

**Louisiana
Maternal & Child Health
Needs Assessment**

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Needs Assessment Table of Contents

	Title	Page
2	Needs Assessment of the Maternal and Child Health Population	2
2.1	Needs Assessment Process	2
2.2	Maternal & Child Health Block Grant 2005 Needs Assessment	7
2.2.1	Direct/Enabling Health Care Services	18
2.2.2	Population Based Services	27
2.2.3	Infrastructure Building Services	34
2.3	Needs Assessment of the Children with Special Health Care Needs Population	43
2.3.1	CSHS Needs Assessment Process	43
2.3.2	Overview of the CSHCN Population	48
2.3.3	Direct Health Care Services	50
2.3.4	Enabling Services	54
2.3.5	Population-Based Services	55
2.3.6	Infrastructure-Building Services	56
2.4	Health Status Indicators	61
2.5	Priority Needs	61
II. E.	Outcome Measures	63
	 Appendices	
A	MCH Needs Assessment Figures	69
B	MCH Needs Assessment Tables	77
C	MCH Needs Assessment Maps	83
D	MCH Needs Assessment Support Materials	92
E	CSHS Needs Assessment Tables	307
F	CSHS Needs Assessment Support Materials	315

2 Needs Assessment of the Maternal and Child Health Population

2.1 Needs Assessment Process

The Maternal and Child Health (MCH) Program formed a needs assessment steering committee in late 2003 to discuss and plan the 2005 Title V Needs Assessment process. The committee consisted of the MCH and Children's Special Health CSHS Program Administrators, the Child Health Medical Director, the CDC assigned MCH Epidemiologist, the MCH Assistant Administrator, the Maternity Medical Director, the Adolescent School Health Initiative Medical Director, the Oral Health Program Director, and the Needs Assessment Coordinator. The steering committee decided to organize the needs assessment process into five subgroups. The subgroups were Adolescent Health, Child Health, Perinatal Health, Oral Health, and Children with Special Health Care Needs. The needs assessment process and results for the Children with Special Health Care Needs subgroup can be found in Section 2.3 **CSHS Needs Assessment Process**

Methods of Collection

The 2005 Title V Needs Assessment consisted of 3 major components of collection: secondary data compilation and review, data collection and reporting on federal and state performance measures and health status indicators, and stakeholder input. Each subgroup worked with an MCH Epidemiologist to systematically review existing databases, state and national reports, and websites for data and information pertinent to describing the health status of Louisiana's MCH population. Each of the five subgroups had their own processes for performing their subgroups needs assessment.

Child Health

The Child Health subgroup was an 18 member committee consisting of representatives from various state agencies and organizations. This group assessed the state's child health population needs by public health region and obtained broad based input from community agencies and organizations outside of the Office of Public Health (OPH). The age group that the Child Health subgroup focused on was birth to 24 years. The Child Health subgroup targeted three types of stakeholders for feedback and input in establishing the needs, priorities, and strategic planning for Child Health in Louisiana: community, provider, and consumer.

To assess community stakeholder input, each of the nine OPH regions conducted a regional child health needs assessment. Participants of each regional assessment included children's advocacy groups, children's coalitions, faith-based community groups, and regional OPH staff. The objective of each regional assessment was to state their region's vision/goals for the child health population, top regional child health needs, long- and short- term activities/strategies for addressing the region's top health needs, and assess the accessibility and availability of child health resources and services (See Appendix D for a

copy of the Child Health Regional Assessment). The Regional assessment teams prioritized their child health needs using an adaptation of the federal MCH Bureau's sorting method.

Provider feedback included public health and private sector healthcare providers such as pediatricians, nurses, social workers, occupational therapists and other service sectors (childcare providers and school health nurses). To assess provider input, the Child Health subgroup developed and utilized an online survey. The survey asked health care professionals to rank top child health needs and activities/strategies for addressing those needs from a given list, with the option to add and rank additional needs/activities not listed. The survey also asked providers to assess the capacity to meet the priority child health needs by examining the availability and accessibility to resources and services in their parish of practice. Three contacts were made to achieve high response rates including sending a pre-notice letter, a questionnaire, and a reminder (See Appendix D for copy of Child Health Provider Survey).

Consumer input consisted of parental feedback. Data from the National Survey on Children's Health (SLAITS), which collects important health care data at state and local levels, were used. This survey examines the physical and emotional health of children birth-17 years of age. Special emphasis is placed on factors that may relate to the well-being of children, which include medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods.

After compiling the community, provider, and consumer input the Child Health subgroup used a tally method to rank the top five health needs of children around the state.

Oral Health

The Oral Health subgroup's needs assessment methodology followed the Association of State and Territorial Dental Director's seven-step needs assessment model utilizing the available dental data from the state as well as national data. The seven steps are: identify partners and form an advisory committee, conduct self assessment to determine goals and resources, plan the needs assessment (conduct inventory of available primary and secondary data, determine need for primary data collection, identify resources, select methods, develop work plan), collect data, organize and analyze data, prioritize issues and report findings (utilize needs assessment for program planning, advocacy, and education), and evaluate needs assessment. The Oral Health subgroup used feedback gathered from the Louisiana Oral Health Program's Oral Health Summit of 2002 and 2004. The Oral Health Summit was a statewide summit that was attended by approximately 125 representatives. A facilitated process was used during the Summit to determine priority needs and strategies to meet those needs.

Adolescent Health

To assure that the voice of the community was heard throughout the needs assessment process, the Adolescent Health subgroup held stakeholders focus groups comprised of professionals representing multiple agencies ranging from STD/HIV to juvenile justice to gay, lesbian, bisexual, and transgender teens. In preparation for the focus groups, data regarding 6 major categories (unintentional and intentional

injury, mental health, tobacco use and substance abuse, chronic disease, reproductive health, and access to care) that encompass the major causes of morbidity and mortality in the adolescent population was collected, analyzed and organized in corresponding data sheets (See Appendix D for a copy of Adolescent Health Data Sheets). The information gathered was presented to OPH personnel, prior to the community focus group, to insure accuracy and obtain feedback. Based on the data presented, using the MCHB sorting method as well as a tally method, the needs facing adolescents in Louisiana were prioritized at the community focus group.

Perinatal Health

The Perinatal Health subgroup developed a Perinatal Needs Assessment Template (PNAT) to ensure systematic assessment of regional vision/goals for the perinatal population; perinatal health priority needs; and strategies for addressing the health needs. The PNAT included a compilation of local, regional and state perinatal health statistics as well as Healthy People 2010 goals; data worksheets based on regional Perinatal Periods of Risk analyses, to enable analysis of statistics and identification of list major gaps that might emerge within regions; and a perinatal health needs prioritization worksheet adapted from the MCHB sorting method (Peoples-Sheps, et al.). The PNAT also included worksheets to assess availability and accessibility of health services, and effectiveness and feasibility of suggested activities to address priorities. The PNAT was used by the nine regional Louisiana Infant Mortality Reduction Initiatives (La-IMRI) and the Orleans Parish La-IMRI to state their vision/goals for their region's perinatal health population, top regional perinatal health needs, long- and short- term activities/strategies for addressing the region's top health needs, and assess the accessibility and availability of perinatal health resources and services. Results from the nine regional and Orleans parish assessment were pooled together by the Perinatal Health subgroup to determine the top statewide perinatal health needs (See Appendix D for Perinatal Health Regional Needs Assessment).

Children with Special Health Care Needs

See Section 2.3.1 **CSHS Needs Assessment Process**

Data Limitation

Most of the subgroups experienced the limitation of some available secondary data being either not recent enough, or in some instances, not broken down by race. The subgroups also encountered major gaps in the collection of quality data on issues such as mental health and obesity. One of the data limitations Adolescent Health encountered was that most health issues pertaining to adolescents are not centrally located in one agency or program; therefore, data was harder to find. Another limitation for Adolescent Health was not being able to use data collected from the YRBS (Youth Risk Behavior Survey). For the past 3 surveys the response rate of the YRBS in Louisiana has not met the requirement of $\geq 60\%$ response rate, therefore, the data could not be weighted and does not reflect the population of 9 -12 graders

throughout Louisiana. The major data limitation for Oral Health was that most of their data comes from the Medicaid Program and does not include the private sector.

Collaboration

The four subgroups Child Health, Adolescent Health, Perinatal Health, and Oral Health worked closely with various community partners throughout every step of their needs assessment process. Oral Health collaborated with the nine regional Office of Public Health (OPH) offices, representing 70 OPH parish health units, for oral health information and feedback. They collaborated with the Children's Coalitions in the nine regions to collect the private sector oral health information, and joined forces with the Child Health subgroup to survey medical professionals for provider feedback. The Oral Health subgroup also used feedback gathered from the Louisiana Oral Health Program's Oral Health Summit of 2002 and 2004. The Oral Health Summit was a statewide summit that was attended by approximately 125 representatives including the Louisiana Dental and Dental Hygiene Associations, the Secretary of Department of Health and Hospitals, the Director of Louisiana Medicaid and staff, the 3 largest federally qualified health centers, New Orleans Health Department, LSUHSC School of Dentistry, Head Start Directors, parents, and the Rural Water Association.

The Child Health Subgroup consisted of representatives from various state agencies and organizations such as the MCH Program, OPH Injury Prevention, Nutrition, Genetics, School Based Health Programs and the New Orleans City Health Department. In the planning phase of the child health needs assessment, the various state level child advocacy groups involved were American Academy of Pediatrics Louisiana Chapter, Louisiana Maternal and Child Health Coalition, Prevent Child Abuse Louisiana, Children's Cabinet Advisory Board, and the You Who child advocacy coalition. These child advocacy groups reviewed and made recommendations for the overall needs assessment plan. The Child Health Subgroup also collaborated with local child advocacy groups for community stakeholder feedback. Partnerships were established with local agencies including, Children's Coalition for Northeast Louisiana, Children's Coalition for Bayou Region, Bridges Committee for Children, Children's Services Collaborative, Agenda for Children, Covering Kids Initiatives, Central Louisiana Children's Cabinet and Greater Baton Rouge Children's Coalition. In the provider-stakeholder feedback, various professional agencies and groups were solicited to assist in the distribution of information about the online survey to their membership including physicians, nurses, clinicians, and social workers. Private partnerships were established with American Academy of Pediatrics Louisiana Chapter, Pediatric Departments of Tulane University Hospital and Oschner Hospital, Women's Hospital, Louisiana Chapter of National Association of Social Workers, Louisiana State Board of Nurses and Association of School Nurses, and Children's Bureau. Public partnerships were established with Pediatric Departments of Louisiana State Universities in Shreveport, New Orleans, Houma, Baton Rouge, Lafayette, Alexandria, and Monroe, City of New Orleans Health Department and Kid-Med Community Care Providers. In addition all OPH regional staff and MCH contracted agencies were asked to participate.

Collaboration with professionals in the public and private sector regarding many different health issues is critical, especially for the Adolescent Health subgroup, since so many of its issues cut across numerous health issues and programs. As a result, Adolescent Health pulled from a variety of existing relationships and formed new partnerships for their needs assessment process. Some of the agencies that partnered with the Adolescent Health subgroup were the Attorney General's Office, Department of Social Services/Office of Community Service, Youth Empowerment Project, Office of Mental Health, Office of Addictive Disorders, and the OPH Adolescent Health Initiative.

The Perinatal Health subgroup collaborated with the nine regional Louisiana Infant Mortality Reduction Initiatives (LA-IMRI) around the state to create the regional perinatal health needs assessment teams. Each regional assessment team consisted of the regional OPH epidemiologist and medical director, LA-IMRI coordinator, members of the FIMR Community Action Team and Case Review Team (See Appendix D for a complete listing of community partners by subgroup).

Process to Consolidate Data Components and Community Input

To consolidate the data and community input of the five subgroups (Oral Health, Child Health, Perinatal Health, Adolescent Health, and CSHCN) into one cohesive list of priorities and set of plans for the state, all staff (42 people) representing each of the 5 subgroups came together in late February 2005 to delineate state priorities. At the 2005 Title V Needs Assessment Priority Setting Meeting the subgroups each gave a presentation that stated their top three health needs; background information related to their top health needs; current performance measures, if any, that addresses their health needs; and if there should be any changes to current performance measures.

Oral Health, Child Health, Perinatal Health, Adolescent Health, and CSHCN top health needs were as follows: Oral Health- (1) Increase the number of dental providers treating Medicaid children and Medicaid eligible pregnant women to provide greater access to dental care; (2) Increase the number of children who receive protective dental sealants through school-based sealant programs; (3) Expand the dental practice requirements in Louisiana for dental hygienists to include general supervision in schools, public health clinics, head start programs, day care center and rural health clinics. Child Health- (1) Ensure access to quality, comprehensive, coordinated care from quality providers; (2) Ensure access to quality, comprehensive mental health services; (3) Decrease child mortality and morbidity due to unintentional and intentional injuries. Children with Special Health Care Services- (1) Ensure access to pediatric sub-specialty care addressing transportation, adequate reimbursement, sub-specialists, and mode of service delivery; (2) Assure transition to adult services; (3) Ensure access to mental health services. Adolescent Health: (1) Ensure access to quality mental health services; (2) Ensure access to quality substance abuse services; (3) Ensure access to health care. Perinatal Health- (1) Decrease fetal and infant mortality and morbidity through expansion of the LA-IMRI to all regions, increasing and supporting regional MCH coalition building, data sharing, community empowerment, and advocacy aimed at improving birth outcomes; (2) Ensure access to quality, comprehensive, coordinated care from quality providers through

increased collaboration with other state agencies and programs such as HIV, STD, Family Planning, Tobacco Control, Office of Addictive Disorders, Office of Mental Health, and Medicaid (3) Increase access to mental health and substance abuse services for all pregnant and postpartum women (See Appendix D for copy of subgroup presentations).

After presentation of health needs by each subgroup, the meeting participants performed an initial evaluation of the health needs using a 1 to 5 scoring system. Participants gave the health needs a “1” if they thought the presented need was a Top Priority, definitely include as a MCH Priority Need; a “2” if they thought it was Priority need, most likely include; a “3” if they would like to debate inclusion, include if there is consensus; a “4” if they thought the need most likely should not be included among priority needs; or a “5” if they thought the need should not be included in the state’s Title V Priority Needs. The outcome of the initial evaluation is available in Appendix D. After scoring each health need using the 1 through 5 scoring system the meeting participants reviewed criteria for selecting an MCH priority need. Criteria included: Is the issue data driven?, Is there a large population affected by the issue?, Is the issue generally recognized as a need by providers and recipients?, Is the need not adequately addressed by others?, Is this a realistic/feasible issue to address?, Impact-what is the likelihood of success?, Sustainability?, Is the issue consistent with MCH Title V Block Grant law? Following the discussion of criteria, the meeting participants revisited the list of needs and came up with ten areas of importance. Those areas were mental health and substance abuse; access to care; quality services; barriers to care; injury prevention; infant mortality and morbidity; oral health; transition to adult services for CSHCN population; collection, capacity, and analysis of data; and unintended pregnancies. The group finally agreed upon 10 MCH Priority Needs for the 2005 Title V Needs Assessment.

2.2 Maternal & Child Health Block Grant 2005 Needs Assessment

Health Care Needs of the State’s Population

A 2004 report by the United Health Foundation ranks Louisiana **last in overall health**, marking Louisiana as the least healthy state in the nation. Louisiana ranked 49th in 2003 and 50th in all previous years (1998-2002). The report is based on 18 measures, including infant mortality, infectious diseases, motor vehicle deaths, children in poverty, adequacy of prenatal care, and other mortality rates. Louisiana’s poor ranking stems from its high prevalence of **smoking, high rate of uninsured, high percentage of children in poverty, high rate of cancer deaths, and high infant mortality rate**. Over the past year, 2003 to 2004, the percentage of health dollars targeted toward public health programs and initiatives in Louisiana has decreased from 3.7% to 1.9%.

According to the US Census from 2000 to 2003 the total population of Louisiana grew by 1.0% to an estimated 4,496,334 people. In terms of racial make up, Louisiana has two main racial groups, white 63.9% and black 32.5%, with 3.6% as other. This is vastly different from the racial make up of the US,

where 75.1% of the population is white, 12.3% of the population is black, and 12.6% is other. Louisiana has a relatively small Hispanic population compared to the US as a whole. A comparison of Louisiana and the Nation's racial and Hispanic origin distributions is available in Figure 1 and Figure 2 of Appendix A respectively. The total number of women of childbearing age has decreased from 1,006,947 (22.5%) in 2000 to 983,257 (21.9%) in 2003. Teenagers 15-19 years and children 0-14 years comprised approximately 7.7% and 21.6% of Louisiana's population respectively in 2003. The parish population estimates from 2000 to 2003 can be found in Table 1 of Appendix B.

Between 2000 and 2003, Louisiana experienced a 4.6% decline in the number of live births; most of the decrease (3.9%) in live births occurred between the years 2000 and 2001. In 2001, 2002 and 2003 Louisiana had 65,193, 64,755, and 64,689 births respectively (See Appendix A, Figure 3). The infant mortality rate in Louisiana decreased from 10.2 in 2002 to 9.3 in 2003; this is the first decrease in Louisiana's infant mortality rate since 2000.

Although 72.6% of the of the state's population lives in an urban setting, geographically Louisiana is a predominantly rural state. Only 27% of the 64 Parishes have at least 70% of their population classified as urban (2000 US Census). Six of those parishes are located in the greater New Orleans metropolitan area.

In 2003, the US Bureau of Economic Analysis reported Louisiana a having a per capita personal income of \$26,038 compared to the national average \$31,459. This shows an increase of 2.9% from 2002. Over the past 3 years, 2000 to 2003, Louisiana has had relatively no change in its median household income of \$34,307. The unemployment rate, reported by the Louisiana Department of Labor, in December of 2004 was 5.7%, this is the lowest unemployment rate that Louisiana has experienced since 1999 (4.9%).

The overall poverty rate has not significantly changed in the past four year, 2000-2003 (See Appendix A, Figure 4). In 2003, Louisiana had an overall poverty rate of 17%, approximately 750,000 people. According to the US Census Bureau, Louisiana had the 4th highest poverty rate in the US for the period 2001-2002. Among the 50 states, Louisiana ranked 47th in child poverty. Only three states; West Virginia, Arkansas, and New Mexico had child poverty rates higher than Louisiana's rate of 25.5% in 2004. The 2004 national rate is 17.6% (United Health Foundation Rankings).

According to the 2002/2003 Fiscal Year Louisiana Medicaid Program Report, 990,544 Louisianans or 22% of Louisiana's population was eligible for Medicaid. Approximately 21% of Louisiana's population received Medicaid services. The percent of Medicaid recipients has increased by 4.2% since the 1999/2000 fiscal year.

Overview of the Maternal and Child Health Population

According to the 2004 National Kids Count Data Book, Louisiana ranked 49th out of the 50 states in "Indicators of Child Well-being." Specific to child health, Louisiana ranked 47th for its child death rate which measures the deaths in children from age 1 -14 years. Other factors contributing to Louisiana's poor ranking relate to prenatal, perinatal events, and adolescent status. Louisiana ranked 48th and 49th for infant

mortality rates and percent of **low birth weight** infants respectively. The status of adolescents in Louisiana ranked 46th because of the high number of **teen deaths due to accidents, homicide and suicide**; 45th for the **teen birth** rate; 43rd for the percent of teens who are high school dropouts; and 48th for percent of teens not attending school and not working. Socioeconomic factors such as the percent of children in poverty; the percent of children in families where no parent has a full-time, year around employment, and the percent of families with children headed by a single parent also influenced Louisiana's low ranking. The state ranked 48th, 48th and 49th in each of these measures respectively. Although these latter indicators are not directly related to health status, they do reflect socioeconomic and environmental factors that affect the health of children.

Teen Births, Unintended Pregnancies and Initiation of Prenatal Care:

Nationally the rate of births among teens 15-17 years has been decreasing since 1998. The state of Louisiana has also seen a decrease in the rate of teen births from 35.0/1,000 in 2000, to 29.3/1,000 in 2003. Statewide, the rate of teen births to black females is disproportionately higher than to white females. A greater decrease in teen births in the black population has occurred as compared to the white population. From 2000 to 2003, the rate of teen births to black females aged 15-17 decreased from 59.2 to 46.8, whereas for white females the rate decreased from 19.6 to 17.6. In 2000 and 2001, the highest rates of teen pregnancy were in the northwest region (40.3 and 35.4 respectively). In 2002, the New Orleans metropolitan region had the highest rate of teen births with a rate of 34.8/100,000. Among white females, the central region had the highest rate of teen pregnancy in 2000 with a rate of 26.5/1,000. In 2001, both the central region and the southwest region had the highest rates of teen pregnancy among whites, with a rate of 24.1/1,000. In 2002, the southwest region remained the area with the highest rate of white teen births, with 24.9/1,000. Among black females, Region 9 had the highest rate of teen pregnancy in 2000 and 2001 with rates of 67.4/1,000 and 61.8/1,000 respectively. In 2002, the central region had the highest rate of teen births for black females with a rate of 53.0/1,000.

Women less than 20 years old have the highest percentage (83.3%) of unintended pregnancies in Louisiana. According to the Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS), the percent of unintended pregnancies in the state has increased from 52% in 2000 to 55% in 2002. Fifty-five percent of all Louisiana women in 2002 reported that they or their husbands were not using birth control when they got pregnant. An unintended pregnancy can significantly influence the interval of time that a woman has between pregnancies. It is recommended that women have an interpregnancy interval of at least 24 months in order to reduce the risk of adverse perinatal and maternal outcomes. In 2000, 24.8% of women waited less than 24 months between pregnancies. In 2003, the percent of women waiting less than 24 months between pregnancies decreased to 22.8%.

Unintended pregnancies can also influence whether a pregnant woman enters prenatal care in a timely fashion. The rate of women entering into prenatal care during their 1st trimester has slowly increased from 83.3% in 2000 to 84.1% in 2003. The improvement in early entry into PNC is largely due to

the increase in the percent of black women receiving early prenatal care. The percent of black women entering into early prenatal care rose from 73.6% in 2000 to 75.5% in 2003. Even though the percent of black women entering into prenatal care during their 1st trimester increased, a large disparity between the white and the black population of Louisiana continues. Louisiana's white population has a rate of entry into early prenatal care 14.6 % higher than black women.

Maternal, Infant, and Child Mortality:

Infant Mortality continues to be a major concern of the Louisiana MCH Program. The United Health Foundation ranked Louisiana 49th in its 2004 report and the National Vital Statistics Reports indicated that Louisiana ranked in the top five states with the highest infant mortality rate (IMR) each year from 1998 to 2002. IMRs for Orleans parish, part of the largest metropolitan area in Louisiana, have risen over the past two years, exceeding the already high statewide rates. Specifically, all-race IMRs were 9.1, 9.2, 8.9, 9.8, and 10.2 for Louisiana and 6.1, 8.7, 7.0, 10.5, and 12.6 for Orleans Parish in 1998, 1999, 2000, 2001, and 2002, respectively. The corresponding average annual percent change during this time was 3.0 for Louisiana and 8.7 for Orleans parish, showing an increasing trend over time, especially for Orleans parish.

Although the 2000 IMR (8.9) was lower than both the 1998 and 1999 IMR, the 2000 rate was underreported, due to unaccounted infant deaths weighing less than 500-grams at birth. Despite this underreporting, Louisiana failed to meet the Healthy People 2000 objective of 7.0. For 2000 to 2002, infant mortality for Caddo Parish (Shreveport) and East Baton Rouge Parish (Baton Rouge) the state's highest IMRs. Preliminary data from 2003 show an IMR of 9.3, indicating a possible change in the increasing trend of infant mortality.

Louisiana has a large racial disparity that exists between whites and blacks in infant mortality (See Appendix A, Figure 5). The IMRs for the state among the black population during 1998-2002 ranged from 2.2 to 2.4 times higher than the white population. The IMR increased from 1998 to 2002 for both whites and blacks. Statewide, white IMRs rose from 5.8 in 1998 to 6.9 in 2002. The average annual percent change for white IMRs from 1998 to 2002 was 4.6% for Louisiana. Black IMRs for the state rose from 14.0 in 1998 to 15.0 in 2002 statewide, corresponding with an average annual percent change of 1.9. These rates indicate that black IMRs are consistently higher on an absolute scale and are increasing less rapidly statewide than the white IMR.

Causes of infant deaths were analyzed using statewide death certificates from 2000 to 2002. The main causes of death for whites and blacks were similar during the neonatal and post neonatal period. For neonatal deaths, 72.0% were due to conditions originating in the perinatal period, 22.0% by congenital malformations, deformations, and chromosomal abnormalities. For post-neonatal death, 25.3% of deaths were due to sudden infant death syndrome (SIDS), followed by 16.8% due to congenital malformations, deformations, and chromosomal abnormalities.

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality. There has been very little change in the VLBW and LBW rates in Louisiana (See Appendix A, Figure 6). In 2003, the VLBW rate was 2.2% and the LBW rate was 10.7%. In the black population, 15% of all births were LBW compared to 7.7% in the white population. This racial disparity can also be seen in the VLBW rate (black=3.5%, white=1.2%).

Prior to 2000, Louisiana experienced an overall decreasing trend in the **child death rate**; since 2000, the rate has increased from 30.8 deaths per 100,000 children to a rate of 34.8 deaths in 2002. Preliminary data for 2003 shows the increasing trend may be reversing; the 2003 preliminary child death rate is 26.5. Louisiana's child death rate remains higher than the 2002 national rate of 21.4 deaths per 100,000 children. For the period 2000 to 2002 the death rate was higher in early childhood, 52.1 deaths per 100,000 children aged 1 -4 years, compared with that in late childhood, 25.3 deaths per 100,000 children aged 5 - 14 years. While there was an ethnic disparity in the death rates among the early childhood population (1.7 times more for blacks than whites), there was essentially no ethnic disparity in late childhood. The early child death rate ranged from 37.2 to 67.9 in the state's nine Public Health Regions. The late child death rate ranged from 22.2 to 31.5 in the state's nine Public Health Regions.

The leading cause of deaths in children aged 1 to 14 was **unintentional injury** followed by **congenital anomalies and homicide**. The rate for unintentional injury deaths in children aged 14 and younger (Health Status Indicators #3A) has been stable from 1999 to 2002. **Motor vehicle crash (MVC)** deaths (National Performance Measure #10 and Health Status Indicator #3B) accounted for the largest number of injury deaths. **Fire and drowning** were the second and third leading cause for death due to unintentional injury. For the period 1999 to 2002, the rate of deaths due to MVCs has been stable, staying between 6.7 and 7.2 deaths per 100,000 children. Preliminary data from 2003 indicates a decrease in the rate for MVCs to 4.6 deaths Statewide; MVCs was the leading cause of death in all of the public health regions that had a sufficient number of deaths to allowing analysis. In the later childhood period, unintentional injury was still the leading cause of death followed by cancer and homicide. (See Appendix B, Table 2)

Maternal, Infant, and Child Morbidity:

Substance use during pregnancy is a problem for certain subpopulations of women in Louisiana. Approximately 4.9% of women in Louisiana reported drinking **alcohol** during their pregnancy in 2002. **Smoking** during pregnancy has been associated with poor perinatal outcomes and low birth weight. According to a 1998-2002 LaPRAMS study by the MCH Program, the rates of maternal smoking have not significantly decreased (13.9%, 12.4%, 12.1%, 10.4%, and 11.9% for 1998 to 2002 respectively). Maternal smoking among whites and blacks occurred more frequently among lower socioeconomic groups and less educated individuals. The LaPRAMS study also revealed that whites smoked more before (33%), during (18%), and after pregnancy (27%) than blacks (10%, 5%, and 9%). White women dealing with a drug and/or alcohol problem were approximately twice as likely to smoke before, during, and after pregnancy than blacks. Stressful events can also play a role in maternal smoking. The study also indicated that the

stress of losing a job increased the risk of smoking before pregnancy for blacks, and that women not being able to pay bills were more likely to smoke during pregnancy.

Studies have demonstrated an association between **maternal depression** and decreased maternal reactivity/sensitivity to infants. Children of depressed women are also at an increased risk for suffering depression, child abuse, and conduct disorder. (Beck CT, *The Effects of Postpartum Depression on Maternal-Infant Interaction: A Meta-Analysis*. Nurs Res 1995). The MCH Program performed a study using 2000 -2001 LaPRAMS data to investigate the determinants of self-reported depression among postpartum mothers in Louisiana. The study showed approximately 9% of postpartum women reported being very depressed, 14% reported being moderately depressed, and 77% reported little or no depression. The study identified stressors such as emotional, partner-associated, financial, and physical abuse to be associated with depression. Women in Louisiana who had an unintended pregnancy were also more likely to experience depression after their pregnancy.

There is limited population based data that can be used to describe morbidity in the childhood period. **Child Abuse:** The rate of child abuse and neglect is used as an indicator of the breakdown in the parent/child and family system. The MCH program tracks the incidence of child abuse and neglect in its State Performance Measure #3, the rate of children under 18 who have been abused or neglected as reported as validated cases of child abuse and neglect. In recent years, there has been a slight decrease in the rate of children under 18 who have been abused or neglected; the rate fell from 8.3 per 1,000 children birth to 17 years in 2002 to 7.9 in 2003. Cases of child neglect comprises approximately one third of the validated cases.

The Louisiana Childhood **Lead Poisoning** Prevention Program has a population based surveillance system based on laboratory reporting of all blood lead tests. In 2003, 18% of children aged 6 months to 6 years were screened for lead poisoning. Five percent of the children screened for lead poisoning had a blood lead level equal to or greater than 10 ug/dl. The national rate is 2.2%. Through the population based lead surveillance system, high risk areas in Orleans Parish and North Louisiana have been defined and targeted for lead elimination efforts.

Provision of risk-appropriate prenatal care services: Risk-appropriate prenatal care services play an important role in identifying medical and behavioral factors that can cause poor birth outcomes. In 2003, 84.1% of women (75.5% black women and 90.1% of white women) entered prenatal care during their first trimester. Many areas in Louisiana continue to lack adequate access to prenatal care services; four out of nine of Louisiana public health regions listed prenatal care as a major need.

Provision of preventive health care services including screening, immunization, and health and parenting education, is essential in maintaining and improving the health of infants, children, and adolescents. Although there has been progress in decreasing financial barriers that affect access to health care services for low-income infants, children, and adolescents through the Medicaid Louisiana Child Health Insurance Program (LaCHIP), access to health care services remain a problem in many areas of the state. Even though the rate of uninsured children has decreased from 24% in 1998 to 11% in 2003 overall,

estimates indicate that a large percentage of the uninsured children are eligible for Medicaid. A lack of health care providers, in general, as well as the number of providers available to see Medicaid clients creates a barrier. This lack of providers coupled with lack of publicly supported transportation systems and Medicaid policies that limit the distance that clients can be transported make access to care even more difficult.

Since 1999, Louisiana has experienced a decline in the percent of 19 to 35 month olds that receive the full schedule of age appropriate immunizations. In 2002, Louisiana reported its lowest immunization rate in four years with only 61% of 19 to 35 month olds receiving the full schedule of age appropriate immunizations. Efforts to increase coverage have resulted in a rate of 66.2% in 2003.

Adolescent Morbidity and Mortality:

The main threats to the health of adolescents (10-24 years) are the choices they make and risky behaviors in which they partake. The six main categories that encompass the major causes of morbidity and mortality in the adolescent population are unintentional and intentional injury, tobacco use and substance abuse, reproductive health, mental health, chronic disease and health promotion, and access to care. The top five **leading causes of death** for all adolescents in Louisiana from 1999 through 2002 were **unintentional injury (43%), homicide (19.8%), suicide (9.2%), malignant neoplasm (4.7%), and heart disease (3.3)**. The top three causes of death for white youth in Louisiana were unintentional injury (56.6%), suicide (13.3%), and homicide (5.8%). For black youth the top cause of death was homicide (36%), followed by unintentional injury (28.5%), malignant neoplasm and suicide tied each contributing to 4.4% of adolescent deaths. (Center for Disease Control, WISQARS, 2003).

In 2002, the leading cause of death for all adolescents was unintentional injury. Sixty-five percent of all deaths due to unintentional injury (397 deaths) were caused by motor vehicle crashes (MVCs). Alcohol was involved in 29% of the MVC related deaths, and among these deaths, 77% of the youth were unrestrained (NHTSA, 2003). The rate of MVC related deaths in Louisiana, 25.4 deaths per 100,000, is higher than the national rate of 20.9 deaths per 100,000 adolescents age 10 to 24 years. In Louisiana adolescents aged 15 to 19 years have the highest rate of deaths due to MVCs, 34.6 per 100,000 (US=27.7); nationally adolescents aged 20 to 24 have the highest rate of deaths due to MVCs, 28.7 deaths per 100,000 (LA=33.3). MVCs also account for the majority of non-fatal unintentional injuries; according to the 2001 Louisiana hospital discharge data, the rate of nonfatal injuries due to MVCs was 124.0 per 100,000 10 to 24 year olds and 147.9 per 100,000 15 to 19 year olds.

Risky behaviors that adolescents engage in can lead to **pregnancy or sexually transmitted diseases (STDs)**. In 2003, 14.4 % of Louisiana births were to teens. Chlamydia and gonorrhea continue to be a problem in the state. Gonorrhea and Chlamydia are more prevalent among the adolescent population than other age groups. By age 21, one in five young adults will have received treatment for an STD. In 2002, there were 11,396 cases of gonorrhea reported in Louisiana; 26.9% of the cases occurred among teens aged 15 to 19 year old, and 38.3% of the cases occurred among 20 to 24 year olds. The Louisiana

chlamydia rate for 2002 was 413 per 100,000 populations. Eighty percent of reported cases of chlamydia in Louisiana in 2002 occurred in females; 35.4% of cases occurred in the 15 to 19 year age group, and 41.4% among 20 to 24 year-olds. In 2003, Louisiana remained the leading state in prevalence of gonorrhea and became the state with the second highest prevalence of chlamydia in the nation (up from fourth in the nation the previous year). Louisiana also ranked 5th in the nation for cases of HIV/AIDS, and 10th in the nation for newly diagnosed cases. Nineteen percent of new AIDS cases and 20% of people living with HIV/AIDS in 2002 were between the ages of 15 and 24 years old (Louisiana STD Annual Report, 2002).

Among adults, cardiovascular disease is a leading cause of death. Behaviors engaged as an adolescent can influence cardiovascular disease in later life. According to the 2002 Communities that Care Survey, **alcohol** is the most commonly used substance among adolescents in Louisiana. The average age for initiation of alcohol use was 12 years. Approximately 29% of 6th, 8th, 10th and 12th graders surveyed stated that they had used alcohol in the past month and 53.6% reported using alcohol at least once in their lifetime. **Cigarettes** were the second most commonly use substance by 6th, 8th, 10th, and 12th graders in Louisiana. The greatest increase in cigarette usage occurred in the 8th grade, roughly the same time regular alcohol consumption began.

Total crime arrest statistics for Louisiana are available for 1998 only. In that year, the rate of **juvenile arrests** was 11,090/100,000. In the nation, total juvenile arrest rates in 1998 rate for juveniles were 8,408/100,000. During 2002, in Louisiana, 403/100,000 adolescents were arrested for violent crimes, 2,161/100,000 adolescents were arrested for property crime, 602/100,000 were arrested for drug abuse, and 91 per 100,000 adolescents were arrested for weapons (*OJJDP Statistical Briefing Book*).

Adolescent health care services in Louisiana are extremely fragmented. The MCH Adolescent School Health Initiative funds and provides technical assistance to School Based Health Centers (SBHCs). Louisiana is at the forefront of the SBHC movement with 56 SBHC's in 23 parishes (See Needs Assessment Appendix C, Map 2), providing convenient access to comprehensive, primary and preventive physical and mental health services for public school students. The SBHCs provide access to approximately 50,000 students during the school year.

Nutritional Health Status:

Inadequate weight gain during pregnancy has been strongly and consistently associated with poor neonatal outcomes, especially low birth weight and very low birth weight. An analysis of the Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS), using data collected during 1998 and 1999, identified **inadequate prenatal weight gain** as an important risk factor for low birth weight. Over 33% of pregnant women in Louisiana did not gain adequate prenatal weight as recommended by the Institute of Medicine. Twelve percent of the women who did not gain enough prenatal weight delivered low birth weight infants, as compared to 7% of women who gained adequate prenatal weight.

The study also showed that the women who had a pre-pregnancy BMI of underweight were more likely to have inadequate prenatal weight gain. Thirty seven percent of women who had a pre-pregnancy BMI of underweight did not gain enough prenatal weight as compared to 27% of women with a pre-pregnancy BMI of normal and overweight. Louisiana MCH Program has implemented initiatives to address this issue, including presentations to health professionals, mailings of educational materials and clinical tools to health professionals, and media campaigns.

The Pediatric Nutrition Surveillance System (PedNSS) collects information on nutritional parameters among children under 5 years who are enrolled in the Women, Infants, and Children Supplemental Food Program (WIC). The percent of children who are **overweight** in Louisiana is 13.3% compared with a national percentage of 14.3%. Louisiana's State Performance Measure #5 tracks the percentage of children (2 to 5 years) on WIC greater than or equal to the 95th percentile for BMI-for-age. This measure indicates an increasing trend in children on WIC at or above the 95th percentile. In 1999, 11.5% of WIC children were at or above the 95th percentile compared to 13.5% and 13.3% in 2002 and 2003. Information from PedNSS indicates that the percentage of young children on WIC with anemia is 14.9% compared with 13.1% nationally.

Oral Health Status:

Fluoridation is one of the most effective, safe, and economical ways to provide caries prevention to the population. Only 43% of Louisiana residents receive the benefits of fluoridated water. Almost all the community water fluoridated parishes are in the southeast portion of the state, leaving the west, central and northern parts of Louisiana without community water fluoridation (See Needs Assessment Appendix C, MAP 3). These areas are also very rural with few Medicaid dental providers, increasing the burden of dental caries on the children in these parishes.

Poor children in Louisiana have many oral health problems. Children from families with low incomes and who are Medicaid-eligible, have more **untreated dental caries** than children from higher income families. These children suffer from dental disease at a rate almost five times greater than their more affluent counterparts, according to the US General Accounting Office, *Oral Health Dental Disease is a Chronic Problem among Low-Income populations and Vulnerable Populations (2000)*. Preventive dental services for these children are very limited. Almost half of the children under age 18 are Medicaid-eligible in Louisiana. In 2003, 694,234 children were enrolled in the Medicaid Program; yet only 200,154 or 28.8% of the eligible children received at least one dental service in that year. Based on data from the 2002-2003 Nurse Screening Survey conducted on 871 Louisiana 3rd graders in 39 schools across 7 parishes (Jefferson, Caddo, St. Landry, Lafourche, Beauregard, Sabine and Plaquemines), only 18% of the surveyed children had **dental sealants** on their first permanent molar; this is down from 22.1% assessed in 1998. An analysis of 2003 Medicaid data for Jefferson, Caddo, St. Landry, Lafourche, Beauregard, Sabine and Plaquemines parishes also revealed an 18% of Medicaid-eligible children age 6-9 received at least one dental sealant. However when the statewide Medicaid data was analyzed it showed that only 7.9 % of all

Medicaid-eligible children age 6 to 9 in Louisiana received the protective benefit of dental sealants (See Needs Assessment Appendix C, MAP 4). According to the statewide Medicaid data analysis, Louisiana is well below the HP2010 target and well below the national average of 50% and 23% respectively.

Louisiana ranks 49th in the nation in low birth weight births and research has shown that a pregnant woman with periodontal disease has a higher risk of delivering a premature infant. According to Louisiana Medicaid data, 12.7% of Medicaid-eligible pregnant women delivered low birth weight babies as compared to 7.4% among the non-Medicaid population. Until November 2003, dental services for Medicaid-eligible pregnant women were unavailable. Limited dental services are now available to these women, but the medical providers are finding it difficult to find a dental provider willing to treat these patients. The Centers for Disease Control and Prevention performed an analysis on Louisiana Oral Health LaPRAMS 1998-2000 data and found that women who did not seek dental care during pregnancy were more likely to have a low birth weight baby compared to women who sought dental care during pregnancy. The data revealed that 5.8% of women who sought dental care during pregnancy gave birth to an infant weighing < 2500 grams as compared to 9.5% of women who did not seek dental care during pregnancy and gave birth to an infant weighing <2500 grams..

Priority Health Problems:

A **high infant mortality rate** continues to be one of the major concerns of the Louisiana MCH Program statewide. Reducing the numbers of **preterm births, LBW babies, and SIDS** deaths are needs that could influence infant mortality in Louisiana. There are areas of the state with particularly low rate of early entry into prenatal care, high infant mortality, and high LBW rates; these areas, along with areas that have prominent racial disparities in these indicators, will be targeted for interventions.

Although Louisiana has seen a recent increase in the percent of women entering into prenatal care during their 1st trimester, **inadequate access to and availability of comprehensive prenatal care** is still a top concern of the MCH Program. Five of the nine public health regions ranked access to prenatal care as a major problem in their area; and six of nine public health regions rated accessibility of prenatal care moderate to poor. The state continues to lack adequate private prenatal care providers and high-risk OB services in rural areas. Local arrangements with prenatal care and transportation providers are needed in underserved areas.

Assuring psychosocial risk assessment and case management components of prenatal care is crucial to meeting the social, emotional, and psychological needs of pregnant women, especially those at risk for poor birth outcomes. **Mental health services/treatment** for pregnant women was the number one need and listed as the least accessible service by the public health regions.

Access to care is also a priority health concern for children. Many children in Louisiana lack access to a medical home to provide quality, comprehensive, and continuous care. Seven of nine the public health regions rated access to care as a major need in the state. Also lacking are services that address **children's social, emotional, and psychological needs. Mental health services and education** for

children and adolescents was the most reported need by the public health regions. Improving the infrastructure and coordination of services for children and families would result in improved access and quality in both primary care and mental health, and is a priority for the MCH Program.

Decreasing intentional and unintentional injury is essential if Louisiana is to improve the rates of child and adolescent mortality and morbidity. Especially concerning are the areas of family violence and firearms. Other priority areas for adolescents include the need to reduce substance use and risky sexual behaviors in order to influence rates of teen pregnancy, sexually transmitted disease, and injuries. Nutrition counseling and education must be integrated into health services in order to influence infant and child morbidity and mortality, and the lack of access to nutrition services is a problem. These services are especially needed to address the state's growing problem of **obesity** in children.

The MCH Program is also concerned with the **oral health** children and pregnant women in Louisiana. Oral health related morbidity can be reduced by increasing community water fluoridation, increasing access to dental services for children and pregnant women. Increasing the number of dental providers that treat Medicaid-eligible children and pregnant women is a priority of the MCH Program.

Gaps in Health Services:

Although there is a publicly financed system of health services through the state-supported hospital system and the parish health units, the degree of coordination varies in different areas of the state. There is also an overall lack of coordination of services between the private and public sector. Although there are some local initiatives to improve access to health care for individuals in rural areas, much needs to be done to assure that a quality system of health care services that is coordinated and allows pregnant women, infants, children, adolescents, and their families access to quality, comprehensive, continuous care exists in all areas of the state.

Medicaid is one of the most common sources of coverage for prenatal care; however, parish health units and the system of State-supported hospitals continue to serve as a safety net for maternity patients without Medicaid or other health insurance or in areas where there is a shortage of private health care providers. Lack of private physicians who accept Medicaid is a significant barrier throughout much of the state.

Medicaid expansions have helped to provide health coverage for many low income infants, children, and adolescents, and pregnant women. Although there has been great progress in decreasing financial barriers through changes in the Medicaid Program and through the LaCHIP and LaMOMS , access to child health care services and prenatal care services remain a problem in many areas of the state, especially in rural areas. **A lack of health care providers** in general, as well as in the number of providers available to see Medicaid clients, creates a barrier.

Transportation is also a major barrier for pregnant women and children. There are few publicly-supported transportation systems and Medicaid policies limit the distance that clients can be transported for services.

Dental services are now provided to Medicaid-eligible pregnant women; however, the number of dentists who accept Medicaid patients is insufficient. Sealants use, an excellent preventive measure, needs to be more widely utilized; sealant programs could reach the populations most susceptible to dental caries. Although fluoridation is the safest, most cost effective way to reduce caries prevalence, fluoridation is underutilized in Louisiana. Many water systems need to repair or replace outdated and broken equipment in order to fluoridate their water.

The existing services for adolescents are fragmented. OPH clinics serving adolescents often are not open during non-traditional hours; do not provide walk-in services; are not youth friendly; have services that are compartmentalized and not comprehensive (i.e., Sexually Transmitted Disease Clinic, Family Planning Clinic); and lack continuity with a consistent provider. There are major gaps in physical and mental health services for youth. These gaps include: inadequate prevention programs/out of school programs designed to bolster family support and to curtail risky behaviors; lack of outpatient mental health, substance abuse and social services for youth; lack of comprehensive health education; and lack of residential treatment centers for emotionally disturbed, behaviorally disordered adolescents.

2.2.1 Direct/Enabling Health Care Services

Louisiana is a predominantly rural state. There are nine state-supported hospitals, 70 Office of Public Health Parish Health Units, six locally supported Health Units, 49 Rural Health Clinics, and 27 Federally Qualified Health Centers (See Needs Assessment Appendix C, Map 5). Despite this, there is evidence of an overall lack of primary care health in many areas of the State. Currently, 56 of the state's 64 parishes are designated as a Health Care Professional Shortage Area (HPSA) for Primary Care; an additional three parishes have applications submitted for approval as HPSA designated areas (See Needs Assessment Appendix C, Map 6). Louisiana also has a shortage of dental providers and mental health providers (See Needs Assessment Appendix C, Map 7).

