁴⁸ Ohio Vital Statistics.

NOM 06: Nationally, the 2008 mortality rate for children ages 1-4 was 28.4 per 100,000 children in that age group. Injuries were the leading cause of death, accounting for 43 percent of deaths.¹⁴⁹ Unintentional injury, specifically, continued to be the leading cause of death among 1-4-year olds, accounting for 35 percent and 37 percent of all deaths, respectively. The next leading cause of death was congenital anomalies (birth defects), followed by malignant neoplasms (cancer), homicide, and diseases of the heart.¹⁵⁰

The overall death rate for children aged 1-4 years in Ohio in 2002 was 30.4, similar to the national rate of 28.4 but higher than the Healthy People 2010 goal of 25. The mortality rate for this age group has declined since 1994, when the rate was 40.9.

Racial/Ethnic Disparities: Black early childhood mortality has remained much higher than for white children. In 2008 the mortality rate for black children aged 1-4 years was 44.0, while the rate for white children was 28.4.¹⁵¹



Data Source: Ohio Vital Statistics

¹⁴⁹ <http://mchb.hrsa.gov/mchirc/chusa>.

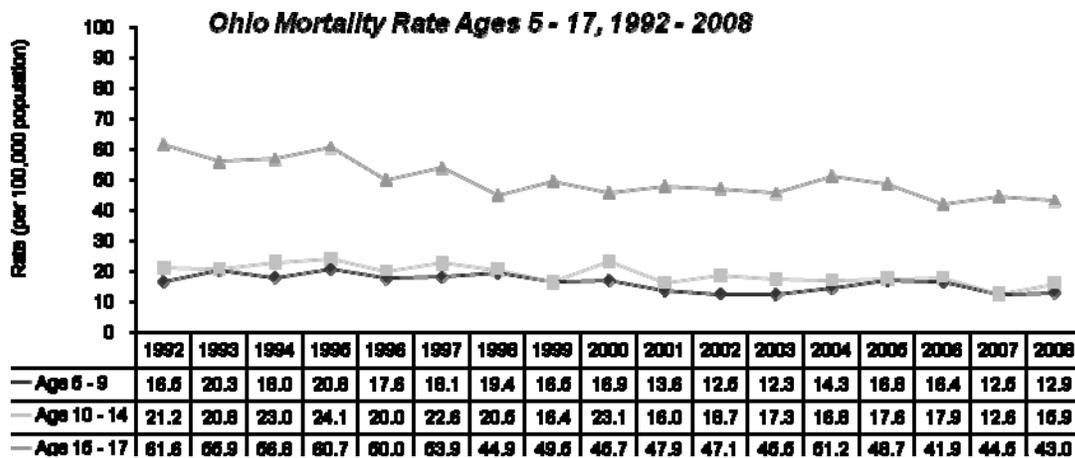
¹⁵⁰ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Apr 12, 2010.

¹⁵¹ Ohio Vital Statistics.

SOM 01: In 2006, the national mortality rate for children in this age group was 15.2 per 100,000, and injuries accounted for 37 percent of all deaths in children ages 5 through 14 in 2006.¹⁵² The second leading cause of death was malignant neoplasms, followed by homicide and congenital anomalies.¹⁵³

The overall death rate for children aged 5 through 14 in Ohio in 2008 was 14.4 per 100,000 and was lower than the national rate. Ohio achieved the HP 2010 targets for children aged 5-9 (Ohio rate: 12.9; HP 2010 target 14.3), and aged 10-14 (Ohio rate: 15.9; HP 2010 target 16.8).

Unintentional injuries accounted for 33.1 percent of all mortality in this age group in the years 2005-2007.¹⁵⁴ MV crashes were by far the leading cause of death from accidental injury, accounting for 48 percent of fatalities, followed by accidental exposure to smoke, fire and flames; accidental drowning and submersion; and other and unspecified, non-transport accidents.



Data Source: Ohio Vital Statistics

B. Performance Measures and Activities that Address Trends in National and State Outcome Measures

B.1 Birth Outcome/Infant Mortality Reduction Measures

Like most states with similar demographics, Ohio has experienced infant and perinatal mortality outcomes that are worse than the nation. Progress is being made in some populations; however the disparity between blacks and whites persists. Black outcomes remain on average worse than white outcomes.

¹⁵² Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Apr 12, 2010.

¹⁵³ Child Health USA, <http://www.mchb.hrsa.gov/chusa08/pdfs/c08.pdf>.

¹⁵⁴ Ohio Vital Statistics.

Ohio Infant Mortality Reduction Initiative Program (OIMRI): The focus of OIMRI changed in 2006 to address disparity in infant mortality in Ohio's African American community. ODH completed the data needs assessment and began work on identifying an appropriate data collection system. The Ohio Infant Mortality Task Force, provided recommendations and strategies in the Preventing Infant Mortality in Ohio: Task Force Report 2009. To continue the work of the Task Force ODH is establishing an ongoing consortium to implement and monitor the recommendations. In 2010, ODH program staff collaborated with Columbus Public Health on the Infant Mortality and Racism Action Learning Collaborative.

Activities to reduce postneonatal mortality are addressed through Ohio's Child Fatality Review. Local CFR boards in each of Ohio's 88 counties review all deaths to children under the age of 18 years and develop local initiatives to prevent future deaths. State initiatives include efforts to raise awareness; develop or change policies; and promote collaboration to address preventable causes of child deaths. Much progress has been made in the area of SIDS and sleep related deaths, the leading causes of postneonatal mortality in Ohio. There are no current state performance measures that address postneonatal mortality, but the development of Ohio's CFR programs was accomplished through a prior state performance measure.

Activities to improve birth outcomes and reduce infant mortality in Ohio have been incorporated into the following National and State Performance Measures:

National Performance Measure 01: Percent Screen Positive Newborns Who Receive Timely Follow Up

Plan for the Coming Year

1. Monitor and reconcile newborn screening cases between the Genetic Center data system, the Metabolic Formula data system, and the ODH Newborn Screening Lab system.
2. Include newborn bloodspot screening diagnoses and diagnoses related to newborn/infant hearing loss in the state's reportable birth defects panel.
3. Provide access to the ODH Newborn Screening Lab system to Regional Sickle Cell Projects to close hemoglobin trait cases at their locations.
4. Participate in the Region 4 Genetics Collaborative.
5. Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs.

National Performance Measure 08: Teen Pregnancy

Plan for the Coming Year

1. Analyze PRAMS data reported by teen mothers to identify issues specific to this population to determine next steps and recommendations.

This infrastructure level strategy will be accomplished by evaluation FP to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy.

2. Evaluate FP programs to determine if utilizing evidence-based practices reduce teen pregnancy.

This infrastructure level strategy will be accomplished by establishing a requirement in the FP RFP that applicant's document use of at least one evidence based teen pregnancy prevention strategy; and train all FP nurses to provide intervention to teens reporting sexual coercion.

National Performance Measure 11: Breastfeeding at Age Six Months
Plan for the Coming Year

1. Support breastfeeding (BF) components of the Ohio Obesity Prevention Plan.
2. Support BF objectives of the Preventing Infant Mortality in Ohio: Task Force Report.
3. Promote and support breastfeeding throughout the State of Ohio.
4. Review BF data to identify targeted population and intervention for Ohio (eg. AA, Appalachians, teens, etc.)

National Performance Measure 15: Prenatal Smoking
Plan for the Coming Year

1. Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use and Dependence Guidelines).
2. Ohio Partners for Smoke-Free Families will accomplish this through the following activities: Assess the MCH healthcare systems (i.e., WIC, CFHS) capacity to support evidence-based smoking cessation intervention; access provider (i.e., WIC, CFHS) awareness of evidence-based smoking cessation interventions; ensure that healthcare systems are in place to screen women for tobacco use and offer treatment; ensure that practitioners have the tools, training and technical assistance needed to treat smokers effectively; and ensure women have access to information that will help them take action to quit smoking. (i.e., Promote Healthy Lives Pledge)
3. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke.
4. Child and Family Health Services will accomplish this through the following activities: Assess the healthcare systems (i.e., CFHS) capacity to support environmental health risk reduction; access provider (i.e., CFHS) awareness of environmental health risks; ensure that systems are in place to screen women for environmental health risks; ensure that practitioners have the tools, training and technical assistance; and ensure women have access to information that will help them take action to reduce environmental exposures.
5. Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women.
6. The Perinatal Smoking Cessation Program will accomplish this through the following activities: Promote evidence-based smoking cessation interventions; collaborate with partners and leverage resource; use the media effectively; convene and facilitate or participate in the following workgroups to address tobacco use and dependence: The Infant Mortality Consortium; The Ohio Comprehensive Tobacco Use and Prevention Strategic Plan-Women of Reproductive Health Workgroup; MCH Block Grant