Pregnant Women

As part of the needs assessment, Louisiana's regional Infant Mortality Reduction Initiatives (IMRIs) assessed the availability and accessibility of health services such as pregnancy testing, prenatal care, home visiting, substance abuse/mental health assessment and treatment, family planning, HIV counseling & testing, infant sleep position and education, and breast feeding promotion. All services are available within Louisiana's 9 regional IMRI and Orleans parish's IMRI, although not all services are available within each parish of the regions. The least accessible services in the state were programs addressing violence, substance use, and mental health, followed by home visiting services. The most accessible services are pregnancy testing, health education and counseling for WIC participants, HIV

counseling and testing, and infant sleep position and environment education. See Appendix D, Regional Perinatal Needs Assessment Results for Table of Availability/Accessibility of Services.

Financial Access

In order to make prenatal care available to more pregnant women, the Louisiana Department of Health and Hospitals implemented LaMOMS on January 1, 2003, as a no-cost health coverage for any pregnant women, married or single, who falls into new expanded income guidelines. Income eligibility limits were expanded at this time for pregnant women from 133% to 200% of Federal Poverty Level. For example, a woman in a family of four (the unborn child is included in the family size) can have a monthly household income up to \$3,225 and still qualify for this program. Income limits increase each year on April 1st.

Many pregnant women who apply and are eligible for LaMOMS health coverage are now receiving their Medicaid card in less than a week, due to collaboration between Medicaid and MCH. This means pregnant women can begin receiving important prenatal care sooner, due to new Medicaid policies and procedures for priority processing of their applications. Early prenatal care is considered to play a role in reducing low birth weight babies and infant mortality –two health indicators that Medicaid and MCH are working to improve. Prior to these recent changes, some applicants throughout the state waited as long as eight weeks between applying for LaMOMS and getting enrolled into the program.

In January 2005, Medicaid processed 4,187 LaMOMS applications and the statewide average number of days from application to a decision was only five days. LaMOMS pays for pregnancy-related services, delivery and care up to 60 days after delivery including doctor visits, lab work/tests, prescription medicines, dental care for periodontal problems, and hospital care. LaMOMS pays for services of any doctor who is enrolled as a Medicaid provider. The program also covers up to three months prior to application if the pregnant woman was eligible on the date the service was provided. The Medicaid/LaMOMS program covered approximately 58% of deliveries in Louisiana during the 2003-2004 Fiscal Year.

Some women who seek coverage from the LaMOMS Medicaid program, obtain a pregnancy test at the Parish Health Units statewide, apply for LaMOMS, and once approved, will then continue their prenatal care with a private obstetrical provider. Parish Health Units and the Charity Hospital statewide continue to see those women who do not qualify for Medicaid, or choose to get their care at that site. The result has been a decreasing maternity caseload in the public health system, and a need for greater public health interaction with the private sector. The public health units and state hospital system do continue to play a significant role in providing maternity services in areas where there is a shortage of health care providers. In 2004, there were approximately 70 parish health units in locations throughout the state. Not all of these units currently provide comprehensive prenatal care, but approximately 24,000 women received a pregnancy test or health education service at one of the state public health clinics or contract sites. There were 4,506 women who received comprehensive prenatal care funded by MCH.

In 2002, PRAMS data reported that 70% of women received most of their prenatal care at a private doctor's office; 15% at a hospital clinic; 4% at a health department clinic; 5% in a primary care setting or a community health center; 2% at a state hospital. The 2002 PRAMS stated that 69% of the women reported Medicaid status. Approximately 59% of the births in Louisiana in 2003-2004 fiscal year were reported to be Medicaid.

After expiration of Medicaid coverage, uninsured women have limited access to care within the public health clinics, including family planning services and STD services. The state hospital system, rural health clinics, and FQHCs also provide care to the uninsured on a sliding scale fee schedule. Expansion of family planning related coverage for LaMOMS recipients to two years post-delivery and possible coverage of reproductive age women below 200% of the federal poverty level are currently under discussion with the state Medicaid program and the Governor's office.

Illegal aliens, legal aliens, and others who do not qualify for Medicaid may still access prenatal services through the public health clinics and contract sites. They are eligible for emergency services and/or emergency labor and delivery services. When the child is born, the child is automatically enrolled in LaCHIP.

Availability

The rural nature of much of Louisiana creates a shortage of women's health care providers in those areas. Many parishes do not have OB/GYN services. While improvements have been made in the number of providers accepting Medicaid, access continues to be a problem. (See Needs Assessment Appendix C, Map 8). Certified nurse midwives only practice in a few urban regions of the state. Nurse practitioners and physician assistants are playing a much larger role in the state within the last 5 years, but Louisiana still ranks high in shortage of obstetric care providers.

In areas of insufficient prenatal care providers, the parish health units, contract sites, and state hospitals serve as the safety net provider. Louisiana also has a network of rural health clinics and an increasing number of federally qualified health clinics (FQHC). While most of these clinics do not provide prenatal care, some FQHCs (Region 8) do deliver significant services to pregnant women. When areas have significant problems with access to care, efforts are made to enhance local care through either existing providers or new contract services. In Region 7 (Shreveport), zip codes of excessively high infant mortality were identified; a partnership was developed with LSUHSC-Shreveport to create a program to address the community's needs in these areas. Contracts were established to create new prenatal clinics in these areas, with nurse practitioners. In the Greater New Orleans area, MCH is the safety net for those women needing maternity services if they are uninsured or do not qualify for Medicaid LaMOMS. The Daughters of Charity Clinic provides culturally and linguistically appropriate primary care for Hispanics, including primary care through the Latino Clinic at Daughters of Charity Health Center. Even with the many challenges, Louisiana performance in early entry into prenatal care compares favorably to similar states.

The MCH Program, also, contracts with the Medical Center of Louisiana to provide comprehensive screening and treatment for substance abusing pregnant women through the Perinatal Enrichment Program (PEP) in New Orleans. In 2004, 1,423 pregnant women were screened using the 4P's Plus screening tool; 173 of the women screened were enrolled in PEP. The program provides a system of coordinated services to high-risk substance abusing women and their drug exposed infants during the perinatal period that addresses their physical and psychological needs. PEP identified reliable transportation to address one of the barriers to participation in outpatient group activities. PEP women receive preferential admittance to resident housing and support services.

Transportation to care is still identified as a barrier to care in some regions of the state. Both Region 6 (Alexandria) and Region 8 (Monroe) identified transportation as a major barrier for prenatal care in their regional needs assessments. While Medicaid does cover non-emergent transportation services, in rural areas the services are occasionally insufficient to meet needs. In urban areas, transportation issues mostly revolve around bus schedules and limited routes.

Subspecialty services are generally available only in the larger urban areas. Most regions do not have local Maternal Fetal Medicine consultation services available and patients must travel significant distances (often over 100 miles) to access such services.

Culturally appropriate care also affects availability of services. Louisiana is primarily composed of two races, black and white. Less than 5% of the population is classified as "other" and 2.4% of the Louisiana population is Hispanic. Limited culturally and linguistically appropriate services are available to the Spanish-speaking migrant population and the Vietnamese population. Social services are available through the New Orleans Archdiocese Catholic Social Services. The MCH Program supports this population by providing maternity services in clinic sites in the Greater New Orleans area. For example, the Daughters of Charity Health Center has a Latino health clinic and provides maternity services for the uninsured and the non-Medicaid eligible. The Hispanic population represents approximately 16% of the Daughters of Charity Clinic clients. Louisiana has four federally recognized and six state recognized Native American tribes. Limited services are available to those tribal groups that are neither state nor federally recognized.

Case management and home visiting services enable high risk families to access the wide range of services needed for a healthy pregnancy. The Nurse Family Partnership (NFP), an evidence based intervention, serves to improve the health and social functioning of low-income first time mothers and their babies. This program begins during pregnancy and continues to the child's second birthday. It uses nurse home visitors to work with families to accomplish three goals: improve maternal and child health outcomes, teach and foster parenting skills to assure optimum child development, and to help women get their lives on track by going back to school or joining the work force. NFP also provides mental health services to their population. The NFP program is available in all regions of the state. However, several

regions recognize the need for expansion of this program. Expansion and continuation of these programs is tied to Medicaid reimbursement and could be adversely impacted by budget considerations.

Outreach services play an important role in enabling pregnant women to access prenatal care. The MCH Program has contracts to supplement the services of the four Healthy Start sites that are responsible for implementing a comprehensive prenatal care program that includes outreach, case management, prenatal education and counseling for all clients. Healthy Start grantees are in New Orleans, Baton Rouge, Lafayette, and North Louisiana.

The MCH Louisiana Risk Assessment tool which includes questions on domestic violence, depression, and substance abuse was piloted in 2004, in four Louisiana parishes. Women who show that they would benefit from receiving mental health counseling are referred to the Office of Mental Health (OMH), Early Childhood Supports and Services (ECSS) program or other appropriate referral sources.

Proper nutrition and weight gain are recognized as important to optimal pregnancy outcomes. Louisiana has a strong WIC program, with an average of 35,397 women participating each month in fiscal year 2004. Of these women, 18,854 are pregnant, 13,062 postpartum, and 3481 breast-feeding. In addition to providing nutritional education, counseling and vouchers, the WIC program has piloted screening to identify pregnant and postpartum women for depression, substance abuse and domestic violence risks. Interventions and referrals are made as indicated.

Infants and Children

Access to and availability of primary health care providers is a major concern for infants and children in Louisiana. An inventory of licensed Primary Care Providers by parish of residence in 2003 showed that 38 (59%) of the state's 64 parishes had two or fewer pediatricians: 20 not having any pediatricians, 11 with one pediatrician, and seven with two pediatricians. The survey also revealed regional differences in the availability of primary care providers who accept Medicaid clients and who were open to accepting new Medicaid clients (See Appendix B, Table 3).

Financial Access

Privatization of health services has led to a decrease in the state Office of Public Health providing direct preventive health services for low-income, uninsured children. The number of children receiving complete screening services has decreased to approximately 2,979 children. The public health units do continue in the role of providing preventive services in areas where there is a shortage of health care providers. The nine state-supported hospitals located throughout the state continue to provide services for the uninsured as do the 27 Federally Qualified Health Centers. The OPH public health units in conjunction with the nine state supported hospitals provide a "safety net" for no- or low-cost preventive and primary care services for low income, uninsured children; especially for children living in HPSA primary care

provider shortage areas. A hospital nurse coordinator, an OPH employee, is housed in each of the state-supported hospitals and assists in transferring information between the hospital and the public health units.

The Medicaid Program has addressed some of the problems of access to primary and preventive care for children enrolled in the Medicaid program through the implementation of the Community Care Program, a primary care case management program for Medicaid enrolled children. Financial barriers to these services remain for the estimated 11% of uninsured children in the state. Medicaid reimbursement levels present a financial barrier to specialty and sub-specialty care. This is particularly true for mental health services through the Medicaid Program.

Availability

Privatization of health services has led to a decrease in the role of the state Office of Public Health in providing direct services for low-income, uninsured children. The number of children receiving complete screening services has decreased to approximately 6,000 children. The public health units do continue in the role of providing preventive services in areas where there is a shortage of health care providers. The nine state-supported hospitals located throughout the state continue to provide services for the uninsured as do the 27 Federally Qualified Health Centers. The OPH public health units in conjunction with the nine state supported hospitals provide a “safety net” for no- or low-cost preventive and primary care services for low income, uninsured children; especially for children living in HPSA primary care provider shortage areas. A hospital nurse coordinator, an OPH employee, is housed in each of the state-supported hospitals and assists in transferring information between the hospital and the public health units.

The Medicaid Program has addressed provider availability for children enrolled in Medicaid through its primary care case management program, Community Care. Through this program, all children enrolled in Medicaid are linked with a primary care provider who is responsible for providing a medical home. A survey of 1,159 primary care providers that was conducted by the Office of Public Health Children's Special Health Services Program found that 53% of Primary Care Providers in Louisiana accepted Medicaid. Unfortunately, 13% of those providers are at their maximum and are not accepting new patients. A Review of the screening and participation reports for the Louisiana's Early Periodic Screening Diagnosis and Treatment (EPSDT) KIDMED Program in 2003 found that overall, 59% of children from birth through age 20, had received at least one EPSDT screening. This participation rate varied in different age groups with the rate at 87% for infants, 70% for 1 – 2 year olds, 56% for 3- 5 year olds, 62% for 6-9 year olds, 49% for 10-14 year olds, 48% for 15-18 year olds, and 20% for 19-20 year olds. The decrease in participation in EPSDT that occurs with increasing age indicates the need for systems to adapt to the circumstances required to provide preventive services for school age children, such as school-based or school-linked services.

In addition to direct medical services for children, there is a need for additional health and social services to enhance and assure availability of services for these vulnerable populations. This is especially

true for children who are at high risk for social and emotional as well as medical problems. Health services should include nutrition services, nursing case management, parenting and health promotion education, and home visiting. Social services should include assessment and support services with referral to community programs to assist families in meeting their needs.

Social work services are available in some areas of the state to provide assessment, counseling, and referral services to those identified with additional psychosocial needs. Unfortunately, the number of social workers available through the State Office of Public Health has decreased over the past few years. The mental health provider situation is dire for children in Louisiana, with many areas in the state not having available mental health services. In most instances mental health services are only available for children with the most severe mental health needs. There are very few public-supported mental health services for children under the age of 5 years. Clinicians need to be trained to provide service for this age population.

Enrollment in the Medicaid Program for the Medicaid-eligible population is the first step in providing access to available health services. Outreach plays an important role in reaching the Medicaid-eligible population. Screening for Medicaid-eligible WIC clients and providing information and assistance to these clients applying for Medicaid is an ongoing activity in the Public Health Units. Other community based outreach efforts for Medicaid include the Regional LaCHIP Outreach Coordinators and a Robert Wood Johnson Covering Kids & Families outreach grant.

Public Health Units are the primary providers of WIC Services in the State. The WIC program provided services to approximately 107,237 infants and children in 2004. There is the opportunity to provide health education in addition to nutrition education to users of WIC services who may not receive these services from their private medical private provider. In 2002, there was a 30% increase in the number of nutritionists in OPH, substantially improving the availability and access to specialized nutritional services. The increase in nutritionists allowed for 28,390 families with children to have nutrition counseling sessions in 2003.

Transportation is a major problem in this state with its large rural area. Although the Medicaid Program does provide transportation, issues of provider reliability and limits on travel distance present a problem for many clients. Furthermore, Medicaid transportation for OPH sponsored mental health services provided by licensed social workers, licensed marriage and family therapists, and licensed psychologists are not available at this time.

Specialty care services are located primarily in the eight urban areas of the state. Although Medicaid will pay for specialty services for conditions found through EPSDT screening, there are limited numbers of specialty providers who accept Medicaid clients.

While the non-white and non-black Hispanic and the Asian population groups make up a small part of the overall child population, access to health care and health related services present challenges to them. The Asian population, which comprises approximately 1.3% of the population, tends to live in specific areas in Louisiana, as do the 2.6% Hispanic population. These groups have significantly different

language and cultural beliefs, which may affect their access to health services. The Hispanic population, through migrant work and industry work such as poultry processing, are becoming more numerous in Louisiana. Besides printed information in Spanish and Vietnamese, outreach efforts to these groups in many areas are limited. It is necessary to learn more about these communities and to find out what their needs are and to specifically target them for needed health and mental health services.

Adolescents

Health services for adolescents are very disjointed, often times split between various agencies. Enabling services play an important role in accessing health care for adolescents.

Financial Access

The number of adolescents who have access to healthcare has greatly increased since the implementation of the LaCHIP program in 1998. Prior to LaCHIP, Medicaid only insured adolescents aged 14 to 18 at TANF income levels of less than 14% of the FPL (See Appendix A, Figure 7). At that time a total of 319,156 children and adolescents were insured through this program. After LaCHIP was implemented, criteria to receive public insurance gradually increased to include those adolescents aged 10-18 who fell at or below 200% of the FPL. Among adolescents aged 13 to 19 the percent insured increased by 200% (from 47,396 prior to LaCHIP to 141,875 with LaCHIP).

Although Medicaid/LaCHIP has made great progress in providing insurance for the children and youth of the state, it still only provides insurance for those who fall at or below 200% of FPL. Medicaid/LaCHIP coverage for mental health services is limited to services provided by Office of Mental Health, mental health rehabilitation centers, and services provided through school systems.

Availability

A statewide focus group for the Adolescent Health subgroup determined access to health care; access to, as well as availability of mental health care; and substance abuse treatment and prevention services as the top three needs of Louisiana adolescents. Mental health care and services including treatment for co-occurring conditions are a large unmet need. Statewide, particularly in rural Louisiana, there is a shortage of psychiatrists and mid-level child mental health providers. To help address the availability of care for adolescents, Louisiana has 56 School Based Health Centers (SBHCs) in 23 parishes, which provide convenient access to comprehensive, primary, and preventive physical and mental health services for public school students. Approximately 50,000 students during the 2004-2005 school years will have access to a SBHC.

Transportation is a major barrier for adolescent health care in both urban and rural Louisiana. To address this barrier some of the SBHCs in Louisiana provide transportation for students from outlying schools. LaCHIP outreach plays an important role in health care access for adolescents. The SBHCs are official enrollment centers for LaCHIP. MCH staff also promoted LaCHIP at Department of Education

conferences statewide. Outreach and registration is very high across the state in all SBHCs. Eighty-three percent of students who had access to SBHCs were registered in the SBHC during the 2003-2004 school years.

One limitation to comprehensive preventive care is the fact that the SBHCs, by law, are not allowed to distribute contraception. The numbers of SBHC's have steadily grown in Louisiana from 40 SBHCs during the 1999-2000 fiscal year to 56 for the 2004-2005 fiscal years. Currently the 56 SBHCs are in 23 parishes in Louisiana and provide access to primary and preventive care to over 50,000 youth.

Oral Health

Financial Access

Louisiana has too few dentists accepting Medicaid dental patients for treatment. Louisiana currently has 2,385 licensed, however, only 935 dentists are enrolled in the Medicaid program. Of these 935 dentists enrolled in Medicaid only 638 treated a Medicaid-eligible recipient in 2003. Of these only 374 dentists billed Medicaid for \$10,000 or more in fiscal year 2003. Eleven parishes did not have a dental provider who billed at the \$10,000 level and two parishes did not have a Medicaid dental provider in that parish.. Many parishes have too few dental providers and the waiting list for services can range from 6 months to a year.

EPSDT dental program provides a comprehensive plan of primary and preventive dental services for eligible children. The EPSDT Medicaid paid more than \$44 million last fiscal year, yet only 28.8 % of the eligible children received dental services. If 100% of eligible children demanded services, Medicaid would not be able to pay for this demand for services. In addition, there would not be enough dentists to meet the demand for treatment. Dental Medicaid over the last few years has consistently paid for about 28-32% of the eligible population to receive dental services.

The Oral Health Program currently does not have the work force or the funding needed to implement a statewide dental sealant program. Small pilot programs have been implemented in three parishes and the Oral Health Program received a HRSA grant to begin implementation of a sealant initiative in four parishes in the first year and will expand into other parishes in the next two years. This grant is targeting 1st and 2nd graders in the parishes selected.

Availability

The Oral Health Program does not provide any direct dental services. Only one Office of Public Health Clinic in the state offers dental services. This Office of Public Health Clinic is in Monroe, and works with the University Of Louisiana Monroe School Of Dental Hygiene, and offers dental preventive services to the patients in this clinic two days a week.

Access to oral health care is also limited by the lack of transportation in many regions. Rural areas usually have no mass transit system. Often Medicaid required transportation in these areas is very limited or almost non-existent. Five of the nine public health regions cited transportation as a hindrance to

accessing health care services; these regions included Region 1 (Jefferson Parish), Region 2 (Baton Rouge), Region 3 (Houma), Region 5 (Lake Charles), and Region 6 (Alexandria).

In most rural areas, federally qualified health care centers and rural health centers are the facility that provides dental services for the poor. Currently there are approximately 56 rural health care centers in Louisiana. Unfortunately, most do not have a dental component but there has been expansion of some of these clinics to add a dental clinic. Sites are seeking funding to expand services to include dental treatment for their population of patients because the need is so great in these areas. The following map shows the officially designated dental shortage areas in Louisiana (See Appendix C, Map 7). These areas qualify for federal loan repayment for dentists who are willing to work in these areas for 2 years. Many areas of Louisiana are dentally under-served, however, they have not applied for the federal designation so they are not on this map. Appendix C, Map 4 shows the parishes that are dental underserved based on Medicaid data from the Medicaid Fluoridation Advisory Committee Report Fiscal Year 2003-2004 Report No. MW-S-03.

The Oral Health Program identified the need to provide oral health services to the Medicaid eligible maternity population who had little or no access to dental services. The Oral Health Program provided the current research and information about the relationship between periodontal disease and preterm low birth weight births to the Secretary of the Department of Health and Hospitals and the Director of Medicaid. This information was reviewed and it was decided that Medicaid would offer dental services to this population of women in order to help improve the birth outcomes of this population. The State Medicaid Expanded Dental Services for Pregnant Women began covering pregnant women in November 2003. In the dental program for pregnant women, the treating obstetrician or nurse must make the dental referral for the pregnant women to receive dental services.

The OPH Children's Special Health Services Program provides a network of clinics through the 9 Regions in the State to assure access to specialty care services for children with eligible for services. These include orthodontics and oral surgery when indicated due to severe dental malformation. Pediatric dentists are the dentists of choice for small children but there are approximately 15 pediatric dentists in Louisiana who accept most of the Medicaid eligible children (Louisiana Dental Association Medicaid Task Force 2002).

Every five years, the Oral Health Program has trained school nurses to conduct oral health screenings and make dental referrals based on the screenings in order to assess the level for National Performance Measure #9, the Percent of third grade children who have received protective sealants on at least one permanent molar tooth. The school nurses make dental referrals for children in need of dental services.

2.2.2 Population Based Services

Population-based services are an important part of the MCH Program in order to improve the health of the MCH population in Louisiana. Population-based services are those that are available for an entire

population, rather than for an individual, and are essential for a comprehensive approach to addressing the needs of the MCH population.

Pregnant Women

Prenatal Care/Partners for Healthy Babies: Louisiana has a large disparity between whites and black entering into prenatal care during the first trimester. In 2003, 84.1% of pregnant women in Louisiana received early prenatal care, only 75.5% of black women entered into early prenatal care as compared to 90.1% of white women. The Perinatal subgroup found that 3 of 9 public health regions and Orleans parish stated early prenatal care as a top priority. Four regions also stated adequate prenatal care or transportation to prenatal care a major concern. In response to Louisiana's prenatal care rates, high infant mortality rates, low birth weight rates, and high teen pregnancy rates, the MCH Program funds Partners for Healthy Babies social marketing campaign. This statewide social marketing campaign promotes healthy behaviors during pregnancy and initiation of early entry into prenatal care. The campaign uses multimedia and multi channel approaches like television, radio, billboard, and bus signage advertising to promote messages about risk behavior. A fundamental component of the Partners for Healthy Babies project is their Title V funded toll-free helpline. This helpline 1800-251-BABY plays a vital role in linking women and their families to services through out the state. The Partners for Health Babies helpline has been managed by the state's Disability Information and Access Line. During 2003 and 2004 respectively, the toll-free helpline received approximately 4,297 and 3,320 calls respectively and made referrals to medical and social services statewide. The helpline has an answering service to ensure 24-hour coverage. In the fall of 2003, extensive formative research was conducted with the project's target audience to assess their needs and provide campaign focus and direction. During that same time, a thorough assessment of the capacity and quality of the helpline services provider was carried out. Based on these results the project is contracting with a new helpline provider who will be able to fully handle the needed and planned helpline expansion.

Louisiana's IMRI (Infant Mortality Reduction Initiative): The MCH Program began a statewide initiative in 2002 to team with organizations and individuals in their communities to improve Louisiana's poor fetal and infant outcomes. The Louisiana Infant Mortality Reduction Initiative's main components include community engagement through **Fetal and Infant Mortality Reviews (FIMR)**. Louisiana Infant Mortality Reduction Initiatives (LA-IMRI) have been established in all nine regions of the state plus Orleans Parish. The FIMRs are population-based interventions delivered at the community level. Each of the regional FIMRs consist of a case review team (CRT) and a community action team (CAT). The CRTs consist of a board of local medical providers that review de-identified stillbirth and infant deaths to identify social, economic and care delivery system changes that might improve outcomes. Recommendations of the CRTs are passed on to the CATs, a team of local individuals committed to improving outcomes. The CATs then takes the recommendations of the CRTs and develops and

implements plans for addressing problems through improved coordination, funding, and other available resources.

Perinatal HIV Transmission: The success of medical intervention in the prevention of vertical HIV transmission makes knowledge of HIV status critical to the implementation of treatment protocols. As of December 2003, there were 5,646 women living with HIV in Louisiana and women accounted for 34% of the new HIV/AIDS cases in the state. Forty-nine percent of these women were in the highest fertility period, childbearing ages of 15-34. There is a large racial disparity in HIV cases, 885 white women and 4,658 black women. As of December 2002 approximately 1,796 babies have been born to HIV-infected women in Louisiana, and 15% were infected with HIV perinatally. The MCH program works closely with the state HIV Program. Issues recently addressed with the HIV Program include HIV testing during pregnancy, use of rapid testing during labor in selected individuals, monitoring of compliance with treatment protocols during delivery, and follow-up of the newborn. In 2003, material on perinatal HIV was sent to all obstetrical and pediatric providers in the state with funding from Title V. The MCH program makes visits to delivering hospitals, private physicians, and Louisiana ACOG to support prevention of HIV transmission.

Sexually Transmitted Diseases: Louisiana is a leader in the rates of STDs within the United States. During 2004 there were 1540 cases of syphilis, 10,598 cases of gonorrhea, and 21,976 cases of chlamydia reported. In 2003 Louisiana had the highest gonorrhea rate of all states, and the second highest chlamydia rate. Ongoing collaboration with the state STD Program is occurring. Information has been mailed concerning this issue to all ACOG members in Louisiana.

Perinatal Substance Abuse: The use of tobacco, alcohol and illicit drugs during pregnancy is an ongoing focus of the MCH Program. PRAMS data reflects that in 2002, 11.9% of Louisiana women smoked and 5.0% of women drank alcohol during pregnancy. Three times more white women smoked during pregnancy than black women. All health units provide a prenatal care screen for tobacco use, and refer to the toll-free helpline and low-cost/no cost cessation treatment. Additionally, piloted WIC clinics perform screening for substance abuse, with brief intervention and referral for intensive therapy as needed.

MCH addressed gaps in smoking cessation services for perinatal populations through a contract to provide the American Cancer Society (ACS) intervention, Make Yours A Fresh Start Family (MYFSF). This program focuses on smoking during pregnancy and trains prenatal providers to screen patients for smoking and to counsel all smokers to quit for both their health and the health of their baby. Since November 2002, MYFSF has trained 48 facilities, which included 116 public health providers and 133 private providers. Of these numbers, in 2004 there were 20 facilities trained, 118 providers trained. Providers include the following: 65 RNs/LPNs, 20 Social Workers, 9 Physicians, and 244 other clinical and private physician's office staff. The program has been implemented in at least 40 of the 48 trained facilities. There have been over 8,800 pregnant women screened for tobacco use, over 2,200 women counseled to quit smoking, and over 150 pregnant women who quit smoking with the MYFSF program. In

2004, MYFSF grew to include more public and private prenatal care providers, raising awareness and implementation of the training program. Survey results estimate that 7.1% of the smokers counseled to quit did quit successfully.

Since April 2005, the contract for the MYFSF is through the Louisiana Public Health Institute (LPHI)- Tobacco Free Living, an organization that focuses on statewide efforts to reduce second hand smoke and is the recipient of the Louisiana Tobacco Tax Fund. Together with LPHI, the CDC funded Louisiana Tobacco Control Program, Louisiana Chapter of Obstetricians and Gynecologists, and Medicaid, MCH is leading a statewide initiative "Tobacco Prevention and Cessation for Women of Reproductive Age".

Folic Acid: The MCH program continues its support for the Louisiana Folic Acid Council. The Council Coordinator is housed within MCH. The Council hosts educational seminars targeted to providers on the importance of folic acid. Public messages on folic acid are presented, especially at local universities. The Council has also targeted a local university student health clinic for promotion of folic acid supplements. More women in Louisiana are becoming aware of folic acid and its role in prevention of birth defects. In 1999, LaPRAMS data showed 66.7% of women surveyed heard that folic acid prevents birth defects. In 2002, the number increased to 71%.

Physical Abuse: In 2002 LaPRAMS data, 5% of women reported physical abuse during pregnancy. Region 3 (Houma) and Region 5 (Lake Charles) identified domestic violence a major need in their regional needs assessments. Visiting nurses, from the Nurse Family Partnership (NFP) program, conduct regular assessments of the presence of physical and sexual abuse of clients. If the presence of abuse is identified, nurses provide support, make referrals, and provide ongoing case management. A 2003 study of the NFP in Louisiana, by Tulane School of Public Health and Tropical Medicine, found that 18% of all women enrolled in the study were victims of partner violence, and 21% were perpetrators of violence while pregnant. However, those in NFP reported a 9% decrease in victimization, and a 27% decrease in perpetrating violence within 6 months after delivery.

Domestic violence emergency referrals/safety cards are provided with region specific shelters and resources. Additionally, in Region 3, domestic violence has been an issue identified through FIMR activities with ongoing community assessment of resources.

Oral Health: The Oral Health Program conducted a media campaign to educate the public about the importance of pregnant women receiving dental care during their pregnancy. A 30 second Public Service Announcement was developed and aired in the six largest cities in Louisiana (New Orleans, Lafayette, Monroe, Shreveport, Alexandria and Baton Rouge). In addition, educational materials were developed for the pregnant women explaining the new dental program coverage and how to access the program. A hotline number with a recorded message about the dental program for pregnant women was installed for easy access to information about the program to the public. The Oral Health Program

participates in health fairs, maternity fairs, and other community activities and provides educational materials and toothpaste and toothbrushes.

Infants and Children

Many population-based activities for infants and children, such as newborn screening, immunization, and lead screening, are at the core of public health efforts to address child health in Louisiana. Population based activities provide a great opportunity to make a difference in health outcomes such as SIDS, unintentional injuries, and health coverage.

Newborn Screening: The Office of Public Health is responsible for oversight of the legislatively mandated newborn screening efforts in the state. The OPH Genetic Diseases Program, in collaboration with the State Central Public Health Laboratory operates a statewide Newborn Heel Stick Screening and Follow-up Program. The Genetics Disease Advisory Committee is comprised of members representing the Medical Schools in the State and provides input to the Genetics Disease staff. Through a revenue enhancement campaign, the program is anticipated to become self-sustaining. Current estimates indicate that 94% of newborns who are screened and identified with a condition, received the appropriate follow-up services. Currently the state screens for PKU, congenital hypothyroidism, biotinidase deficiency, sickle cell disease, and galactosemia homocystinuria, maple syrup urine disease (MSUD), medium chain AcylCoA dehydrogenase deficiency (MCADD), citrullinemia and argininosuccinic aciduria (ASA). The State Newborn Screening Program needs to continue to improve on the comparing of State Laboratory data with birth certificate data, in order to assure that all newborns are screened. A scheduled upgrade of the laboratory data management system will reactivate the plan for matching newborn screening data with the birth records. This upgrade will greatly improve the matching process. The Newborn Screening Advisory Committee provides recommendations to the State Newborn Screening Program.

Newborn Hearing Screening: The Hearing, Speech, and Vision Program is responsible for the development and implementation of the law pertaining to the identification of hearing impairment in infants. All of the 68 birthing hospitals in Louisiana provide universal newborn hearing screening. In 2003, 93.6% of the 64,513 infants born in Louisiana hospitals were screened prior to discharge. Of the infants screened, 6.5% were found to be in need of additional testing. OPH has contract staff to assist the program in tracking and monitoring in order to meet the national goals set for: screening accomplished by one month of age, audiology assessment by three months of age, and early intervention by six months of age.

Sudden Infant Death Syndrome (SIDS) Services: The Maternal and Child Health Program oversees and funds the statewide SIDS Counseling and Risk Reduction Program. Education and counseling is provided to families who have lost an infant to SIDS by local public health nurses and/or social workers. Although there has been a decrease in the number of deaths due to SIDS, the mortality rate for SIDS in Louisiana remains approximately twice the national rate and the rate for black infants remains twice that for white infants. Public and professional education on risk factors for SIDS especially for low-

income, minority populations needs to be conducted to further decrease mortality from SIDS. A public awareness campaign began in 2002 to focus on safe sleep environment.

Lead Screening: The Louisiana Childhood Lead Poisoning Prevention Program (LACLPP) is in the Office of Public Health. Through a Childhood Lead Poisoning and Prevention Grant from the Centers for Disease Control, a population-based surveillance system for lead levels in children has been established through the Office of Public Health. The grant also enhanced patient case management and allowed the program to expand its target population from children screened at parish health units to all children across the state. Approximately 5% of 6 month to 6 year old children who are screened have elevated blood lead levels. Information from the surveillance system is used to determine high risk populations in the state and focus efforts to assure screening for all those at risk with the most efficient use of available resources. LACLPP oversees environmental evaluation, tracking, and follow-up of those children found to have elevated lead level. LACLPP also works with other agencies and organizations with an interest in childhood lead poisoning such as the Department of Environmental Quality and the Tulane School of Public Health Center for Applied Environmental Health. A majority of children aged six months to six years of age have not been reached through screening.

Nutrition: The Office of Public Health is responsible for the oversight of the Louisiana Council on Obesity Prevention and Management; a council mandated by state legislation. The MCH Program actively participates with this council. In 2003, the council was instrumental in passing legislation that requires 30 minutes of physical activity in public schools grade kindergarten to 5 each day. Other activities include an initiative to promote a requirement that any vending machine in public schools to provide only health food and drink items. Conferences on childhood obesity have targeted school staff as well as worksite wellness with the emphasis on obesity. . In 2004, the Council on Obesity Prevention and Management worked with community partners to develop the *Louisiana on the Move* program in conjunction with *America on the Move*. The council also produced a supplement on obesity to the Louisiana Medical Society Journal. OPH provides limited funding to the Council on Obesity Prevention and Management through the Preventative Block Grant.

Immunization: The Immunization Program in the Office of Public Health is responsible for oversight of immunization efforts in the state. The MCH Program provides funding to assist the program in their efforts. The public relations campaign, Shots for Tots, has improved access to immunizations, decreased cost to families, improved public awareness of the need for immunizations, and educated health care providers about proper immunization practices. Immunization rates for children at age two showed a decrease in 2002 which has resulted in intensified efforts to increase this immunization rate. The Shots for Tots campaign, conducted through the Immunization Program in the Office of Public Health, coordinates local initiatives to increase immunization levels and needs to continue efforts in the areas of public education and service offerings to increase these rates. The Immunization Program has also implemented Louisiana Immunization Network for Kids Statewide (LINKS), a statewide web-based immunization and tracking system. LINKS currently has 1,329 provider enrolled, and 3,836 users.

Intentional and Unintentional Injury: The preventability of the major causes of mortality and morbidity in infants and children indicate the need for continued initiatives to provide information and education to the public. The impact of unintentional injury as the leading cause of death in children from 1 to 21 years of age reinforces the need for continued efforts to provide information to families. Public education campaigns and other initiatives through the SAFE KIDS Program, supported by the MCH Program in conjunction with the Office of Public Health Injury Research and Prevention Program and Children's Hospital in New Orleans, need to be continued and expanded to focus community-based efforts on decreasing injury deaths. The SAFE KIDS Program operates through a Coalition which is a 501(c) 3 organization. The Maternal and Child Health Program provides funding for Executive Director of the Program as well as 9 Regional Injury Prevention Coordinators who are responsible for addressing the leading cause of child death in their areas through educational programs and networking with other community organizations.

Child deaths due to intentional injury, and the number of child abuse and neglect cases indicates the need to sustain statewide child abuse prevention efforts and to increase efforts in the areas of parenting education and resources. A newsletter which addresses psychosocial issues related to parenting has been developed by the MCH Program staff and is to be sent to all new parents who request it. The newsletter will be distributed through the parish health units and public and private birthing hospitals, and by OPH Vital Records and Statistics current distribution of birth certificates. The MCH Program also works with the Department of Social Services (DSS) in the implementation of state legislation for infant relinquishment entitled Safe Haven. DSS and the MCH program both work to promote train, education and public awareness of Safe Haven.

Oral Health:

Fluoridation: The Oral Health Program's community water initiative has targeted communities in the state for community water fluoridation efforts. Three communities have received the support of the water fluoridation program and are now or in the process of fluoridating their water. These communities include the cities of Litcher, Oakdale and Crowley. Efforts are underway to gain support for fluoridation in the city of Baton Rouge. The fluoridation program also works closely with the Center for Environmental Health to ensure that all water operators are trained in the safety and reporting requirements for water fluoridation.

Education: The Oral Health Program participates in health fairs and other community activities to provides educational materials and whenever possible toothpaste and toothbrushes. Educational courses on dental topics have been provided to childcare providers, nurses, teachers and other professionals that work with children.

Sealants: The Oral Health Program has recently instituted a school-based dental sealant initiative funded by HRSA. This initiative will provide a dental sealant program in parts of the state that are lacking in dental providers thus increasing the access to dental preventive services for this underserved population of children. Medicaid currently does not reimburse dental hygienists for dental sealants nor do they reimburse nurses or dentists for dental screenings.

Adolescents

There are very few population based activities addressing the health of adolescents in Louisiana. Public Awareness and health education campaigns are needed activities that target youth and focus on risky behavior prevention.

Suicide Prevention: The Louisiana Youth Suicide Prevention Task Force which is chaired by the Louisiana Adolescent Health Initiative (AHI) was developed to prevent youth suicide and suicidal behaviors, improve access and availability of prevention services statewide, provide appropriate and timely help, and to develop the Louisiana Youth Suicide Prevention Plan. There are 4 key components of the Plan: suicide prevention for Louisiana youth; treatment and training; awareness and advocacy; and resources, resolution, and recommendations. The task force takes part in providing suicide prevention programs in Louisiana school and trains health professionals and school personnel to identify and help prevent suicide. Each year the task force hosts a Yellow Ribbon Youth Suicide Prevention and Awareness week which is sponsored by the Office of Public Health. In conjunction with the Yellow Ribbon Youth Suicide Prevention and Awareness Week the task force hosts the Louisiana Youth Suicide Essay/Poster Contest.

Teen Pregnancy Prevention: Louisiana has one of the highest teen birth rates in the nation. The state ranks 42nd in the nation in births to teens. To address teen pregnancy, the Adolescent Health Initiative (AHI) promotes a number of activities through out the year. AHI hosts youth rallies and summits that address issues such as teen pregnancy and violence. The initiative also encourages parents to talk to their children about sexuality through the promotion of Let's Talk Month. Statewide programs that provide counseling and medical services can be found in the Louisiana Teen Pregnancy Prevention Directory. AHI organizes a National Day to Prevent Pregnancy, Teen Pregnancy Prevention Month, and the Louisiana observance of National Women's Health Week. Last fiscal year, the AHI presented to 11, 600 people and has distributed over 8,070 materials to the citizens of Louisiana during the above mentioned state observances and at various youth conferences, community summits, church events and school initiatives.

In addition to teen pregnancy prevention activities, the Adolescent Health Initiative also led many other health promotion and disease prevention activities. The AHI has provided technical assistance to agencies and schools statewide on teen pregnancy prevention initiatives. In September 2004, the AHI Coordinator presented to over 10, 000 youth at the Annual Teen Summit on the issue of Teen Pregnancy Prevention-*Are You Ready For Parenthood*. The AHI has reached a total of 19, 670 people with its health education efforts.

2.2.3 Infrastructure Building Services

In order to assure access and availability of comprehensive, continuous, community-based, quality care for the maternal, infant, child, and adolescent population, the combined efforts of many providers of care as well as the financiers and supporters of the care are required. First, there must be

commitment from the state government to develop evidence-based programs and policies to respond to needs identified with reliable data. Second, a commitment is needed among the public providers of care to collaborate and coordinate efforts to provide cost effective and efficient services. Finally, there must be ongoing feedback and evaluation on the efforts to assure that the desired outcomes are being achieved and that quality is maintained.

Information Systems/Assessment and Surveillance

The development of information systems that are capable of providing timely and appropriate data for planning and evaluation of programs and policies is a necessity. In 1996, the MCH Program became a recipient of a Center for Disease Control & Prevention (CDC) MCH Epidemiology Grant. This grant helped establish the Epidemiology, Assessment, and Evaluation (EAE) program within the MCH Program. Since 1996, the EAE program has grown and today is composed of a CDC assignee MCH Medical Epidemiologist, a State Systems Development Initiative (SSDI) Data Manager, SSDI Coordinator, CDC-ORISE Fellow, New Orleans MCH Epidemiologist, Needs Assessment Coordinator, and graduate master degree students of public health. The Program actively participates in MCH epidemiological studies; the Block Grant data retrieval and analysis; objective data preparation for policy-building process and other specific projects; analyses of data from different data sources such as vital records, the Pregnancy Risk Assessment Monitoring System (PRAMS), and other program data. Members of the program are also actively engaged in epidemiological analysis with specific regions of the state in an effort to reduce perinatal mortality rates. EAE program provides teaching activities both at the OPH and at the different local universities. The Program leads and collaborates in the dissemination process of MCH information statewide. The MCH assessment and surveillance activities include linked birth and death certificate files, PRAMS, Louisiana hospital discharge data, the childhood lead poisoning surveillance system, the Nations Survey of Children with Special Health Care Needs, and the National Survey on Children's Health.

Pregnancy Associated Mortality Review: Currently, review of maternal deaths is a limited process in conjunction with CDC surveillance. Steps have been initiated to implement a formal Pregnancy Associated Mortality Review (PAMR) process. The MCH Epidemiology, Assessment, and Evaluation Program (EAE) has been collaborating with vital records in preparing for this endeavor. EAE is now receiving death certificates necessary to initiate the process. Committee members are being identified and review of all deaths of women within one year of pregnancy delivery will be accomplished.

The MCH assessment and surveillance activities include linked birth and death certificate files, PRAMS, Louisiana hospital discharge data, the childhood lead poisoning surveillance system, the Nations Survey of Children with Special Health Care Needs, and the National Survey on Children's Health.

Pregnant Women

Standards of Care

The MCH program has been an active participant with the Louisiana Perinatal Commission on revision of the state Perinatal Guidelines for hospital care. The MCH Epidemiology section is vital to the

ongoing understanding of outcomes and effectiveness of care. Currently, Medicaid has limited monitoring on the quality of care provided through its program. The MCH program medical directors plan to play an important role in promoting that process for the MCH population.

Monitoring

For direct services and contract sites, monitoring is performed directly by MCH Program staff. Contracts are monitored monthly and are based on clinic site audits. At contract sites funded through Title X and Title V, the clinic audits are conducted jointly by Family Planning and Maternal and Child Health. Site audits consist of onsite evaluation, patient chart audits, exit interview, and follow-up for remaining issues. The MCH Maternity Program Nurse Coordinator conducts Technical Assistance on demand. The MCH Epidemiology division has an active ongoing surveillance system at the state, regional and local level. Within the regional FIMR groups, the CQI process and principles have been incorporated. The activities of the FIMR groups are based on continuous quality improvement principles.

Collaborations/Coordinated Efforts

To address the high infant mortality and large racial disparity in the state, the Louisiana Infant Mortality Reduction Initiative (LA-IMRI) was launched to coordinate systems of care, improve and begin new systems, and serve as the catalyst for community involvement. The formation of Fetal Infant Mortality Review (FIMR) groups in all regions of the state is a major part of the Initiative. These Medical Case Review Teams and Community Action Teams are serving at the regional level to assess needs, plan for improved care systems, and set priorities. This process is being established in all regions and will be an ongoing process, with needs assessment updates yearly. The MCH program funds a LA-IMRI coordinator in each region to coordinate efforts at that level and assure ongoing activities. The implementation of Nurse Family Partnership programs in all regions of the state is linked with the LA-IMRI.

Through continued development and maturation of the region FIMR and LA-IMRI activities, the concept of “Regional MCH Forum” development has emerged (See Appendix D, MCH Region Forums). The Forum will serve as an ongoing coordinator of all regional activities involving the MCH population. The FIMR case review and community action teams will be the core group of the Forum, but will coordinate activities with public agencies, private providers, business, government, organizations, and individuals within the community. The Forum will give community ownership to MCH issues, serve as the collective community voice for MCH, and work with the community to implement change. The statewide LA-IMRI will work with each Forum and coordinate statewide activities. Continued twice yearly conferences will occur with the groups and regular communication to exchange information will occur. Development of a LA-IMRI website, newsletter, and web-based discussion forums is planned. The structure of the Forums is being finalized with a consultant and will be submitted for legislative authority. The MCH funded LA-IMRI coordinator will serve to coordinate Forum activities at each regional level.

The MCH program has ongoing collaboration with Medicaid. Expansion of Medicaid to 200% of the federal poverty level, the initiation of oral health services for pregnant women, fee revisions for dental providers, and more expedited Medicaid approval processes are all examples of coordination efforts with the Medicaid program. Access to family planning, preconception care, and inter-conception care are common priority needs in the regions. There are also beginning discussions on moving Medicaid to a “pay for performance” model, in which outcomes would be more closely followed and linked to reimbursements.

The MCH program meets with the state’s HIV Program on a regular, scheduled basis. There is a Perinatal HIV workgroup that discusses outcome and issues. Recent work includes efforts to increase the percentage of women with prenatal HIV testing, implementation of rapid testing at all delivering hospitals, and enhanced follow-up after delivery in HIV positive mothers. The MCH program through the LA-IMRI, has been promoting perinatal HIV prevention at the regional level.