Performance Measure 15 Workgroup, The Ohio Tobacco Control and Resource Group and Ohio Partners for Birth Defects Prevention.

7. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

National Performance Measure 17: Percent of Very Low Birth Weight Infants Delivered at Facilities for High Risk Deliveries and Neonates

Plan for the Coming Year

1. Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.
2. This infrastructure-level strategy will be accomplished by: 1) developing web-based regional perinatal reports that include information about preterm birth and the percent of babies by birth weight born in hospital identified by level designation; 2) disseminating regional profile reports to DCFHS staff; and 3) continue to plan a project that would: a) identify 2 regions with the highest percentage of VLBW babies born in level I facilities: and, b) perform descriptive analyses to identify the characteristics of VLBW infants who are born in level I facilities in these regions in order to identify why VLBW infants are born in the Level I facilities.
3. Fund, monitor and evaluate DCFHS programs designed to take data to action.
4. This infrastructure-level strategy will be accomplished by: 1) strengthen partnership with ODJFS to implement quality improvement activities among local maternal and child health providers and 2) align DCFHS programs to implement the recommendations identified in Preventing Infant Mortality in Ohio: Task Force Report.

National Performance Measure 18: Percent of Infants Born to Pregnant Women Receiving Prenatal care in the First Trimester

Plan for the Coming Year

1. Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities.

This infrastructure-level strategy will be accomplished by analyzing FP referral data including chart audits, FP data, other qualitative data to see if it varies by intendedness, perinatal depression/mental health; developing report based on analysis that identifies trends and opportunities for technical assistance and/or quality improvement recommendations; identifying opportunities to implement pre/interconception service protocols for public health and private providers within ODH; and using focus group results of women of childbearing age and providers of WCA women of childbearing age re: pre/interconception care (P/IC) to inform design/delivery of health education messages interventions and align DCFHS programs to promote those messages.

2. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity.

This infrastructure-level strategy will be accomplished by gathering and analyzing data about first trimester entry into prenatal care in BCFHS funded programs by age, marital status, income, education, parity, payer, race and ethnicity; reviewing literature of evidence-based practices on getting women into prenatal care in the first trimester; and providing technical assistance to BCFHS funded programs to strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care based on data.

3. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.

This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup to develop culturally competent programs.

4. Support the work of the consortium which formed as a result of the *Preventing Infant Mortality in Ohio: Task Force Report*.

This infrastructure-level strategy will be accomplished by strengthening partnership with ODJFS to implement quality improvement activities among local maternal and child health providers; and aligning DCFHS programs to implement the recommendations identified in *Preventing Infant Mortality in Ohio: Task Force Report*.

State Performance Measure 01: Increase State Capacity to Reduce Unintended Pregnancies among Populations at High Risk for Poor Birth Outcomes
Plan for the Coming Year

- A. Examine disparities in pregnancy rates in regards to age, relationship status, income, education and race and ethnicity.
 1. ODH family planning program data and PRAMS data for 2004-6 was studied to examine rates of unintended and unwanted pregnancies among diverse groups. This data is being utilized to develop the RFP for the new ODH Family Planning Program that will combine the three current family planning projects into one program.
 2. Program will regionalize family planning projects in order to increase fiscal and programmatic efficiencies and to provide support for small projects.
 3. Program is developing a set of indicators from MCHB, HP 2010-2020, Title X Family Planning Priorities; and other resources in order to provide a cohesive set of requirements statewide.
 4. Program is collaborating with Ohio Domestic Violence Network to provide training to all family planning nurses to enable them to adequately counsel patients involved in sexual abuse and/or sexual coercion and to build networks within the counties for resources to assist these patients.
 5. Increasing surveillance of projects serving few teens, African-Americans and low income patients in order to increase services to the target population.

6. Discussions held to review prioritizing preconception and interconception services for diverse population groups and to suggest changes in program funding.
 7. Program is developing a “Reproductive Life Plan” to include in new RFP for ODH Family Planning Program that will be a requirement for each patient.
- B. Work with Ohio’s Medicaid program to expand eligibility for family planning services to uninsured men and women aged 18-55 with incomes at or below 200% of the Federal Poverty Level (FPL);
1. BCFHS collaborated with Ohio Medicaid Program to develop information to support Family Planning Medicaid Waiver; to revise lists of Medicaid reimbursable family planning services; and to meet with public officials to encourage the application of this waiver to CMS.
 2. Information regarding activities of the above has been shared with relevant stakeholders that include family planning providers, health commissioners and members of groups that serve low-income and diverse populations of women and children.
 3. Family Planning Medicaid Waiver workgroup has recommended to ODJFS that they pursue the state waiver process to provide family planning services to clients whose incomes are at or below 200% of the FPL. State is waiting for rules governing this process from the federal government.
- C. Assess progress in providing culturally competent care.
1. All ODH supported family planning programs submitted three strategies for the culturally and Linguistically Appropriate Services assessment tool when applying for grant funds; progress toward achieving these goals are reported at the close of the grant cycle.
 2. See <http://www.odh.ohio.gov/odhPrograms/cfhs/famx/familyx1.aspx>, click on CLAS tool.
 3. Training and technical assistance for staff members of delegate agencies for CLAS needs and objectives was monitored during all comprehensive reviews and technical assistance visits to agencies.

State Performance Measure 02: Percent of Low Birth Weight Black Births Among all Live Births to Black Women
Plan for the Coming Year

Collaborate with the Ohio Infant Mortality Consortium to implement statewide recommendations of the Ohio IMTF, specifically those recommendations targeting racism and disparities. Infrastructure level strategy will be implemented by supporting and/or integrating recommendations into new and existing ODH efforts to address infant mortality and disparities.

Engage other ODH partners whose programs impact maternal and child health to develop and fund a social marketing campaign to reduce low birth weight births. Infrastructure-level strategy will be accomplished by facilitating the collaboration of multiple ODH MCH serving programs to develop, fund and implement a social marketing campaign focused on prenatal smoking cessation, gestational diabetes and fetal alcohol spectrum disorder.

Incorporate activities from the Gestational Diabetes Mellitus (GDM) and Chronic Disease Integration Project into the Ohio Infant Mortality Reduction Initiative (OIMRI) program. Infrastructure-level strategy will be accomplished by identifying appropriate activities from the GDM and CD Integration Project that can be delivered by community health workers funded through the OIMRI program.

State Performance Measure 04: Degree to Which Division of Family and Community Health Services Programs can Incorporate and Evaluate Culturally Appropriate Activities and Interventions
Plan for the Coming Year

1. Develop and enhance a division-wide profile of populations served by DFCHS programs.
 - a. Finalize a DFCHS profile of populations served by program (information also needed annually for MCH BG Forms 7 and 8), and distribute across DFCHS bureaus.
 - b. Distribute and implement findings and recommendations from the DFCHS survey process: Assessment of the DFCHS Programs for collection, storage and reporting of racial, ethnic, and primary language data.
2. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.
 - a. When finalized, the ODH: Proposed Race and Ethnicity Guidelines report will be shared as an official DFCHS guide and the recommendations implemented.
 - b. Train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.
3. Development of an Ohio Title V program plan that maps out a process to assist state-level Title V program staff and local grantees in moving along the continuum to cultural and linguistic competency. The plan should include guidance and/or tools for incorporating cultural/linguistic competence into each of the MCH BG national and state performance measures, as appropriate and for monitoring progress at both the state and grantee levels.
 - a. Develop an implementation proposal for the cultural competency definitions/language drafted by the ODH Cultural and Linguistic Competency work group in cooperation with the Office of Healthy Ohio, Health Equity Coordinator.
 - b. Outline initiatives/activities/proposal associated with MCH programs and the collaboration with the statewide cultural competency group called Multi-ethnic Advocates for Cultural Competency (MACC) lead by Executive Director Charleta Tavares, former Ohio House of Representatives member.
 - c. Develop a train-the-trainer workshop that Ohio can use to implement the plan described in “3 above” and that will market the importance and the “how-to’s” of cultural/linguistic competency to our state/local partners.
 - d. Draft a technical assistance request for the train-the-trainer workshop.
 - e. Seek input from the Ohio Commission on Minority Health, as appropriate.