The MCH program works closely with the Office of Addictive Disorders (OAD) on multiple fronts. The MCH program provides pregnancy testing for OAD female clients, with referrals as needed. In Region 8, MCH and OAD have partnered to provide screening in prenatal clinics for substance abuse, depression and domestic violence. OAD counselors perform the screening, provide brief interventions, and refer as needed. OAD also operates an intensive outpatient treatment program specifically for pregnant women in the area. Referrals are made for inpatient care as needed. For the time period of July 2004 through March 2005, 769 women were screened and had brief intervention in this program. Referrals for further assessment occurred in 47 women, and 16 were referred for the intensive outpatient treatment program. Currently, MCH and OAD are collaborating to initiate a similar program on a statewide basis. Recently the OAD has launched an expanded voucher-based treatment program, Access to Recovery. Pregnant women are one of the targeted groups for this program. It will provide a voucher to pay for treatment services at any approved treatment facility within the state.

Availability of care for mental health services has been identified as a need throughout the state. Individuals with less severe mental health issues have limited access to care, as the Office of Mental Health generally accepts only individuals with severe mental illness into their caseload. Ongoing collaborative efforts to enhance mental health services are occurring.

The MCH program has a close relationship with the Louisiana American College of Obstetrics & Gynecology (ACOG) Chapter. The Chapter President is an active member of the MCH Tobacco Prevention and Cessation- Action Learning Lab. ACOG has endorsed many state MCH activities and has written correspondence to its members about these activities. The appropriate weight gain in pregnancy efforts, smoking cessation services, high rates of STDs in Louisiana, and oral health in pregnancy projects have all been promoted to ACOG members. In addition, MCH has been provided a exhibitors table for promotion of its programs at the last two annual Louisiana ACOG Meetings.

The Louisiana Public Health Institute (LPHI) is a non-profit New Orleans based organization whose purpose is to evaluate and promote improved health outcomes within the state. The LPHI is the

recipient of a significant portion of the state's tobacco settlement funds, and is charged with oversight of anti-tobacco educational activities within Louisiana. The MCH program meets regularly with LPHI staff and has contracted with LPHI to promote smoking prevention and cessation activities targeting pregnant women.

The Louisiana MCH Coalition is a Baton Rouge based non-profit advocacy organization that has a 16 year history of promotion of improved health for women and children of Louisiana. The MCH Coalition is the premiere advocate for women and children health issues. MCH Title V representation on the Coalition Board is strong, and there are regular meetings with the Coalition. The Executive Director of the Coalition has many successful years as a lobbyist for the Louisiana Legislature and has been instrumental in many state MCH legislative activities.

Infant and Children

Standards of Care

The Child Care Health Consultant (CCHC) Program, focuses on improving the quality of health and safety in out-of-home care settings. The consultants provide mandated health and safety trainings to childcare providers and work to support, assist, and problem-solve with childcare providers in order to achieve safer, healthier childcare. The Early Childhood Comprehensive Systems Building Initiative (ECCS) needs assessment identified unmet needs of child care, child care use and poverty, quality child care, special needs children and child care, problems with current child care arrangements as the top areas on which it needed to focus. The CCHC Program has identified the following programmatic needs: periodic review of existing individual training modules; implementation of standardized training modules; revision of the consultant's monthly reporting instrument; revision of the consultant's evaluation tool for the child care providers; establishment of a web page to offer services.

The MCH Program provides the staff support for the Louisiana Child Death Review Panel which is a legislatively mandated 25 member State Panel to review all unexpected deaths in children 14 years of age and younger. The State Panel along with local Child Death Review Panels review the deaths and make recommendations to the Legislature for the prevention of deaths. The Panel has worked to establish linkages with local coroners, law enforcement, and fire departments in the investigation of unexpected child deaths.

The Louisiana SIDS Counseling and Risk Reduction Program initiated a three-year statewide social marketing media campaign to educate the community about safe sleep and environment with a focus on the low-income population. The MCH Program performed a study to investigate the infant sleep position policies and practices in Louisiana well-baby nurseries. The study found that 7% of urban birthing hospitals and 46% of rural birthing hospital do not follow AAP Guidelines on placing babies to sleep on their backs only or back and side. For these hospitals, in-service trainings were given. Teaching efforts on SIDS risk factors for private hospitals and rural hospitals have been increased to influence change in hospital policy.

Training

Coordination with other programs and agencies is a necessity for the MCH Program in order to serve the multiple needs of Louisiana's child population. The MCH program works with the existing system for the provision of prevention and primary services for children, consisting of the publicly supported local public health units, state supported hospitals, rural health clinics, the 27 Federally Qualified Health Centers, and the Community Care Program, a program which links Medicaid enrolled children to a primary care provider.

The CCHC Program trains, supports, and oversees the efforts of health care workers who provide training and consultation for health and safety in childcare settings. The program has worked with the State Licensing Agency for Child Care Centers to identify programmatic needs in areas such as periodic review of existing individual training modules and the implantation of standardized training modules.

Monitoring

The MCH Epidemiology, Assessment, and Evaluation Program monitors rates, causes and factors associated with infant and childhood mortality. Louisiana hospital discharge data provides information on morbidity in children and will assist the MCH Program in developing program and policies. The MCH Program works closely with OPH Injury Research and Prevention Section, which monitors injury mortality in the state through death certificate data, the head and spinal cord trauma registry, child death review, and SIDS databases.

Within the OPH, health care services in the local Parish Health Units are monitored through a Continuous Quality Improvement (CQI) System. Audits conducted by Medicaid EPSDT Program are reviewed to assure that health unit services comply with state standards. Audits by state and federal staff for the WIC Program assure compliance with program requirements.

The MCH Program works closely with the nine Regional Public Health Offices in addressing local service system needs. In conjunction with the Regional Offices, the MCH has supported the establishment of 9 Regional Injury Prevention Coordinators to establish and implement injury prevention efforts specific to the needs of the Community.

Collaboration/Coordination Efforts

Coordination with other programs and agencies is a necessity for the MCH Program in order to serve the multiple needs of Louisiana's child population. The MCH program works with the existing system for the provision of prevention and primary services for children consists of the publicly supported local public health units, state supported hospitals, rural health clinics, the 27 Federally Qualified Health Centers, and their Community Care Program, a program which links Medicaid enrolled children to a primary care provider.

The Child Care Health Consultant Program (CCHC) focuses on improving the quality of health and safety in out-of-home care settings. The CCHC Program collaborates with the Department of Social

Services Child Care Licensing Section and the Office of Public Health Center on Environmental Health. The program also has a Statewide Advisory Board composed of all entities related to childcare.

The State Medicaid Program and the MCH Program in the Office of Public Health are both located within the Department of Health and Hospitals. The MCH Program Director along with executive staff of the State Medicaid Program are members of the Advisory Committee for the Robert Wood Johnson Covering Kids and Families which works toward increasing outreach efforts for LaCHIP. Representatives of the Medicaid Program have been ongoing participants in the Louisiana Early Childhood Comprehensive Systems Building Initiative particularly in the area of addressing issues of access to medical homes. The State EPSDT Coordinator has been a member of the Louisiana Childhood Lead Poisoning Prevention Program Advisory Committee to facilitate the efforts of both programs to address lead poisoning in the Medicaid population.

The Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) and the MCH Program are closely coordinated at the state and local levels. At the State level, the MCH Program and the Nutrition Program, which the WIC Program is a part of, are in the Center for Preventive Health Services. The Child Health Medical Director also serves as the Medical Consultant for the WIC Program. At the local level, children receive WIC benefits from parish public health units. Families who receive their health services from private providers and use parish health units for WIC services can also receive health education services provided by health unit staff funded by the MCH Program

The Child Health Program has worked closely with the Office of Mental Health in the implementation of the Early Childhood Supports and Services (ECSS) Program, which provides assessment and intervention services for young children to age 6 who are at risk for poor psychosocial and developmental outcomes. This program currently operates in 6 parishes of the State with plans to expand to an additional 8 parishes in 2005.

The MCH Program works closely with the Office of Community Services (OCS) within the Department of Social Services to prevent child abuse and neglect. A Memorandum of Understanding (MOU) between the agencies exists for joint home evaluations in cases of suspected child neglect. An OCS staff is a member of the Louisiana Child Death Review Panel and works at the State and local levels to address the issues of preventable child deaths. The MCH Program also works with the Children's Bureau, a New Orleans not-for-profit social services agency, to provide counseling to children who have been affected by violent deaths and families who have lost children unexpectedly.

The Child Health Medical Director has been an active member of the Louisiana Chapter of the American Academy of Pediatrics, serving as a co-facilitator for the Community Access to Child Health (CATCH) Program and as treasurer. The MCH Director is a member of the MCH Coalition Board and the Child Health Medical Director is a member of the Agenda for Children Advisory Committee.

Adolescents

Standards of Care/Training/ Monitoring

The Office of Public Health Adolescent School Based Initiative (OPH-ASHI) sets policies and standards for the School Based Health Centers operation. The initiative also provides technical assistance, monitors contract compliance assures continuous quality improvement, and generates statistical reports on service delivery. Additionally, OPH-ASHI collaborates with the Adolescent Health Initiative to discuss and improve methods in which adolescents are served throughout the state.

All SBHCs are required to comply with The Principles, Standards, and Guidelines for School Based Health Centers. Trainings based on these guidelines are offered throughout the year to SBHC staff. Each of the SBHCs undergoes a CQI (Continuous Quality and Improvement) review using the LaPERT tool. CQIs are performed every three years by the OPH-ASHI, Office of Mental Health, and peer reviewers. The LaPERT tool has recently been revised to include assessment of clinical outcomes.

In order to assure continuous monitoring and evaluation, each SBHC site reports quarterly to OPH-ASHI. The reports detail SBHC registration, utilization, the number of comprehensive physicals, and predetermined sections of the LaPERT tool. Bi-annually, patient statistics, insurance figures, and SBHC outcome measures are reported.

Coordination Efforts/Collaboration

The school-based health centers (SBHCs) in Louisiana have been an integral part of providing comprehensive health and mental health services to adolescents. The SBHCs have also successfully united many different agencies and community groups that focus on youth. The OPH-ASHI regularly convenes meetings with the network of SBHC administrators and providers. The Louisiana Assembly on School Based Health Care has an annual conference that many members of the network attend. Additionally, each of the SBHCs utilizes a standardized data collection system. Through an agreement with Medicaid, Louisiana SBHCs are exempt from Community Care's prior authorization requirement. This alleviates one major barrier in access to care for the adolescent population. The MCH, HIV, and STD Programs pool funds to provide STD medications and laboratory testing in order for the SBHCs to be able to provide STD testing and treatment.

Oral Health

Systems of Service

To improve the system of dental services in Louisiana the Oral Health Program advocates higher Medicaid reimbursement rates for dental services, more private providers to accept Medicaid patients, and awareness of the population for good oral health. The program also works with the dental safety net providers (rural health centers and federally qualified health care centers) to provide dental services to identified dental shortage areas.

The oral health care delivery system in Louisiana is almost entirely based on private providers providing dental treatment and preventive services to the maternal and child populations. Children in families above the 200% federal poverty level (FPL) must pay for dental services “out of pocket” or with private insurance. Children in families at or below the 200% FPL are eligible for Medicaid covered dental services. In 2003, 694,234 children were enrolled in the Title XIX/Title XXI SCHIP program; yet only 28.8% of the enrolled children received any dental services.

Collaborative Efforts

Through collaborative efforts between the Oral Health Program and the Bureau of Health Services Financing (Medicaid), dental services are now provided to Medicaid-eligible pregnant women. This is a new benefit that began in November 2003. Prior to that time, there was no dental coverage for adult pregnant women. The Oral Health Program, also, coordinated an informational and educational mail-out in December 2003 with the Louisiana Chapter of the American College of Obstetrics and Gynecology to the members relating information on the dental program for Medicaid eligible pregnant women. The Oral Health Program also provided this information at the State ACOG meeting in March 2004.

Children of families at or below 200% of poverty are eligible for comprehensive dental benefits through the EPSDT Medicaid Program; preventive as well as a full range of dental treatment options are available to all eligible children.

2.3 Needs Assessment of the Children with Special Health Care Needs Population

2.3.1 CSHS Needs Assessment Process

The CSHS Needs Assessment was a comprehensive study of the capacity, needs, and resources of pediatric medical providers and families of Children with Special Health Care Needs (CSHCN) from all nine Department of Health and Hospitals (DHH) regions of the State. The overall purpose of the needs assessment was to describe current access to health and related systems of care for children from birth through 21 years of age in Louisiana, with special emphasis on CSHCN and Medicaid populations.

The needs assessment plan was developed by the Louisiana State University Health Sciences Center Early Intervention Institute (LSU-HSC EII) and the CSHS management team. The LSU-HSC EII was contracted by CSHS to conduct the Needs Assessment and to analyze the data, while the CSHS team helped to frame the Needs Assessment and provided the support necessary to access personnel participating at the regional and local levels. Data was collected from April 2003 through June 2004 via surveys, telephone interviews, and family focus groups.

Additional data was compiled from a variety of sources such as the 2000 Census data, The State and Local Area Integrated Telephone Survey (SLAITS), the American Academy of Pediatrics (AAP), the Maternal and Child Health Bureau (MCHB), Georgetown University Child Development Center, Heller School, Brandeis University, Institute for Child Health Policy, University of Florida, and Los Angeles Medical Home Project for Children with Special Health Care Needs (November 2001).

The Objectives of the Needs Assessment were: Objective 1: To determine current access to primary and specialty medical care, related health services, and early intervention services for children in Louisiana and to produce a comprehensive map of providers who care for children with special health care needs (CSHCN). Objective 2: To describe access variables, utilization patterns, existing needs, and existing supports related to current medical, health related, and early intervention service delivery systems from the perspective of family members of CSHCN. Objective 3: To describe access variables, utilization patterns, existing needs, and existing supports related to current medical care for CSHCN from the perspective of specialty medical providers who deliver such care in Louisiana. Objective 4: To determine current capacity of related health care providers to serve the Early Steps population in all regions in Louisiana.

The CSHS Needs Assessment project included an Advisory Group made up of individuals and agencies from around the state (See CSHS Needs Assessment Appendix F) to provide advice on how to collect the information, what information to collect, and how to access health care providers. Community stakeholder input included other related health care providers including Early Steps, Family Helping Families, CSHS Parent Liaisons, Pyramid Parent Training Program, Children's Hospital, Family Voices,

Ochsner Medical Center, Louisiana State University Medical School, Tulane University School of Medicine, and regional OPH and parish health units.

Provider stakeholder input included public and private sector pediatric primary care and specialty care providers. An attempt was made to contact every pediatric primary care and specialty provider in the state through telephone listings, Community Care enrollment records, and the Louisiana State Board of Medical Examiners physician license list. Provider practices that reported serving CSHCN answered a brief phone survey (CSHS Needs Assessment, Appendix F) on access variables in their practice. Data was collected from 1159 primary care providers throughout Louisiana and 528 specialty physicians who reported serving CSHCN.

A convenience sample of 108 specialists was interviewed about their perspectives on the current system of health care for CSHCN in either an individual or small group format using a semi-structured interview protocol (CSHS Needs Assessment Appendix F). Part A addressed the constructs of accessibility, resources, barriers, and system change in reference to each specialist's individual practice and the State's system of care for CSHCN, while Part B utilized a Likert-type scale to capture specialists' thoughts on reimbursement issues, community resources, family needs, and public relation strategies for CSHS (CSHS Needs Assessment, Appendix F). The 108 respondents represented 22 different medical specialties and every DHH region of the State. Quantitative interview data were summarized by frequency counts, while qualitative interview data were analyzed by synthesizing responses across questions according to the a priori constructs that formed the basis for the interview protocol content.

The Needs Assessment staff reviewed the Early Steps (Part C of IDEA) provider enrollment records of December 31, 2003 in order to identify disciplines under-represented as Early Steps providers statewide or in an individual region of the state. Under-representation was determined by calculating ratios of providers in a region to every 100 children enrolled in Early Steps in a region as of December 31, 2003. Ratio of providers/100 children were then compared among disciplines and to state averages to highlight under-represented professionals.

National Performance Measures (NPM) were incorporated in the Needs Assessment process to assess the needs of the CSHCN population, including NPM-02, the percentage of families that partner in decision making at all levels; NPM-03, the percentage who receive coordinated, ongoing, comprehensive care within a medical home; NPM-04, the percentage of families that have adequate private and/or public insurance to pay for services they need; NPM-05, the percentage of families who report community-based service systems are organized; and NPM-06, the percentage of children with special health care needs that received the services necessary to make transition to all aspects of adult life. CSHS health status indicators were included in the development of the CSHS needs assessment results for all stakeholder feedback. The CSHS Needs Assessment provides ratios of Primary Care Providers and Specialists that see CSHCN with Medicaid by region to number of CSHCN in that region. Data analysis was conducted by region to determine shortage areas. Barriers to access were addressed through Family Focus Groups.

Qualitative Methods

Family Focus Groups

To gain an informed understanding of the current system from the viewpoint of those who actively use it, family members of children with special health care needs (CSHCN) were asked to participate in 1 of 19 focus groups held throughout the State to discuss their experiences in locating and using medical and related health care for their children. Families were invited to the focus groups by Families Helping Families local offices, CSHS regional staff (particularly Parent Liaisons), and Pyramid Parent Training Center in New Orleans.

A total of 127 families, representing 132 CSHCN, participated in the focus groups. The average number of families per focus group was six, and the majority of families represented older children (average age was 12 years old) with multiple and severe disabilities. The racial composition of participants was almost equally divided between Caucasian (61) and African American (59), although 5 Asian families also participated. Approximately half of the families (69) utilized Children's Special Health Services (CSHS). Sixty percent (77) utilized some form of public insurance as their primary reimbursement source.

Group discussion was organized by an interview script of 13 questions designed to identify areas of the health care system that were helpful to their children and barriers to health care that exist for CSHCN. The guiding questions were organized into six categories: accessibility, coordinated care, CSHS system, family-centered care, compassionate care and current structure of care.

Focus group discussions were transcribed into written documents by transcriptionists present at each discussion. Documents were then entered into QRS N6 qualitative analysis software to assist in the creation of distinct themes based on the focus group responses. Response themes were developed from both the initial interview questions (a priori constructs) and from additional responses that were common to families during the focus group discussion (emergent constructs.) The major constructs that emerged during the analysis were: system accessibility, utilization of medical care, impact of illness on family, and CSHS system of care.

In the analysis, each construct was found to have several sub-themes. For example, the construct of system accessibility had several sub-themes: unmet needs, reimbursement barriers, transportation barriers, logistical barriers, transition issues, and links to related services. The sub-themes for utilization of medical care were out of state care, medicine/drug issues, medical resources, barriers to services, and communication. The sub-themes for impact of illness on family were caretaking burden, care coordination, resources for families, and fears for children. The sub-themes for CSHS system of care were CSHS as a resource, barriers to services, and suggestions for change.

Because of the tremendous amount of data collected by the LSU-HSC EII staff and the direct contact they had with providers, physicians, staff and families, the LSU_HSC EII staff provided a summary of some of the areas of consensus related to the service delivery model and brainstorming ideas on how to proceed with recommendations on the CSHS Long Range Plan (See Appendix E, Table 1).

Data Limitations

The strength of the CSHS Needs Assessment is that it provided a comprehensive picture of the capacity of pediatric health care in Louisiana. While not surprising, the results fully documented the lack of access families of CSHCN have in most areas of the state. They highlighted the main barriers to care and included input from all parts of the system, providing detailed information to complement the findings of the SLAITS data in Louisiana. In combination with SLAITS, the CSHS Needs Assessment provides a firm foundation with which to make decisions about needs of the CSHCN population in Louisiana and about the Long Range Plans for the CSHS program. An added advantage to performing such a comprehensive and widespread assessment is that it fostered many discussions and increased public awareness of the issues of this population and the Title V program in the state.

Some of the specific limitations of the CSHS Needs Assessment were: One, the telephone survey of primary care physicians and specialty physicians was limited by (a) Information was collected from office managers primarily and the physicians themselves may not have replied as the office managers did; (b) a few practices refused to participate in a telephone survey; (c) the main source for finding physicians was telephone listings (phone book and Internet) and it was difficult to find accurate phone listings in smaller cities and towns.; (d) survey informants did not always understand the questions or know the correct responses to board certification issues, leading to sometimes inaccurate recording of whether the physician was a pediatric specialist or not; (e) data on interns, residents, or fellows was not included as their practices were temporary and accurate counts difficult.

Second, the major limitation to the methodology for family focus groups was that we used Families Helping Families and Pyramid Parent Training to locate and invite families; consequently, all data came from families well connected to the system. This was considered strength as well as a weakness in that only those families using the system would be knowledgeable about its strong points and needs.

Third, in regard to specialty physician interviews, specialty physicians were contacted through our telephone survey and asked if they would agree to meet in person. Consequently, the group interviewed was comprised of physicians that either knew the interviewer or had a vested interest in CSHS programs. The interviewed group was not randomly chosen, and therefore, should be considered as a non-representative sample.

Collaboration

The CSHS Needs Assessment was built and developed on a foundation of partnership with MCH programs, other Department of Health programs, community partners and families. In response to agency downsizing and recommendations for elimination of direct medical services by the Title V program in Louisiana, CSHS and stakeholders developed a Long Range Plan to assess the needs of the CSHCN population and improve the CSHS program. Stakeholders included: Family Voices, Families Helping Families Agencies, Children's Hospital, Tulane Hospital for Children, Shriner's Hospital, LSU Health

Sciences Center, Earl K. Long Dept of Pediatrics, CSHS contract physicians, individual parents, CSHS and MCH Central Office and Field clinic staff, self advocates, Regional OPH staff, LSU Dental School representatives, CSHS Parent Liaisons, nutritionists, audiologists, social workers, nurses, and clerical staff.

Analysis of the data gathered by the Needs Assessment was performed by 9 regional teams of community partners including the Regional OPH administrator and/or medical director, the CSHS staff, parent liaisons and other family members, allied health professionals, regional epidemiologists and physicians participating in the program clinics. Each regional team evaluated the data and formulated recommendations for service delivery in their unique communities.

After the Regional Teams made recommendations a plan was formulated by the CSHS Management Team that will be reviewed with significant stakeholders prior to implementation. Families are represented at each step in this process, either as individuals or through CSHS Parent Liaisons or the CSHS Parent Consultant.

In addition to the stakeholder group that developed the CSHS Long Range Plan, the needs assessment process had an advisory group that provided survey input, interview and focus group questions, suggestions for data collection methodology, and that eventually reviewed the recommendations of each region to formulate the Long Range Plan. The CSHS program held a 3 day conference to bring local stakeholders into the process of interpreting the needs assessment data as described earlier. The Regional Teams attended the conference, worked toward developing a consensus of recommendations and reported to the full conference and CSHS Management Staff. The CSHS Management Staff held several meetings to review needs assessment data and develop the top 3 priorities for this population group. CSHS Management Staff then met with MCH and other OPH staff in a meeting to develop a consensus for state priority needs and related performance measures. CSHS Management Staff is continuing to work on development of a new model of service delivery for CSHCN in Louisiana based on the Long Range Plan and CSHS Needs Assessment data.

As a result of the entire process beginning with the stakeholder group that developed the Long Range Plan and including the development and implementation of the Needs Assessment in partnership with the LSUHSC EII staff, a tremendous amount of formal and informal collaboration has been obtained. This is considered a major strength of the Needs Assessment. The amount of data collected during this process can be viewed as a strength and a weakness. It is a strength in that a comprehensive picture of the state's pediatric health care delivery system was created that can be shared with other state agencies and stakeholder groups. The data provide a basis for recommendations for change for the Title V CSHCN program and have implications for the Medicaid program, family support organizations and the general MCH population. Because of the large amount of detailed data, it took time, expertise and resources to analyze and interpret. For example, to assist each Regional Team in looking at the data specifically for their region, Regional Epidemiologists were enlisted to interpret and present data. The result of all of the collaborative efforts should be a consensus on how to proceed with the future of the Title V CSHCN program in Louisiana that is supported by all stakeholders.

2.3.2 Overview of the CSHCN Population

Louisiana has an extremely high percentage of children with special health care needs (CSHCN) compared to other states. According to the National Survey of CSHCN based on the State and Local Area Integrated Telephone Survey (SLAITS) data, this state has the second highest percentage of CSHCN in the nation (15.9%). This is supported by statistics for the number of children under age 16 receiving federally administered SSI payments. Louisiana is the 11th highest state in the number of children receiving SSI while the US Census indicates that Louisiana ranks 24th in population (2004 Census estimates).

In comparison to the national average, Louisiana consistently ranks below other states on most of the SLAITS indicators. Families report that their children and youth with special health care needs have less access to health care, require more time and financial resources and have more absences from school than their peers in other states.

Disparities in health status have been documented by the SLAITS data for Louisiana compared with the nation. Louisiana has a significantly higher percentage of CSHCN among children of Hispanic ethnicity (LA= 20.7%; US= 8.5%) and among those in multi-racial categories (LA= 26.9%; US= 15.1%).

Pediatric primary and subspecialty care are concentrated in the major urban areas of the state. With recent movements in reorganization and downsizing of state government agencies, access to comprehensive pediatric care is a major concern without the safety net clinics provided by Children's Special Health Services. A large-scale comprehensive needs assessment was undertaken as part of the CSHS Long Range Plan to determine the capacity of pediatric health care in Louisiana and whether CSHS could stop providing direct health care services.

Data indicates that many of the pediatric sub-specialists were concentrated in the New Orleans area (27%) with many reporting that they traveled to more rural areas to provide care. The distribution of primary care for CSHCN was relatively equal by pediatricians and family practitioners across the state, with pediatricians located primarily in urban areas and family practitioners in rural areas. Only 52% of primary care physicians (PCPs) reported that they accepted Medicaid as compared to 69% of specialists. In addition, when further analyzed as to physicians open to CSHCN and CSHCN with Medicaid, data shows that in some rural regions of the state, half or more of the physicians do not accept patients with special needs and/or Medicaid (Regions 2,3,5,7) . Therefore, even with Medicaid coverage, CSHCN in Louisiana may not have access to care in their communities. In some regions, without the services of the CSHS Clinics, there are no pediatric sub-specialists in the community, or those that do exist do not take Medicaid. This was reinforced by family focus groups that were conducted during the Needs Assessment. The most often reported barrier to care was lack of services or providers in an area.

Priority Health Problems: The priorities for CSHCN in Louisiana were determined after consideration of all data compiled by the CSHS Needs Assessment, Regional Team recommendations and priorities for each region of Louisiana as determined at the CSHS Conference and a series of discussions

with CSHS Management team staff. The priorities and needs of the prior 5 year Needs Assessment were compared and few changes were noted. The main factor affecting shifting priorities was related to changes in state government and de-emphasis on public health providing direct health care services.

Many of the barriers to pediatric specialty care were discussed and emphasized by the Regional Teams in their top needs presented at the CSHS Conference. This was a direct result of the Needs Assessment data presented to them and their personal experiences with families who attend CSHS clinics and the physicians who conduct the clinics. Common themes were obtained through the Needs Assessment data, the Regional Team reports and CSHS Management Team experiences and were combined under the general area of “Access to Pediatric Sub-Specialty Care”.

Transition to adult services was another need stated by families in the 2000 CSHS Needs Assessment, and again in the current Needs Assessment. This was also shown by the SLAITS data with very poor indicators in this area for both Louisiana and the nation. The aging demographics of the CSHS population with the majority of enrolled children being adolescents was also considered a major factor in this priority.

Mental and dental health services were needs that were expressed 5 years ago by families listing their top needs. These again appear as priority needs in the current SLAITS data despite attempts to increase capacity in these areas over the past 5 years.

Gaps in Health Services: As described above, Louisiana’s PCP’s and specialists are disproportionately located in and around its major metropolitan areas: New Orleans, Baton Rouge, and to some extent, Shreveport. As noted above, the shortage in rural areas is exacerbated by the fact that many physicians do not take Medicaid. Lack of providers and/or services was the number one barrier in the CSHS Needs Assessment mentioned by families. Ratios of PCPs open to CSHCN to CSHCN, and of CSHCN with Medicaid to number of CSHCN, were calculated for each region, with the state ratios being 1:145 for CSHCN and 1:256 for CSHCN with Medicaid. While New Orleans had the most PCP’s, it also had the most children, making it a region with one of the higher ratios (1:170 and 1:261 respectively). For this reason, New Orleans Health Department has continued to provide primary care services in its six child health clinics. The most severe shortages of PCP’s are in Lake Charles (1:211 and 1: 480 respectively) and Alexandria (1:159 and 1:274). (See Appendix E, Table 2)

For specialists, the state ratios were 1: 211 for specialists who take CSHCN and 1: 326 for specialists who take CSHCN with Medicaid. In many areas, specialists exist for CSHCN but not for CSHCN with Medicaid. Shortages were worse in Lafayette (1: 294 and 1:840), Monroe (1:173 and 1:529), Shreveport (1:323 and 1:339), and Alexandria (1:165 and 1:348).

The CSHS Needs Assessment also assessed number of allied health providers available to children enrolled in Early Steps. Ratios of providers in each discipline per 100 children enrolled were calculated for each region to determine under-represented area (See Appendix E, Table 3). The following disciplines were underrepresented on a statewide basis: audiology, counseling, nutrition, registered nursing psychology, school psychology, and social work. Shortages in occupational therapy were noted in regions

3,5,6,and 7 and physical therapists were short in regions 6,7 and 8. When the total number of professionals in each region was obtained from the licensing board, data revealed that with the exception of audiologists, there are ample professionals in each region, however most were not yet enrolled in the program. This may be because some providers do not provide services to the pediatric population.

2.3.3 Direct Health Care Services

Financial Access

Financial access to comprehensive health care is a greater need in Louisiana than in most states due to Louisiana's high poverty rate and the fact that Louisiana has the second highest rate of children with special health care needs of any state at 15.9%, (SLAITS data 2002). According to the SLAITS data, only 51.9% of Louisiana CSHCN families said they had adequate public or private insurance to pay for the services they need, compared with 59.6% nationally. Forty-nine percent of CSHCN families have an income that is less than or equal to 200% of the federal poverty level. Twenty-two percent have Medicaid as their only source of insurance, 28.1% have more than one type of insurance, 41.5% have private insurance, and 8.1% are uninsured. To compound this, many PCP's as well as specialists do not take Medicaid in Louisiana. According to the 2004 CSHS Needs Assessment conducted by the LSU Early Intervention Institute, 48% of PCP's do not accept Medicaid and 31% of specialists indicated that they do not accept Medicaid.

The CSHS program provides specialty care and care coordination in its nine regional clinics for families who meet medical and financial eligibility. Children receiving Medicaid and families with incomes under the federal poverty level meet financial eligibility criteria for these direct services. A new proposal to increase eligibility above the federal poverty level is currently being evaluated. This proposal alone would make comprehensive care accessible to an additional 30.25% of CSHCN (SLAITS data 2002). If eligibility criteria remain the same, many families who do not receive Medicaid but have no health insurance or inadequate health insurance will continue to be denied access to coordinated, comprehensive care. Unfortunately, it is unlikely that CSHS will be able to afford such an expansion of eligibility criteria.

According to the SLAITS data, the racial distribution of CSHCN mirrors the distribution in the state: 57% are white, 37% are black, 4% describe themselves as biracial, and 2% describe themselves as "other". Of CSHCN families surveyed, 82.5% said doctors "were sensitive to values and customs" versus 87% nationally. Because a higher percentage of black families are below the federal poverty level and depend on Medicaid for health insurance coverage, access issues that are exacerbated by poverty disproportionately affect this population. In particular, lack of PCP's and specialists that take Medicaid will make access more difficult for cultural groups with greater levels of poverty. The role of regional CSHS specialty clinics and care coordination in access to care is therefore more important for this population. Cultural diversity of CSHS clinic staff and parent liaisons reflect that of the population that is served, as do pictures on public health educational brochures. Care is taken to insure that the literacy level of printed materials is at the 5th grade level or less.

Of the 1159 PCP's (See Appendix E, Table 4) in the state, 79% are open to CSHCN, 52% take Medicaid, and 45% are open to CSHCN with Medicaid. When ratios of number of children in the regions to PCP's open to CSHCN with Medicaid were calculated, lack of access to a PCP was a particular problem in Lake Charles, Thibodaux, and Shreveport compared to other areas of the state. Lack of PCP's who take Medicaid was also mentioned as a barrier in family focus groups in the CSHS Needs Assessment. Financial burdens in caring for their children and the need to take time off from working to care for CSHCN were also noted as issues for families.

A greater percent of specialists take Medicaid than PCP's. Of 631 specialists that take CSHCN, 409 or 65% take Medicaid. However, the lack of availability of specialists in many areas compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. A majority of specialists interviewed mentioned low Medicaid reimbursement rates as a barrier in the CSHS Needs Assessment, and many said the only reason they could take Medicaid is because they worked for an organization that provided a safety net, such as LSU or CSHS. Medicaid reimbursement for certain tests, home health care, pharmaceuticals, durable medical equipment, and mental health services was also mentioned as a barrier to accessing services. Interviewed specialists in every region mentioned the cumbersome referral process from PCP to specialist required by Medicaid's primary care case management model of service delivery as a barrier to accessing specialist care. CSHS clinics in each region provide this access to specialists for many CSHCN families who meet financial eligibility.

Physicians voiced concern over adequacy of care for CSHCN who do not meet CSHS financial eligibility requirements. As noted above, restrictive financial eligibility for CSHS clinics makes access to specialty care through this safety net impossible for many CSHCN. Many specialists indicate that they travel to different areas of the state to provide care, however access to specialists still remains a major problem, especially in rural areas. Physicians felt that lack of access to certain non-procedure oriented specialists such as neurologists was a particular problem, since Medicaid reimbursement is greater for procedures. As noted above, increasing financial eligibility for CSHS clinics would make regional specialist care available to more CSHCN.

Family focus groups in the CSHS Needs Assessment requested mental health services most often and dental services second. According to the SLAITS data, dental care was the second most frequent need of CSHCN reported by families (73.2%) and mental health the 8th most frequent need (22.5%). When asked about unmet needs, mental health was the third most frequent unmet need (26%) and dental care was the seventh most frequent unmet need (13.55%). CSHS provides dental care for children with cleft palates and cleft lips and in designated locations for all eligible children. Lack of Medicaid providers for both mental health and dental services is perceived as a problem by families in both the SLAITS data and the CSHS Needs Assessment.

Louisiana's Part C of IDEA early intervention program was moved to the Department of Health and Hospitals in July 2003. Capacity of the new program, "Early Steps" and early intervention/habilitation services, was assessed in the CSHS Needs Assessment and is described below. Until this year, all Part C

Services have been provided to families at no charge to them, regardless of ability to pay. However, due to the significant increase in the number of children enrolled and limited financial resources, a cost participation program has been proposed to begin in July, 2005. Therefore, for children in the 0 to 3 year age range, current barriers to obtaining services were not financial.

For older children, occupational, physical, and speech therapy are covered by Medicaid. CSHS covers therapy services for children seen in CSHS clinics who do not have another source of third party reimbursement or who do not receive those services in schools. Lack of access to these habilitation services was not mentioned by families as a need in the CSHS Needs Assessment.

Availability

Family focus groups in the CSHS Needs Assessment were asked to elaborate on barriers to care. Many access issues were listed, including lack of Medicaid providers, transportation, inadequate insurance coverage, lack of care coordination, and lack of mental health services. The racial composition of the focus groups was 61 white, 59 black and 5 Asian parents. Access issues mentioned were similar across cultural groups, however most were exacerbated by personal financial constraints (e.g.: lack of a car, restriction to providers that accept Medicaid, etc.).

Due to the urban concentration of physicians in the state, access to PCP's and specialists in more rural areas of the state is extremely difficult for many CSHCN. Physicians who take CSHCN are concentrated around the two medical schools, children's hospitals, and leading medical institutions that are located in New Orleans and, to a lesser extent, Shreveport. According to the CSHS Needs Assessment, primary care is approximately equally divided between pediatricians and family practitioners in the state (513 versus 564 respectively), however pediatricians are more likely to be located in major metropolitan areas (44% are in New Orleans or Baton Rouge areas) and family practitioners are distributed more evenly throughout the state (See Appendix E, Table 6). PCP's who take CSHCN are more likely to be pediatricians, are more likely to take Medicaid and to have more than 25% of their practice use Medicaid and less than 50% of their practice use private insurance. Hence, PCP's who take CSHCN are more accessible in the major metropolitan areas.

Since Louisiana's Part C Early Intervention Program, Early Steps, was moved under CSHS from the Department of Education in July 2003, coordination of public health services including CSHS clinics, Early Steps Early Intervention services, and Medicaid services is now easier. A common application has been developed and approved to facilitate entry into all three programs. CSHS staff have been trained to identify and refer children eligible for Early Steps. A follow-up coordinator has recently been hired for the Soundstart program to help ensure that newborn hearing screening results are sent to OPH and that eligible children are referred to Early Steps. It is hoped that in the near future all infants with identified hearing loss will be referred to Early Steps in a timely manner, and that comparison of data from the two programs will permit an accurate estimation of the percent of children with hearing loss who are enrolled in early intervention by six months of age to meet national quality indicators.

Specialists who serve CSHCN are also concentrated in the New Orleans area (145/528 residing in Region I). Otolaryngologists and ophthalmologists were most prevalent (83 and 54 respectively). Statewide distribution by specialty was determined by the CSHS Needs Assessment (See Appendix E, Table 7). The total number of pediatric specialists in the state in many specialties is very low (e.g.: 29 neurologists, 11 endocrinologists, 9 nephrologists, 3 geneticists). Lack of neurologists is a particular problem and was specifically mentioned by physicians interviewed.

Many specialists travel to rural areas to work in CSHS clinics and, to a lesser extent, to private clinics. Ratios of CSHCN to specialists were particularly high in Lafayette and Monroe. Since many specialists do not take Medicaid, the only access that many CSHCN have to specialty care is that provided in CSHS clinics. CSHS financial eligibility is currently limited to children on Medicaid and those with incomes at the federal poverty level or less. Hence, access to specialty care is not possible for many families that cannot travel to urban areas, unless it is through CSHS clinics. Because of limited eligibility, numbers of patients seen in CSHS clinics has declined each year for the past several years, from 6960 visits in 2000 to 5361 in 2004. Specialists interpreting the CSHS Needs Assessment data said low clinic numbers decrease incentive for many specialists to travel. Increased eligibility for CSHS clinics would increase numbers in these clinics and make regional access to specialty care available for many more CSHCN.

CSHS subspecialty clinics are held in OPH Health Units in each of the nine regions. Some clinics are held in private physician offices and in hospital clinics. For cystic fibrosis, clinics are held in two centers of the state with comprehensive services. Specialist physicians throughout the state are contracted both from medical schools and private physician practices. Many physicians travel from major medical centers to regional clinic sites once per month or once every other month to provide regional access to specialty care.

As in all states, the increasing number of older CSHCN with conditions such as cystic fibrosis, spina bifida, and congenital heart defects has created a need for transitional services. According to the SLAITS data, 4.5% of CSHCN received the services necessary to make transitions to all aspects of adult life, including adult health care and independence, compared with 5.8% nationally. Therefore, a new transition program was added to our CSHS clinics last year to ensure that these needs are addressed. Future population based care coordination activities will also address transition issues.

Finally, it is becoming harder for CSHS to find specialists who are willing to travel to remote areas for its clinics. For example, Lake Charles has not had access to pediatric orthopedic coverage and Alexandria has not had access to pediatric neurology coverage for several months. While these shortages are being resolved, a new emphasis on care coordination is emerging to help families travel to access these services in other regions. Most children that are currently being served have Medicaid. CSHS is using its Needs Assessment results as well as its clinic statistics to devise a long range solution to this problem.

2.3.4 Enabling Services

Transportation was the number one concern among both families and physicians in the CSHS Needs Assessment. Lack of services or providers in essential areas was the most often reported barrier to assessing care, making transportation to urban areas where specialists are located essential for families. Focus group families described the existing Medicaid transportation system as unreliable, un-family friendly, and inefficient. Approximately 90% of transportation comments were negative comments on the system. Bus terminals are located in towns that are spread out in rural areas and not located near major medical centers in cities. Using the system to access medical appointments therefore frequently necessitates at least one overnight stay in a major city, reliance on a car to reach the bus station from home and reliance on a taxi to reach the medical center on arrival. This quickly becomes too expensive and too cumbersome for families, especially those needing multiple specialist appointments. There is no rail system throughout the state and transportation by car is not affordable for many families.

Pediatric sub-specialists also mentioned transportation as a critical barrier to accessing care. Unreliable transportation was seen as contributing to a high number of missed appointments. This was especially noted by specialists who travel throughout the state, who noted that they could provide more and better care if they had more assistance from other specialists throughout the state in caring for CSHCN. There was concern that they would not be able to continue to travel to remote regions to attend clinics that had frequent missed appointments. Region I physicians suggested creating Centers of Excellence with access to various specialists in major medical centers as a potential solution. These would require an effective statewide transportation system, available housing for families, and regional case management.

Another barrier mentioned by specialists and families alike in all areas of the state was the referral system imposed by Medicaid's Community Care program, which requires a referral for all Medicaid specialty consultations from the PCP. Families mentioned excessive paperwork and long waits for specialist appointments as barriers. Other difficulties in navigating the healthcare system mentioned by family focus groups included limited knowledge of non-medical resources for CSHCN, including mental health services, by physicians. Almost all families felt they were doing their own care coordination with little support from the health care system except from within the CSHS system. They mentioned the importance of parent organizations such as Families Helping Families and other opportunities to learn about social services and education as being of utmost importance.

Families receiving services from the CSHS clinics thought the support received in navigating the healthcare system from social workers, nurses, and family liaisons was very effective. The EII Needs Assessment family focus groups described CSHS staff as knowledgeable, compassionate, good communicators, and effective in acquiring needed services for CSHCN. They also said nurses, social workers, and family liaisons were "most appreciated for the assistance they give the families in coordinating the complex, multi-layered system of care required by their children. However, greater outreach to other parents, to PCP's, and to multiple points of entry into the system was recommended, as

was broader eligibility to include families with incomes slightly above current eligibility levels. Increasing care coordination services in the clinics by increasing the number of social workers was also suggested.

Financial caretaking burdens, lack of qualified home health care assistance, and long term care were other concerns voiced by families. Improved access to health education materials such as easy to read brochures, DVD's/CD's, and internet sites was also listed as a need by families. Services such as respite care are available for financially eligible families through EPSDT personal care services, however many physicians are unaware that they exist or unaware of how to access them.

Increased Medicaid reimbursement for ancillary services was listed as a need by specialists, especially for nutrition services. While WIC services are available for children from birth to five in financially eligible families, older children needing special formulas had financial difficulty obtaining them.

2.3.5 Population-Based Services

Outreach for CSHS services:

Information regarding CSHS services is distributed in each of the nine regional CSHS offices. However, there has been a steady decline in visits in CSHS clinics (see clinic numbers under "Availability" above). This is due to restrictive financial eligibility criteria combined with increased Medicaid coverage to 200% poverty permitting children to be seen in private clinics. There is a need for outreach to private PCP's to increase awareness of these clinics. Some efforts have been made this past year to increase awareness among pediatricians including letters and distribution of CSHS brochures at medical conferences, however a major outreach effort has been postponed due to current limitations of expansion of staff positions, workload of existing staff and budget constraints.

Birth Defects Registry

One population based service that has started data collection is the Louisiana Birth Defects Registry which is a program of CSHS. The purpose of the registry is to provide information to families of children identified as having birth defects on available medical, social and educational services. Legislation enacting the Louisiana Birth Defects Monitoring Network (LBDMN) was passed in 2001 and a program coordinator was hired in 2002 and surveillance staff have been hired. LBDMN has just recently begun surveillance for birth defects in Louisiana resident children under age 3 at birthing and pediatric hospitals in Bossier, Caddo, Calcasieu, East Baton Rouge, Jefferson, and Orleans parishes. In addition to helping families access services, data will be analyzed to determine frequency of birth defects and to plan for future educational and preventive efforts. The registry will provide important information for parents of CSHCN regarding services available, and the information gained from data collected will be vital in planning future CSHS directions.

Outreach for Early Steps Early Intervention Program:

Early Steps has performed extensive outreach as part of its Child Find activities to make early intervention possible for every child with developmental delay or with a medical condition with a high risk of developmental delay. In fact, outreach through clinics, physicians offices, public health offices, Medicaid, conferences for healthcare professionals, TV announcements, etc has been so successful that in its first year under DHH enrollment in Louisiana's Part C program increased 45% from July 2003 to July 2004. Percent of children age birth to three enrolled in the program increased from 1.25% in 12/1/2002 to 2.1% by June 2004.

As a result of this successful outreach, the program experienced budget overruns in its first two years. Therefore, eligibility for the program is being revised, provider pay is being decreased, a parent cost-participation plan is being implemented, and providers are being encouraged to use a "coaching" model to enable daycare workers and parents to provide services between visits so that services can be decreased in frequency. It is hoped that with these changes the program can continue to provide needed services to all eligible children, and outreach can be continued to ensure that all eligible children are enrolled.

Soundstart Newborn Hearing Screening Program

Universal newborn hearing screening has been mandated for Louisiana's birthing hospitals since 2002. In 2003, 93.6% of infants (60,388) were screened for hearing loss before hospital discharge. Of these, 6.4% were referred for an audiological evaluation, and of these 91 were diagnosed with a permanent childhood hearing loss. Reporting of audiological evaluation results and follow-up information is incomplete, in part because it is not legislatively mandated. Current activities of this program are to develop a system to track children after screening to enrollment in early intervention and determine barriers to successful follow-up services. However, data sharing with EarlySteps, Department of Education and other sources will be explored in the future. Soundstart is funded by grants from CDC and MCHB and is a program in the Hearing, Speech and Vision Program under CSHS.