B.2 Child and Adolescent Mortality Reduction Measures that Address NPM 06 and SPM 01

Over the last ten years, Ohio has experienced a steady decline in the overall rate of deaths to children ages 1 through 14 years. Looking just at deaths due to injury, Ohio is better than the nation. However, there are disparities between black and white children for certain types of injury deaths, particularly for deaths due to homicide, where black children have a death rate 3.7 times higher than for white children. The disparity is 2.3 for fire/burns and 1.8 for both pedestrian and drowning deaths.

The overall death rate for adolescent's ages 15 through 19 years has been relatively stable, but in regard to disparities, white adolescents have higher death rates than blacks from unintentional injuries, mostly due to motor vehicles and suicide. On the other hand, black youth have a homicide death rate that is almost 13 times higher and a firearms rate that is 6.6 times higher than the white rate. Child and adolescent deaths were not ranked among the top ten priorities in the 2004/2005 MCH needs assessment.

Ohio's Child Fatality Review Program (see discussion in Section I above) addresses deaths from all causes in the age group birth to 18 years. Deaths due to motor vehicles and due to suicide have been areas of special focus. Homicide deaths were identified as a concern in the last meeting of the state CFR Advisory Committee in June 2007.

Activities to address deaths due to motor vehicles and suicide are incorporated into the following two national and one state performance measures.

National Performance Measure 10: Motor Vehicle Deaths in Children age 14 years and Younger **Plan for the Coming Year**

Use Vital Statistics data to monitor rate of MV deaths to children 1-14 yrs old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths. This infrastructure-level strategy will be accomplished through the following activities: Be alert to possible data quality issues; Access additional data sources that include injury data to provide a more comprehensive look at the impact of MV crashes for 1-14 yr olds.

Analyze factors that contribute to MV deaths of children 1-14 yrs old using CFR data and crash report data from ODPS. Share information with ODH programs, state agencies, local health departments, child health partners and policymakers/legislators. This infrastructure-level strategy will be accomplished through the following activities: Use analysis to identify groups with increased risks across the age group; Include injury data for more comprehensive perspective; Continue MV focus section in CFR annual report; Use strategy workgroup plus other external partners to review data and give input; Use multiple venues to disperse findings, e.g., ODH Website, e-mails, conference exhibits and presentations.

Encourage local CFR Boards to share information and recommendations about prevention of MV deaths of children 1-14 yrs old with local partners who can reach families and children, e.g., local media, Help Me Grow, county Family and Children First, Ohio Buckles Buckeyes, service agencies such as Kiwanis Clubs, child care providers and legislators. This infrastructure-level strategy will be accomplished through the following activities: Provide TA, training and tools to local CFR boards re: ways to present and share information to audiences, including use of CFR data for funding applications; Encourage cultural and linguistic competency in development of activities to prevent deaths/injuries from MV crashes, especially for pedestrian safety in urban areas and for educating public about new child booster seat law; Work with CFHS Program Consultants to strengthen collaborations between local CFR boards/CFHS projects; Review CFHS work plans and activities related to required strategy for CFR; Prepare fact sheets from data for MV deaths to 1-14 yr olds and risk factors unique to age group.

Collaborate with injury programs at ODH and other state agencies, to develop strategies to decrease MV injuries/deaths among children, including proper use of safety devices and increasing pedestrian safety. This infrastructure-level strategy will be accomplished through the following activities: Educate partners regarding issues, priorities and need to collaborate for solutions; Use CFR Advisory Committee, strategy workgroup and Ohio Injury Prevention Partnership recommendations to engage partners, leverage influence and coordinate efforts to identify and implement changes to policy, practice or legislation to reduce child MV deaths.