2.3.6 Infrastructure-Building Services

Systems of Services

At the PCP level, CSHS seeks to improve comprehensiveness of care and care coordination activities for CSHCN through its medical home initiative. According to the CSHS Needs Assessment, 79% of PCP's take CSHCN in their practices. A notable proportion of interviewed specialists expressed concern about the quality of care provided by PCP's for children with some diagnoses. CSHS held its first medical home training program in 2002 in collaboration with Louisiana's American Academy of Pediatrics State Chapter and Family Voices. Three other medical home trainings have been held in Houma, Shreveport, and Monroe for pediatricians, families and allied health professionals. Louisiana participated in the national Hawaii conference on the medical home in 2002 and in the NICHQ Medical Home Learning

Collaborative in 2003. As part of the activities for the Learning Collaborative, CSHS placed care coordinators in two large private pediatric practices, one urban and one rural. Most recently a care coordinator was placed in the LSU faculty practice/resident urban clinic to incorporate medical home training into the pediatric resident curriculum. A workshop on the medical home was held for LSU faculty and clinic staff, and data are being collected to demonstrate improvement in “medical homeness” in the clinic as perceived by physicians and by families. ER visits and hospitalizations of CSHCN are also being tracked to determine whether the addition of medical home activities leads to a decrease in need for these services. If so, data will be presented to Medicaid to encourage funding of care coordination activities as an effective means of decreasing health care costs.

At the specialist level, CSHS provides clinics in each region to make access to specialists possible for CSHCN in all parts of the state. Dictated clinic notes are sent to PCP’s to prevent care fragmentation. Tertiary services are available in contracted local hospitals, in the Charity Hospital System which has regional hospitals, and in large medical centers such as Children’s Hospital, LSU Health Science Center, Tulane Hospital, and Ochsner Hospital.

CSHS clinics only serve 3% of the CSHCN population of the state. CSHS is currently examining utilization of these clinics by region and by specialty, as well as models of care coordination. For some CSHS sub-populations, CSHS staff may be better utilized in population based care coordination activities as opposed to provision of direct care in specialty clinics (see emerging issues).

Local Delivery Systems

Care for most CSHCN remains fragmented. Using SLAITS data to estimate total CSHCN and CSHS clinic data, only 3% of CSHCN in Louisiana receive care through CSHS specialty clinics. For CSHCN receiving care in CSHS clinics, clinic social workers and parent liaisons ensure that families are linked to community support services and public health services, and clinic notes are sent to the PCP. CSHS Needs Assessment parent focus groups spoke very highly of the coordinated care received in these clinics.

However, financial eligibility for CSHS clinics has not been updated in many years and is equivalent to Medicaid and LaCHIP eligibility. In addition, specialists said that many PCP’s do not know about CSHS clinics and do not refer eligible families to them. Families said more families needed to know about the clinics.

For the other 97% of CSHCN in the state care is frequently fragmented. Lack of care coordination for these families was mentioned in parent focus groups in the Needs Assessment. Physicians expressed fear that privatization of CSHS clinics would lead to more fragmented care, and would not be feasible in most regions due to a limited number of specialists available. Transportation to services both within regions and to specialists outside of the region remains a concern. There is definitely a need for care coordination among CSHCN not followed in CSHS clinics.

Collaboratives

CSHS collaborates with many agencies and providers to ensure a coordinated system of care. A common application has been developed for Medicaid, CSHS clinical services, and Early Steps Part C Intervention Program to provide one point of entry for all of these programs (see Availability, above). Medicaid reimburses for transportation services to CSHS medical appointments and links all Medicaid recipients to a PCP. In turn, CSHS provides access to specialists for CSHCN with Medicaid. Eligible CSHS children are referred to Early Steps. In the near future children with hearing loss identified by newborn hearing screening will be referred to Early Steps within CSHS. Children identified through the Louisiana Birth Defects Monitoring Network (LBDMN) will be referred to both programs as appropriate.

In New Orleans, CSHS collaborates with Children's Hospital to provide CSHS clinical space, and with LSU and Tulane physicians for medical services. The diabetes pilot project at Children's Hospital that was begun in 2001 has continued, where CSHS provides team services that are not reimbursable and Children's Hospital provides medical services. CSHS contracts with Tulane Medical Center to provide multidisciplinary services for cystic fibrosis patients. In Shreveport, CSHS provides care coordination and wrap around services for specialty clinics run by Shriner's Hospital. Most CSHS specialty clinics are held in OPH regional clinic sites using CSHS staff and contracted specialists.

LBDMN collaborates with numerous organizations. The Birth Defects Registry has an Advisory Board consisting of geneticists from the two medical schools, a pediatrician from the LA State Medical Society, a parent representative from the Spina Bifida Association of Greater New Orleans, an obstetrician from the March of Dimes, and an epidemiologist from the Office of Public Health. Within CSHS, the LBDMN collaborates with Early Steps and with the Newborn Hearing Screening program by referring babies with birth defects to Early Steps and to the Newborn Screening Program, as appropriate. It is investigating ways to share data in the future. Within MCH, LBDMN collaborates with the Fetal and Infant Mortality Reduction Program (FIMR) which provides a birth defects coordinator at 50% time. LBDMN Program Coordinator and staff participate in the FIMR Review Committees. Louisiana Pregnancy Risk Assessment and Monitoring System (LaPRAMS) and the Epidemiology, Assessment and Evaluation Program (EAE) participate on the LBDMN advisory board. EAE also provides epidemiology support. Within OPH, the Environmental Epidemiology and Toxicology Program, Genetics Program, Infections Disease Epidemiology Program, and Nutrition Program all participate on the Advisory Board and provide expertise as needed. Within the community LBDMN collaborates with Families Helping Families, Louisiana Public Health Institute which is the contractor for three field surveillance staff positions, Louisiana Folic Acid Council, March of Dimes, and Spina Bifida Association of Greater New Orleans. Families of children in the registry are also supplied with information about numerous other resources in the community.

In its Medical Home Initiative, CSHS collaborates with Family Voices, the Louisiana AAP chapter, LSU Pediatric Department, and two private physician's practices to create model medical homes and to incorporate medical home training into resident curriculum, to improve the capacity of pediatricians

to provide true medical homes for CSHCN. Medical home trainings have had participation of many other stakeholder organizations as well including Children’s Hospital, Tulane Medical Center, the Department of Education, the Governor’s Office of Disabilities, Shriner’s Hospital, Agenda for Children, Area Health Education Consortiums (AHEC), Families Helping Families, Medicaid, the MCH Coalition, and state legislators.

Coordination Efforts

Social workers in CSHS clinic provide applications for Medicaid and for Part C of IDEA Early Intervention Services (Early Steps). A common application form has been developed for both of these programs and for CSHS clinics. Medicaid provides transportation to CSHS appointments and links children to a PCP. Social workers in CSHS clinics refer eligible families to SSI, to Office for Citizens with Developmental Disabilities (OCDD) services including Personal Care Attendants/Respite Services, Waiver services and the cash subsidy program, to the Office of Mental Health Services which include mental health services for clients who are homicidal, suicidal or gravely disabled, to the Office of Family Support for TANF funds, to Louisiana Rehabilitation Services which provides vocational training and job placement, and to WIC nutritional services. CSHS participates in a core inter-agency team to address transition issues of teens and young adults with special health care needs with Louisiana Rehabilitation Services, Department of Education, OCDD, and Families Helping Families. CSHS is currently reviewing alternative population based models for care coordination to improve access to these services.

CSHS has extensive collaboration with LSU and Tulane Medical Schools in the provision of direct services as described above, as well as contracts with local hospitals and the statewide Charity Hospital System.

In addition, CSHS collaborates with the Louisiana Chapter of the AAP in its medical home project. The LA Chapter AAP Newsletter has been an important vehicle for informing pediatricians of CSHS programs, and has provided mailing labels routinely for statewide CSHS educational mail-outs to pediatricians. The Statewide CSHS Parent Consultant and Parent Training Consultant collaborate with Families Helping Families to train parent liaisons in CSHS clinics and community outreach specialists in Early Steps in family advocacy and family support skills. Family Voices has been a key participant in the Medical Home Initiative, providing a program coordinator for the care coordinators and participating in the National Learning Collaborative and the Promise to the State. CSHS social workers refer to “Project Prompt”, an advocacy program of Families Helping Families that provides assistance with obtaining special education services through the public school system, to “Federation for Families” which provides advocacy for mental health services, and to “Parent to Parent”, another parent support group for CSHCN in certain parts of the state.

CSHS coordinates with Medicaid which provides transportation to CSHS appointments and links children to a PCP. CSHS social workers refer to programs of the Office for Citizens with Developmental Disabilities including respite and PCA services, waiver services and cash subsidies. They refer eligible children to the SSI disability program, to Louisiana Rehabilitation Services, and to the Office for Family

Support for TANF funds. They collaborate with Families Helping Families (FHF) for parent advocacy training, and refer families to FHF as well as several other parent support organizations for educational and support services. CSHS collaborates with Family Voices in its Medical Home Project and with various hospitals, clinics and private providers in the provision of direct services. The Part C Early Intervention program was moved under CSHS in 2003 facilitating referral of children from CSHS clinics into Early Steps and vice versa. Staffs have been trained and a common application has been devised to facilitate referrals. Older children needing special education services are referred to the Department of Education Part B services. A core transition team with representatives from Department of Education, Louisiana Rehabilitation Services, OCDD and FHF is developing comprehensive, coordinated transition services for Louisiana's youth.

At the community level, social workers in each region are familiar with services in their communities. Families are linked with public health programs, family support organizations, educational programs, and other services in each area. A population based model of care coordination is being explored to improve access to these services and programs for CSHCN not seen in CSHS clinics. See CSHS Needs Assessment Appendix F, for a list of groups and individuals involved in the CSHS needs assessment process.

Monitoring

A series of steps have been taken to improve services for CSHCN in the state Health Units:

- Implementation of a Physicians contracts monitoring system (team includes: CSHS Medical Director, State Nurse Consultant, Program Specialist and Program Epidemiologist)
- Continuation of Physicians Advisory Group has the objective to provide guidance and input on the Long Range Planning
- Review of several data sources including CSHS appointment system and the Encounter National Billing Form to address National and State Priorities (Program Medical Director, Program Manager and Program Epidemiologist)
- Annual visits to the Regional Clinics to address issues concerning the local region, distribute pertinent data and other issues of relevance to services of CSHCN (Central Office Team)
- Monthly reports from the Regional Parent Liaisons
- Ongoing CQI process in regional clinics that involves a self-assessment and audit of records that is shared with Regional OPH Administrators
- Annual self-assessment of training needs by nurses with one week training based on results of assessment

In addition to these monitoring activities, the CSHS policy manual and CSHS physician's manual are in each clinic for easy reference regarding eligibility, policies, and procedures. As part of the physician contract monitoring, medical licenses are verified with the state licensing board to be sure they are current

and in good standing. Number of patients seen each year in each clinic is reviewed and clinic nurse supervisors complete a form regarding patient and nurse satisfaction with the physician's services.

Development of the CSHS Long Range Plan

The CSHS Needs Assessment has provided a comprehensive view of pediatric health care for CSHCN in Louisiana including, PCPs, specialists, and families' needs. Barriers to improved access such as transportation are clearly stated. Shortages in availability of specialists and access to PCPs are clearly evident. Coordination with Medicaid to improve access by improved reimbursement for primary care services and development of an effective transportation system is ongoing. Results of the Needs Assessment indicate that the optimal mode of service delivery for CSHS children may be a combination of case management services, Centers of Excellence for children with complex conditions where expertise exists only in Metropolitan areas, and continuation of some safety net regional CSHS specialty clinics. Increased care coordination activities will permit ongoing assessment of the ability of families to meet their healthcare needs, which will permit continued assessment of the adequacy of community-based systems. Recommended actions included in the Long Range Plan are to continue to develop infrastructure and increase access to primary and specialty care.

2.4 Health Status Indicators

See Supporting Documents, Form 20, for Health Status Indicator Forms and Detail Sheets.

2.5 Priority Needs

See Supporting Documents, Form 14.

The original ten Title V priority needs for the State's Block Grant created in 2000 were: (1) to decrease infant mortality and morbidity, preterm births, and LBW; (2) to decrease mortality and morbidity among adolescents; (3) to decrease intentional and unintentional injury in the MCH and CSHCN populations; (4) to increase care coordination among children with special health care needs; (5) to increase access to and utilization of comprehensive primary, preventive, and specialty care services for women of reproductive age, infants, children, adolescents, and children with special health care needs with particular emphasis on transportation and provider availability; (6) to assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services; (7) to assure the oral health needs of the MCH and CSHCN populations are met; (8) to address the social, emotional, and psychological needs of the MCH and CSHCN populations; (9) to assure early identification and referral of substance abuse, domestic violence, and child abuse and neglect; and (10) to reduce unhealthy and risk taking behaviors of adolescents, pregnant women, and parents through public, professional, and patient education.

Following the 2005 needs assessment process the MCH and CSHS staff created the following new priority needs for Louisiana's Title V Block Grant: (1) Decrease infant mortality and morbidity in

collaboration with regional coalitions comprised of public and private health and social service providers; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations; (3) Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation; (4) Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment; (5) Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral; (6) Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination. (7) Promote pre-conceptional and inter-conceptional health care including family planning and folic acid education; (8) Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations; (9) Improve the health behaviors of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity; (10) Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity, b) develop preventive public health campaigns targeting high risk populations, and c) perform process and outcome evaluation.

Many areas that were the focus of Louisiana's 2000 needs assessment continue to be a priority. Infant mortality, low birthweight, prenatal care, care coordination, oral health, intentional and unintentional injury remain focus areas of the MCH Program. Assuring access to primary care providers, for both the uninsured and Medicaid populations, also continues to be a major focus of the MCH and CSHS Programs. Since eligibility rates for LaCHIP have increased, more of Louisiana's children are becoming insured. Assuring access to a primary care provider for these children must be a priority. A number of children continue to lack access to CSHS services.

New areas have emerged as priorities, and have been specified in the new list of priority needs. The need to collaborate and help build capacity at the regional level to address infant mortality and morbidity was specifically mention in priority need #1. The need to address healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity was purposely stated in priority need #9 in an attempt to provide areas focus for improving health behaviors of the MCH and CSHS populations. The Title V Program decide to address the collection and use of reliable and valid data in priority need #9 so that MCH high-risk population can be better identified and target with evidence-based program and public health campaigns, and that MCH programs can be better evaluated.

II. E. Outcome Measures

See Supporting Documents, Form 12.

1. The infant mortality rate per 1,000 live births

The National Performance Measures that may produce an impact in infant mortality include the teen birth rate (# 8), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17) and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact infant mortality include women who have been physically abused (#6), substance abuse in pregnancy (#7) and Sudden Infant Death Syndrome (SIDS) activities (#11). The Health System Capacity Indicators that impact infant mortality are the percent of women with adequate prenatal care using the Kotelchuck Index (#4) and the Medicaid and Non-Medicaid comparison for pregnancy outcome indicators (#5). The Annual Health Status Indicators that impact infant mortality are the percent of low birth weight (LBW) births (#1A and #1B) and the percent of VLBW births (#2A and #2B).

The infant mortality rate decreased from 10.2 deaths per 1000 live births in 2002 to 9.3 in 2003. Although the Annual Outcome Objective of 8.1 was not met, this was the first decrease in infant mortality since 2000. The decrease in Louisiana's infant mortality rate reflects a decrease in the neonatal mortality rate; the post-neonatal mortality has not changed (See Outcome measures 3 and 4). The race-specific infant mortality rates show a decrease for both whites, 6.9 to 9.4 deaths per 1000 white births, and blacks, 15 to 13.8 deaths per 1000 black births (See Outcome Measure 2). Geographically, all but one of Louisiana's nine public health regions showed a decrease in their infant mortality rates. Region 9's infant mortality rate increased from 6.8 deaths per 1000 births to 8.3.

During 2003 there was a decrease in the rate of teen births from 31.2 to 30.1 births per 1000 teenagers aged 15-17 year), an increase in the percent of women receiving prenatal care in the first trimester from 83.8 to 84.2%, a slight increase in the percentage of VLBW infants from 2.1% to 2.2%, and an increase in the percentage of VLBW infants born in hospitals with tertiary care services from 84.3% to 84.4%. PRAMS 2002 data indicates that 5% of women reported physical abuse during their most recent pregnancy; 12% of mothers reported smoking cigarettes during their 3rd trimester; and 5.0% of mothers reported consuming alcohol during 3rd trimester. The SIDS mortality rate increased from 1.0 deaths per 1,000 live births in 2002 to 1.1 in 2003. The annual performance objective for this indicator was not met. The percentage of women receiving adequate prenatal care as measured on the Kotelchuck Index showed a increase to 83.5% from 80.7%, the percent of LBW births overall did not change (10.7%) with singleton births increasing from 8.6% to 8.7%, and the percent of VLBW births overall increased slightly from 2.1% to 2.2% with singleton births increasing from 1.7% to 1.8%. Comparison of Medicaid and Non-Medicaid populations for pregnancy outcome indicators showed that on all four indicators (infant mortality rate, LBW rate, first trimester entry into prenatal care and adequacy of prenatal care), Medicaid populations fared much worse than non-Medicaid populations.

There are a multitude of factors that are related to the infant mortality rate including maternal health and habits; access to risk-appropriate prenatal, perinatal and post-partal care for the pregnant woman; access to risk-appropriate neonatal and infant health care for newborns and infants; and parental education in the areas of prenatal care and care of the infants. The increase in the infant mortality rate in 2002 is difficult to understand since we had virtually no change in the LBW and VLBW rates which are the primary associated risk factors for infant death. Analysis of feto-infant mortality in the state for 2000-2002, based on the Perinatal Periods of Risk methodology, shows that while the State's excess mortality continues to be in the areas of early and late fetal deaths, neonatal death for those infants of less than 1500 grams, and postneonatal deaths of infants born at more than 1500 grams, were the two areas with the greatest excess mortality (See Outcome Measure 5). Analysis of data from the Louisiana PRAMS Program has provided further information on specific risk factors and has helped to target MCH intervention efforts. This has

lead to the development of a systematic statewide approach to decreasing infant mortality. In 2002, the MCH program initiated a statewide approach to infant mortality as opposed to only focusing on those areas of the State with increasing infant mortality rates. The MCH program has given grants to the regional groups working in the Fetal and Infant Mortality Reduction Initiative (see National Performance Measure # 17 and State Performance Measure # 9). The efforts are linked to other programs, such as the three federally funded Healthy Start grants. In this way, the MCH Program supports the active, community-based initiatives now in 7 out of the 9 regions in the state. These efforts coupled with the establishment of local Infant Mortality Review Initiative programs, will help define the local antecedents of infant death. Initiation of similar community-based efforts in the remaining areas will help to further define barriers present in local areas and implement programs to address them. The impact of these efforts should be successful in reestablishing a downward trend of the infant mortality rate.

2. The ratio of the black infant mortality rate to the white infant mortality rate

The National Performance Measures that impact this ratio include the teen birth rate (#8), VLBW births (#15), VLBW infants delivered in tertiary care facilities (#17) and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact this ratio include women who have been physically abused (#6) and substance abuse in pregnancy (#7). The Health System Capacity Indicator that impacts infant mortality is the percent of women with adequate prenatal care on the Kotelchuck Index (#4). The Annual Health Status Indicators that impact infant mortality are the percent of low birth weight (LBW) births (#1A and #1B) and the percent of VLBW births (#2A and #2B).

In 2003, the white infant mortality rate was 6.4 deaths per 1000 white births and the black infant mortality rate was 13.8 per 1000 black births, resulting in a ratio of the black to the white infant mortality rates of 2.2. This is the same as the ratio in 2002 of 2.2. During 2003, there was an increase in the percent of black women receiving prenatal care in the first trimester (74.7% to 76.3%) with this percent significantly lower than the 88.6% of white women receiving prenatal care in the first trimester. There was a slight increase in the overall percentage of VLBW infants from 2.1% to 2.2%, the proportion of VLBW births increased in black infants to 3.5% and in white infants to 1.2%. Although 84.4% of all infants less than 1,500 grams were born in Level III facilities, a similar percentage of black VLBW infants (84.2%) were born in Level III facilities compared to white VLBW infants (84.1). PRAMS 2002 data indicate that a higher percentage of white women smoked and drank alcohol during their most recent pregnancy (21.8% for white women versus 8.5% for black women, and 53.4% for white women versus 22.6% for black women, respectively). The percent of pregnant women who have been physically abused before and during their most recent pregnancy was higher for black women (14.9%) than for white women (7.0%). In 2002, there was a slight decrease in the SIDS death rate for black infants to 1.1 from 1.2 deaths per 1000 births with an increase in the rate to 0.9 from 0.8 deaths per 1000 live births for white infants.

Efforts to decrease racial disparity include assuring access to risk-appropriate quality care services for all pregnant women and their infants. The *Partners for Healthy Babies* public information campaign uses focus groups of high-risk populations, including black women and teens, in order to develop prenatal care messages. More information is needed on the reasons for delayed entry into prenatal care for black women in order to develop interventions that address these reasons. MCH is developing initiatives to increase access to comprehensive prenatal care services in areas with poor outcomes of pregnancy through the development of community-based programs. The higher mortality rate due to SIDS in black infants further indicates the need for continued efforts on risk reduction for SIDS targeted to the black population.

3. The neonatal mortality rate per 1,000 live births

The National Performance Measures that impact this rate include the teen birth rate (#8), VLBW births (#15), VLBW infants delivered in tertiary care facilities (#17) and infants born to mothers who received

early prenatal care (#18). The State Performance Measures that impact this rate include women who have been physically abused (#6) and substance abuse in pregnancy (#7). The Health System Capacity Indicator that impacts infant mortality is the percent of women with adequate prenatal care on the Kotelchuck Index (#4). The Annual Health Status Indicators that impact infant mortality are the percent of low birth weight (LBW) births (#1A and #1B) and the percent of VLBW births (#2A and #2B).

The 2003 neonatal mortality rate of 5.7 deaths per 1000 births is a decrease from the rate of 6.6 in 2002; however it still did not meet the Annual Outcome Objective of 4.8. This increase is not statistically significant. Nevertheless, the state MCH program has increased the efforts for outreach within the high-risk population targeting the areas with the highest concern in the state. There were decreases in both the white and black neonatal mortality rates with the white neonatal mortality rate decreasing from 4.4 to 3.9, and the black neonatal mortality rate decreasing from 9.7 to 8.5. The percentage of women receiving adequate prenatal care as measured on the Kotelchuck Index showed a slight increase, the percent of LBW births overall did not change, and the percent of VLBW births overall decreased slightly.

4. The post-neonatal mortality rate per 1,000 live births

The National Performance Measures that impact post-neonatal mortality include immunization rates (#7), uninsured children (#13) and Medicaid services (#14). The State Performance Measures that impact post-neonatal mortality include substance abuse in pregnancy (#7), SIDS activities (#8) and child abuse and neglect (#3). The Health Systems Capacity Indicators that impact post-neonatal mortality is the percent of Medicaid and SCHIP enrollees under 1 year of age with one periodic screen (#2 and #3).

In 2003, the post-neonatal mortality rate per 1,000 live births in Louisiana was 3.6, which was the same as the rate of 3.6 in 2002. The Annual Outcome Objective of 3.0 was not met. The black post-neonatal mortality rates and the white post-neonatal mortality rates in 2003 did not differ from the 2002 rates of 5.3 and 2.5 respectively.

5. The perinatal mortality rate per 1,000 live births and stillbirths

The National Performance Measures that impact the overall perinatal mortality include the teen birth rate (#8), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17) and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact infant mortality include women who have been physically abused (#6), and substance abuse in pregnancy (#7). The Health System Capacity Indicators that impact infant mortality are the percent of women with adequate prenatal care on the Kotelchuck Index (#4) and the Medicaid and Non-Medicaid comparison for pregnancy outcome indicators (#5). The Annual Health Status Indicators that impact infant mortality are the percent of low birth weight (LBW) births (#1A and #1B) and the percent of VLBW births (#2A and #2B).

In 2003, the perinatal mortality rate was 12.1, which was a slight increase from the rate of 12.6 in 2002 and did not reach the Annual Outcome Objective of 10.8. The decrease in the overall perinatal rate was associated with a decrease in the neonatal mortality rate and a decrease in the black perinatal mortality rate.

The rate of teen births continues to decrease in Louisiana, in 2003 the teen birth rate (15-17 years) decreased to 29.8. During 2003 there was also an increase in the percent of women receiving prenatal care in the first trimester, a decrease in the percentage of VLBW infants, and an increase in the percentage of VLBW infants born in hospitals with tertiary care services. The percentage of women receiving adequate prenatal care as measured on the Kotelchuck Index showed a slight increase, the percent of LBW births overall did not change, and the percent of VLBW births overall decreased slightly. Comparison of Medicaid and Non-Medicaid populations for pregnancy outcome indicators indicated that on all four

indicators (infant mortality rate, LBW rate, first trimester entry into prenatal care and adequacy of prenatal care), Medicaid populations fared much worse than non-Medicaid populations.

Further analysis of perinatal deaths has been done utilizing the Perinatal Periods of Risk approach. This approach uses time of death and birth weight to assess the areas of excess mortality and to help pinpoint areas such as Maternal Health, Maternal Care, Neonatal Care or Infant Care as areas that need to be addressed. Data from this analysis indicated that the state has had a non-significant change from the previously reported rates (1997-1999) to the latest analyzed period (2000-2002). There continues to be an increase in deaths in those born at less than 1500 grams and in the group of infants born at more than 1500 grams and dying in the post-neonatal period. Premature birth and SIDS continue to be the top causes of death within these population subgroups. A large disparity between the black and the white population, especially for the less than 1500 grams deaths, is being addressed and specifically targeted by state-wide efforts such as the Nurse Family Partnership Home Visiting Program, the Feto-Infant Mortality Review (FIMR), and improving outreach and access to health services for the black population.

6. The child death rate per 100,000 children aged 1-14

The National Performance Measures that impact the child death rate include CSCHN children with a medical home (#3), immunization rates (#7), motor vehicle crash deaths (#10), uninsured children (#13) and percent of potentially Medicaid eligible children who received a services paid by the Medicaid Program (#14). The State Performance Measures that impact the child death rate include access to School-Based Health Centers (SBHC) (#1) and child abuse and neglect (#3). The Health Systems Capacity Indicator that impacts the child death rate includes the rate of children hospitalized for asthma related conditions (#1). The Annual Health Status Indicators that impact the child death rate include the death rate of children due to unintentional injuries especially motor vehicle crashes (#3A - #3B), and the rate of non-fatal injuries among children including motor vehicle crashes (#4A -#4B).

In 2003, the child death rate per 100,000 children aged 1-14 in Louisiana was 29.7 deaths per 100,000 children aged 1-14 years, which was a decrease from the rate of 34.8 in 2002. Louisiana surpassed the Annual Performance Objective of 31.0. The leading cause of deaths in children aged 1 to 14 was unintentional injury followed by congenital anomalies and homicide. Immunization rates, rates of uninsured children and percentages of income eligible children who receive Medicaid services are indirect indicators of access to preventive and primary health care services. Hospitalization rates for asthma and non-fatal injuries along with mortality rates for unintentional injuries address the leading causes of mortality and morbidity in children age 1 - 14 years. Immunization rates and the percentage of children without health insurance improved, as did the percent of potentially Medicaid eligible children who received a service paid by the Medicaid Program.

Services to children and adolescents in SBHCs include education on high-risk behaviors, as well as assessment and management of health problems. In 2002, the percentage of children and adolescents enrolled in public schools that had access to SBHCs increased slightly to 6.9% from 6.1% in 2001. Increases in this performance measure would mean that more children and adolescents have access to preventive health services, which could impact the child mortality rate.

Child deaths due to intentional injury and neglect are reflected in the rate of children under 18 who have been abused or neglected. For 2003, the rate reported of 7.9 children per 1000 children under age 18 is a slight decrease from the rate of 8.3 in 2002. Screening for families at-risk for abuse and neglect, as well as interventions for prevention including education and family support services, has the potential to decrease intentional child deaths through the prevention of child abuse and neglect.

The increase in the Child Mortality rate has led to further efforts to decrease child mortality focusing on the prevention of unintentional injury through public and professional education and other initiatives addressing specific causes of unintentional injury such as those aimed at car safety seat and passenger restraints. Regional Injury Prevention Coordinators as well as a statewide SafeKids Coordinator are supported by the MCH Program to develop and implement community-based injury prevention activities to decrease injuries as the leading cause of death in this age group.

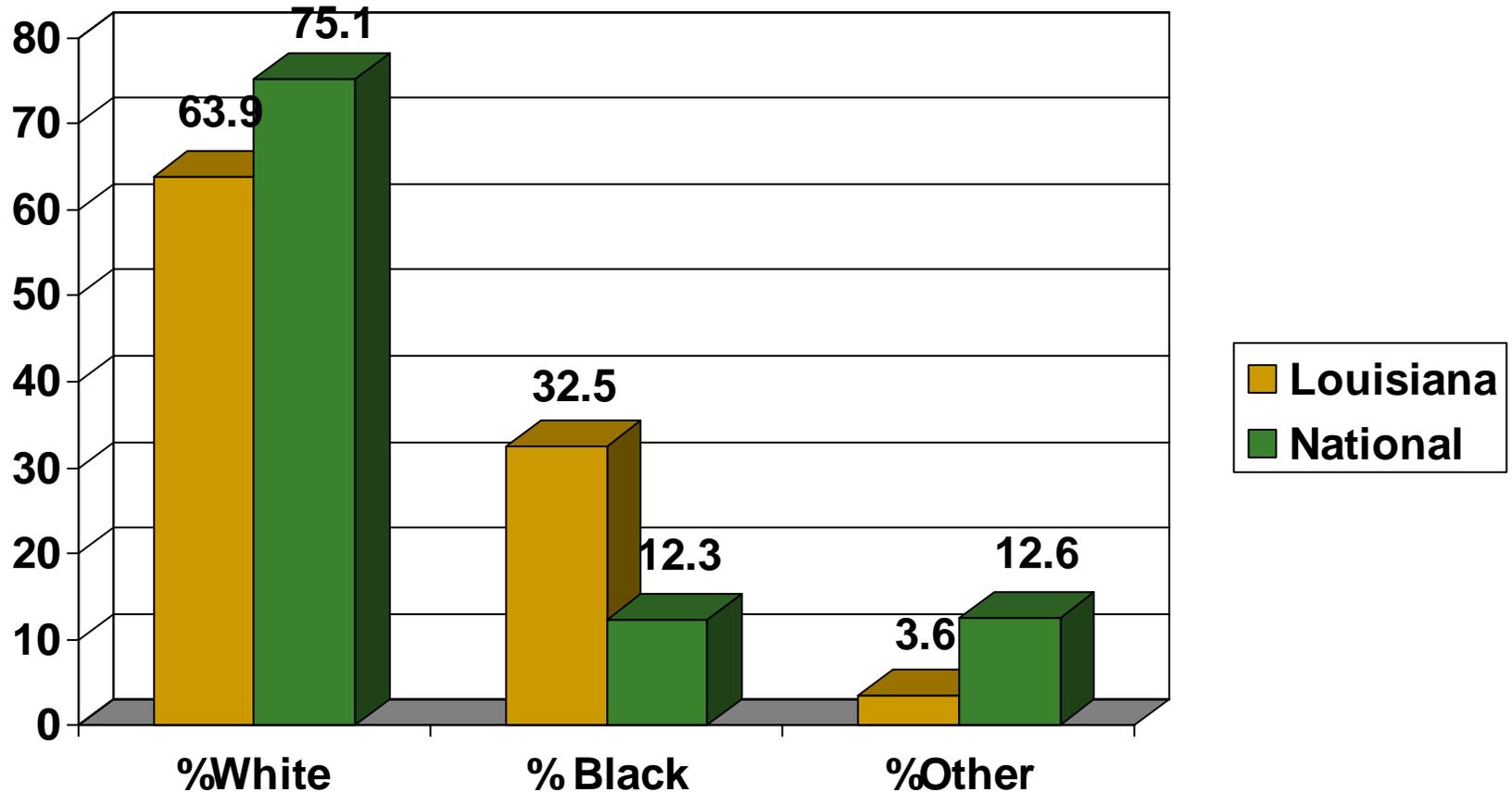
APPENDIX A

FIGURES TITLE

FIGURE 1-----	Racial Distribution, 2003
FIGURE 2-----	Hispanic Origin Distribution, 2003
FIGURE 3-----	Louisiana Live Births by Race
FIGURE 4-----	Poverty Rates, 1990-2003
FIGURE 5-----	Louisiana Infant Mortality Rates by Race, 1998-2003
FIGURE 6-----	Louisiana Low Birthweight by Race, 1998-2003
FIGURE 7-----	Medicaid/LaCHIP Eligibility

Racial Distribution

Louisiana and National

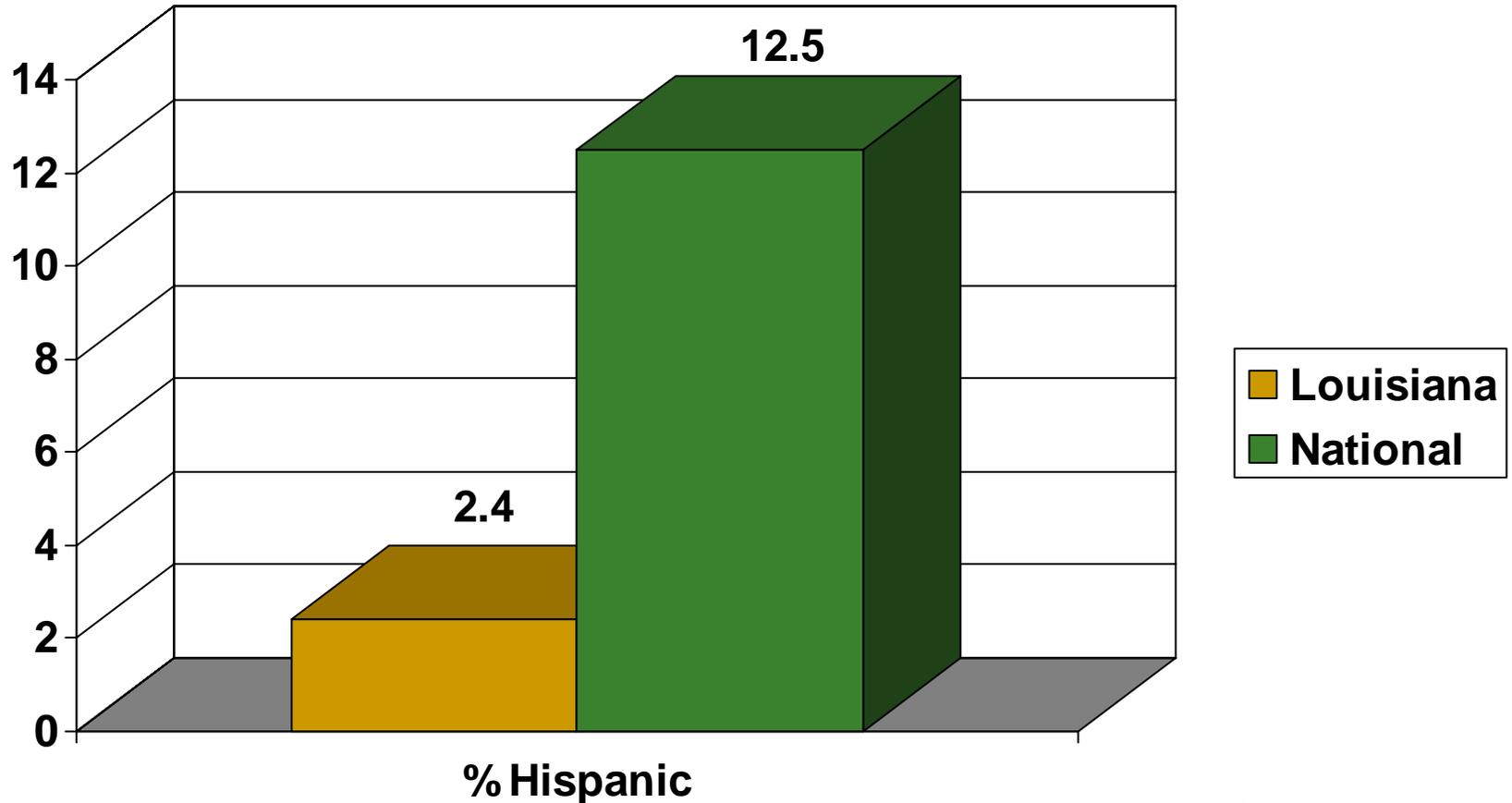


2003 Population Estimates

FIGURE 1, APPENDIX A

Hispanic Origin Distribution

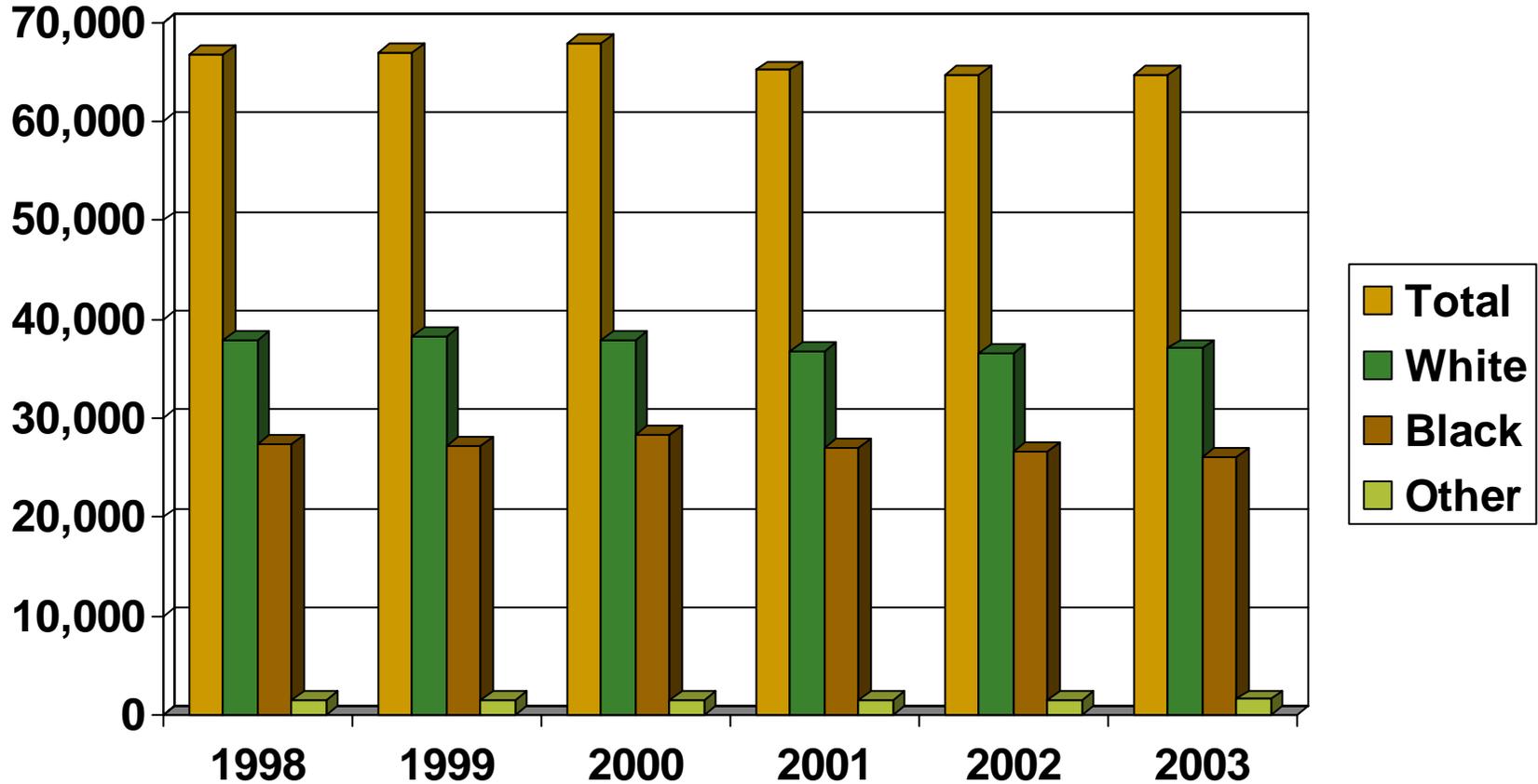
Louisiana and National



2003 Population Estimates

FIGURE 2, APPENDIX A

Louisiana Live Births by Race, 1998-2003.



2003 Population Estimates

FIGURE 3, APPENDIX A

Poverty Rates:1990-2003

Louisiana and National

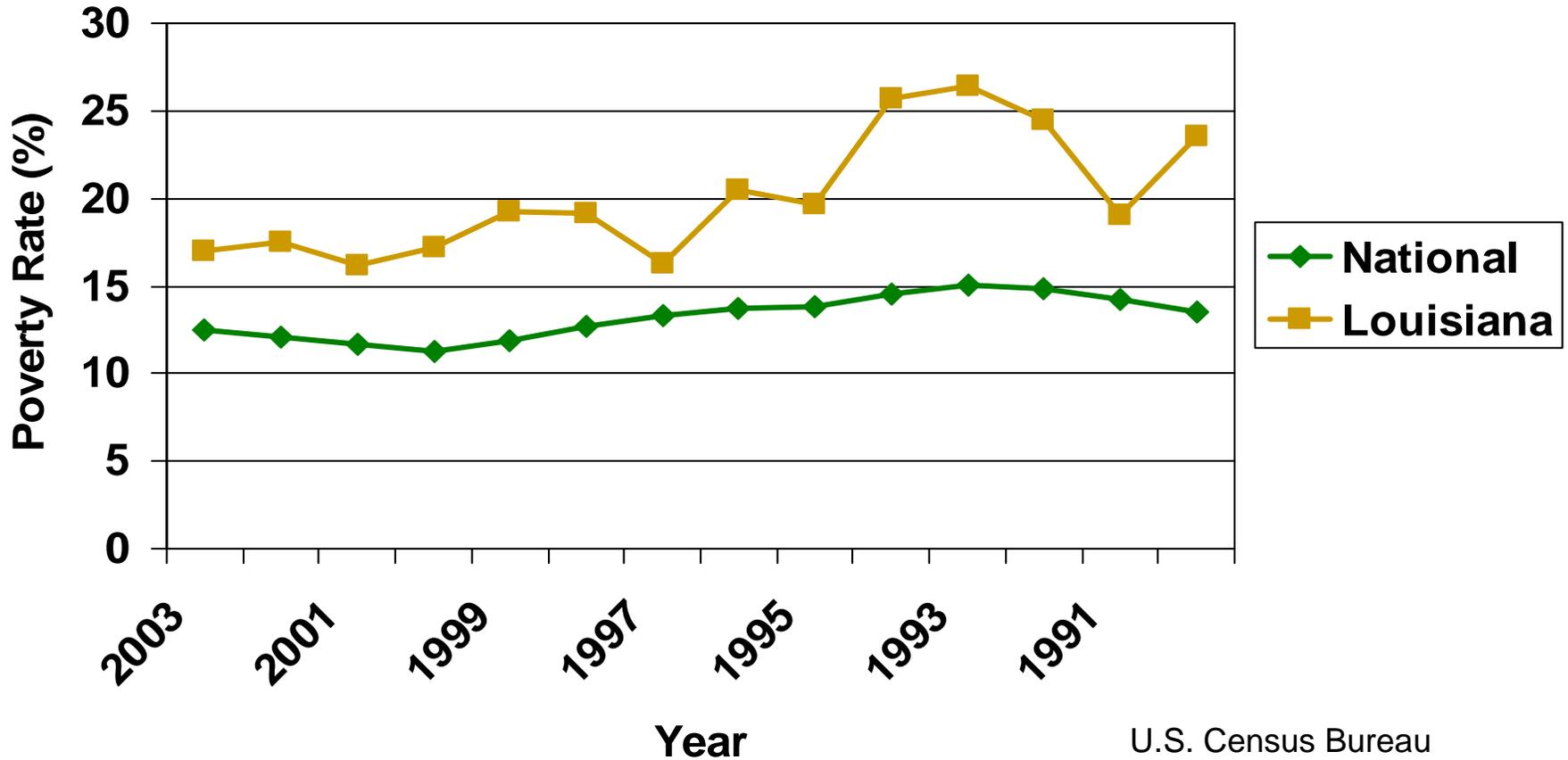


FIGURE 4, APPENDIX A

Louisiana Infant Mortality Rates by Race, 1998-2003

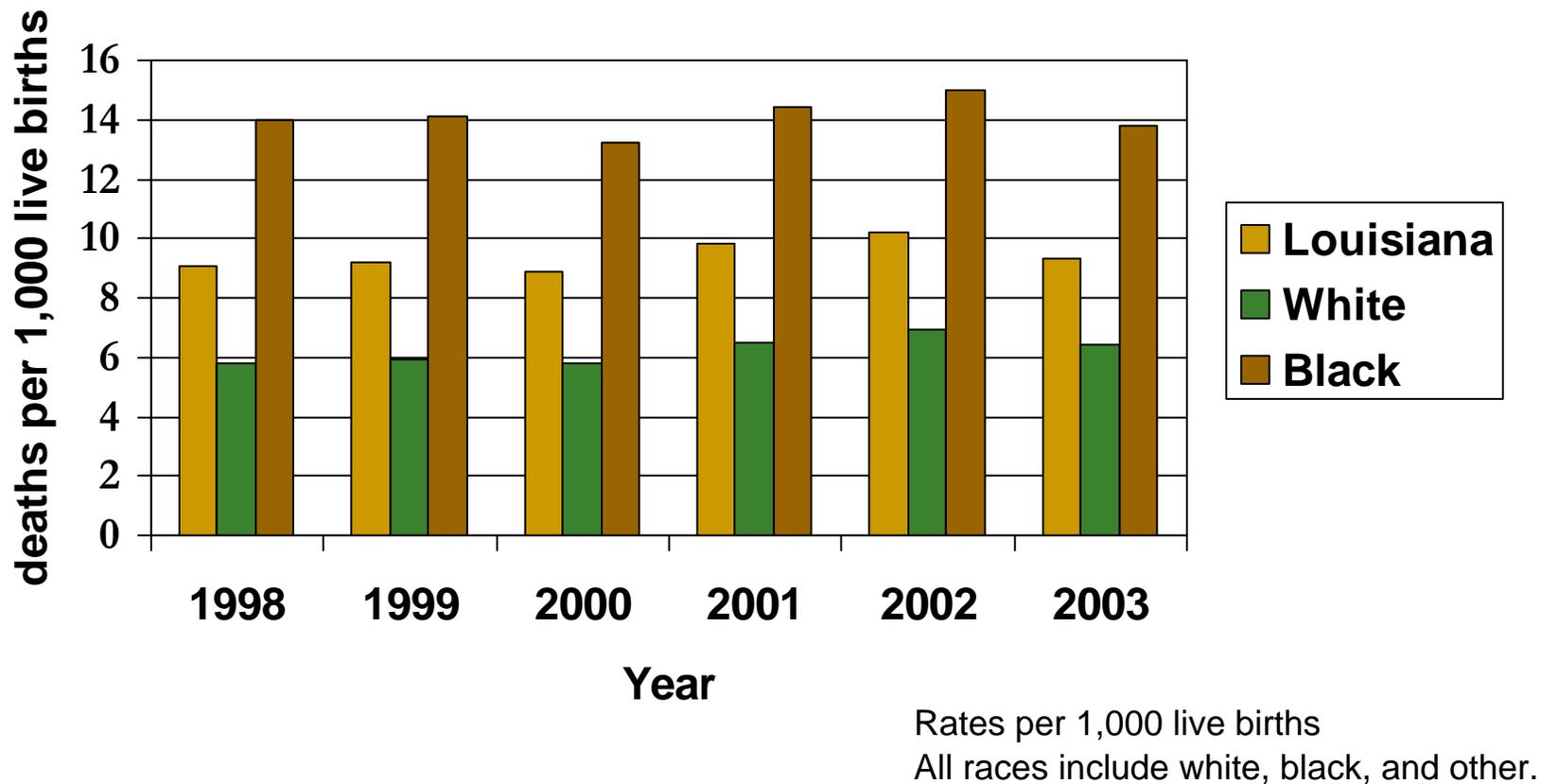


FIGURE 5, APPENDIX A

Louisiana Low Birth Weight by Race, 1998-2003

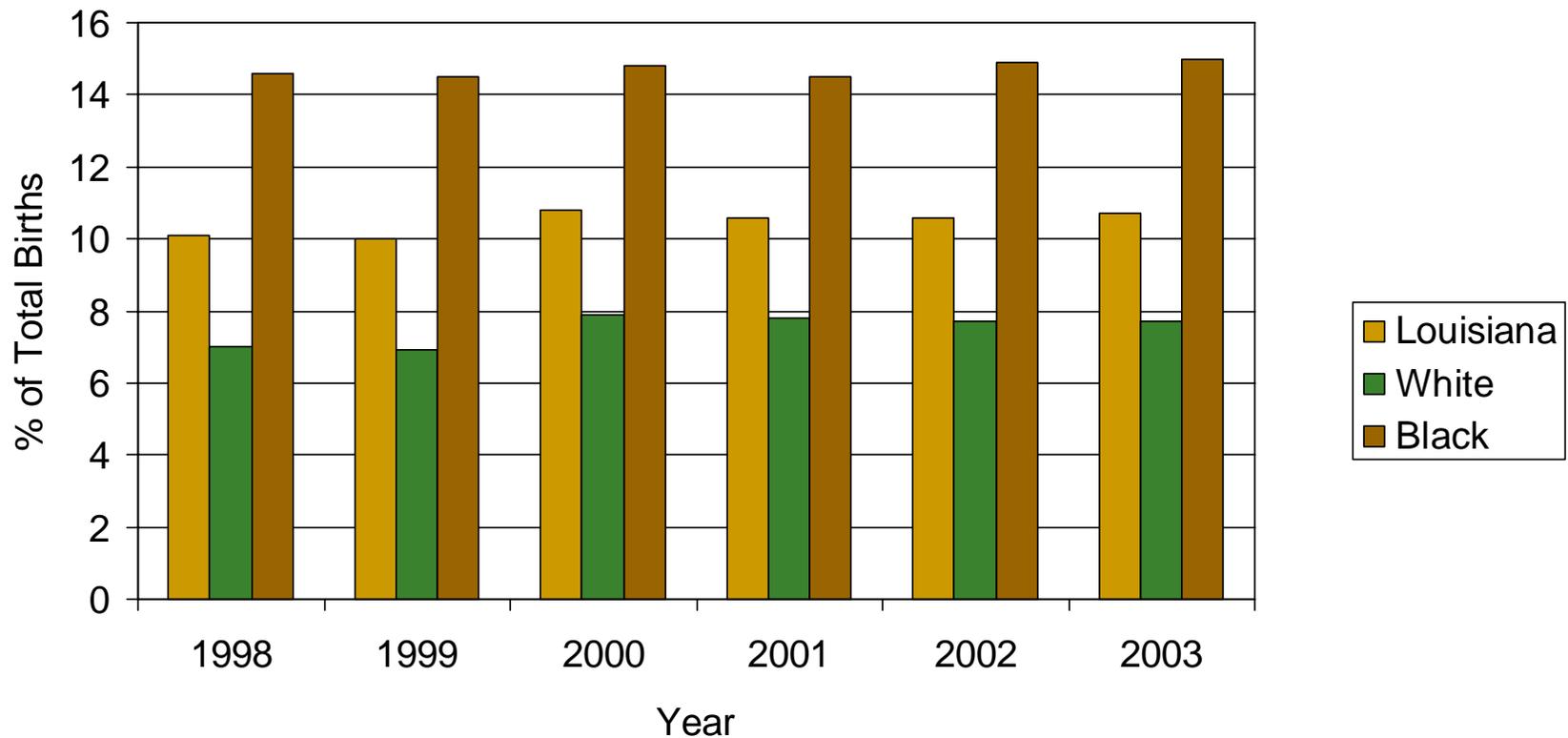


FIGURE 6, APPENDIX A

Medicaid/LaCHIP Eligibility

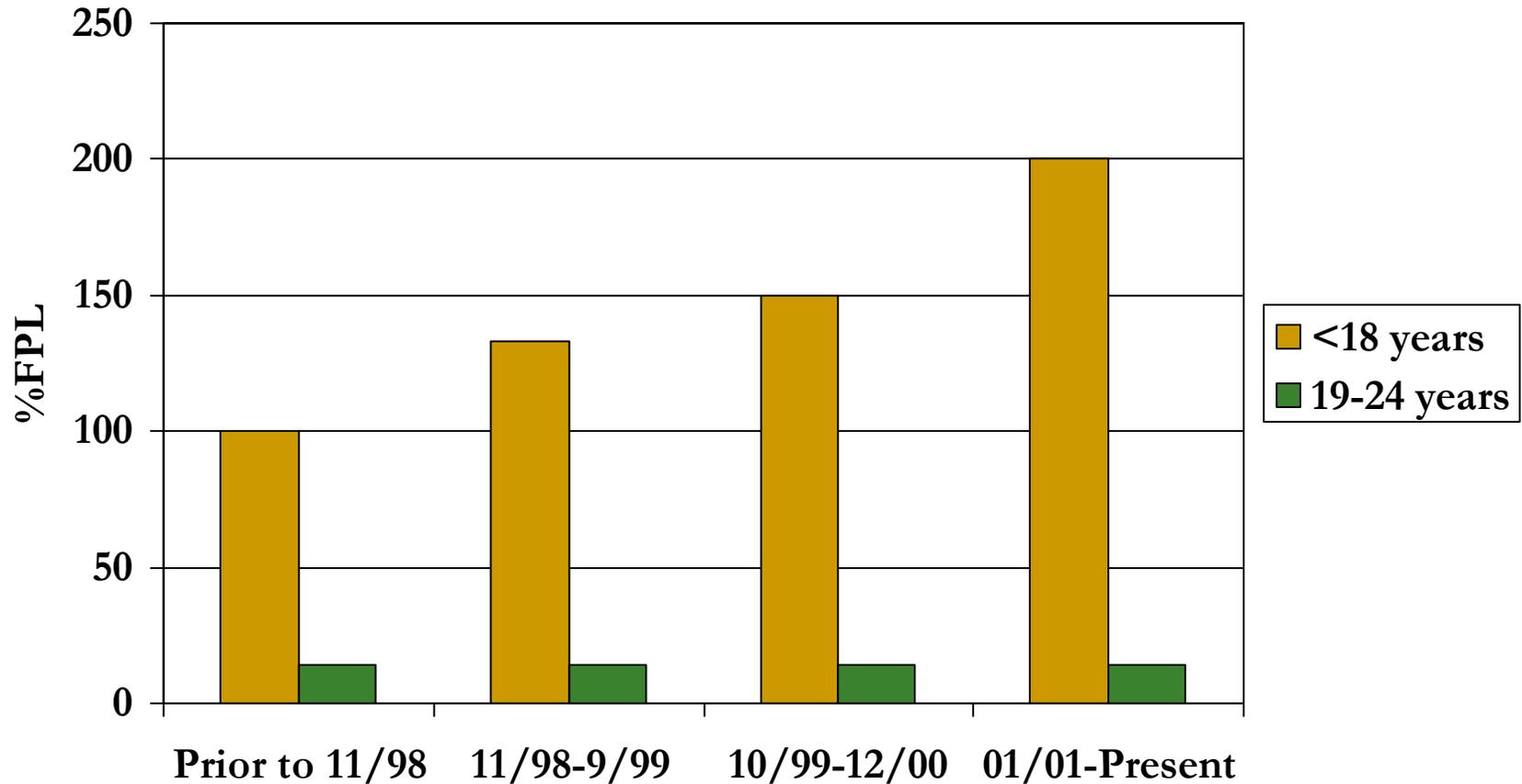


FIGURE 7, APPENDIX A

APPENDIX B

TABLES

TITLE

TABLE 1----- 2003 Parish Population Estimates

TABLE 2- ----- Number (Rate) of Child Deaths by Age
and Cause of Death, 2000-2002

TABLE 3- ----- Number of Primary Care Provider by
Parish, 2003.

2003 Parish Population Estimates

Parish	4/1/2000 Census	7/1/2003 Estimate	% Change 2000-2003	7/1/2003 % of State
Acadia Parish	58,861	59,246	1%	1.3
Allen Parish	25,440	25,268	-1%	0.6
Ascension Parish	76,627	84,424	10%	1.9
Assumption Parish	23,388	23,269	-1%	0.5
Avoyelles Parish	41,481	41,791	1%	0.9
Beauregard Parish	32,986	33,514	2%	0.7
Bienville Parish	15,752	15,320	-3%	0.3
Bossier Parish	98,310	101,999	4%	2.3
Caddo Parish	252,161	250,342	-1%	5.6
Calcasieu Parish	183,577	183,889	0%	4.1
Caldwell Parish	10,560	10,599	0%	0.2
Cameron Parish	9,991	9,708	-3%	0.2
Catahoula Parish	10,920	10,615	-3%	0.2
Claiborne Parish	16,851	16,534	-2%	0.4
Concordia Parish	20,247	19,730	-3%	0.4
De Soto Parish	25,494	25,990	2%	0.6
East Baton Rouge Parish	412,852	412,447	0%	9.2
East Carroll Parish	9,421	8,997	-5%	0.2
East Feliciana Parish	21,360	21,095	-1%	0.5
Evangeline Parish	35,434	35,149	-1%	0.8
Franklin Parish	21,263	20,860	-2%	0.5
Grant Parish	18,698	18,887	1%	0.4
Iberia Parish	73,266	74,146	1%	1.6
Iberville Parish	33,320	32,811	-2%	0.7
Jackson Parish	15,397	15,259	-1%	0.3
Jefferson Davis Parish	31,435	31,113	-1%	0.7
Jefferson Parish	455,466	452,459	-1%	10.1
La Salle Parish	14,282	14,179	-1%	0.3
Lafayette Parish	190,503	194,239	2%	4.3
Lafourche Parish	89,974	91,281	1%	2.0
Lincoln Parish	42,509	42,413	0%	0.9

TABLE 1, APPENDIX B

2003 Parish Population Estimates

(Continued)

Parish	4/1/2000 Census	7/1/2003 Estimate	% Change 2000-2003	7/1/2003 % of State
Livingston Parish	91,814	102,046	11%	2.3
Madison Parish	13,728	13,079	-5%	0.3
Morehouse Parish	31,021	30,671	-1%	0.7
Natchitoches Parish	39,080	39,002	0%	0.9
Orleans Parish	484,674	469,032	-3%	10.4
Ouachita Parish	147,250	147,898	0%	3.3
Plaquemines Parish	26,757	28,025	5%	0.6
Pointe Coupee Parish	22,763	22,564	-1%	0.5
Rapides Parish	126,337	127,394	1%	2.8
Red River Parish	9,622	9,524	-1%	0.2
Richland Parish	20,981	20,623	-2%	0.5
Sabine Parish	23,459	23,406	0%	0.5
St. Bernard Parish	67,229	66,113	-2%	1.5
St. Charles Parish	48,072	49,353	3%	1.1
St. Helena Parish	10,525	10,307	-2%	0.2
St. James Parish	21,216	21,118	0%	0.5
St. John the Baptist Parish	43,044	44,816	4%	1.0
St. Landry Parish	87,700	89,041	2%	2.0
St. Martin Parish	48,583	49,911	3%	1.1
St. Mary Parish	53,500	52,357	-2%	1.2
St. Tammany Parish	191,268	207,743	9%	4.6
Tangipahoa Parish	100,588	103,591	3%	2.3
Tensas Parish	6,618	6,247	-6%	0.1
Terrebonne Parish	104,503	106,107	2%	2.4
Union Parish	22,803	22,966	1%	0.5
Vermilion Parish	53,807	54,222	1%	1.2
Vernon Parish	52,531	50,669	-4%	1.1
Washington Parish	43,926	43,947	0%	1.0
Webster Parish	41,831	41,404	-1%	0.9
West Baton Rouge Parish	21,601	21,717	1%	0.5
West Carroll Parish	12,314	12,236	-1%	0.3
West Feliciana Parish	15,111	15,235	1%	0.3
Winn Parish	16,894	16,397	-3%	0.4
Louisiana	4,468,976	4,496,334	1%	100.0

TABLE 1, APPENDIX B
(CONTINUED)

Number (Rate) of Child Deaths by Age and Cause of Death, 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	172 (22.5)	232 (11.6)	1021 (48.7)
MVC	64 (8.4)	131 (6.6)	727 (34.7)
Other	108 (14.1)	101 (5.1)	294 (14.0)
Septicemia	**	**	12 (0.6)
Congenital Malformation	41 (5.4)	25 (1.3)	36 (1.7)
Diseases of the heart	10 (1.3)	10 (0.5)	86 (4.1)
Cancer	25 (3.3)	59 (3.0)	95 (4.5)
Homicide	40 (5.2)	36 (1.8)	539 (25.7)
Influenza and pneumonia	5 (0.7)	5 (0.3)	9 (0.4)
Suicide	0	6 (0.3)	233 (11.1)
Chronic lower respiratory dis.	7 (0.9)	6 (0.3)	15 (0.7)
HIV	**	**	27 (1.3)
Cerebrovascular diseases	**	10 (0.5)	16 (0.8)
Diabetes mellitus	0	**	14 (0.7)
All other causes	90 (11.8)	107 (5.4)	308 (14.7)

Source: Louisiana State Center for Health Statistics

** Denotes numbers less than 5.
Top 5 Causes are Bolded

Number of Primary Care Providers by Parish, 2003

Number of Selected Health Professionals by Parish									
Louisiana, 2003									
Location	Primary Care Physicians (PCPs)							Mental Health Provider	
Parish	Family Practice	General Practice	Infectious Disease	Internal Medicine	Obstetrics & Gynecology	Pediatrics	Total PCP	Psychiatrists	Social Workers
Acadia	15	3		5	3	5	31	1	8
Allen	5	1		1		3	10		4
Ascension	9	7		11		4	31	1	22
Assumption	4	1					5		2
Avoyelles	9	5		3			17		10
Beauregard	7			3	3	2	15		6
Bienville							0		3
Bossier	17	2		29	10	9	67	2	31
Caddo	68	7	2	217	54	77	423	40	164
Calcasieu	58	8		57	27	23	171	14	82
Caldwell	4			2		1	7		2
Cameron	1			2			3		0
Catahoula	3	1					4		1
Claiborne	5			1		1	7		3
Concordia	4	1		1	2		8		5
DeSoto	1	3		1	2	1	8	1	4
East Baton Rouge	102	35	1	204	78	101	520	42	577
East Carroll	2			1			3		0
East Feliciana	6	5		1	1		13	2	14
Evangeline	7	5		10	4	2	28		1
Franklin	3			1			4		3
Grant	3				1		4		4
Iberia	17	10		13	8	12	60	2	18
Iberville	7	2		6	2	3	20		14
Jackson	1			3		1	5		3
Jefferson	60	29	4	317	90	125	621	61	376
Jefferson Davis	3	5		7	2	2	19	1	7

TABLE 3, APPENDIX B

Number of Primary Care Providers by Parish, 2003

Number of Selected Health Professionals by Parish Louisiana, 2003									
Location	Primary Care Physicians (PCPs)						Mental Health Provider		
Parish	Family Practice	General Practice	Infectious Disease	Internal Medicine	Obstetrics & Gynecology	Pediatrics	Total PCP	Psychiatrists	Social Workers
Lafayette	48	15		103	42	42	250	20	181
Lafourche	21	6		21	11	8	67	2	23
LaSalle	2	2		3			7		1
Lincoln	6	2		13	3	3	27	1	15
Livingston	7	1		2		1	11		25
Madison		2		1		1	4		2
Morehouse	7	3		5	3	2	20		3
Natchitoches	5	4		7	3	8	27	2	15
Orleans	64	27	3	428	109	201	829	158	798
Ouachita	44	12		74	19	32	181	17	96
Plaquemines	3	2		2			7	2	4
Pointe Coupee	9	3		1	1		14		8
Rapides	38	5		66	19	27	153	20	111
Red River	2	1		1			4		3
Richland	7	1		2	2		12		5
Sabine	2	2		5		1	10		3
St. Bernard	1	1		16	1	3	22	1	15
St. Charles	4	1		4		5	14	2	14
St. Helena	2	1					3		1
St. James	5	1		3	1	2	12	1	6
St. John	7	1		7	4	2	21		12
St. Landry	25	8		18	11	13	75	2	26
St. Martin	5	1		1			7		4
St. Mary	12	2		7	6	3	30		7
St. Tammany	38	9	1	122	38	51	258	34	214
Tangipahoa	19	6		26	8	11	70	3	59
Tensas		2					2		0
Terrebonne	10	7		31	17	16	81	6	39
Union	2	2		4			8		11
Vermilion	4	3		5	1	4	17	2	14
Vernon	3	2		7	2	3	17	1	5
Washington	7	6		9	2	1	25	1	11
Webster	12	4		5	4	2	27		9
West Baton Rouge	5						5		4
West Carroll	1	1		2		1	5		2
West Feliciana	3			2		1	6		11
Winn	2	2		2		1	7		2
Total	849	278	11	1901	594	817	4439	442	3133

Source: Louisiana Board of Medical Examiners, January 2003

Louisiana Board of Certified Social Work Examiners, 2000

TABLE 3, APPENDIX B
(CONTINUED)

APPENDIX C

MAPS

TITLE

MAP 1----- Louisiana Public Health Regions

MAP 2----- Louisiana Adolescent School Health Initiative

MAP 3----- Louisiana Population Drinking Fluoridated Water

MAP 4----- Percent of Medicaid-Eligible 6-9 yr olds who Received at Least 1
Dental Sealant, by Parish.

MAP 5----- Louisiana Rural Health Clinics & Federally Qualifies Health
Centers

MAP 6----- Louisiana's Health Professional Shortage Area (HPSA)
Designations

MAP 7----- Dental Health Professional Shortage Areas (HPSAs)

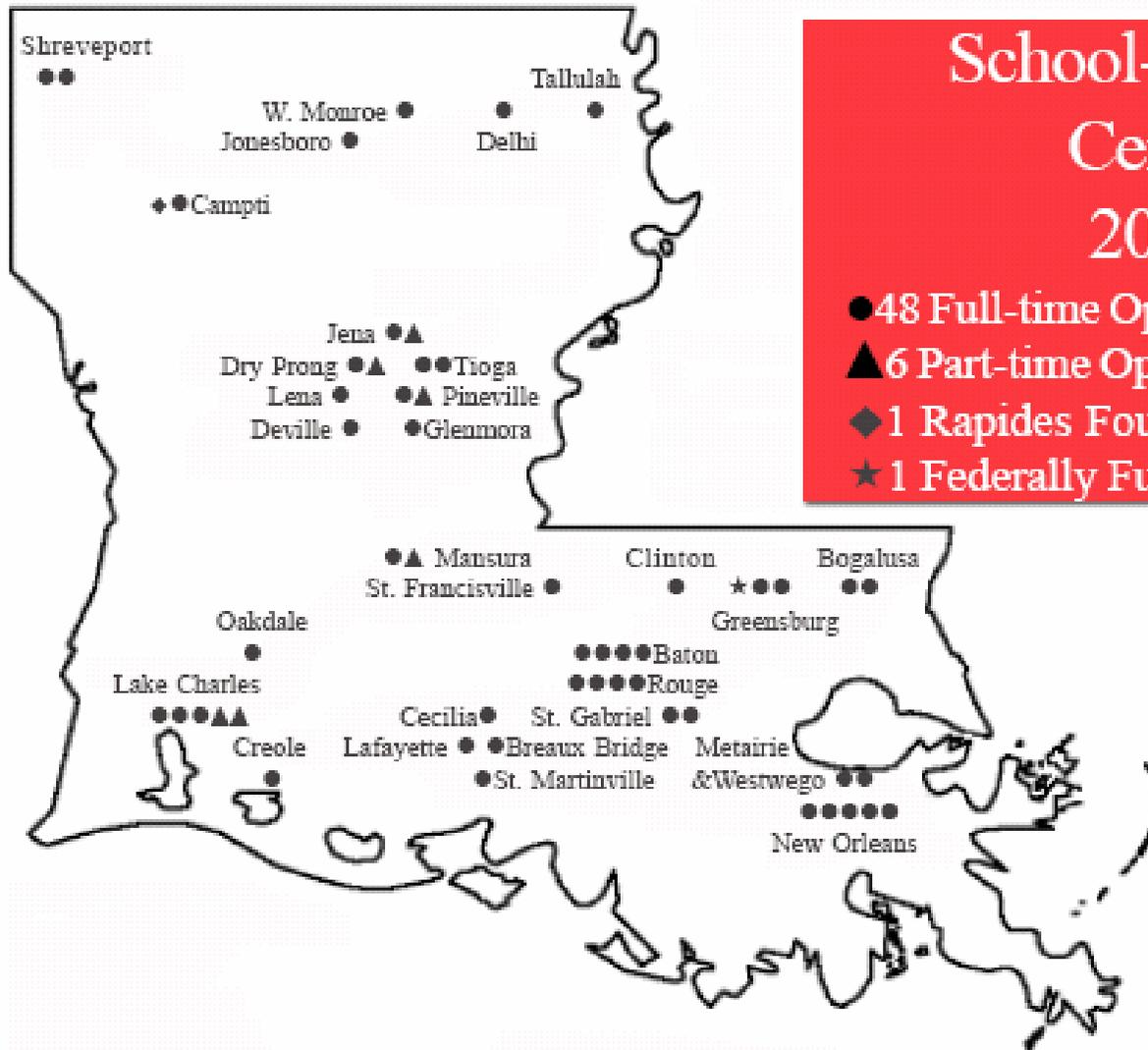
MAP 8----- Number of Private OB/GYN Services Accepting Medicaid

Louisiana Public Health Regions



MAP 1, APPENDIX C

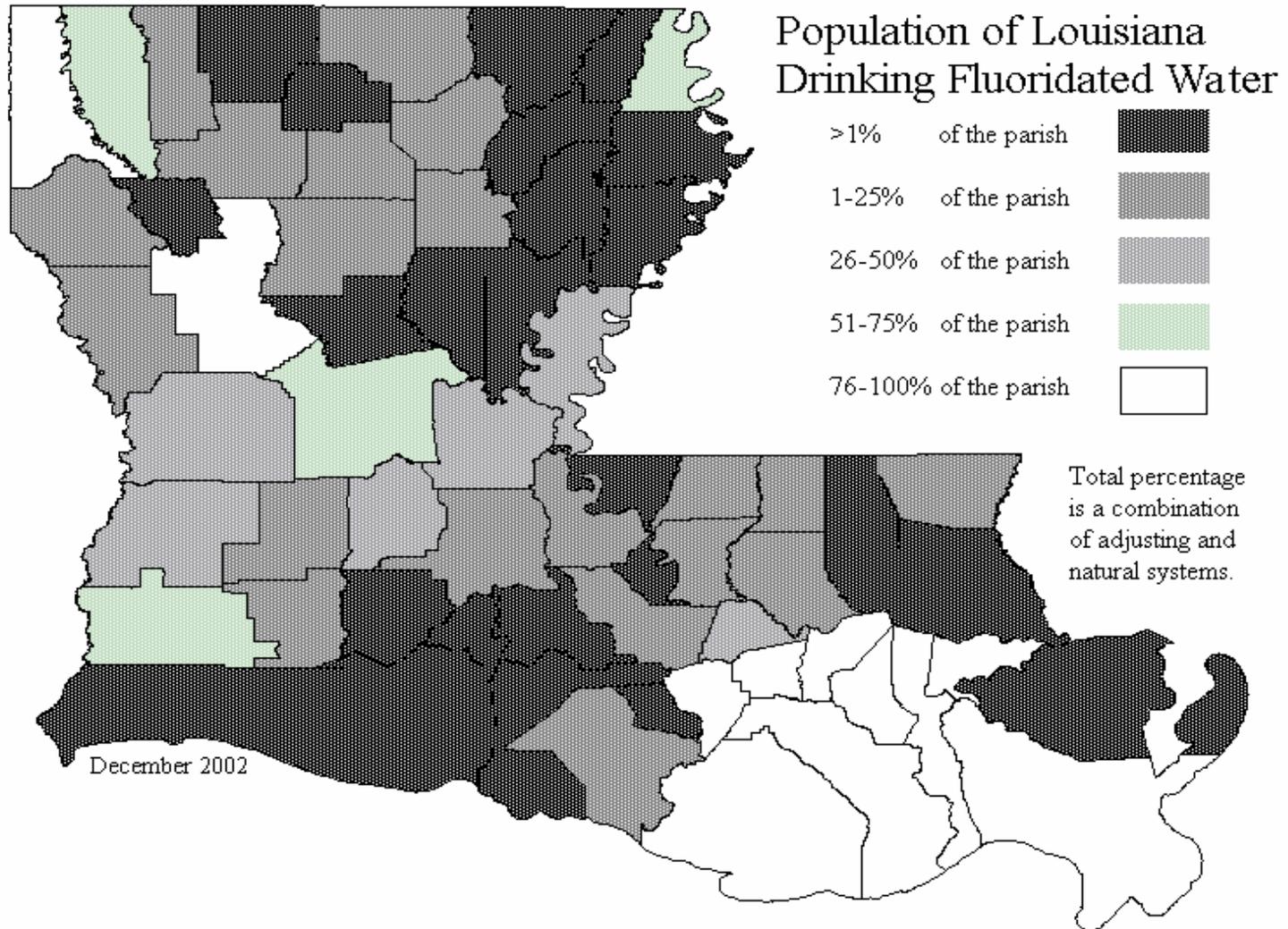
Louisiana Adolescent School Health Initiative



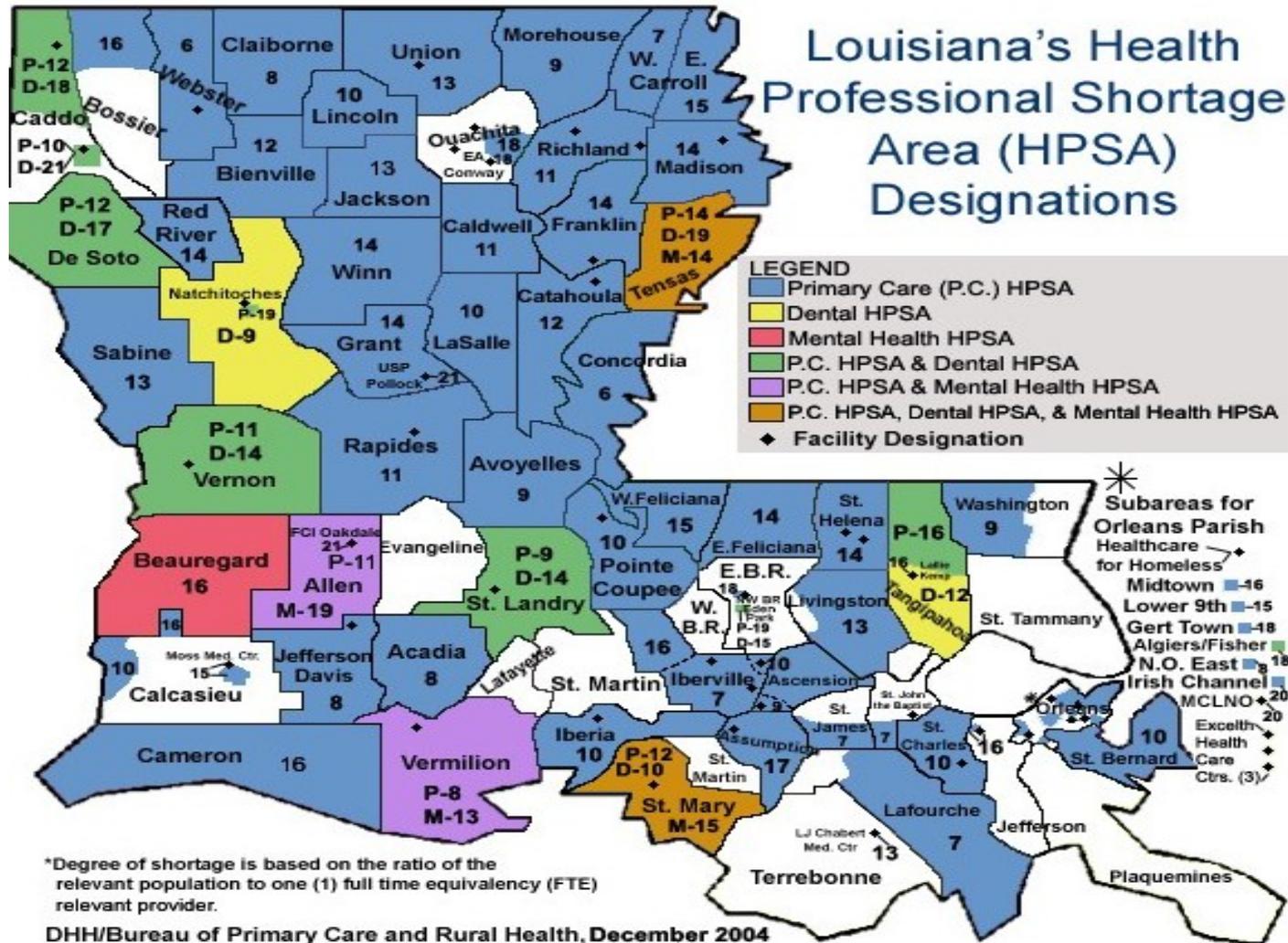
School-Based Health Center Sites 2004-2005

- 48 Full-time Operating Sites
- ▲ 6 Part-time Operating Sites
- ◆ 1 Rapides Foundation Funded Site
- ★ 1 Federally Funded Site

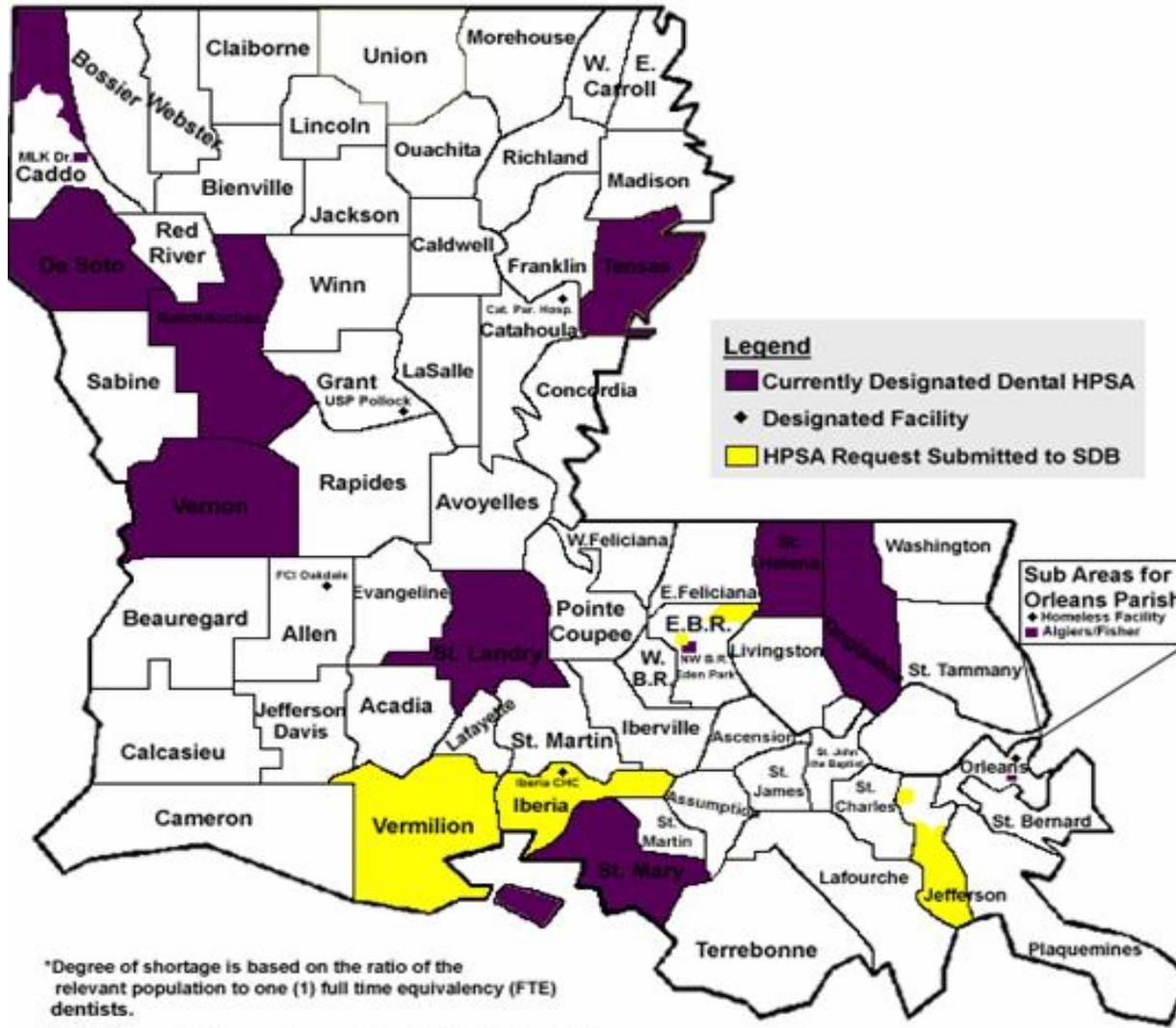
Louisiana Population Drinking Fluoridated Water



Louisiana's Health Professional Shortage Area (HPSA) Designations

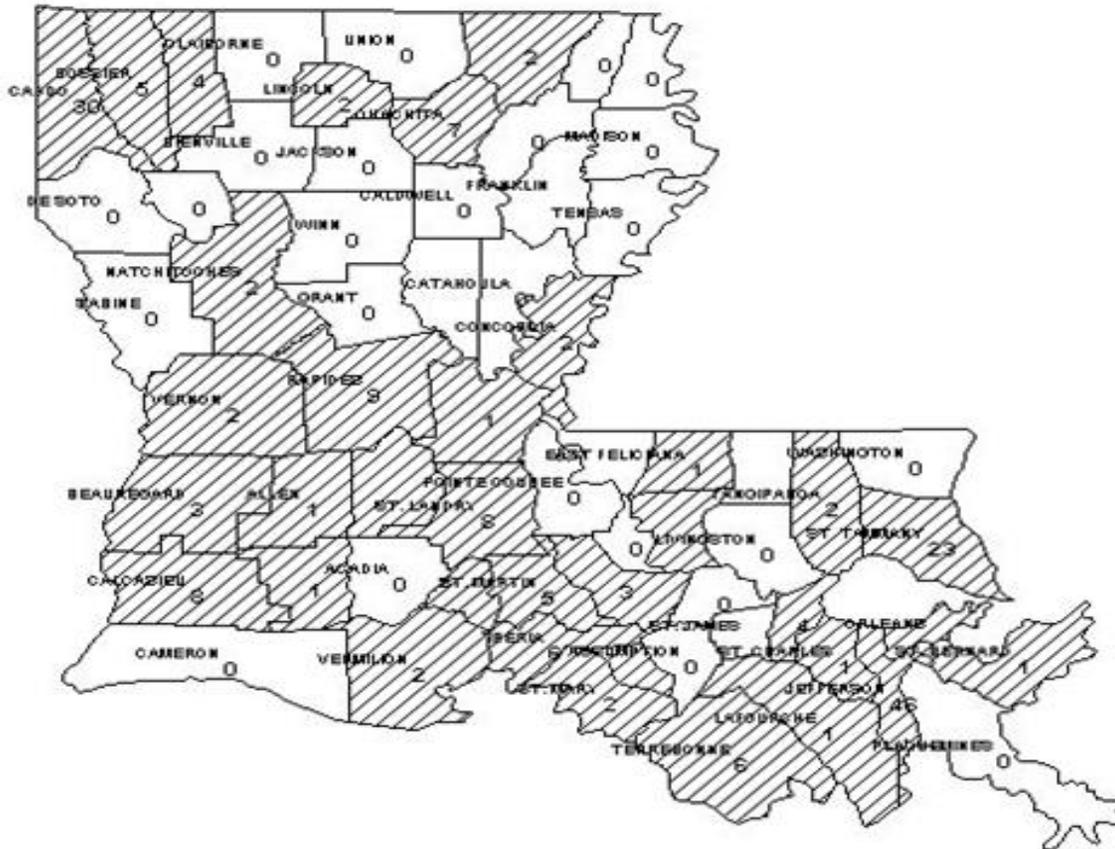


Dental Health Professional Shortage Areas (HPSAs)



Number of Private OB/GYN Services Accepting Medicaid

Number of OB/GYN Services



Parish/Region	Number	Parish/Region	Number
Jefferson	46	Avoyelles	1
Orleans	17	Catahoula	0
Plaquemines	0	Concordia	2
St. Bernard	1	Grant	0
Region 1	64	LaSalle	0
Ascension	0	Rapides	9
E. Baton Rouge	33	Vernon	2
E. Feliciana	1	Winn	0
Iberville	3	Region 6	14
Pt. Coupee	0	Bienville	0
W. Baton Rouge	0	Bossier	5
W. Feliciana	0	Caddo	30
Region 2	37	Claiborne	0
Assumption	0	DeSoto	0
Lafourche	1	Natchitoches	2
St. Charles	1	Red River	0
St. James	0	Sabine	0
St. John	4	Webster	4
St. Mary	2	Region 7	41
Terrebonne	6	Caldwell	0
Region 3	14	E. Carroll	0
Acadia	0	Franklin	0
Evangeline	5	Jackson	0
Iberia	6	Lincoln	2
Lafayette	12	Madison	0
St. Landry	8	Morehouse	2
St. Martin	5	Ouachita	7
Vermilion	2	Richland	0
Region 4	38	Texas	0
Allen	1	Union	0
Beauregard	3	W. Carroll	0
Calcasieu	8	Region 8	11
Cameron	0	Livingston	0
Jeff. Davis	1	St. Helena	0
Region 5	13	St. Tammany	23
		Tangipahoa	2
		Washington	0
		Region 9	25
		State	257

MCH APPENDIX D

- I. Child Health Need Assessment Regional Workbook
 - II. Child Health Needs Assessment Regional Results
 - III. Child Health Provider Survey
 - IV. Adolescent Health Data Sheets
 - V. Perinatal Needs Assessment Template (PNAT)
 - VI. PNAT Regional Results
 - VII. Community Partners
 - VIII. Oral Health Priority Needs Presentation
 - IX. Child Health Priority Needs Presentation
 - X. CSHS Priority Needs Presentation
 - XI. Adolescent Health Priority Needs Presentation
 - XII. Perinatal Health Priority Needs Presentation
 - XIII. Initial Evaluation of Louisiana Needs
-

**Louisiana Office of Public Health
Maternal and Child Health Program**

**Child Health Needs Assessment
2004**

**STATE
Workbook**

Table of Contents

Introduction	3
OPH Regional Map	4
Data	5
<i>Population Characteristics</i>	
<i>Health Status</i>	
<i>Data Sources</i>	15
Child Mortality Deaths	7
<i>Child Mortality Worksheet</i>	29
Identified Needs of Children and Adolescents in Louisiana	30
<i>Child and Adolescent Health Identified Needs Worksheet</i>	32
<i>Maternal and Child Health Bureau (MCHB) Identified Needs Prioritization Method</i>	34
<i>Scoring Method</i>	36
<i>Possible Solutions to an Identified Child Health Need</i>	37
<i>Possible Solutions to an Identified Adolescent Health Need</i>	40
<i>Finalized Needs Worksheet</i>	43
Appendix	46
<i>Parish Poverty Level by OPH Region</i>	46
<i>Child Mortality Deaths – United States – 2002</i>	48

Introduction

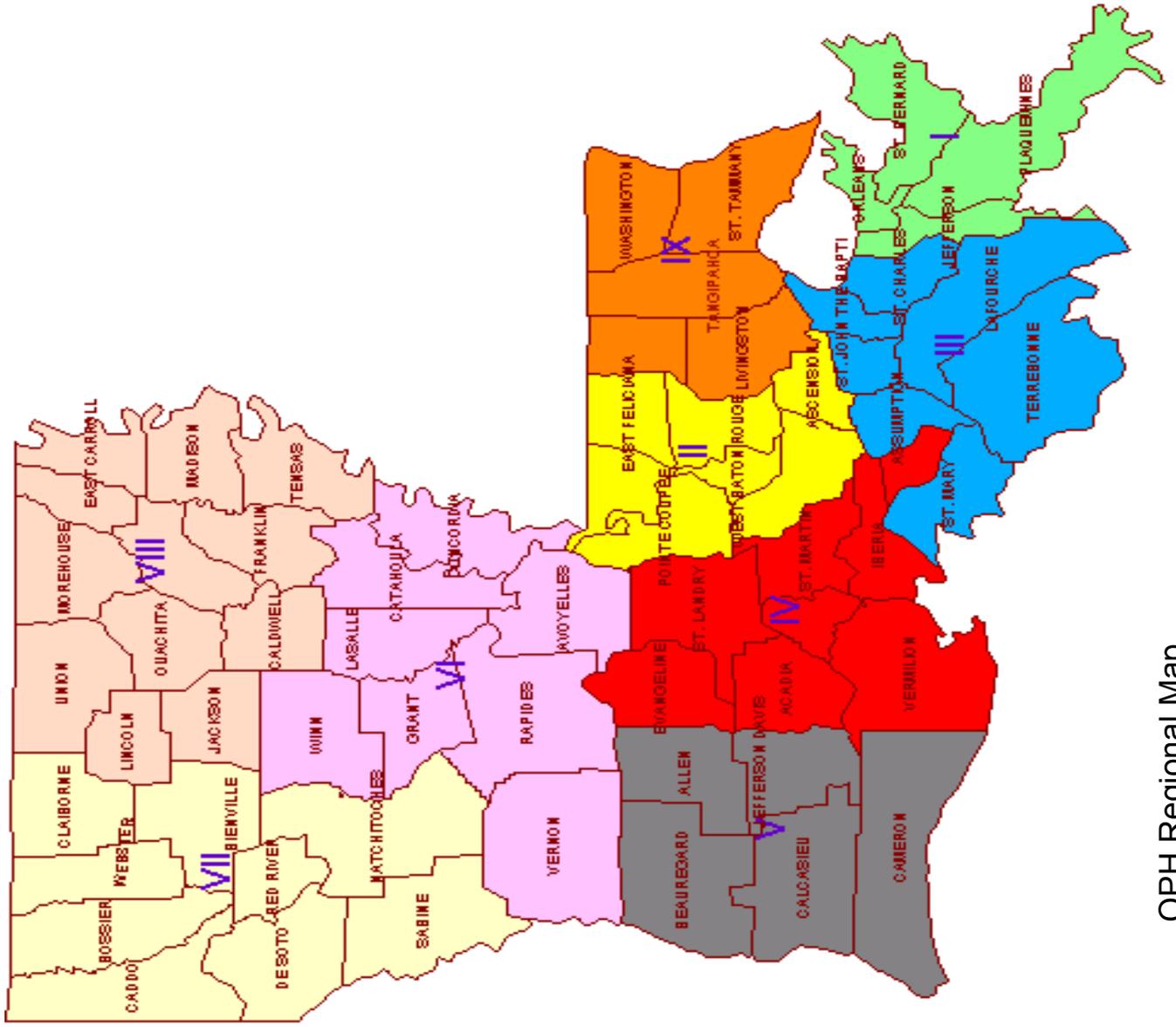
The Title V Maternal and Child Health (MCH) Block Grant is a federal government grant which provides approximately \$15 million to fund MCH services throughout Louisiana through the Office of Public Health's MCH Program. Every five years, State Title V agencies are required to conduct a comprehensive needs assessment to identify state MCH priority needs, arrange programmatic and policy activities around these priorities needs and develop measures to monitor the success of their efforts. The Child Health Program would like input from community agencies and families on what are the needs of Louisiana's children that we can address through the State MCH Program during the next five years.