National Performance Measure 16: Suicide Deaths Among Youth Ages 15-19 **Plan for the Coming Year**

Review data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and disseminate results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide strategies.

Conduct 2011 Youth Risk Behavior Survey (YRBS), in Ohio schools.

**C. Stakeholder Participants in the ODH FFY11 Five Year
Maternal and Child Health Needs Assessment**

Women's Health, Birth Outcomes, and Newborn Health

Gail Bagwell, Nationwide Children's Hospital, Columbus
Carrie Baker, Ohio School Based Health Care Association, Columbus
Erika Bantz, Nurse-Family Partnership National Service Office, Massillon
Nora Ellis, Breastfeeding & Outreach Coordinator Meigs County Health Dept., Pomeroy
Melissa Federman, The Center for Community Solutions, Cleveland
Viola Gomez, Rural Opportunities, Inc., Toledo
Dee Keith, Ohio Breastfeeding Alliance, Columbus
Yolanda Lewis, City of Refuge Point of Impact, Columbus
Courtney Lynch, OSU College of Public Health, Columbus
Lisa Matthews, Moms First of Cleveland, Cleveland
Dodie Melvin, Mental Health America of Knox County, Licking-Knox
Ann Nevar, Rainbow Babies & Children's Hospital, Cleveland
Sara Paton, Wright State University, Dayton
Kathy Paxton, OSU Center for Learning Excellence, Columbus
Katrina Ransom, ODRC- Adult Parole Authority, Columbus
Dennis Schultz, Morrow County Family & Children First Council, Marion
Kelly Baroch, Cincinnati Children's Hospital Medical Center, Cincinnati
Annette Haban Bartz, Nationwide Children's Hospital, Columbus
Marilyn Benjamin, Cleveland Perinatal Network, Cleveland
Karen Boester, Ohio Department of Job and Family Services, Columbus
Claire Boettler, Cuyahoga County Board of Health, Cleveland
Donna Bush, Ohio Department of Job and Family Services, Columbus
Chris Day, La Leche League, Columbus
Sandra Domoracki, Regional Infant Hearing Program, Akron
Sylvia Ann Ellison, Wright State University, Dayton
Kimberly Friedman, Nurse-Family Partnership National Service Office, Columbus
Karen Gromada, TriHealth, Columbus
Terri Hazen, Hillcrest Hospital, Cleveland
Becky Johnson-Rescola, March of Dimes, Columbus
Liz Maseth, Ohio Lactation Consultants Association, Cleveland
Connie Motter, Akron Children's Hospital, Akron
Mary Murphy, North Coast Pediatrics, Northfield
Linda Post, Unison Health Plan of Ohio, Columbus
Carman Rashid, Buckeye Community Health Plan,
Carole Rogers, American College of Obstetricians and Gynecologists, Columbus
Bill Spears, Wright State University, Dayton
Ann Spicer, Ohio Academy of Family Physicians, Columbus
Teleange Thomas, Cleveland City Health Department, Cleveland
Leslie Yaussy, Delaware General Health District, Delaware
Katie Ziegler, Ohio State University Medical Center, Columbus