Priority needs for the Child Health Program that have been addressed in previous years include: 1) decreasing infant deaths due to SIDS, 2) decreasing unintentional injuries in children, and 3) decreasing child abuse and neglect. Based on these needs, program activities have been developed including a statewide SIDS Risk Reduction Public Awareness campaign, intensive nurse home visiting programs in low income first time mother, training in infant mental health for public health staff, development of an assessment tool for early identification of families in need of additional support, and establishment of Regional Injury Prevention Coordinators.

The focus of this Child and Adolescent Needs Assessment is for ages 1-24 years. In separate processes, the needs of children under one year of age are being addressed through a Perinatal Needs Assessment and the needs of adolescents, ages 10-24 years, are being addressed through an Adolescent Needs Assessment. Your additional input for older children and adolescents ages 10-24 years will be shared with the Adolescent Needs Assessment group.

We are asking your assistance in working with us in this process. This workbook contains information on the status of children in your Region, a list of previously identified needs, a system for ranking needs, and a form to feedback to us the results of your assessment.

When this workbook is completed, please return to the entire workbook to Tracy Hubbard, Office of Public Health, Maternal & Child Health, 325 Loyola Avenue, Room 612, New Orleans, LA 70112. (504) 568-5073. thubbard@dhh.la.gov



OPH Regional Map

Region 1 Data *

Population Characteristics

	Region 1	Louisiana	United States
Children <5	36,440	322,952	19,669,147
Children < 20	147,613	1,330,080	81,022,584
Number of Births	14,424	64,755	4,027,376
Births by Race			
Black	55.2%	41.7%	14.7%
White	41.1%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 1	Louisiana	United States
Infant Mortality Rate (0 - <1)	901.2	963.9	693.6
Early Child Mortality Rate (1-4)	48.7	52.1	31.2
Middle Child Mortality Rate (5-14)	24.1	25.3	17.5
Adolescent Mortality Rate (15-24)	150.9	114.9	81.5
% Low Birth Weight	11.4 %	10.5 %	7.8%
% Very Low Birth Weight	2.4 %	2.1 %	1.5%
% of children with Elevated Blood Lead Level	9.7%	5.02%	2.2%
% of Children with Anemia	19.8%	14.9%	13.1%
% of Children who are Overweight	13.9%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	9.6%	11.1%	10.1%

* Data Sources follow at end of section

Region 2 DATA *

Population Characteristics

	Region 2	Louisiana	United States
Children <5	44,136	322,952	19,609,147
Children < 20	179,050	1,330,080	81,022,584
Number of Births	8,604	65,708	4,027,376
Births by Race			
Black	49.2 1%	41.7%	14.7%
White	48.42%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 2	Louisiana	United States
Infant Mortality Rate (0 - <1)	950.4	963.9	693.6
Early Child Mortality Rate (1-4)	44.4	52.1	31.2
Middle Child Mortality Rate (5-14)	26.1	25.3	17.5
Adolescent Mortality Rate (15-24)	94.4	114.9	81.5
% Low Birth Weight	11.2%	10.5 %	7.8%
% Very Low Birth Weight	2.3%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	3.3%	5.02%	2.2%
% of Children with Anemia	15.3%	14.9%	13.1%
% of Children who are Overweight	13.9%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19.	10.8%	11.1%	10.1%

* Data Sources follow at end of section

Region 3 Data *

Population Characteristics

	Region 3	Louisiana	United States
Children <5	11,240	322,952	19,669,147
Children < 20	46,785	1,330,080	81,022,584
Number of Births	5,656	64,755	4,027,376
Births by Race			
Black	31.97%	41.7%	14.7%
White	63.80%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 3	Louisiana	United States
Infant Mortality Rate (0 - <1)	1026.7	963.9	693.6
Early Child Mortality Rate (1-4)	50.2	52.1	31.2
Middle Child Mortality Rate (5-14)	26.6	25.3	17.5
Adolescent Mortality Rate (15-24)	107.4	114.9	81.5
% Low Birth Weight	10.3%	10.5 %	7.8%
% Very Low Birth Weight	2.0%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	2.5%	5.02%	2.2%
% of Children with Anemia	13.1%	14.9%	13.1%
% of Children who are Overweight	14.5%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	11.4%	11.1%	10.1%

* Data Sources follow at end of section

Region 4 Data *

Population Characteristics

	Region 4	Louisiana	United States
Children <5	21,210	322,952	19,669,147
Children < 20	86,489	1,330,080	81,022,584
Number of Births	8,378	64,755	4,027,376
Births by Race			
Black	34.10%	41.7%	14.7%
White	64.19%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 4	Louisiana	United States
Infant Mortality Rate (0 - <1)	959.6	963.9	693.6
Early Child Mortality Rate (1-4)	50.2	52.1	31.2
Middle Child Mortality Rate (5-14)	22.2	25.3	17.5
Adolescent Mortality Rate (15-24)	97.2	114.9	81.5
% Low Birth Weight	10.5%	10.5 %	7.8%
% Very Low Birth Weight	1.9%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	1.9%	5.02%	2.2%
% of Children with Anemia	11%	14.9%	13.1%
% of Children who are Overweight	12.1%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	11%	11.1%	10.1%

* Data Sources follow at end of section

Region 5 Data *

Population Characteristics

	Region 5	Louisiana	United States
Children <5	4,036	322,952	19,669,147
Children < 20	16,585	1,330,080	81,022,584
Number of Births	4,062	64,755	4,027,376
Births by Race			
Black	26.46%	41.7%	14.7%
White	71.84%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 5	Louisiana	United States
Infant Mortality Rate (0 - <1)	950.1	963.9	693.6
Early Child Mortality Rate (1-4)	59.5	52.1	31.2
Middle Child Mortality Rate (5-14)	22.9	25.3	17.5
Adolescent Mortality Rate (15-24)	99.8	114.9	81.5
% Low Birth Weight	8.8%	10.5 %	7.8%
% Very Low Birth Weight	1.3%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	1.6%	5.02%	2.2%
% of Children with Anemia	13.6%	14.9%	13.1%
% of Children who are Overweight	11.6%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	15.7%	11.1%	10.1%

* Data Sources follow at end of section

Region 6 Data *

Population Characteristics

	Region 6	Louisiana	United States
Children <5	9,109	322,952	19,669,147
Children < 20	34,632	1,330,080	81,022,584
Number of Births	4,508	64,755	4,027,376
Births by Race			
Black	32.17%	41.7%	14.7%
White	65.24%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 6	Louisiana	United States
Infant Mortality Rate (0 - <1)	967.8	963.9	693.6
Early Child Mortality Rate (1-4)	59.8	52.1	31.2
Middle Child Mortality Rate (5-14)	31.5	25.3	17.5
Adolescent Mortality Rate (15-24)	110.4	114.9	81.5
% Low Birth Weight	9.5%	10.5 %	7.8%
% Very Low Birth Weight	1.8%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	4.8%	5.02%	2.2%
% of Children with Anemia	11.4%	14.9%	13.1%
% of Children who are Overweight	14.5%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	6.3%	11.1%	10.1%

* Data Sources follow at end of section

Region 7 DATA *

Population Characteristics

	Region 7	Louisiana	United States
Children <5	19,696	322,952	19,669,147
Children < 20	80,578	1,330,080	81,022,584
Number of Births	7,503	64,755	4,027,376
Births by Race			
Black	46.38%	41.7%	14.7%
White	51.89%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 7	Louisiana	United States
Infant Mortality Rate (0 - <1)	1186.8	963.9	693.6
Early Child Mortality Rate (1-4)	59.2	52.1	31.2
Middle Child Mortality Rate (5-14)	30.5	25.3	17.5
Adolescent Mortality Rate (15-24)	117.2	114.9	81.5
% Low Birth Weight	11.2%	10.5 %	7.8%
% Very Low Birth Weight	2.3%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	4.4%	5.02%	2.2%
% of Children with Anemia	16.2%	14.9%	13.1%
% of Children who are Overweight	14.8%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	15.2%	11.1%	10.1%

* Data Sources follow at end of section

Region 8 Data *

Population Characteristics

	Region 8	Louisiana	United States
Children <5	7,736	322,952	19,669,147
Children < 20	33,514	1,330,080	81,022,584
Number of Births	5,102	64,755	4,027,376
Births by Race			
Black	46.14%	41.7%	14.7%
White	52.98%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 8	Louisiana	United States
Infant Mortality Rate (0 - <1)	1150.4	963.9	693.6
Early Child Mortality Rate (1-4)	37.2	52.1	31.2
Middle Child Mortality Rate (5-14)	23.4	25.3	17.5
Adolescent Mortality Rate (15-24)	101.3	114.9	81.5
% Low Birth Weight	10.3%	10.5 %	7.8%
% Very Low Birth Weight	1.8%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	6.7%	5.02%	2.2%
% of Children with Anemia	14.6%	14.9%	13.1%
% of Children who are Overweight	14%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	11.1%	11.1%	10.1%

* Data Sources follow at end of section

Region 9 Data *

Population Characteristics

	Region 9	Louisiana	United States
Children <5	24,619	322,952	19,669,147
Children < 20	106,860	1,330,080	81,022,584
Number of Births	6,518	64,755	4,027,376
Births by Race			
Black	21.08%	41.7%	14.7%
White	77.78%	56.9%	79.0%
Poverty Level < 18	(See Appendix)	25.5%	17.6%
Unemployment Rate		6.4%	5.4%

Health Status

	Region 9	Louisiana	United States
Infant Mortality Rate (0 - <1)	670.6	963.9	693.6
Early Child Mortality Rate (1-4)	67.9	52.1	31.2
Middle Child Mortality Rate (5-14)	23.0	25.3	17.5
Adolescent Mortality Rate (15-24)	118.4	114.9	81.5
% Low Birth Weight	8.6%	10.5 %	7.8%
% Very Low Birth Weight	1.6%	2.1 %	1.5%
% of children with Elevated Blood Lead Level	2.7%	5.02%	2.2%
% of Children with Anemia	11.7%	14.9%	13.1%
% of Children who are Overweight	9.6%	13.3%	14.3%
Oral Health			
Untreated Caries 6-8 yrs		37.3%	29%
Dental Caries Experience 6-8 yrs		63.4%	52%
Dental Sealants Utilization 6-8 yrs		18%	23%
% of Uninsured Children, under 19	10.4%	11.1%	10.1%

* Data Sources follow at end of section

Data Sources

Population

Children <5, Children < 20

- ❑ Source: U.S. Census Bureau, 2002 data.

Number of Births and Births by Race

- ❑ Louisiana - Source: Louisiana Vital Records Data and Louisiana Population Estimates 2000-2002 (U.S. Census Bureau).

United States

- ❑ United States - Source: U.S. Natality File, 2002.

Births by Race

- ❑ Source: Louisiana Maternal and Child Health Data Book, 1990-2000. Louisiana Department of Health and Hospitals, Office of Public Health, Maternal and Child Health Program.

Poverty Level

- ❑ United States - Source: U.S. Census Bureau, Current Population Survey, Poverty Status by State, 2003, Below 100% and 125% of Poverty – People under 18 Years of Age. Census Annual Demographic Survey, March Supplement, 2004.
- ❑ Louisiana - Source: U.S. Census Bureau, 2000, Summary File 3, Income and Poverty in 1999, Percent of population for whom poverty status is determined, Related Children under 18 years.

Unemployment Rate

- ❑ Source: U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Data, Regional and State Employment and Unemployment: August 2004, Table 4. Civilian labor force and unemployment by state and selected areas, not seasonally adjusted, July 2004.

Mortality

- ❑ Louisiana - Source: Louisiana Vital Records Data and Louisiana Population Estimates 2000-2002 (U.S. Census Bureau).
- ❑ United States - Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.

Low Birth Weight

- ❑ Louisiana - Source: Source: Louisiana Vital Records Data and Louisiana Population Estimates 2000-2002 (U.S. Census Bureau).
- ❑ National - Source: Center for Disease Control, National Vital Statistics Reports, "Births: Final data for 2002," Vol. 52, no. 10, December 17, 2003.

Elevated Blood Lead Level

- ❑ Source: Louisiana Childhood Lead Poisoning Prevention Program, Louisiana Childhood Blood Lead Surveillance System, Louisiana Department of Health and Hospitals, 2003.

Anemia

- ❑ Source: Centers for Disease Control, Data analysis of the Louisiana Pediatric Nutrition Surveillance System, 2003. Based upon the WIC population.

Overweight

- ❑ Source: Centers for Disease Control, Data analysis of the Louisiana Pediatric Nutrition Surveillance System, 2003. Based upon the WIC population.

Oral Health

- ❑ Parish statistics - Source: Based on data from Nurse Screening Survey conducted on 3rd graders, 10/01/02 – 05/01/03.
- ❑ National Statistics - Source: U.S. Department of Health and Human Services. *Healthy People 2010*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, November 2000.

Insurance

- ❑ Source: Louisiana Health Insurance Survey, sponsored by Louisiana Department of Health and Hospitals, the Public Policy Research Lab, 2004.

CHILD MORTALITY DEATHS
NUMBER (Percentage of deaths within age group)
BY AGE AND CAUSE OF DEATH

LOUISIANA – 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	172 (22.5)	232 (11.6)	1021 (48.7)
MVC	64 (8.4)	131 (6.6)	727 (34.7)
Other	108 (14.1)	101 (5.1)	294 (14.0)
Septicemia	**	**	12 (0.6)
Congenital Malformation	41 (5.4)	25 (1.3)	36 (1.7)
Diseases of the heart	10 (1.3)	10 (0.5)	86 (4.1)
Cancer	25 (3.3)	59 (3.0)	95 (4.5)
Homicide	40 (5.2)	36 (1.8)	539 (25.7)
Influenza and pneumonia	5 (0.7)	5 (0.3)	9 (0.4)
Suicide	0	6 (0.3)	233 (11.1)
Chronic lower respiratory dis.	7 (0.9)	6 (0.3)	15 (0.7)
HIV	**	**	27 (1.3)
Cerebrovascular diseases	**	10 (0.5)	16 (0.8)
Diabetes mellitus	0	**	14 (0.7)
All other causes	90 (11.8)	107 (5.4)	308 (14.7)

Source: Louisiana State Center for Health Statistics

** Denotes numbers less than 5.
Top 5 Causes are Bolded

Region 1: Child Mortality Deaths
 NUMBER (rate per 100,000 in age group) BY RACE AND AGE

REGION 1: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	400 (901.2)	82 (48.7)	106 (24.1)	682 (150.9)
White	95 (524.1)	18 (25.8)	34 (19.1)	216 (108.6)
Black	288 (1170.1)	61 (67.7)	72 (29.9)	450 (194.4)
Other	17 (1032.2)	3 (35.6)	0	16 (74.1)

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

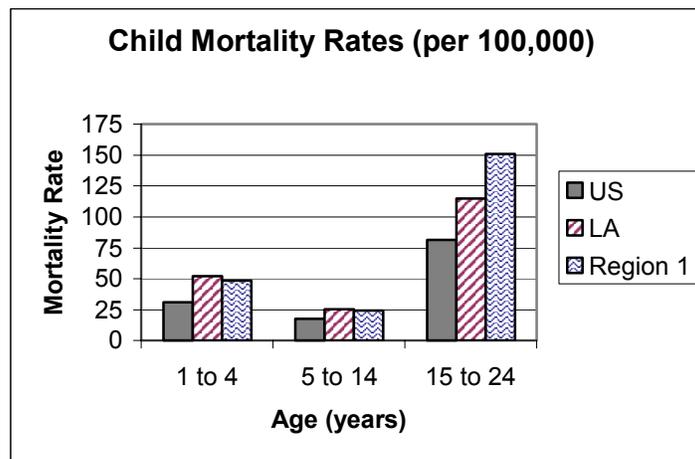
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



CHILD MORTALITY DEATHS
NUMBER (Percentage of deaths within age group)
BY AGE AND CAUSE OF DEATH

REGION 1 – 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	26(15.4)	42 (9.5)	155 (34.3)
MVC	6 (3.6)	26 (5.9)	82 (18.1)
Other	20 (11.9)	16 (3.6)	73 (16.2)
Septicemia	**	0	**
Congenital Malformation	7 (4.2)	6 (1.4)	**
Diseases of the heart	**	*	23 (5.1)
Cancer	2 (1.2)	16 (3.6)	20 (4.4)
Homicide	7 (4.2)	8 (1.8)	303 (67.0)
Influenza and pneumonia	2 (1.2)	**	**
Suicide	0	**	45 (10.0)
Chronic lower respiratory dis.	**	**	7 (1.5)
HIV	**	**	5 (1.1)
Cerebrovascular diseases	**	**	7 (1.5)
Diabetes mellitus	0	0	5 (1.1)
All other causes	29 (17.2)	24 (5.5)	106 (23.5)

Source: Louisiana State Center for Health Statistics

** Denotes numbers less than 5.
Top 5 Causes are Bolded

N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 2: CHILD MORTALITY DEATHS
 NUMBER (rate per 100,000 in age group)
 BY RACE AND AGE

REGION 2: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	253 (950.4)	46 (44.4)	68 (26.1)	301 (94.4)
White	80 (613.6)	14 (26.8)	26 (19.9)	134 (76.5)
Black	171 (1311.6)	32 (66.3)	41 (33.1)	164 (122.1)
Other	2 (3333.3)	0	1 (14.7)	3 (32.3)

Source: LA State Center for Health Statistics

LOUISIANA: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

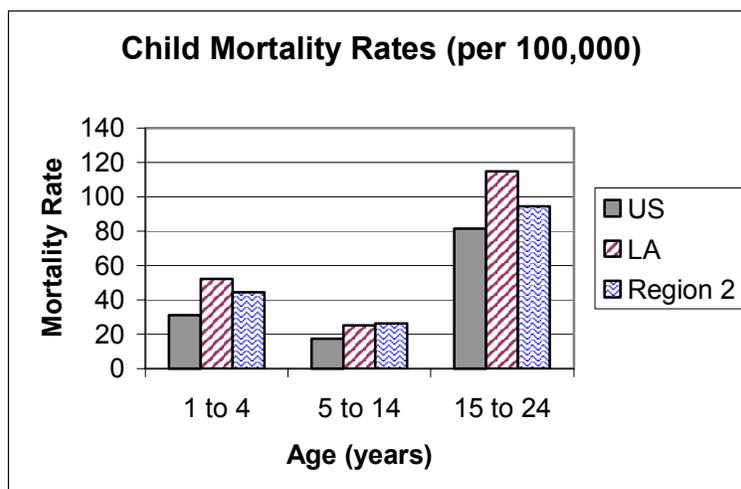
Source: LA State Center for Health Statistics

UNITED STATES: 2002

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13,

February 11, 2004.



CHILD MORTALITY DEATHS
NUMBER (Percentage of Deaths within Age Group)
NUMBER BY AGE AND CAUSE OF DEATH

REGION 2 – 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	26 (56%)	20 (29%)	138 (45%)
MVC	12 (26%)	12 (17%)	110 (36%)
Other	14 (30%)	6 (8%)	28 (9%)
Septicemia	0	**	**
Congenital Malformation	5 (10%)	5 (7%)	**
Diseases of the heart	**	**	6 (2%)
Malignant neoplasm	5 (10%)	10 (14%)	12 (3%)
Homicide	5 (10%)	5 (7%)	73 (24%)
Influenza and pneumonia	0	0	0
Suicide	0	**	28 (9%)
Chronic lower respiratory dis.	0	**	0
HIV	0	**	15 (5%)
Cerebrovascular diseases	0	**	**
Diabetes mellitus	0	**	**
All other causes	**	13 (19%)	21 (7%)

Source: Louisiana State Center for Health Statistics

** Denotes numbers less than 5.

Top 5 Causes are Bolded

N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 3: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 3: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	177 (1026.7)	34 (50.2)	49 (26.6)	192 (107.4)
White	83 (760.4)	21 (48.8)	32 (27.5)	122 (104.3)
Black	87 (1559.4)	12 (57.0)	14 (24.2)	64 (120.7)
Other	7 (940.9)	1 (27.3)	3 (30.9)	6 (68.7)

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

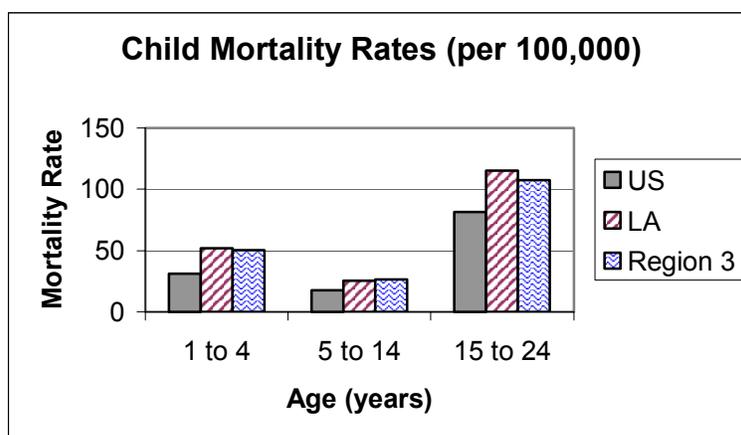
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



Region 3: N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 4: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 4: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	243 (959.6)	50 (50.2)	57 (22.2)	251 (97.2)
White	91 (565.7)	23 (36.8)	29 (17.7)	176 (102.0)
Black	150 (1702.8)	26 (76.1)	28 (32.2)	74 (92.9)
Other	2 (465.1)	1 (35.0)	0	1 (16.8)

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

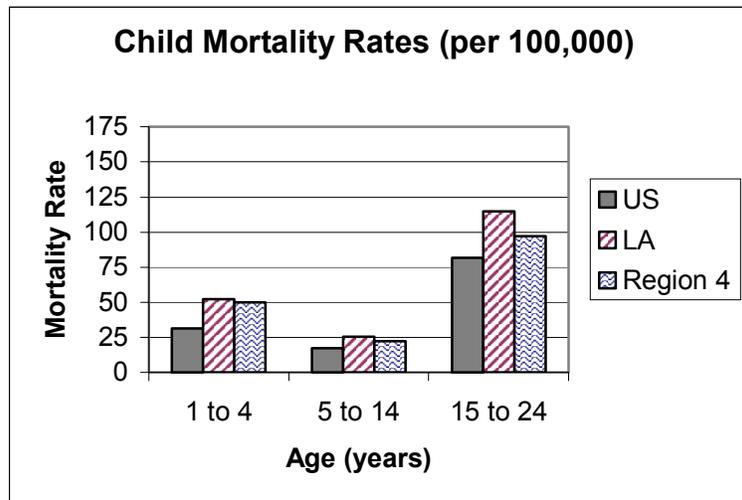
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



CHILD MORTALITY DEATHS
NUMBER (Percentage of deaths within age group)
BY AGE AND CAUSE OF DEATH

REGION 4 – 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	26 (52%)	28 (49%)	138 (54%)
MVC	13 (26%)	10 (17%)	90 (35%)
Other	13 (26%)	18 (31%)	48 (19%)
Septicemia	0	0	0
Congenital Malformation	6 (12%)	**	8 (3%)
Diseases of the heart	0	**	5 (2%)
Malignant neoplasm	**	10 (17%)	10 (4%)
Homicide	5 (10%)	**	14 (5%)
Influenza and pneumonia	0	0	0
Suicide			
Chronic lower respiratory dis.	0	0	**
HIV	0	0	0
Cerebrovascular diseases	**	0	**
Diabetes mellitus	0	0	0
All other causes	10 (20%)	14 (24%)	75 (29%)

Source: LA State Center for Health Statistics.

** Denotes numbers less than 5.
Top 5 Causes are Bolded

Region 5: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 5: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	117 (950.1)	29 (59.5)	29 (22.9)	127 (99.8)
White	69 (775.9)	21 (60.4)	24 (26.2)	97 (104.3)
Black	48 (1467.9)	8 (63.8)	5 (15.7)	29 (91.8)
Other	0	0	0	1 (37.8)

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

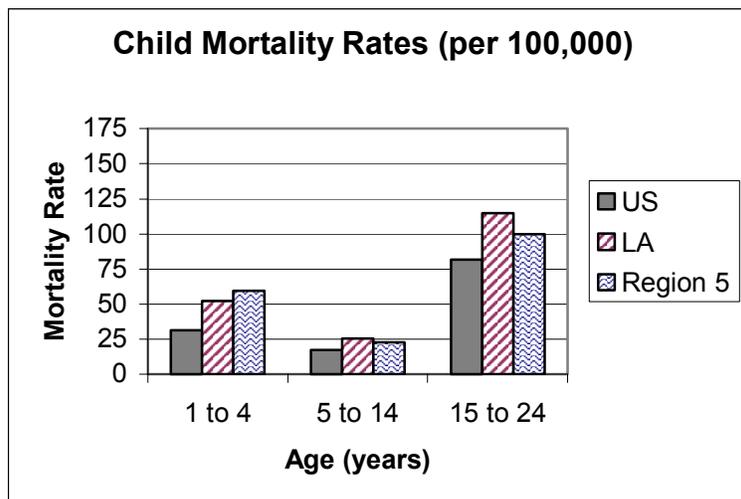
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 6: CHILD MORTALITY DEATHS
 NUMBER (rate per 100,000 in age group)
 BY RACE AND AGE

REGION 6: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	133 (967.8)	32 (59.8)	42 (31.5)	153 (110.4)
White	52 (583.0)	17 (49.5)	33 (57.4)	114 (126.8)
Black	78 (1736.4)	15 (89.1)	9 (21.2)	39 (88.5)
Other	3 (903.6)	0	0	0

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

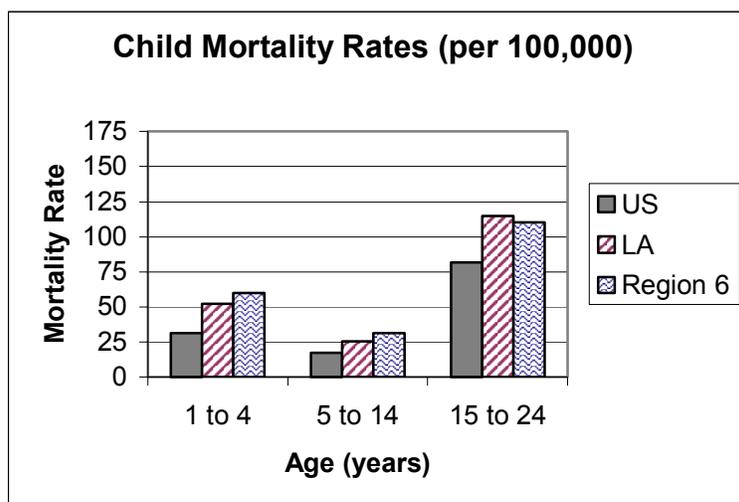
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 7: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 7: 2000-2002 Average

	<1 year	1 – 4 years	5 – 14 yrs	15 – 24 yrs
All	271 (1186.8)	52 (59.2)	70 (30.5)	281 (117.2)
White	80 (678.0)	26 (57.6)	25 (31.9)	122 (94.8)
Black	190 (1782.0)	26 (65.1)	44 (40.8)	159 (151.8)
Other	1 (268.8)	0	1 (22.5)	0

Source: LA State Center for Health Statistics

LOUISIANA: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

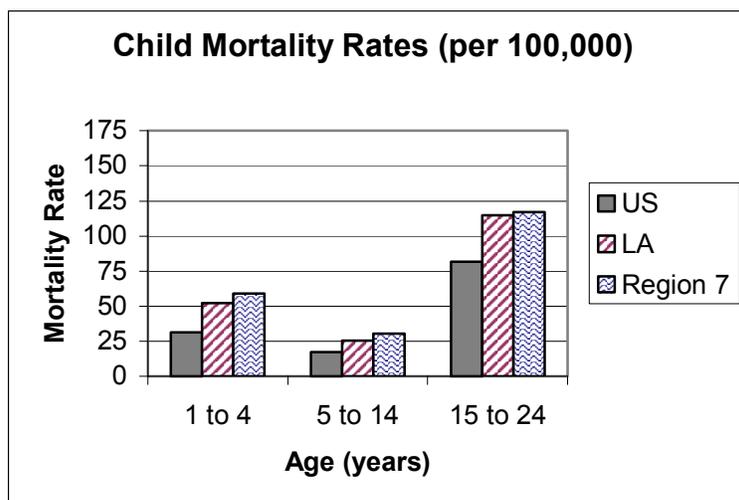
Source: LA State Center for Health Statistics

UNITED STATES: 2002

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13,

February 11, 2004.



CHILD MORTALITY DEATHS
NUMBER (Percentage of Deaths within Age Group)
NUMBER BY AGE AND CAUSE OF DEATH

REGION 7 – 2000-2002

Cause	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
Accidents	21 (40%)	30 (42%)	121 (43%)
MVC	12 (23%)	16 (22%)	92 (32%)
Other	9 (17%)	14 (20%)	29 (10%)
Septicemia	0	0	**
Congenital Malformation	5 (9%)	**	8 (2%)
Diseases of the heart	**	**	17 (6%)
Malignant neoplasm	**	7 (10%)	12 (4%)
Homicide	7 (13%)	**	56
Influenza and pneumonia	**	0	0
Suicide	0	0	22 (7%)
Chronic lower respiratory dis.	**	**	**
HIV	**	0	**
Cerebrovascular diseases	**	**	**
Diabetes mellitus	0	0	**
All other causes	8 (15%)	18 (25%)	36 (12%)

Source: Louisiana State Center for Health Statistics

** Denotes numbers less than 5.

Top 5 Causes are Bolded

Region 8: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 8: 2000-2002 Average

	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	180 (1150.4)	22 (37.2)	36 (23.4)	187 (101.3)
White	77 (927.0)	10 (31.4)	18 (22.0)	111 (109.4)
Black	102 (1411.0)	12 (45.3)	18 (25.6)	76 (94.4)
Other	1 (892.9)	0	0	0

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

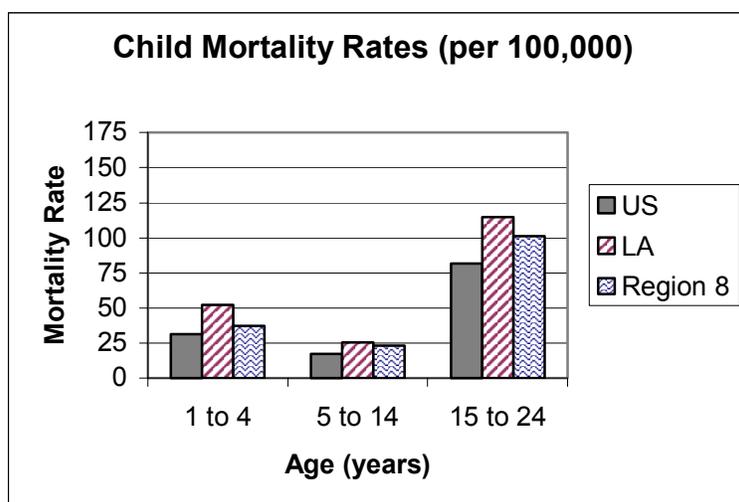
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Region 9: CHILD MORTALITY DEATHS
NUMBER (rate per 100,000 in age group)
BY RACE AND AGE

REGION 9: 2000-2002 Average

	<1 year	1 – 4 years	5 – 14 yrs	15 – 24 yrs
All	132 (670.6)	52 (67.9)	48 (23.0)	237 (118.4)
White	83 (546.5)	31 (52.4)	34 (19.9)	189 (120.5)
Black	47 (1096.1)	21 (133.7)	13 (9.1)	46 (116.0)
Other	2 (961.5)	0	1 (7.9)	2 (53.7)

Source: LA State Center for Health Statistics

LOUISIANA – 2000-2002 Average

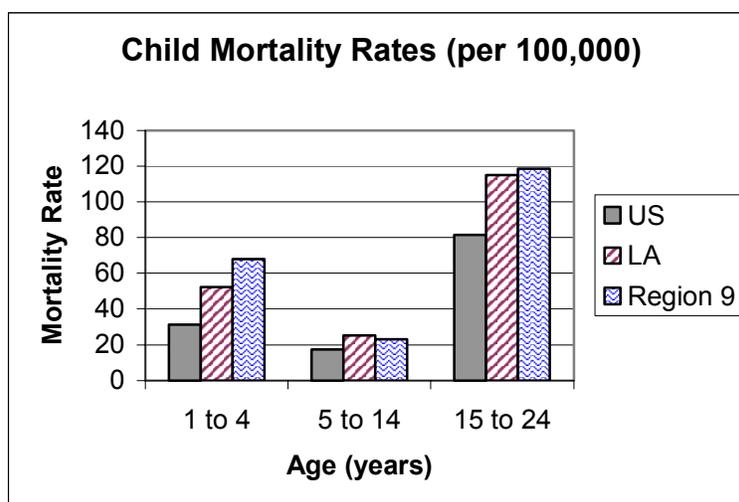
	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	1906 (963.9)	399 (52.1)	505 (25.3)	2411 (114.9)
White	710 (638.1)	181 (41.8)	255 (23.9)	1281 (103.9)
Black	1161 (1417.2)	213 (69.8)	244 (27.0)	1101 (158.6)
Other	35 (761.2)	5 (18.4)	6 (8.6)	29 (44.2)

Source: LA State Center for Health Statistics

UNITED STATES – 2002

	<1 year	1 – 4 years	5 – 14 years	15 – 24 years
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
White	13,492 (577.1)	2,518 (27.3)	4,050 (16.1)	19,521 (76.1)
Black	8,446 (1252.0)	1,192 (46.9)	1,678 (24.7)	7,040 (113.6)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004.



N.B. If your region does not have a regional table of Child Mortality Deaths by Age and Cause of Death, it means that the regional numbers were too small to provide any meaningful information.

Child Mortality Worksheet

Instructions: Fill in the sections below, as indicated, based upon the data in the mortality tables for the particular region.

For the period 2000-2002, <u>the mortality rate of children between the age of 1 and 4 was -----</u>
which is <input type="checkbox"/> above the national rate of -----
<input type="checkbox"/> below
<input type="checkbox"/> equal to
If information is available, the 3 Leading cause of death were:

For the period 2000-2002, <u>the mortality rate of children between the age of 5 and 14 was -----</u>
which is <input type="checkbox"/> above the national rate of -----
<input type="checkbox"/> below
<input type="checkbox"/> equal to
If information is available, the 3 Leading causes of death were:

For the period 2000-2002, <u>the mortality rate of children between the age of 15 and 24 was -----</u>
which is <input type="checkbox"/> above the national rate of -----
<input type="checkbox"/> below
<input type="checkbox"/> equal to
If information is available, the 3 Leading causes of death were:

Identified Needs of Children and Adolescents in Louisiana

Based on recommendations from
*You Who Coalition Health and Safety Work Group and
Prevent Child Abuse Louisiana Platform for Children*

Underneath each identified need is a list of strategies. Please add any additional needs or strategies that your organization recommends.

Access to health care

- a. Increase the number of children covered by Louisiana Child Health Insurance Program (LaCHIP)
- b. Improve the quality of health care
- c. Increase number of health care providers for underserved populations
- d. Use of school-based health services, clinics and mobile units in areas of decreased access
- e.
- f.

Children's mental health

- a. Access to services for young children
- b. Expand mental health treatment for children and youth
- c. Mental health and treatment for young people within the juvenile justice system
- d.
- e.

Substance abuse

- a. Expand evidence based substance abuse prevention programs and treatment services
- b. Expand evidence based substance abuse treatment services
- c.
- d.

School health issues

- a. Assure a healthy school environment for all children
- b. Assure comprehensive health education including prevention
- c. Increase school based health centers in underserved areas
- d.
- e.

Immunizations

- a. Increase educational efforts for immunization
- b. Expand LA Immunization Network for Kids Statewide (LINKS) to all providers
- c.
- d.

Dental/Oral needs

- a. Assure access to oral health services

- b. Expand sealant programs
- c.
- d.

Injury Prevention

- a. Increase injury prevention efforts
- b.
- c.

Child abuse and neglect

- a. Expand prevention efforts to eradicate abuse and neglect before it starts
- b.
- c.

Other:

- a.
- b.
- c.

Other:

- a.
- b.
- c.

Maternal and Child Health Bureau (MCHB) Identified Needs Prioritization Method

This method of setting priority needs incorporates a framework that considers various criteria (the extent of the health problem, the severity of consequences, resource availability and acceptability). The Prioritization Method is used as a way of organizing a discussion to achieve consensus among different people and groups for ultimately setting priority child and adolescent health needs within the region.

Instructions:

1. Using the list of needs facing your region identified on the “Child and Adolescent Health Identified Needs Worksheet,” enter these Needs into the column labeled “Child and Adolescent Needs/Problems Facing Region.”
2. Fill out table using the scoring method provided.
3. Once the extent of the health problem, the severity of consequences, resource availability, and acceptability have been scored for each Child and Adolescent Need/Problem, calculate a total score for each Child and Adolescent Need/Problem.
4. Record the three highest scoring Child and Adolescent Needs/Problems (These are your Top 3 Child and Adolescent Needs).
5. Before making final decisions about the priority needs, the process and the results should be reviewed and agreed upon by all participants.

Example:

Scoring Method

Extent

- 1 = low incidence or prevalence
- 2 = moderate incidence or prevalence in some subgroups
- 3 = moderate incidence or prevalence in all groups
- 4 = high incidence or prevalence in some subgroups
- 5 = high incidence or prevalence in all subgroups

Severity of Consequences

- 1 = not life threatening
- 2 = slightly debilitating to individuals or society
- 3 = moderately debilitating to individuals or society
- 4 = life threatening or debilitating to individuals or society
- 5 = life threatening and debilitating to individuals and society

Acceptability

- 1 = not perceived as a health problem; any effort to address it would be opposed
- 2 = not perceived as a health problem; efforts to address it would not be opposed
- 3 = recognized as a health problem; any effort to address it would be opposed
- 4 = recognized as a health problem; efforts to address it would not be opposed
- 5 = recognized as a health problem; efforts to address it would be welcomed

Resources Available

- 1 = no resources available
- 2 = resources moderately available
- 3 = resources highly available

Child and Adolescent Issues/Problems Facing Region	Extent (High incidence/prevalence)	Severe Consequences	Acceptability to citizens	Sub-Total	Resources Available	Total
Injuries	4	4	5	13	3	16
Without Healthcare Coverage	4	5	5	14	3	18
Obesity	2	3	4	9	1	10
Percent of Elevated Lead Blood Levels	4	4	4	12	2	14

Scoring Method

Extent

- 1 = low incidence or prevalence
- 2 = moderate incidence or prevalence in some subgroups
- 3 = moderate incidence or prevalence in all groups
- 4 = high incidence or prevalence in some subgroups
- 5 = high incidence or prevalence in all subgroups

Severity of Consequences

- 1 = not life threatening
- 2 = slightly debilitating to individuals or society
- 3 = moderately debilitating to individuals or society
- 4 = life threatening or debilitating to individuals or society
- 5 = life threatening and debilitating to individuals and society

Acceptability

- 1 = not perceived as a health problem; any effort to address it would be opposed
- 2 = not perceived as a health problem; efforts to address it would not be opposed
- 3 = recognized as a health problem; any effort to address it would be opposed
- 4 = recognized as a health problem; efforts to address it would not be opposed
- 5 = recognized as a health problem; efforts to address it would be welcomed

Resources Available

- 1 = no resources available
- 2 = resources moderately available
- 3 = resources highly available

Child and Adolescent Issues/Problems Facing Region	Extent (High incidence/prevalence)	Severe Consequences	Acceptability to Citizens	Sub-Total	Resources Available	Total

Possible Solutions to an Identified Child Health Need

Child (Age 1-14) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

Possible Solutions to an Identified Child Health Need

Child (Age 1-14) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

Possible Solutions to an Identified Child Health Need

Child (Age 1-14) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

Possible Solutions to an Identified Adolescent Health Need

Adolescent (Age 15-24) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

Possible Solutions to an Identified Adolescent Health Need

Adolescent (Age 15-24) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

Possible Solutions to an Identified Adolescent Health Need

Adolescent (Age 15-24) Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered “no”, what priority is this need now that you’ve considered solutions? (Higher, lower) _____
- Do you need to reconsider this need being one of the top 3 needs?

3. For Resources and Services in the Region please “√” all that apply.

Resources/Services		Present within State	In State - Available to All	In State - Available to <u>Limited*</u> Populations	*Limited How?	Don't Know
Injury Prevention Education	Children					
	Adolescents					
Mental Health Services	Children					
	Adolescents					
Substance Use Assessment	Adolescents					
Substance Use Treatment/Intervention	Adolescents					
Early Head Start						
Early Steps						
Information on Health Care Coverage						
Training for Child Care Centers-Health and Safety						
Nutrition Education/ Counseling						
Immunization Services						
Parent Education Programs						
Emergency Medical Services for Children						
Lead Poisoning Assessment and Education						
Research and Referral Centers for Child Care						
Dental Sealant Programs						
Suicide Prevention Programs						
HIV Counseling & Testing						
School-based Health Centers						
Family Support Services						

*For example, limited by geographic location or financial criteria.

4. List the Top 3 Child and Adolescent Health Needs that were identified by using the ranking method.

5. Propose short term (1 year) and long-term (5 year) activities that you have confirmed to be effective and that have resources available for addressing your Top 3 priority Child and Adolescent Health Needs.

6. In order for your needs assessment data to become a successful evaluation of the current health needs, outside input is required. Please list all of the outside input used (sources/partners/individuals/organizations).

When this workbook is completed, please return to the entire workbook to Tracy Hubbard, Office of Public Health, Maternal & Child Health, 325 Loyola Avenue, Room 612, New Orleans, LA 70112. (504) 568-5073 Phone 504-568-8162 Fax e-mail: thubbard@dhh.la.gov

APPENDIX: Parish Poverty Level by OPH Region

REGION	PARISH	PARISH POVERTY LEVEL (18 and under)
Region 1	JEFFERSON	20.0
	ORLEANS	40.3
	PLAQUEMINES	20.7
	ST. BERNARD	16.5
Region 2	ASCENSION	16.3
	EAST BATON ROUGE	22.7
	E. FELICIANA	28.7
	IBERVILLE	30.1
	POINTE COUPE	30.2
	W. BATON ROUGE	22.2
	W. FELICIANA	25.3
Region 3	ASSUMPTION	28.4
	LAFOURCHE	21.9
	ST. CHARLES	14.2
	ST. JAMES	27.7
	ST. JOHN	21.7
	ST. MARY	31.3
	TERREBONNE	25.9
Region 4	ACADIA	30.3
	EVANGELINE	39.1
	IBERIA	31.5
	LAFAYETTE	18.2
	ST. LANDRY	37.7
	ST. MARTIN	27.7
	VERMILION	30.0
Region 5	ALLEN	22.6
	BEAUREGARD	19.5
	CALCASIEU	19.9
	CAMERON	13.1
	JEFFERSON DAVIS	25.4

Region 6	AVOUELLES	32.5
	CATAHOULA	41.8
	CONCORDIA	42.0
	GRANT	27.3
	LASALLE	23.7
	RAPIDES	26.3
	VERNON	18.6
	WINN	28.4
Region 7	BIENVILLE	34.0
	BOSSIER	19.0
	CADDO	30.8
	CLAIBORNE	36.3
	DESOTO	33.8
	NATCHITOCHEs	32.7
	RED RIVER	40.1
	SABINE	29.0
	WEBSTER	29.6
Region 8	CALDWELL	27.1
	E. CARROLL	56.8
	FRANKLIN	41.4
	JACKSON	26.3
	LINCOLN	30.1
	MADISON	51.6
	MOREHOUSE	35.9
	OUACHITA	29.7
	RICHLAND	39.5
	TENSAS	48.2
	UNION	25.6
	W. CARROLL	30.8
Region 9	LIVINGSTON	11.7
	ST. HELENA	35.5
	ST. TAMMANY	11.8
	TANGIPAHOA	28.6
	WASHINGTON	32.2

Source: U.S. Census Bureau, 2000, Summary File 3. GCT-P14: Income and Poverty in 1999. Income in 1999 below poverty level. Percent of population for whom poverty status is determined, Related Children under 18 years.

APPENDIX

CHILD MORTALITY DEATHS NUMBER (rate per 100,000 in age group) BY AGE AND CAUSE OF DEATH

UNITED STATES – 2002

Cause	<1 year	1 – 4 yrs	5 – 14 yrs	15 – 24 yrs
All	27,568 (693.6)	4,862 (31.2)	7,169 (17.5)	32,252 (81.5)
Congenital Malformations	5,655 (140.7)	521 (3.3)	395 (1.0)	472 (1.2)
Short gestation/prematurity	4,598 (114.4)			
SIDS	2,035 (50.5)			
Maternal complications of pregnancy	1,723 (42.9)			
Complications of the placenta	1,017 (25.3)			
Resp. distress of the newborn	958 (23.8)			
Accidents		1,609 (10.3)	2,692 (6.6)	15,026 (37.0)
MVC	893 (22.2)	602 (3.9)	1,603 (3.9)	11,303 (28.5)
Other		1,007 (6.5)	1,089 (2.7)	3,722 (9.2)
Neonatal Sepsis/Septicemia	734 (18.3)	82 (0.5)	100 (0.2)	
Diseases of the heart	649 (16.1)	164 (1.1)	237 (0.6)	948 (2.3)
IU hypoxia and birth asphyxia	578 (14.4)			
Cancer		401 (2.6)	1,061 (2.6)	1,728 (4.3)
Homicide		384 (2.5)	342 (0.8)	5,070 (12.5)
Influenza and pneumonia		107 (0.7)	92 (0.2)	
Suicide			259 (0.6)	3,932 (9.7)
Chronic lower respiratory dis.		62 (0.4)	118 (0.3)	172 (0.4)
HIV				175 (0.4)
Cerebrovascular diseases				163 (0.4)
Diabetes mellitus				163 (0.4)

Source: Center for Disease Control, National Vital Statistics Reports, Vol. 52, no. 13, February 11, 2004. Table 7: Deaths and death rates for the 10 leading causes of death in specified age groups: United States, preliminary 2002.



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

Date: April 1, 2005

To: OPH Regional Staff

From: Tracy Hubbard, MPH MCE

Re: 2004 Child and Adolescent Needs Assessment

cc: Jean Takenaka, MD
Regional Medical Directors
Regional Administrators
Regional Nurse Managers
Jaime Slaughter
Irene Schiavo

We would like to take this opportunity to thank each OPH Region for your participation in the 2004 Child and Adolescent Needs Assessment for Maternal and Child Health. We have compiled a report for you to see your region's needs compared to the other regions in the state. Priority needs related to the adolescent group were given to the Adolescent Needs Assessment Group and incorporated into their top five priority needs. The priority needs reported for each region related to children were used to select the top five overall child health needs for the MCH Program to address this upcoming 5 year funding period. The top five child health needs selected were as follows:

1. Ensure that every child has access to quality, comprehensive, coordinated care from quality providers. This includes access to transportation services in areas of increased need, increasing the number of healthcare providers, and maximizing utilization of school based health center services.
2. Ensure all children have access to quality, comprehensive mental health services.
3. Decrease the child mortality and morbidity due to intentional and unintentional injuries.
4. Need for development of a comprehensive, quality database for collection of child health data.
5. Promote and increase "family development." Family development is inclusive of parenting skills and education.

Using the top priority needs from each of the subgroups in the needs assessment (oral health, children with special health care needs, perinatal, child and adolescent), the MCH Needs Assessment Group selected the



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Page -2-

overall top 10 priority needs for Maternal and Child Health:

1. Decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers
2. Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations
3. Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation
4. Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment
5. Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral
6. Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination.
7. Promote pre-conceptional and inter-conceptional health care including family planning and folic acid education
8. Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations
9. Improve the health of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity
10. Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation

Your input has helped to frame and develop the roadmap for the future of the MCH population in Louisiana. Please distribute this packet other participants in your region's needs assessment. As always thank you for your time and your assistance in this endeavor. If you have any questions please contact me at 504-568-5073 or thubbard@dhh.la.gov.

**Louisiana Office of Public Health
Maternal and Child Health Program**

**Child Health Needs Assessment
2004**

Regional Compiled Report

1. State your established vision/goals for the Child and Adolescent population in your region.

Region	
1	Our vision for children and adolescents in Region 1 to be safe, physically healthy, mentally healthy and reach their full potential.
2	All children (1-24 yrs) will have access to health care and mental health. A school based health center will be available in every school.
3	Healthy Educated in a Healthy Environment Receive services they are entitled
4	To meet the health care needs of the children and improve their quality of life.
5	To provide Children and Adolescents in Region 5 with adequate medical, dental, and mental health services that will maximize development and establish healthy habits to ensure productive and healthy adults for the future of Louisiana.
6	Multiple vision/goals for all agencies the participated. Can be viewed upon request.
7	Not Submitted
8	Our goal is to reduce regional child and adolescent mortality rates toward the national averages in these age groups over the next five years by focusing efforts toward the development of activities and strategies to intervene in the causes of death most in need of improvement: accidents (including motor vehicle), homicide, suicide and diseases of the heart among 15-24 year olds. We envision a population that will become increasingly more informed about the importance of caring for their and/or their children's health and safety and will have greater access to the preventative medicine and education needed to prevent avoidable child and adolescent death.
9	To create and assure optimal conditions for health and safety of child and adolescent population of Region 9.

2. List the identified Child and Adolescent health needs based on the current existing health status data.

CH Priority Needs (Age 1-14)	# of Regions Listing	Region
Access to Health Care		
<input type="checkbox"/> Dental/Oral Services	3	3, 4, 6
<input type="checkbox"/> Health Care Providers	6	1, 2, 3, 4, 5, 7
<input type="checkbox"/> LaCHIP Enrollment	4	1, 2, 3, 9
<input type="checkbox"/> Transportation	6	1, 2, 3, 5, 6, 7
<input type="checkbox"/> Specialty Services	1	7
Immunizations		
<input type="checkbox"/> Expand LINKS	1	3
Injury Prevention		
<input type="checkbox"/> Health Education	4	1, 7, 8, 9
<input type="checkbox"/> Parenting	3	1, 7, 8
<input type="checkbox"/> Suicide Prevention	1	1
Mental Health		
<input type="checkbox"/> Abuse and Neglect	5	1, 3, 4, 7, 9
<input type="checkbox"/> Expand Svcs/Providers	6	1, 2, 3, 5, 6, 8
<input type="checkbox"/> Health Education	1	1
Nutrition		
<input type="checkbox"/> Obesity	3	7, 8, 9
School Health		
<input type="checkbox"/> Health Ed. Classes	2	2, 6
<input type="checkbox"/> School Based Health Ctrs	1	2

CH Priority Needs (Age 15-24)	# of Regions Listing	Region
Access to Health Care		
<input type="checkbox"/> Dental/Oral Services	1	3
<input type="checkbox"/> Health Care Providers	4	2, 5, 7, 9
<input type="checkbox"/> LaCHIP Enrollment	4	2, 3, 6, 9
<input type="checkbox"/> Transportation	4	2, 3, 5, 6, 7
<input type="checkbox"/> Specialty Services	1	7
Immunizations		
<input type="checkbox"/> Expand LINKS	1	3
Injury Prevention		
<input type="checkbox"/> Health Education	4	1, 3, 7, 9
<input type="checkbox"/> Parenting	3	1, 6, 7
<input type="checkbox"/> Suicide Prevention	2	1, 9
Mental Health		
<input type="checkbox"/> Abuse and Neglect	2	3, 7
<input type="checkbox"/> Expand Svcs/Providers	4	3, 4, 5, 8
<input type="checkbox"/> Health Education	2	2, 8
Nutrition		
<input type="checkbox"/> Obesity	2	6, 7
School Health		
<input type="checkbox"/> Health Ed. Classes	4	1, 2, 4, 6
<input type="checkbox"/> School Based Health Ctrs	3	1, 2, 3
Substance Abuse		
<input type="checkbox"/> Prevention Svcs	4	1, 3, 4, 6
<input type="checkbox"/> Treatment	4	1, 3, 4, 6

4. List the Top 3 Child and Adolescent Health Needs that were identified using the ranking method and short term (1 year) and long-term (5 year) activities that you have confirmed to be effective and that have resources available for addressing your Top 3 priority Child and Adolescent Health Needs.

Top Three Child Health Priority Needs and Activities (Ages 1-14) by Region	
Region 1	<ul style="list-style-type: none"> ● Increase Injury Prevention Efforts- gun safety, reduce Shaken Baby Syndrome, car seat safety, reduce deaths due to drowning, and suicide prevention. ● Increase Access to Health Care-increase LACHIP enrollment, increase underserved providers, SBHC, mobile units, promote transportation services and existing resources. ● Decrease Child Abuse and Neglect – increase parenting program, create media campaign, increase education for providers
Region 2	<ul style="list-style-type: none"> ● Increase Access to Health Care - increase LACHIP enrollment, increase underserved providers, SBHC and transportation providers. ● Mental Health – expand services, parent education ● School Health Issues – increase SBHC, health education in classes, self esteem awareness, awareness of available resources
Region 3 (Age 1-4)	<ul style="list-style-type: none"> ● Increase Access to Health Care-increase LACHIP enrollment and increase transportation ● Mental Health – expand access and treatment services ● Immunizations – expand LINKS, education efforts ● Dental/Oral Needs – increase access, increase providers, preventive education, underserved populations ● Increase Injury Prevention Efforts – increase staffing, create media campaign ● Decrease Child Abuse and Neglect/Violence Prevention – increase education for providers on mandatory reporting, parent education
Region 4	<ul style="list-style-type: none"> ● Dental/Oral Needs – increase providers, preventive education, water fluoridation ● Decrease Child Abuse and Neglect - parent education, increase home visiting to high risk Medicaid, work with DSS on cases, ● Increase Access to Health Care- case coordination
Region 5	<ul style="list-style-type: none"> ● Transportation – increase services ● Health Education Services – PSA media, coordination ● Increase Medicaid/LaCHIP Providers – provide mobile units
Region 6	<ul style="list-style-type: none"> ● Dental/Oral Needs – increase providers, preventive education, insurance programs ● Mental Health – expand access and treatment services, increase providers, mobile units and transportation to services ● Health Education in School Setting – teen pregnancy/STD prevention, expand injury prevention, promote nutrition and physical activity
Region 7	<ul style="list-style-type: none"> ● Obesity nutrition education ● Parenting Skills ● Access to care- Transportation and increase number of providers in rural areas ● Injury prevention ● Lack of Specialty Services ● Child abuse and child neglect education and awareness
Region 8 (Age 1-4)	<ul style="list-style-type: none"> ● Increase Parenting Skills/Education – home visiting, parenting classes
Region 9	<ul style="list-style-type: none"> ● Increase Injury Prevention Efforts- Car Seat Safety Law Enforcement ● Increase Healthcare Providers – LaCHIP, family support services, underserved providers ● Obesity – nutrition education, SBHC

**Top Three Child Health Priority Needs and Activities
(Ages 15-24) by Region**

Region 1	<ul style="list-style-type: none"> ● Increase Health Education and Promotion Efforts – parenting program, SBHC, community involvement (Playgrounds, community centers) violence prevention ● Increase Injury Prevention - reduce deaths due to drowning, gun safety and suicide prevention. ● Substance Abuse – Expand treatment and prevention programs
Region 2	<ul style="list-style-type: none"> ● Increase Access to Health Care - increase LACHIP enrollment, increase underserved providers, SBHC and transportation providers. ● Mental Health – expand services, parent education ● School Health Issues – increase SBHC, Health education in classes, Self esteem awareness, awareness of available resources
Region 3 (Age 5-24)	<ul style="list-style-type: none"> ● Increase Access to Health Care-increase LACHIP enrollment and increase transportation ● Mental Health – expand services, increase access, transportation ● Substance Abuse – expand treatment and prevention programs ● School Health Issues – increase SBHC, promote healthy environment ● Immunizations – expand LINKS, education efforts ● Dental/Oral Needs – increase access, increase providers, preventive education, underserved populations ● Increase Injury Prevention Efforts – increase staffing, create media campaign ● Decrease Child Abuse and Neglect/Violence Prevention – increase education for providers on mandatory reporting, parent education
Region 4	<ul style="list-style-type: none"> ● Substance Abuse – expand treatment and prevention programs, school education, case coordination ● Sexual activity prevention to decrease teen pregnancy and STD's – increase providers, SBHC, school education ● Mental Health – more counselors in PHU, promote 1-800 Hotline number
Region 5	<ul style="list-style-type: none"> ● Transportation – increase services ● Health Education Services – PSA media, coordination ● Increase Medicaid/LaCHIP Providers – provide mobile units
Region 6	<ul style="list-style-type: none"> ● Health Education in School Setting – teen pregnancy/STD prevention, substance abuse, mental health, nutrition and parenting skills education ● Increase Access to Health Care - increase LACHIP enrollment, increase transportation. ● Job training/Parenting Classes – community education/resource center
Region 7	<ul style="list-style-type: none"> ● Obesity/Nutrition education ● Parenting Skills ● Access to care- transportation and increase number of providers in rural areas ● Injury prevention ● Lack of specialty services ● Child abuse and child neglect education and awareness
Region 8 (Age 5-24)	<ul style="list-style-type: none"> ● Obesity – nutrition education, SBHC ● Mental Health – expand access and treatment services, increase providers, ECCS Program, SBHC ● Decrease injury due to Motor Vehicle Accidents –education car seat safety, law enforcement, helmet use etc.
Region 9	<ul style="list-style-type: none"> ● Injury Prevention – substance abuse education, safe driving education ● Suicide Prevention – expand mental health treatment, education ● Increase Healthcare Providers – LaCHIP, family support services, underserved providers

3. For Resources and Services in the Region please “√” all that apply.

Resources/Services		Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Region 7		Region 8		Region 9	
		All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes	All Parishes	Limited Parishes
Injury Prevention Education	Children	√		√		?	?		√	√		√				√		√	
	Adolescents	√			√	?	?		√	√		√				√		√	
Mental Health Services	Children		√		√		√		√		√	√					√	√	
	Adolescents		√		√		√		√		√	√					√	√	
Substance Use Assessment	Adolescents		√		√	√			√		√	√				√		√	
Substance Use Treatment & Intervention	Adolescents		√		√	?	?		√		√	√				√		√	
Early Head Start			√	√			√		√	?	?		√				√		√
Early Steps		√		√		√		√		√		√					√	√	
Information on Health Care Coverage		√		√			√	√		√		√				√		√	
Training for Child Care Centers-Health and Safety		√			√	√			√	√		√					√	√	
Nutrition Education/ Counseling			√		√		√		√		√	√					√		√
Immunization Services		√		√		√		√		√		√				√		√	
Parent Education Programs		√			√		√	?	?		√	√					√		√
Emergency Medical Services for Children		√			√	√		?	?	√		√				√		√	
Lead Poisoning Assessment and Education		√			√		√		√	√		√				√		√	
Research and Referral Centers for Child Care		√			√	√		?	?		√	√				?	?	√	
Dental Sealant Programs		?	?	?	?		√	?	?	?	?	?	?				√		√
Suicide Prevention Programs		√			?	?	NP	NP	?	?		√	√				√		√
HIV Counseling & Testing		√			√	√		√			√	√				√		√	
School-based Health Centers			√		√	NP	NP		√		√		√				√		√
Family Support Services			√	√		√		?	?		√	√				√		√	

Check Mark = Available, NP = Not Present, ? = Not Sure, Shaded area means not submitted

Child Health Needs Assessment Healthcare Provider Survey

The Title V Maternal and Child Health (MCH) Block Grant is a federal government grant which provides approximately \$15 million to fund MCH services throughout Louisiana through the Office of Public Health's (OPH) MCH Program.

Every five years, State Title V agencies are required to conduct a comprehensive needs assessment to:

- identify state MCH priority needs
- arrange programmatic and policy activities around these priorities needs
- develop measures to monitor the success of their efforts.

The OPH Child Health Program would like input from healthcare professionals on what are the needs of Louisiana's children that we can address through the State MCH Program during the next five years.

Priority needs for the Child Health Program that have been addressed in previous years include: 1) decreasing infant deaths due to SIDS, 2) decreasing unintentional injuries in children, and 3) decreasing child abuse and neglect. Based on these needs, program activities have been developed including a statewide SIDS Risk Reduction Public Awareness campaign, intensive nurse home visiting programs to low income first time mothers, training in infant mental health for public health staff, development of an assessment tool for early identification of families in need of additional support, and establishment of Regional Injury Prevention Coordinators.

The child health needs assessment will focus on ages 1 to 21 years, with overlap in the adolescent age group and the Children with Special Health Care Needs group. In separate processes, the needs of children under one year of age are being addressed through a Perinatal Needs Assessment and the needs of adolescents, ages 10-24 years, are being addressed through an Adolescent Needs Assessment. Your additional input for adolescents will be shared with the adolescent group.

We are asking your assistance in working with us in this process by taking this healthcare professional survey.

[Click here to take survey](http://www.surveymonkey.com/s.asp?u=68111662274)

Adolescent Health Data Sheets

Chronic Disease Prevention & Health Promotion

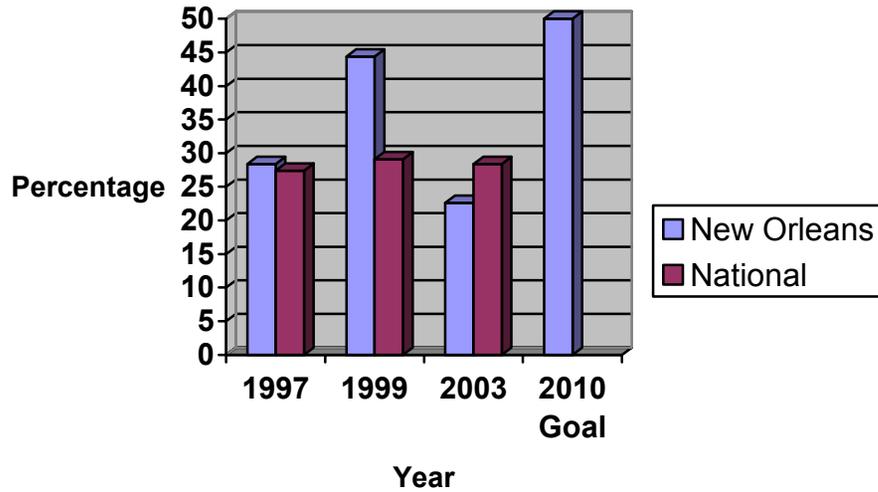
Highlights

- Among the major cities cited*, New Orleans adolescents ranked #1 in eating at least 5 fruits and vegetables daily. (YRBS 2003)
- New Orleans adolescents ranked last with regard to receiving adequate amounts of physical activity (moderate, 14.9%; vigorous, 40.1%). (YRBS, 2003)
- Almost ½ of all students are enrolled in PE (above the median). 55.7% of these students report being active for at least 20 consecutive minutes, which is last of all reporting cities. (YRBS, 2003)
- 13% of New Orleans adolescents are overweight and 15.4% are at risk for becoming overweight, but rank last in perception of being overweight (21%), trying to lose weight (30.5%), and restricting calories or exercising to lose weight (27.3% and 38.7% respectively). However, these adolescents rank in the top 3 with regard to vomiting or taking a laxative to prevent weight gain (7.1%). (YRBS, 2003)
- Diabetes is the 5th leading cause of death in LA, affecting 7% of adults. 1.3% (13 of 1,029) of students who were considered high risk for Type II (formerly known as adult onset diabetes) tested positive for the disease in 2002-2003. (Chronic Disease Department, Office of Public Health and Adolescent School Health Initiative Department; Office of Public Health, 2003)
- Diabetes cost the state over \$2 billion in 1997.

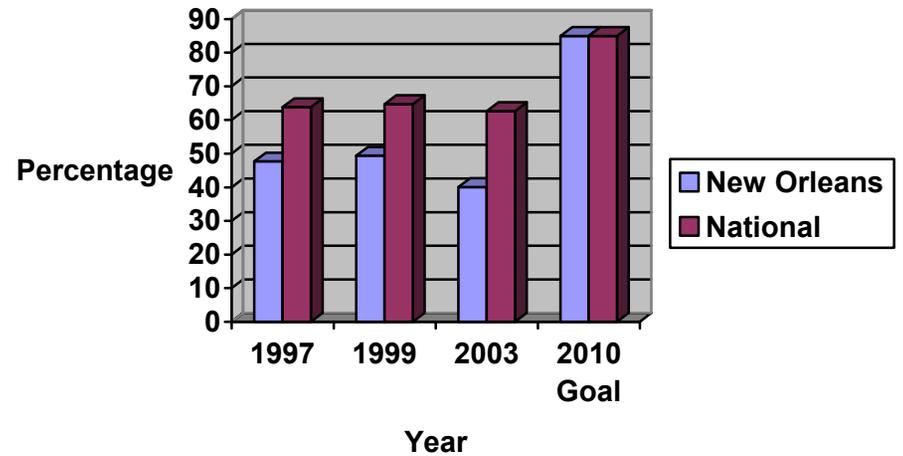
* Cities include: Boston; Broward County, FL; Chicago; Dallas; DeKalb County, Ga; Detroit; D.C.; L.A.; Memphis; Miami-Dade County, FL; Milwaukee; New Orleans; New York City; Orange County, FL; Palm Beach County; Philadelphia; San Bernardino; San Diego.

Adolescent Health Data Sheets

Percentage of Students who Participate in PE Daily



Percentage of Adolescents who engage in activities promoting cardiovascular fitness for at least 3 days/week



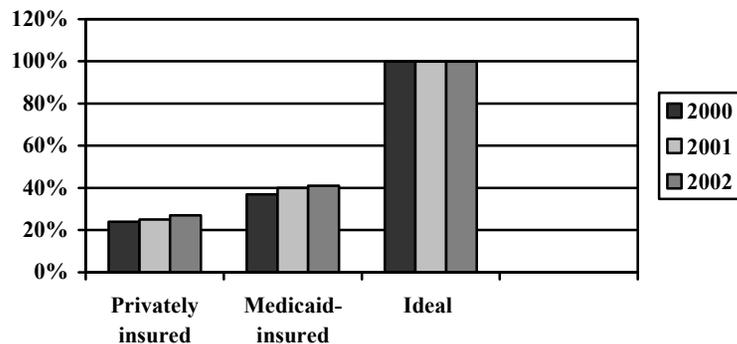
Source: Youth Risk Behavior Surveillance- United States, Centers for Disease Control & Prevention. Surveillance Summaries, May 21, 2004. MMWR 2004:53(No. SS-2)

Adolescent Health Data Sheets

Access to (Quality) Care

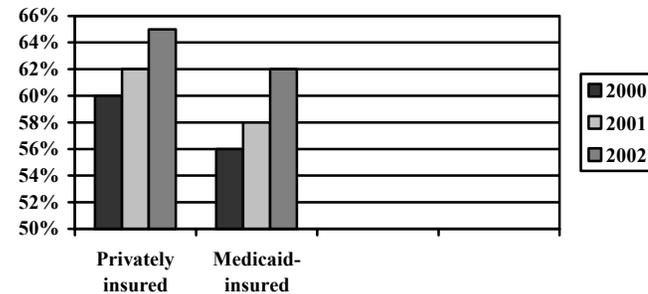
- 11% of LA 6-18 year olds were uninsured in 2003.
Source: Health Insurance Study conducted by DHH
- 12.9% of LA children < 19 in families with incomes less than 200% of the federal poverty level were uninsured. All these children are eligible for Medicaid/LaCHIP. Source: Health Insurance Study conducted by DHH
- In 2003, 91% of children (0-18) were vaccinated against Hepatitis B, an increase from 57% in 1997.
Source: Immunization Program/OPH
- In 1997, less than 1/2 of U.S. adolescents reported that they had ever discussed the most recommended health risk topics with their doctor or other health care professional. Source: The Quality of Health Care for Children & Adolescents: A Chartbook. Commonwealth Fund. April 2004.

Percent U.S. sexually active females (16-20 years) who received a test for chlamydia infection in the past year (2000-2002).



Source: The Quality of Health Care for Children & Adolescents: A Chartbook. Commonwealth Fund. April 2004.

Percent U.S. adolescents (10-17 years) with persistent asthma who received a prescription for an appropriate preventive medication for long-term asthma control by insurance type.



Source: The Quality of Health Care for Children & Adolescents: A Chartbook. Commonwealth Fund. April 2004.

Number and percent of expected health screening provided to LA youth in 2002-2003. **(The Periodicity schedule used by Medicaid calls for screenings every two years beginning at age 6.)**

Ages 10-14

1. Total individuals eligible for EPSDT: 163,926
2. Expected number of screenings: 89,795
3. Total screenings received: **52,239 (58%)**

Ages 15-18

1. Total individuals eligible for EPSDT: 112,135
2. Expected number of screenings: 50,183
3. Total screenings received: **28,504 (57%)**

Source: LA Medicaid-HCFA 416 Report for 10/1/02-9/30/03

Adolescent Health Data Sheets
LA Hospital Discharge Data

Top 5 Diagnoses, Ages 13-17 Years, LA, 2000

<u>Principal Diagnoses</u>	<u># Discharges</u>
#1 - Affective disorders	<u>792</u>
#2 - Other complications of birth and the puerperium	<u>696</u>
#3 - Other complications of pregnancy	<u>518</u>
#4 - Trauma to perineum/vulva	<u>511</u>
#5 - Early or threatened labor	<u>411</u>
Total Top 5 Discharges	<u>2928</u>
Total Discharges in 2000	<u>11,325</u>

#10 – Crushing/internal injury	<u>86</u>
Total Top 10 ER Admissions	<u>1320</u>
Total ER Admissions in 2000	<u>3541</u>

Source: LA Hospital Inpatient Discharge Data www.oh.dhh.state.la.us/recordstatistics/statistics/page0cda.html?page=117

Top 10 Principal Diagnoses Admitted through Emergency
Room, Ages 13-17, LA, 2000

<u>Principal Diagnoses</u>	<u># Discharges</u>
#1 – Appendicitis	<u>217</u>
#2 – Affective disorders	<u>207</u>
#3 – Fracture of lower limb	<u>157</u>
#4 – Sickle Cell Anemia	<u>136</u>
#5 – Asthma	<u>125</u>
#6 – Poisoning by meds/drugs	<u>109</u>
#7 – Intracranial injury	<u>101</u>
#8 – Diabetes with complications	<u>95</u>
#9 – Other complications of pregnancy	<u>87</u>

Adolescent Health Data Sheets

Mental Health

Statistics for the United States

The Need

- Among 9-17 year olds, an estimated 21 % experience signs and symptoms of a DSM-IV diagnosed disorder, 11 % experience significant impairment, and 5% experience extreme functional impairment.
Source: The Center for Health & Health Care in Schools, 2004.
- Only 25 % of children with mental health impairment/disorders receive sufficient mental health care.
Source: The Center for Health & Health Care in Schools, 2004.

Disparities

- Minorities have less access to mental health services and are less likely to receive needed care.
Source: The Center for Health & Health Care in Schools, 2004.
- Minorities in treatment often receive a poorer quality of mental health care.
Source: The Center for Health & Health Care in Schools, 2004.

Homelessness & Mental Illness

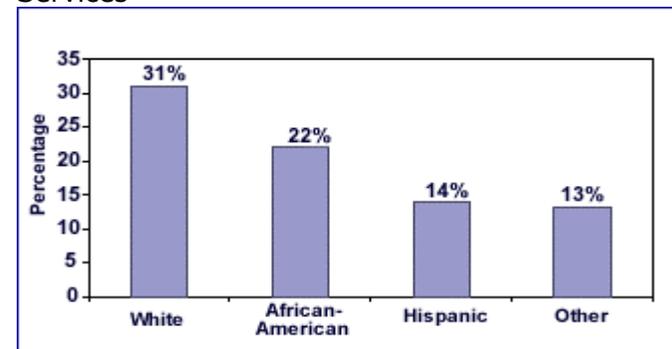
- Almost 50 % of homeless children and adolescents have anxiety, depression, or withdrawal. Source: NMHA
- 33 % of homeless children and adolescent have one major mental disorder that interferes with daily activities.
Source: NMHA
- 33% of homeless children and adolescents manifest delinquent and aggressive behavior. Source: NMHA

Common Mental Health Disorders And the Number of Children/Youth Affected

Disorder	Number of Children/Youth Affected
Anxiety	8-10 out of 100
Conduct	7 out of 100
Depression	6 out of 100
Learning	5 out of 100
Attention	5 out of 100
Eating	1 out of 150
Substance Abuse	Unknown

Source: Olbrich S. Children's Mental Health: Current Challenges and a Future Direction. May 2002. Accessed on the web at www.healthinschools.org on 5/2/03.

Children and Youth Receiving Needed Mental Health Services



Source: RAND Health Research Highlights. Calculations are based on data from the National Health Interview Study, 1998.

Adolescent Health Data Sheets

Statistics for Louisiana

The Need

- An estimated 19.6% (273,884/1.4 million) of LA children/youth (0-21) have a serious emotional or behavioral disorder (EBD).
- LA Office of Mental Health (OMH) only serves 6% of these children/youth.
- Most of the 45 mental health centers in LA do not serve children/youth. There are almost no child psychiatrists in rural LA.

In 2004, 3,586 children/youth were served by LA OMH:

Primary Diagnosis	% Total Visits
Major Affective Disorder	25.4
ADD/ADHD	16.1
Depression	11.6
Oppositional Defiant Disorder	7.0
Conduct Disorder	4.9
Psychotic Disorder	4.8
Anxiety Disorder	4.4
Adjustment Disorder	3.5
Other	22.3

- An estimated 56,702 LA adolescents are in need of substance abuse services. LA Office of Addictive Disorders (OAD) only serves 4.5% of these adolescents.

- In 2003, mental health ranked 2nd in rural LA and 3rd in urban LA in the “Top 10” reasons for visit to a SBHC.

Homelessness

- In the U.S., 33% of the homeless population are homeless families.
- 500,000 children are homeless nationwide.
- Between 17,000 and 19,000 homeless women, men and children reside in New Orleans.

Source: Healthcare for the Homeless Program.
www.cityofno.com/portal.aspx?portal=48&tabid=6 Retrieved 7/21/04.

Child Abuse

- Neglect is the highest form of child abuse reported in LA.
- In LA in 2003, there were 13,546 cases of abuse involving 9,898 children/youth:
 - *71% physically neglected *19% physically abused
 - *6.3% sexually abused *3% cases emotional abuse
- *43 children died from abuse/neglect

Source: Prevent Child Abuse LA, The LA Dept of Social Services, Office of Community Services

Foster Care

- Roughly 5,700 children are in foster care in Louisiana.
- 3 years is the average length of time children remain in foster care.

Adolescent Health Data Sheets

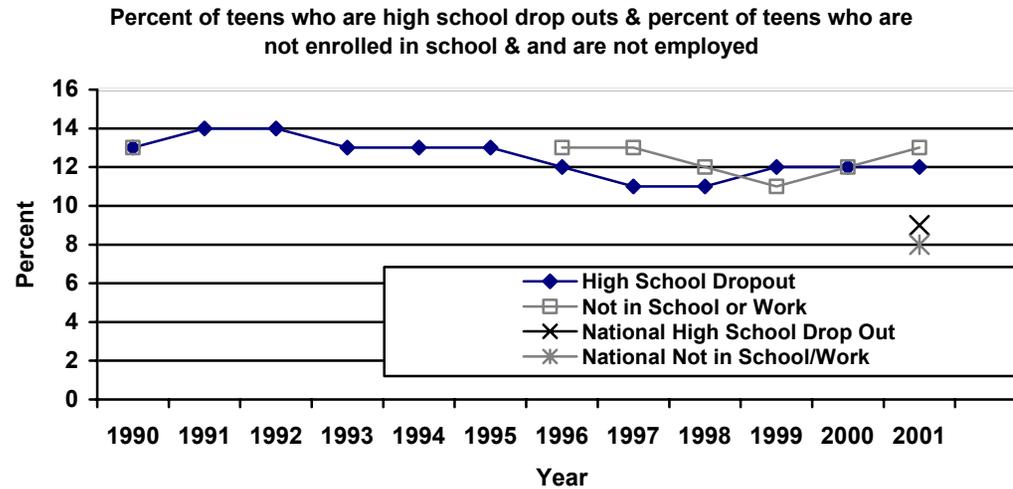
- Many foster children are considered “special needs children”, making it difficult to find permanent placement.

Source: Adrift in the System, Louisiana’s children in crisis.
www.lpb.org/programs/adrift/fcla.html Retrieved 7/22/04.

High School Dropout Rates

- LA ranks 43rd in nation with regard to HS Dropout Rates
- LA ranks 48th in nation with regard to children/adolescents not enrolled in school and not currently employed.

These rankings have remained relatively stable for the past 5 years.



Source: National Committee to Prevent Child Abuse, The LA Office of Social Services, and Kids Count, 2004.

Adolescent Health Data Sheets

Reproductive Health

Sexually Transmitted Diseases

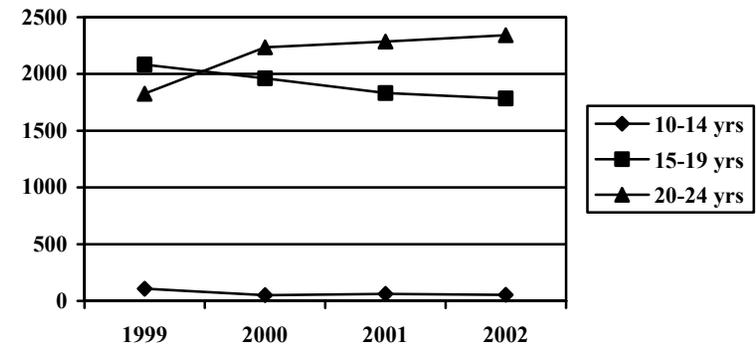
- LA ranked 1st in the nation & 4th in the nation for rates of gonorrhea and chlamydia infection respectively in 2003. In 2003, LA remained 1st in the nation for cases of gonorrhea and became 2nd in the nation for cases of chlamydia.
- Adolescents (15-24 years) have the highest rates of chlamydia and gonorrhea in the state.
- LA ranks 5th highest in state AIDS case rates and 10th in the number of new AIDS cases detected in the US in 2001. (CDC HIV/AIDS Surveillance Report [vol 14])

HIV/AIDS

- 19% of persons with HIV/AIDS detected in 2003 were 13-24 years old.
- 20% of persons living with HIV/AIDS in LA are 13-24 years old.

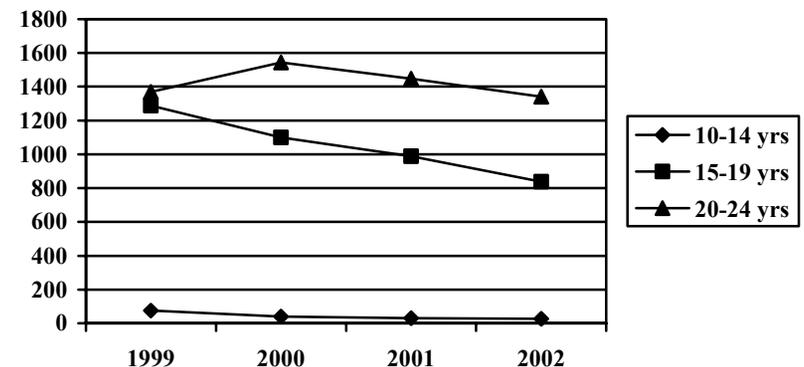
Teen Pregnancy

- Teen births (15-17year olds) in LA have steadily decreased since 1994.
- LA ranks 45th among states in teen births (2001).
- 16% of all births in LA are to teen mothers.



RATES OF CHLAMYDIA (#/100,000)

RATES OF GONORRHEA (#/100,000)



Adolescent Health Data Sheets

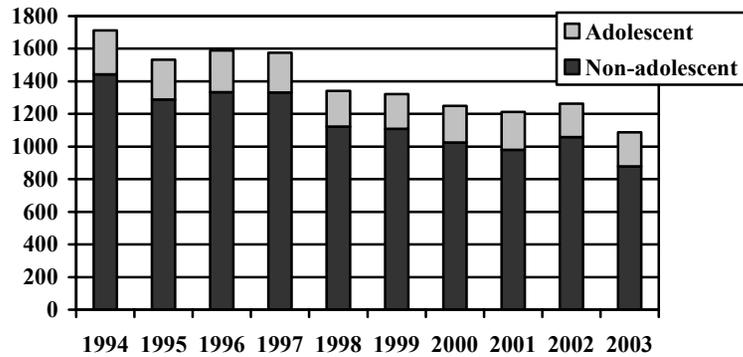
HIV/AIDS Among Adolescents (13-24) in LA

	HIV/AIDS detected in 2003		Cumulative HIV/AIDS cases	
	N	%	N	%
Race				
Other/Unknown	1	0.48	23	0.59
Black non-Hispanic	181	87.02	2864	73.47
Hispanic	4	1.92	58	1.49
White non-Hispanic	22	10.58	953	24.45
Sex				
Female	108	51.92	1629	41.79
Male	100	48.08	2269	58.21
Region				
1	73	35.10	1732	44.43
2	45	21.63	821	21.06
3	10	4.81	124	3.18
4	23	11.06	208	5.34
5	13	6.25	185	4.75
6	9	4.33	182	4.67
7	22	10.58	287	7.36
8	8	3.85	232	5.95
9	5	2.40	127	3.26

	HIV/AIDS detected in 2003		Cumulative HIV/AIDS cases	
	N	%	N	%
Mode of exposure				
MSM	51	24.52	1135	29.12
IDU	11	5.29	348	8.93
MSM/IDU	1	0.48	215	5.52
Adult Hemophl	.	0.00	39	1.00
Hetsx Contact	28	13.46	825	21.16
Transfusion	.	0.00	23	0.59
Not Specified	117	56.25	1313	33.68
Total	208	100.00	3898	100.00

HIV/AIDS Detections in LA by Year

Adolescent Health Data Sheets



LA TEEN BIRTH RATE (15-19 y/o)

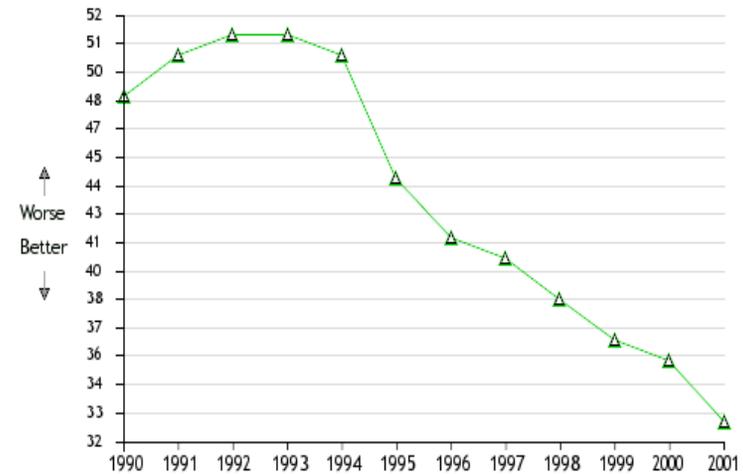
Births per 1,000 female population

	White	Black	Others	Total
2000	43.9	92.5	22.4	62.0
2001	41.4	84.6	27.0	58.1
2002	39.6	81.1	22.8	55.1

% TEEN BIRTHS (15-19 y/o)/TOTAL BIRTHS IN LA

	White	Black	Others	Total
2000	12.0	23.1	9.9	16.6
2001	11.4	22.0	9.8	15.8
2002	11.2	21.6	10.4	15.5

Teen birth rate (births per 100,000 females ages 15-17)



[Source: <http://www.kidscount.org/>]

Youth Risk Behavior Survey (9-12th graders)- New Orleans 2003

Sexual Behavior	NEW ORLEANS			NATIONAL		
	Female	Male	Total	Female	Male	Total
Ever had sex (%)	48.1	70.2	58.3	45.3	48.0	46.7
1 st event < 13 yrs (%)	3.7	27.0	14.3	4.2	10.4	7.4
> 4 partners lifetime (%)	9.2	39.1	22.8	11.2	17.5	14.4
Currently sexually active (%)	35.6	49.7	42.0	34.6	33.8	34.3
Used condom last intercourse (%)	71.2	76.4	74.1	57.4	68.8	63.0
Birth control used before last intercourse (%)	6.7	6.7	6.7	20.6	13.1	17.0

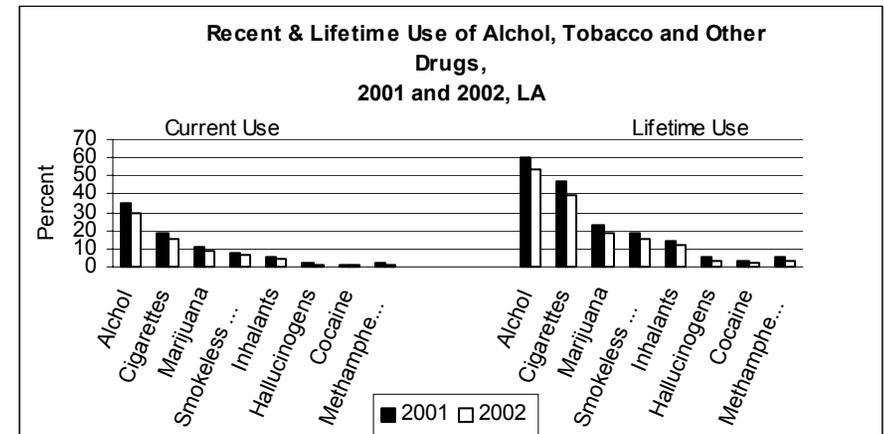
Adolescent Health Data Sheets

Used drugs/alcohol before last sexual encounter (%)	10.4	23.0	17.2	21.0	29.8	25.4
Been pregnant/gotten someone pregnant (%)	11.5	8.8	10.2	4.9	3.5	4.2
Taught in school about HIV or AIDS (%)	81.1	76.1	78.8	88.7	87.2	87.9

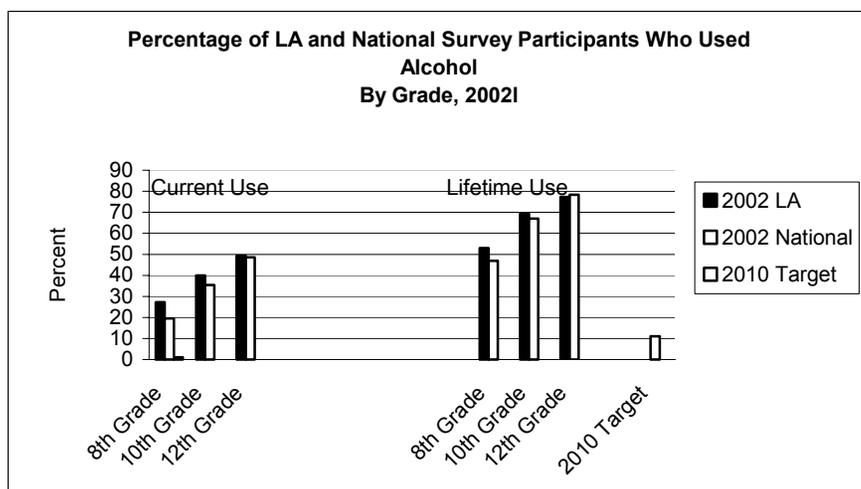
Adolescent Health Data Sheets

Substance Abuse & Tobacco Use

- Alcohol is the most commonly used substance among adolescents in Louisiana followed by cigarette use.
- In 2002, 29.4% of 6th, 8th, 10th, and 12th grade students stated that they have used alcohol in the past month and 53.6% reported use at least once in their lifetime.
- Average age of first sip was 12.5 yrs.
- Average age of first regular drinking was 14 yrs.
- There is little difference in alcohol use between male and female students (29.9% & 29.2% respectively).
- In 2002 the percentage of students who used alcohol and engaged in binge drinking decreased.
- In 2002, 6.6% of 6th, 8th, 10th, and 12th grade students stated that they have used smokeless tobacco in the past month, 20.4% reported use at least once in their lifetime.
- From 2001 to 2002 smokeless tobacco use decreased in all grades.
- 39.5% of students have used cigarettes at least once in their lifetime.