Early Childhood

Rick Cornett, Ohio Optometric Association,
Erika Bantz, Nurse-Family Partnership National Service Office, Massillon
Donna Bush, Ohio Department of Job and Family Services, Columbus
Sandi Domoracki, Regional Infant Hearing Program, Akron
Viola Gomez, Rural Opportunities, Inc., Toledo
Yolanda Lewis, City of Refuge Point of Impact, Columbus
Ann Nevar, Rainbow Babies & Children's Hospital, Cleveland
Kay Rietz, Ohio Department of Mental Health, Columbus
Karen Mitchell Columbus Speech & Hearing Center, Columbus
Liz Maseth, Ohio Lactation Consultants Association, Columbus
Barbara Hickcox, ODH Asthma Program, Columbus
Kathy Hills, ODJFS Bureau of Child Care & Development, Columbus
Sylvia Ann Ellison, Wright State University, Dayton
Ann Spicer, Ohio Academy of Family Physicians, Columbus
Candace Valach, Ohio Children's Trust Fund, Columbus
Sandy Erb-Wilson, Voices for Ohio's Children, Columbus
Kimberly Friedman, Nurse-Family Partnership National Service Office, Columbus
Terrie Hare, Ohio Department of Job and Family Services, Columbus
Marla Himminger, Ohio Department of Mental Health, Columbus
Christian Hurr, Butler County Board of MRDD, Cincinnati
James Scott, Ohio Department of Education, Columbus
Sherry Williams, Prevent Blindness Ohio, Columbus
Theresa Wukusick, Anthem Foundation of Ohio, Cincinnati
Maria Battaglia-Gentile, Ohio Department of Job and Family Services, Columbus
Carrie Baker, Ohio School Based Health Care Association, Columbus
Christy Beeghly, Ohio Department of Health Injury Program, Columbus
Karen Boester, Ohio Department of Job and Family Services, Columbus
Richard Bunner, Prevent Blindness America, Delaware
Harvey Doremus, Ohio Department of Job and Family Services, Columbus

School Age and Adolescent

Bridget DeCrane, Ohio Department of Education, Columbus
Barbara Hickcox, Ohio Department of Health Asthma Program, Columbus
Carrie Baker, Ohio School Based Health Care Association, Columbus
J. D. Beiting, Children's Hunger Alliance, Columbus
Shon Buckley, Community Research Partners, Columbus
Donna Bush, Ohio Department of Jobs and Family Services, Columbus
Cheryl Holton, Ohio Suicide Prevention Foundation, Columbus
Iris Meltzer, Akron Children's Hospital, Akron
Kay Rietz, Ohio Department of Mental Health, Columbus
Linda Tvorik, Columbus Public Health,
Harvey Doremus, Ohio Department of Job and Family Services, Columbus
Sylvia Ellison, Wright State University, Dayton
Carolyn Givens, Ohio Suicide Prevention Foundation, Columbus
Liz Henrich, Ohio Association of County Behavioral Health Authorities, Columbus

Sherry Williams, Prevent Blindness Ohio, Columbus
Maria Battaglia Gentile, Ohio Department of Job and Family Services, Columbus
Christy Beeghly, Ohio Department of Health Injury Program, Columbus
Dodie Melvin, Mental Health America of Knox County, Licking-Knox
Linda Post, Unison Health Plan of Ohio, Columbus
Katrina Ransom, Ohio Department of Rehabilitation and Corrections, Columbus

Children with Special Health Care Needs

Kelly Baroch, Cincinnati Children's Hospital Medical Center, Cincinnati
Dan Farkas, Autism diagnosis Education Pilot Project, Columbus
Chris Heldman, CareSource Management Group,
Donna Bush, Ohio Department of Jobs and Family Services, Columbus
Katrina Bush, Ohio Dept. of Mental Retardation Developmental Disabilities, Columbus
Barbara Hickcox, Ohio Department of Health Asthma Program, Columbus
Christina Hurr, Butler County Board of MRDD, Cincinnati
Carol Keltner, Family Voices Ohio,
Liz Henrich, Ohio Association of County Behavioral Health Authorities, Columbus
Matthew Pastore, Nationwide Children's Hospital, Columbus
Robert Stone, Children's Hospital Medical Center of Akron, Akron
Kay Treanor, Ohio Developmental Disabilities Council, Columbus
Leslie Yaussy, Delaware General Health District, Delaware
Harvey Doremus, Ohio Department of Job and Family Services, Columbus
Sylvia Ann Ellison, Wright State University, Dayton
Richard Bunner, Prevent Blindness America, Delaware

Access Stakeholder Group

Carrie Baker, Ohio School Based Health Care Association, Columbus
Shawn Frick, Ohio Association of Community Health Centers, Columbus
Susan Isaac, Ohio University, Athens
Ann Spicer, Ohio Academy of Family Physicians, Columbus
Sherry Williams, Prevent Blindness Ohio, Columbus
Theresa Wukusick, Anthem Foundation of Ohio, Cincinnati
Leslie Yaussy, Delaware General Health District, Delaware