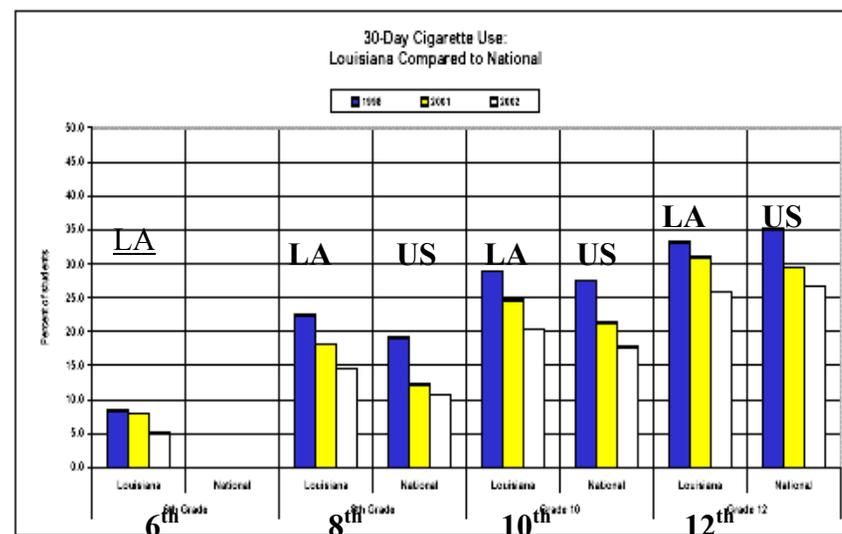
Adolescent Health Data Sheets



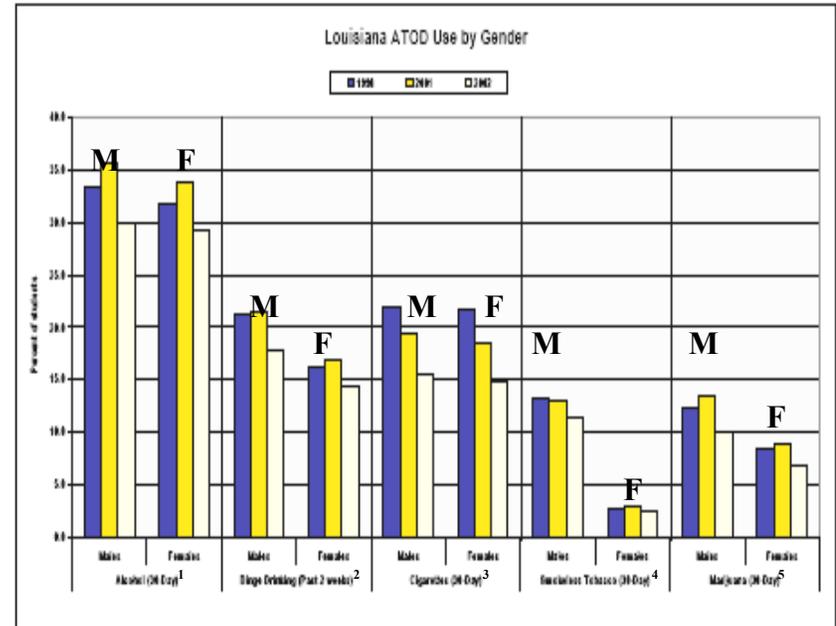
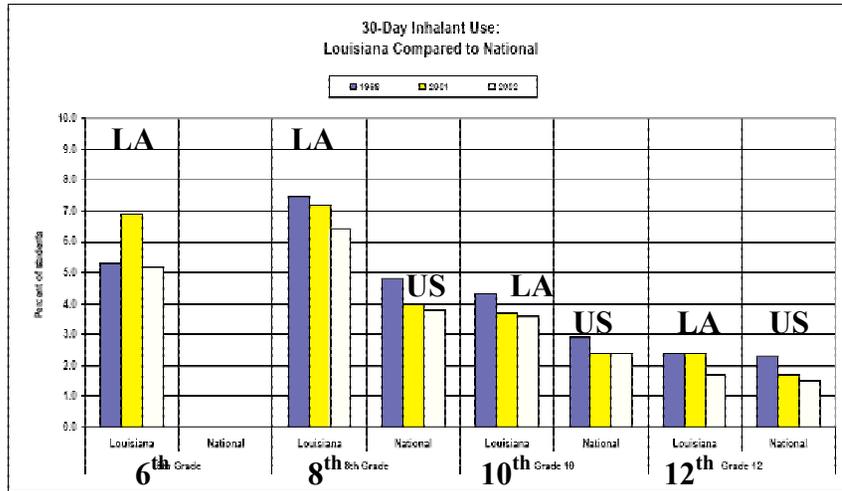
- The average age of initiation for marijuana was 13.5.
- 37.5% of students indicated that marijuana was easy to obtain, third to alcohol and cigarettes.
- In general, the percentage of lifetime illicit drug use declined slightly from 2001 to 2002.

- Students use cigarettes at younger age (11.9) than they use alcohol or marijuana.
- The greatest increase in cigarettes use occurs when the students enter 8th grade.
- In 2002, 15.6% of males and 14.9% females reported use in the past 30 days.
- Cigarette use by students in 8th & 10th grades is higher in LA than nationally.
- In 2002 an estimated 11.5 percent of 6th, 8th, 10th and 12th grade students were current illicit drug users.
- Marijuana is the most commonly used illicit drug, with 8.3% of students reporting use.
- Marijuana, hallucinogens, methamphetamines and cocaine use increases with increased grade level.
- The rate of inhalant use was highest among 6th and 8th grade students.

Ref. LA 2002 Communities That Care Survey



Adolescent Health Data Sheets



Age of Initiation			
Louisiana			
Substance Use	1998	2001	2002
First Alcohol Sip or More	12.2	12.5	12.5
First Regular Alcohol Use	13.8	14.0	14.0
First Cigarette Use	11.9	12.0	11.9
First Marijuana Use	13.5	13.5	13.5

- 1- Alcohol (30 days)
- 2- Binge Drinking (past 2 wks)
- 3- Cigarette (30 Days)
- 4- Smokeless Tobacco (30 Days)
- 5- Marijuana

Ref. 2002 LA Communities That Care Survey

Ref. 2002 LA Communities That Care Survey

Adolescent Health Data Sheets

Unintentional Injury & Violence

Accident, homicide and suicide

- In Louisiana, the rate of teen deaths by accident, homicide, and suicide has steadily been declining since 1994, although there was an increase in 2001. (*KIDS COUNT*, 2004)

Motor vehicle crashes and alcohol (US data)

- In 2002, 29 percent of 15- to 20-year-old drivers killed in motor vehicle crashes had been drinking. (NHTSA, 2003)
- 77 % of young drivers who had been drinking and were killed were unrestrained. (NHTSA, 2003)

Violence

- According to the *2002 Louisiana Communities That Care Student Survey Report*, the percent of students who have attacked someone with the intention of hurting them appears to be declining (p value unknown).

- When comparing the national data to the New Orleans data for the 2003 YRBS, New Orleans youth report being in physical fights on school grounds at almost double the amount of the national percent (22.5% to 12.8%). This difference is even greater when looking just at females (18.5% to 8%).

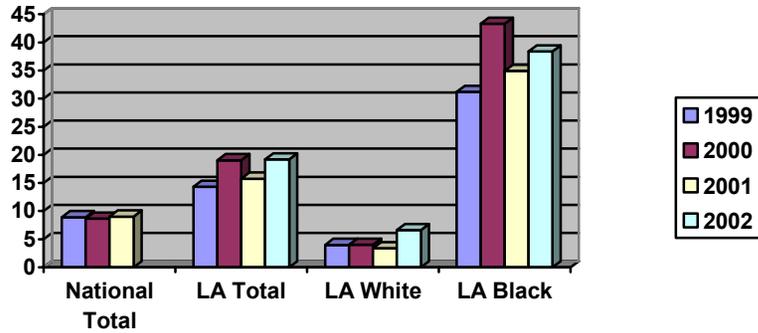
Suicide & Homicide

- The Louisiana suicide rate for white youths jumped to 12.9 in 2002 (up from 8.58 in 2001).
- The Louisiana homicide rate for black youths remains disproportionately high at 38.4 in 2002 (up from 35 in 2001 and 31.2 in 1999, but down from 43.4 in 2000).

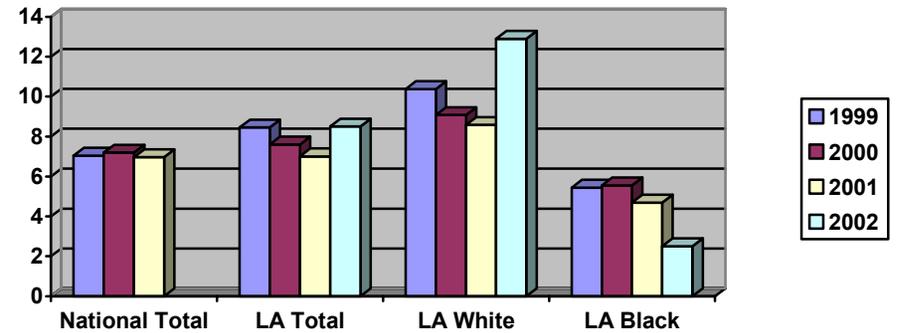
Adolescent Health Data Sheets

The following graphs show death rates for teens ages 10-24 by selected causes and by race for Louisiana and nationally. (CDC National Center for Injury Prevention and Control, OPH Health Statistics.)

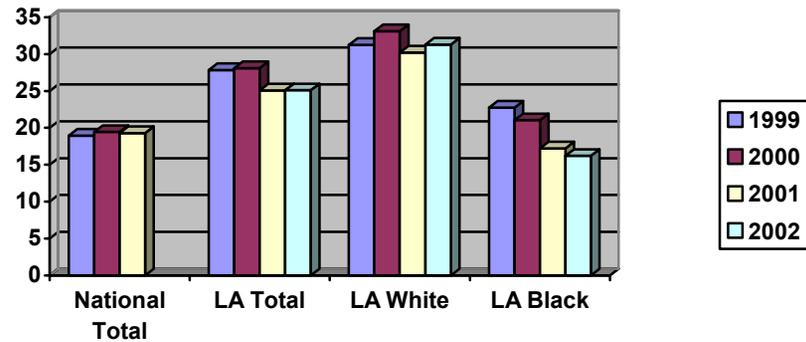
Homicide



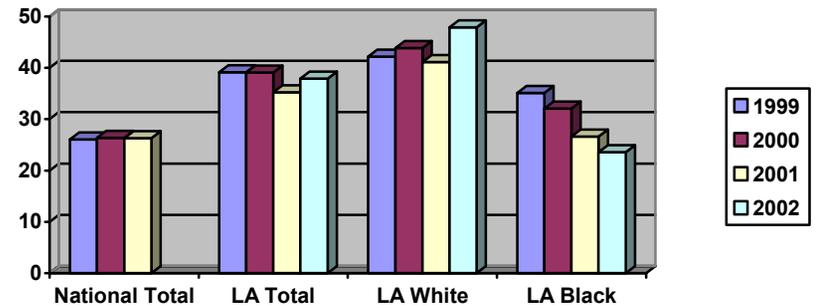
Suicide



Motor Vehicle Crashes

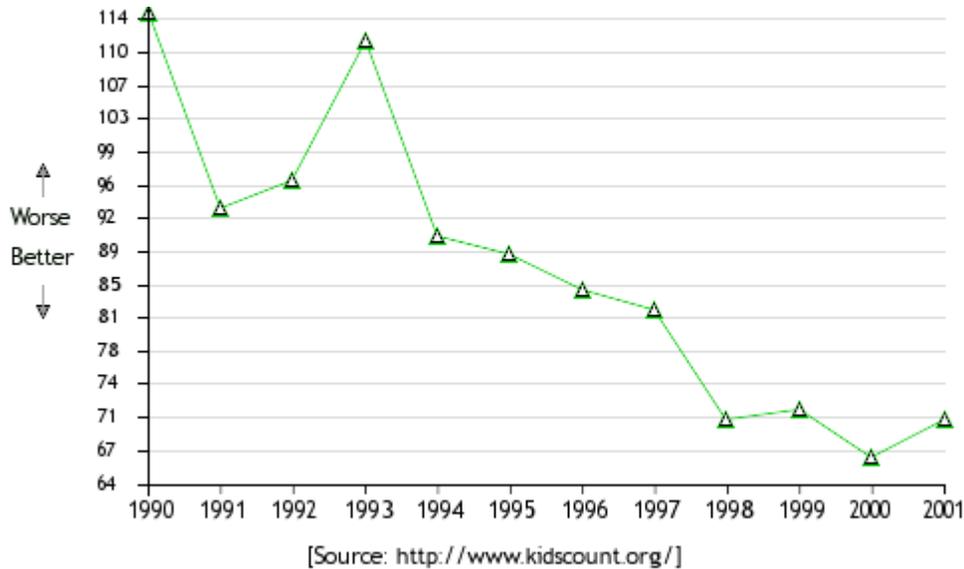


Unintentional Injuries and Adverse Effects



Adolescent Health Data Sheets

Rate of teen deaths by accident, homicide, and suicide (deaths per 100,000 teens ages 15-19) in LA



Rate of Teen Deaths by Accident, Homicide, and Suicide (deaths per 100,000 teens ages 15–19) is the number of deaths from accidents, homicides, and suicides to teens between ages 15 and 19, per 100,000 teens in this age group. (Editions of the *KIDS COUNT Data Book* prior to 1997 referred to this measure as the Teen Violent Death Rate.) The data are reported by place of residence, not the place where the death occurred.

Comparison based on: *KIDS COUNT* 2004 National Data

Delinquent Behavior of Louisiana Students

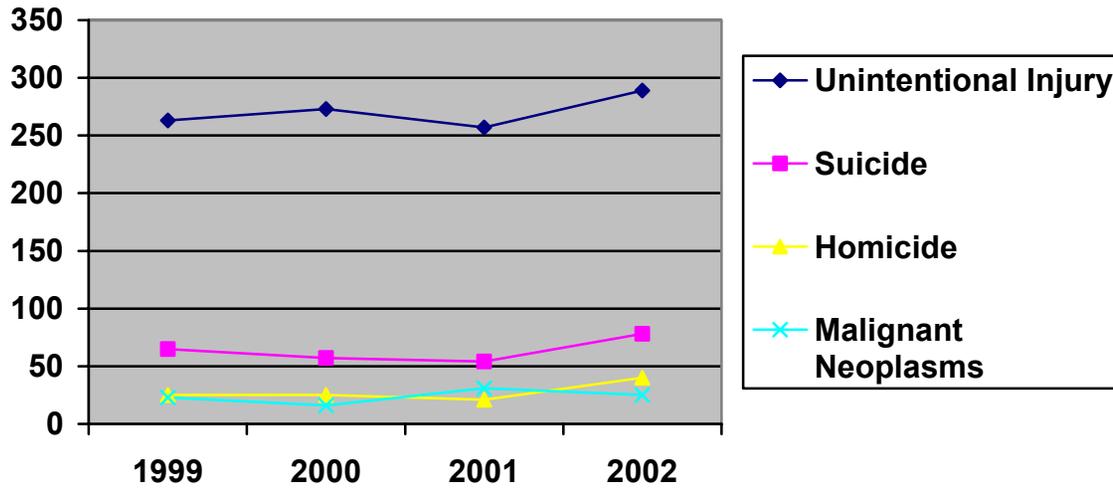
The *2002 Louisiana Communities That Care Student Survey Report* shows the percent of students that engage in the following delinquent behaviors at least once in the past year.

Source:
<http://www.dhh.state.la.us/offices/publications/pubs-23/CTC%20Louisiana%202002.pdf>

Adolescent Health Data Sheets

Leading Causes of Death in Louisiana for Ages 10-24

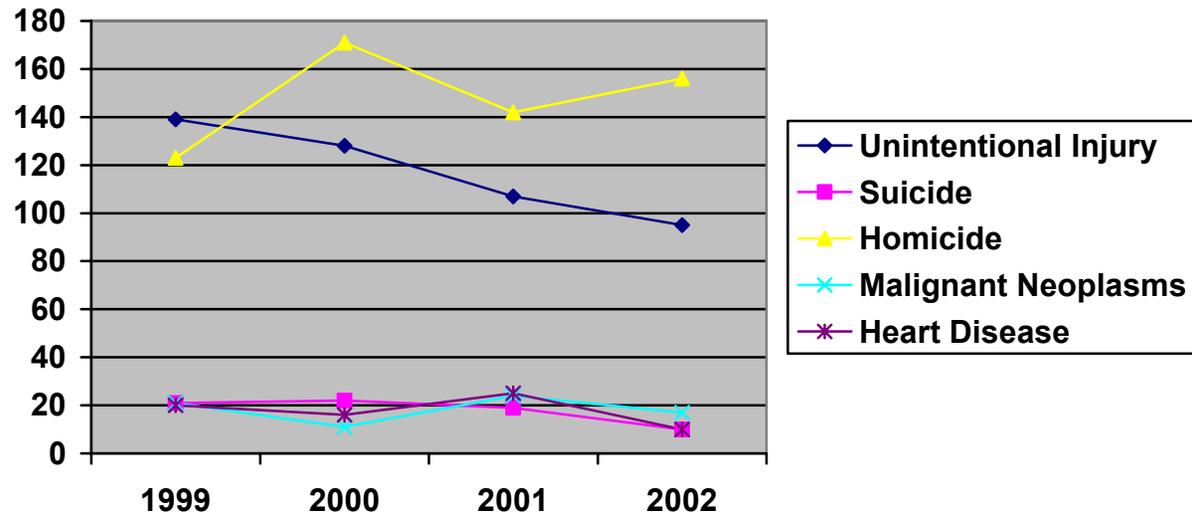
White, Both Sexes



The leading causes of death have remained unintentional injury, suicide and homicide except for 2001 when malignant neoplasms jumped ahead of homicide (see chart at left).

Source: CDC National Center for Injury Prevention and Control and LA OPH Health Statistics.

Black, Both Sexes



Homicide has been the leading cause of death since 2000 among black youth. Unintentional injury is on the decline.

Source: CDC National Center for Injury Prevention and Control and LA OPH Health Statistics.

Adolescent Health Data Sheets

Suicide, Injury, Mental Health: 2003 YRBS

	New Orleans 9-12 graders			National		
	Female	Male	Total	Female	Male	Total
Suicide						
Suicide Attempt*	10.9%	10.0%	10.4%	11.5%	5.4%	8.5%
Suicide Attempt req. medical attention* –	3.6%	4.2%	3.9%	3.2%	2.4%	2.9%
Violence						
In physical fight on school grounds* +	18.5%	26.9%	22.5%	8.0%	17.1%	12.8%
Absent from school due to fear for safety* +	16.9%	15.6%	16.2%	5.3%	5.5%	5.4%
Victim of theft or damage of belongings at school	21.8%	29.3%	25.3%	26.2%	33.1%	29.8%
Brought weapon to school	3.7%	8.5%	6.0%	3.1%	8.9%	6.1%
Threatened/injured with weapon at school* –	7.6%	14.9%	11.1%	6.5%	11.6%	9.2%
In physical fight* –	38.3%	48.5%	43.1%	25.1%	40.5%	33.0%
Injured in physical fight* –	4.8%	10.1%	7.4%	2.6%	5.7%	4.2%
Carried a weapon*	9.8%	23.2%	16.3%	6.7%	26.9%	17.1%
Carried a gun* +	2.6%	15.8%	8.9%	1.6%	10.2%	6.1%
Experienced dating violence* –	13.5%	12.7%	13.1%	8.8%	8.9%	8.9%
Physically forced sexual intercourse	7.7%	8.7%	8.2%	11.9%	6.1%	9.0%
Travel High Risk Behavior						
Rarely/never wore seatbelts* –	15.4%	21.5%	18.4%	14.6%	21.5%	18.2%
Rarely/never wore bicycle helmet*	93.8%	93.6%	93.5%	84.2%	87.2%	85.9%
Rode with driver who had been drinking alcohol* –	31.3%	31.7%	31.4%	31.1%	29.2%	30.2%
Drove after drinking alcohol*	5.7%	11.7%	8.6%	8.9%	15.0%	12.1%

* Above median for major cities listed.

+ Ranked number 1 among all major cities listed.

– Ranked between 2-5 of all major cities listed.

∂ Last among all cities reported.

Cities include: Boston; Broward County, Fl; Chicago; Dallas; DeKalb County, Ga; Detroit; D.C.; L.A.; Memphis; Miami-Dade County, Fl; Milwaukee; New Orleans; New York City; Orange County, Fl; Palm Beach County; Philadelphia; San Bernardino; San Diego.

Adolescent Health Data Sheets

Death rates for teens ages 10-24 by selected causes and by race in LA and nationally 1999

Cause of Death	National – Total	LA – Total	LA – White	LA - Black
Homicide	89.0	14.31	3.98	31.18
Suicide	7.04	8.45	10.38	5.44
Injuries and adverse effects	26.04	39.17	42.19	35.11
Motor Vehicle Crashes	18.94	27.84	31.25	22.76

Death rates for teens ages 10-24 by selected causes and by race in LA and nationally 2000

Cause of Death	National – Total	LA – Total	LA – White	LA - Black
Homicide	8.66	19.05	4.02	43.41
Suicide	7.19	7.60	9.08	5.55
Injuries and adverse effects	26.37	39.06	43.85	32.06
Motor Vehicle Crashes	19.44	28.09	33.11	21.04

Death rates for teens ages 10-24 by selected causes and by race in LA and nationally 2001

Cause of Death	National – Total	LA – Total	LA – White	LA - Black
Homicide	9.01	15.75	3.38	34.93
Suicide	6.97	7.01	8.58	4.69
Injuries and adverse effects	26.30	35.25	41.12	26.59
Motor Vehicle Crashes	19.28	25.07	30.22	17.23

Death rates for teens ages 10-24 by selected causes and by race in LA and nationally 2002

Cause of Death	National – Total	LA – Total	LA – White	LA - Black
Homicide		19.2	6.6	38.4
Suicide		8.5	12.9	2.5
Injuries and adverse effects		37.9	47.9	23.6
Motor Vehicle Crashes		25.1	31.3	16.2

**Perinatal Needs
EXAMPLE
Assessment
Template
Region I**

Table of Contents

OPH Regional Map	3
Perinatal Periods Of Risk Analysis.....	4
<i>Methodology</i>	<i>4</i>
<i>Calculating Excess Rates Worksheet</i>	<i>6</i>
PPOR Map Labels to Actions	7
Table I: Feto-infant mortality rates per 1,000 live births and fetal deaths	8
Table II: Excess Feto-infant mortality rates per 1,000 live births and fetal deaths.....	8
Table III: Adequacy of PNC for Region in Louisiana (2000-2002).....	9
Table IV: Adequacy of PNC: Parishes in the Bottom Quartile in Louisiana (2000-2002).....	10
Table II: Adequacy of PNC: Other Large Parishes in Louisiana (2000-2002).....	11
Adequate Prenatal Care Worksheet.....	12
Feto-Infant Mortality Worksheet.....	13
Perinatal Needs Identified Worksheet.....	16
Prioritizing Perinatal Needs.....	17
<i>Instructions.....</i>	<i>17</i>
<i>Example.....</i>	<i>18</i>
<i>Worksheet.....</i>	<i>19</i>
Possible Solutions to an Identified Perinatal Health Need.....	20
Finalized Needs Worksheet.....	21

Office of Public Health Regional Map



Region I- Jefferson Parish, Orleans Parish, Plaquemines, St. Bernard
Region II- Ascension Parish, East Baton Rouge, East Feliciana Parish, Iberville Parish, Pointe Coupee Parish, West Baton Rouge Parish, West Feliciana Parish
Region III- Assumption Parish, Lafourche Parish, St. Charles Parish, St. James Parish, St. John Parish, St. Mary Parish, Terrebonne Parish
Region IV- Acadia Parish, Evangeline Parish, Iberia Parish, Lafayette Parish, St. Landry Parish, St. Martin Parish, Vermilion Parish
Region V- Allen Parish, Beauregard Parish, Calcasieu Parish, Cameron Parish, Jeff Davis Parish
Region VI- Avoyelles Parish, Catahoula Parish, Concordia Parish, Grant Parish, LaSalle Parish, Rapides Parish, Vernon Parish, Winn Parish
Region VII-Bienville Parish, Bossier Parish, Caddo Parish, Claiborne Parish, Desoto Parish, Natchitoches Parish, Red River Parish, Sabine Parish, Webster Parish
Region VIII-Caldwell Parish, E. Carroll Parish, Franklin Parish, Jackson Parish, Lincoln Parish, Madison Parish, Morehouse Parish, Ouachita Parish, Richland Parish, Tensas Parish, Union Parish, West Carroll Parish
Region IX- Livingston Parish, St. Helena Parish, St. Tammany Parish, Tangipahoa Parish, Washington Parish

PERINATAL PERIODS OF RISK ANALYSIS

As part of an initiative to address Louisiana's high perinatal mortality rates, the Louisiana Office of Public Health (LAOPH), through the MCH Program performed a state-wide analysis of the perinatal mortality rates by the perinatal periods of risk approach (PPOR) during 2003, using 2000-2002 infant and fetal death linked data.

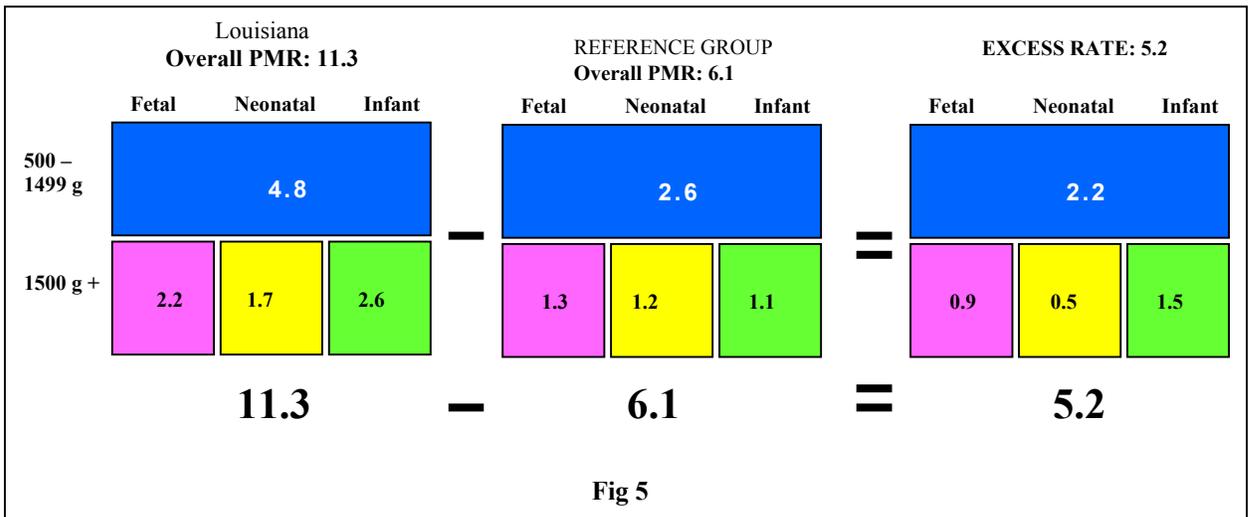
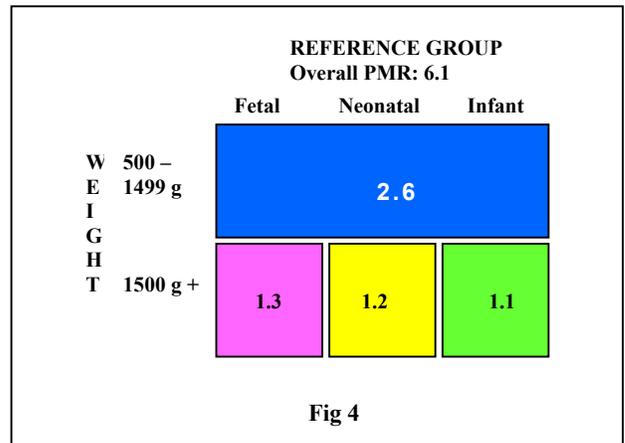
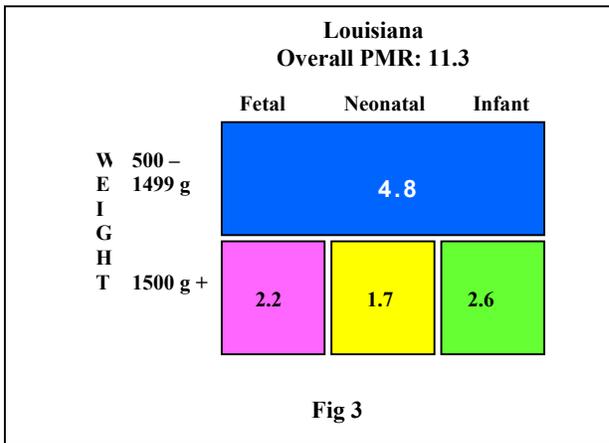
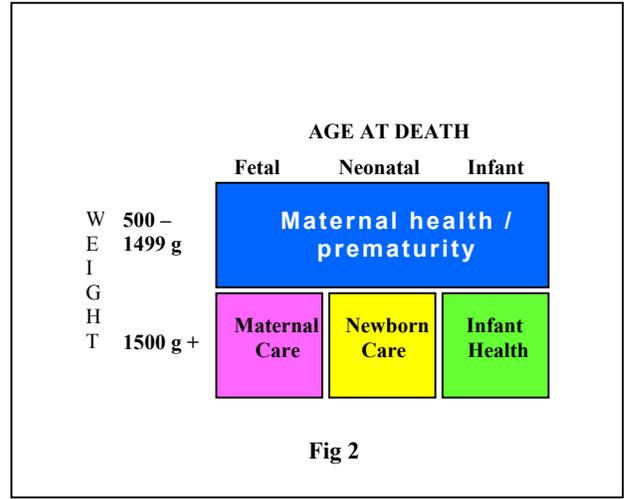
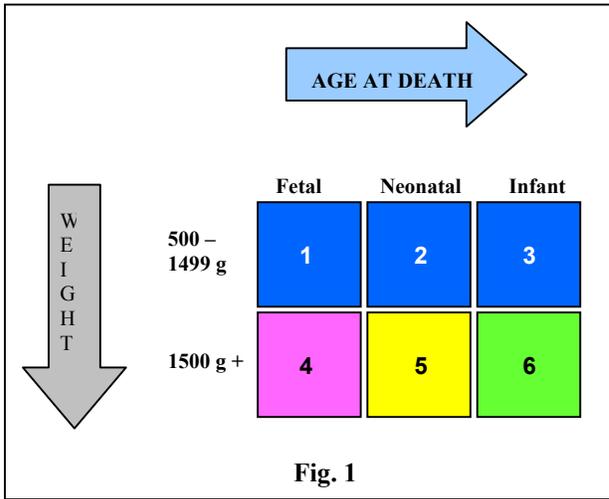
PPOR is a simple approach used to analyze perinatal mortality rates (including fetal and infant mortality rates), developed by Brian McCarthy M.D., the Center for Disease Control and Prevention (CDC) and the World Health Organization, to easily address the issue of perinatal mortality in developing countries. PPOR has been widely used in the US by City-MatCH (www.citymatch.org). The PPOR approach focuses on the analysis of mortality rates for the fetal period and the mortality rates for the infant period as part of the whole perinatal mortality rate. The community component helps to mobilize the community by identifying gaps and targeting resources for intervention.

A. PPOR Methodology

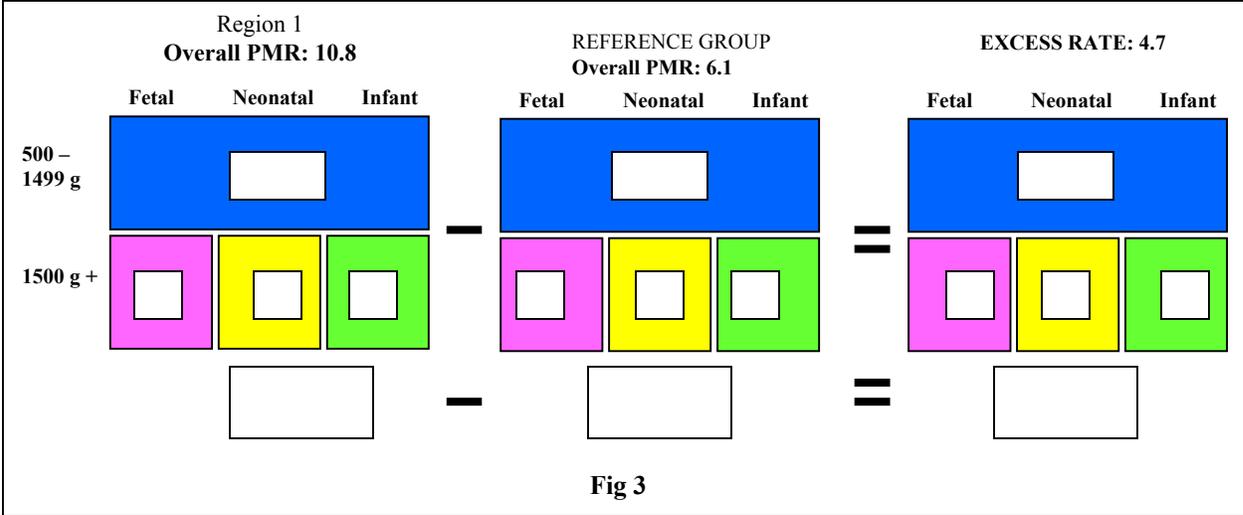
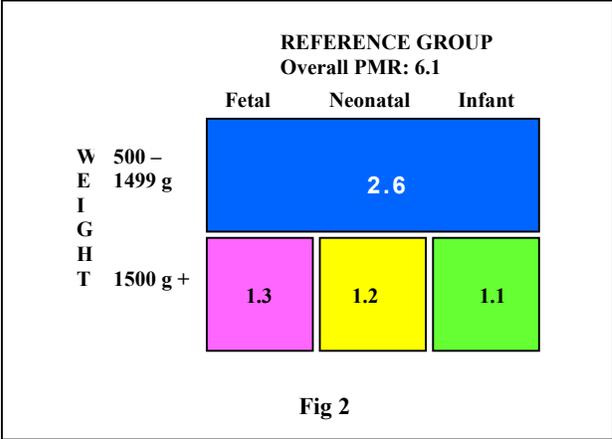
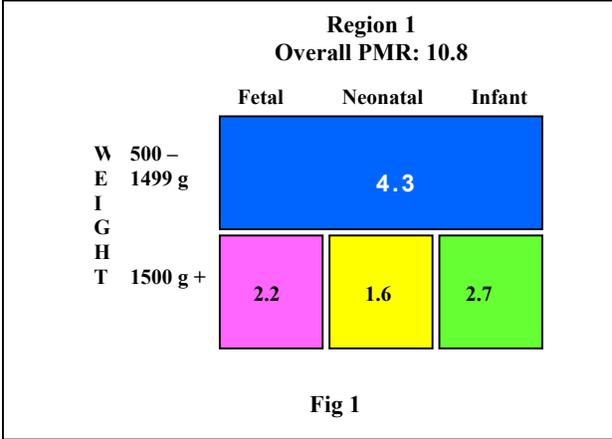
Linked birth-death files from 2000 through 2002 are used for data analysis. PPOR data analysis is done in the following steps and is reflected in the tables provided:

1. Calculate the total perinatal mortality rate for a given place (see Table I for results by state and region). The numerator is the total number of fetal and infant deaths. For fetal deaths the gestational age should be greater than or equal to 24 weeks and the birth weight equal to or more than 500 grams. For infant deaths, the child must be at most one year old with a birth weight equal to or greater than 500 grams. The denominator is the number of live births plus fetal deaths.
2. Divide the total perinatal mortality rate, based on birth weight and age of death, into four cells or components of interest (Figure 1 below), which in turn reflect possible causes of death and/or types of interventions during the perinatal period (Figure 2).
3. Each death in the area defined is then assigned to one of the four cells in Figure 1, depending on the birth weight and the age at death. The overall rate is further split into three components, which add to the initial rate, and correspond to each perinatal period. Each perinatal period, fetal, neonatal, and infant, corresponds to a specific cell, defined by weight and age of death. For each period, the numerator is split but the denominator is kept equal to that of the overall rate.
4. Calculate the excess rate, by a comparison with a reference group (Figure 4), usually of lower mortality than the study group: usually white, non-Hispanic, more educated mothers, who are 20 years of age or older. This group could be internal (a sub-group of the same study population) or external (an outside standard group). In this approach, in order to have a uniform statewide comparison, the state of Louisiana's reference group was used. *The excess rate provides an indicator of the best window of opportunity for interventions; the highest difference obtained is usually the greatest priority for intervention.* The excess rate is calculated by subtracting the corresponding reference group cell from the study group rate Figure. The higher the excess rate in a given group, the better the opportunity for intervention.

5.



Calculating excess rates: fill in the blanks



The Excess feto-infant mortality rate represents the number of deaths avoided if you could get your population to the best scenario.

Map Labels to Actions

Labels were designed to suggest Preventive Action

Maternal Health/ Prematurity	<ul style="list-style-type: none">■ Preconceptional Health (Folic Acid Intake, Smoking, Alcohol Use)■ Unintended Pregnancies■ Maternal Risk factors (HBP, BV)■ Easy Access to Family Planning
Maternal Care	<ul style="list-style-type: none">■ Early & Continuous Prenatal Care■ Appropriate Weight Gain■ Referral System of High Risk Pregnancies■ High Risk OB Care■ Maternal Health Risks (management of diabetes and seizures)
Newborn Care	<ul style="list-style-type: none">■ Perinatal Management■ Pediatric Surgery■ Advance Neonatal Care■ Treatment of Congenital Anomalies
Infant Health	<ul style="list-style-type: none">■ Sleep Position & Safe Sleep Environment■ Breast Feeding promotion■ Access to Medical Homes■ Injury Prevention

Table 1: Feto-infant mortality rates per 1,000 live births and fetal deaths.

Region	Maternal Health/ Prematurity		Maternal Care		Newborn Care		Infant Health		Feto-Infant Mortality	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Louisiana	954	4.8	427	2.2	339	1.7	510	2.6	2230	11.3
Region I	191	4.3	97	2.2	71	1.6	119	2.7	478	10.8
White	41	2.3	35	1.9	28	1.5	30	1.7	134	7.4
Black	142	5.8	57	2.3	39	1.6	86	3.5	324	13.2

Table 2: Excess Feto-infant mortality rates per 1,000 live births and fetal deaths.

Region	Maternal Health/ Prematurity	Maternal Care	Newborn Care	Infant Health	Excess Total Feto-Infant Mortality
	Rate	Rate	Rate	Rate	Rate
Louisiana	2.2	0.9	0.5	1.5	5.2
Region I	1.7	0.9	0.4	1.6	4.7
White	-0.3	0.6	0.3	0.6	1.3
Black	3.2	1	0.4	2.4	7.1

Table III: ADEQUACY of PNC for Region I in Louisiana (2000-2002)

Location	Year	# Adequate PNC	Total # Births	% Adequate PNC	# White Adequate PNC	Total # White Births	% Adequate PNC White	# Black Adequate PNC	Total # Black Births	% Adequate PNC Black
Region I	2000	12077	15190	79.5	4985	6138	81.2	6648	8476	78.4
	2001	11666	14737	79.2	4819	6050	79.7	6404	8141	78.7
	2002	11354	14411	78.8	4770	5920	80.6	6176	7969	77.5
	3-yr Average	35097	44338	79.2	14574	18108	80.5	19228	24586	78.2
Louisiana	2002	52960	65574	80.8	32007	37308	85.8	19721	26703	73.9
Healthy People Goal	2010			90.0						

Table IV: ADEQUACY of Prenatal Care: Parishes in the Bottom Quartile in Louisiana (2000-2002)

Region	Parish	Period	# Moms with Adequate PNC	Total # Moms	% Adequate PNC	# White Moms with Adequate PNC	Total # White Moms	% Adequate PNC White	# Black Moms with Adequate PNC	Total # Black Moms	% Adequate PNC Black
8	Tensas	2000-2002	152	287	53.0	65	84	77.4	87	202	43.1
6	Concordia	2000-2002	495	837	59.1	294	396	74.2	197	433	45.5
8	Lincoln	2000-2002	1035	1632	63.4	632	846	74.7	386	762	50.7
4	Acadia	2000-2002	1775	2727	65.1	1432	2083	68.7	340	636	53.5
3	St. John	2000-2002	1360	2081	65.4	713	949	75.1	621	1093	56.8
8	Franklin	2000-2002	640	962	66.5	403	524	76.9	237	438	54.1
4	Iberia	2000-2002	2332	3467	67.3	1502	1960	76.6	767	1396	54.9
3	St. James	2000-2002	670	992	67.5	326	398	81.9	341	591	57.7
6	Catahoula	2000-2002	273	402	67.9	211	257	82.1	61	144	42.4
2	Iberville	2000-2002	1006	1443	69.7	511	590	86.6	490	846	57.9
5	Jefferson Davis	2000-2002	1028	1457	70.6	849	1146	74.1	173	298	58.1
8	Morehouse	2000-2002	991	1395	71.0	473	627	75.4	514	763	67.4
4	St. Martin	2000-2002	1616	2242	72.1	1011	1303	77.6	591	915	64.6
7	Red River	2000-2002	296	410	72.2	174	195	89.2	121	214	56.5
8	Union	2000-2002	699	965	72.4	524	647	81.0	170	313	54.3
3	St. Charles	2000-2002	1512	2075	72.9	1072	1368	78.4	424	687	61.7

Table V: ADEQUACY of Prenatal Care: Other Large Parishes in Louisiana (2000-2002)

Region	Parish	Period	# Moms with Adequate PNC	Total # Moms	% Adequate PNC	# White Moms with Adequate PNC	Total # White Moms	% Adequate PNC White	# Black Moms with Adequate PNC	Total # Black Moms	% Adequate PNC Black
7	Caddo	2000-2002	8497	11240	75.6	4186	4728	88.5	4188	6359	65.9
5	Calcasieu	2000-2002	7306	8218	88.9	5165	5605	92.1	2055	2519	81.6
2	East Baton Rouge	2000-2002	14896	17987	82.8	7095	7740	91.7	7359	9702	75.9
1	Jefferson	2000-2002	14558	18847	77.2	8918	11304	78.9	4899	6566	74.6
4	Lafayette	2000-2002	6623	8632	76.7	4607	5734	80.3	1893	2730	69.3
1	Orleans	2000-2002	17631	21851	80.7	3380	3948	85.6	13818	17372	79.5
8	Ouachita	2000-2002	5827	6851	85.1	3321	3725	89.2	2451	3062	80.0
6	Rapides	2000-2002	4985	5718	87.2	3175	3414	93.0	1722	2199	78.3

Adequate Prenatal Care Worksheet

REGION _____

Instructions: Fill in the numbers indicated in the bolded, underlined and italicized sections or indicate the appropriate words for the particular region.

All Mothers:

For the period 2000-2002, _____% pregnant women in the region receive adequate prenatal care, which is	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the state percent of 80.8.
The percent of pregnant women receiving adequate prenatal care in the region is :	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the Healthy People 2010 goal of 90%.
Are there any Parishes in your Region that rank in the bottom quartile in Louisiana for Adequacy of Prenatal Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the parishes.		

White:

From 2000-2002, this region had _____% white women receiving adequate prenatal care.		
This percent is	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the 2002 state percent for white women of _____% .
The percent of white pregnant women receiving adequate prenatal care in the region is :	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the Healthy People 2010 goal of 90%.

Black:

From 2000-2002, this region had _____% black women receiving adequate prenatal care.		
This percent is	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the 2002 state percent for black women of _____% .
The percent of black pregnant women receiving adequate prenatal care in the region is :	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	the Healthy People 2010 goal of 90%.

Feto-Infant Mortality Worksheet

REGION _____

Instructions: Fill in the numbers indicated in the underlined sections or indicate the appropriate words for the particular region.

All Infants:

For the three year period of 2000 through 2002, the region had an overall feto-infant mortality rate of _____ deaths per 1,000 live births plus fetal deaths.		
This rate is:	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	2000-2002 state rate of 11.3 deaths per 1,000 live births and fetal deaths.
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the highest feto-infant mortality rate.
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the second highest feto-infant mortality rate.
Excess feto-infant mortality rates were highest for the		<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)
Excess feto-infant mortality rates were second highest for the:		<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the highest excess.		
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the second highest excess.		

Whites:

For the three year period of 2000 through 2002, the region had an overall feto-infant mortality rate of _____ deaths per 1,000 live births plus fetal deaths.			
This rate is:	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	2000-2002 state rate of 11.3 deaths per 1,000 live births and fetal deaths.	
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the highest feto-infant mortality rate.	
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the second highest feto-infant mortality rate.	
Excess feto-infant mortality rates were highest for the		<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell.
Excess feto-infant mortality rates were second highest for the:		<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell.
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the highest excess.			
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the second highest excess.			

Blacks:

For the three year period of 2000 through 2002, the region had an overall feto-infant mortality rate of _____ deaths per 1,000 live births plus fetal deaths.		
This rate is	<input type="checkbox"/> above <input type="checkbox"/> below <input type="checkbox"/> equal to	2000-2002 state rate of 11.3 deaths per 1,000 live births and fetal deaths.
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the highest feto-infant mortality rate.
The	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell had the second highest feto-infant mortality rate.
Excess feto-infant mortality rates were highest for the	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell.
Excess feto-infant mortality rates were second highest for the:	<input type="checkbox"/> Maternal health/prematurity (blue) <input type="checkbox"/> Maternal care (pink) <input type="checkbox"/> Newborn care (yellow) <input type="checkbox"/> Infant health (green)	cell.
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the highest excess.		
Using the "Map Labels to Actions" Handout what are some suggest preventive actions for the cell that has the second highest excess.		

Perinatal Needs Identified Worksheet

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MCHB Prioritization Method

This method of setting priority needs incorporates a framework that considers various criteria (the extent of the health problem, whether the trend is increasing, the severity of consequences, Healthy People 2010 Goals, resource availability, and acceptability). The Prioritization Method is used as a way of organizing a discussion to achieve consensus among different people and groups for ultimately setting priority perinatal health needs within the region.

Instructions:

1. Using the list of needs facing your region identified on the “Perinatal Need Identified Worksheet,” enter these Perinatal Needs into the column labeled “Perinatal Needs/Problems.”
2. Fill out table using the scoring method provided.
3. Once the extent of the health problem, whether the trend is increasing, the severity of consequences, Healthy People 2010 Goals, resource availability, and acceptability have been scored for each Perinatal Need/Problem, calculate a total score for the Perinatal Need/Problem.
4. Record the three highest scoring Perinatal Needs/Problems (These are your Top 3 Perinatal Needs).
5. Before making final decisions about the priority needs, the process and the results should be reviewed and agreed upon by all participants.

Example:

Scoring Method

Extent

- 1 = low incidence or prevalence
- 2 = moderate incidence or prevalence in some subgroups
- 3 = moderate incidence or prevalence in all groups
- 4 = high incidence or prevalence in some subgroups
- 5 = high incidence or prevalence in all subgroups

Trends Increasing

- 1 = rapid decrease in past 5 years
- 2 = moderate/slow decrease in past 5 years
- 3 = no change in past 5 years
- 4 = moderate/slow increase in past 5 years
- 5 = rapid increase in past 5 years

Severity of Consequences

- 1 = not life threatening
- 2 = slightly debilitating to individuals or society
- 3 = moderately debilitating to individuals or society
- 4 = life threatening or debilitating to individuals or society
- 5 = life threatening and debilitating to individuals and society

Healthy People 2010

- 1 = not tracked by MCHB
- 2 = subset of an objective for the nation, tracked by MCHB
- 3 = main focus of an objective for the nation, tracked by MCHB

Resources Available

- 1 = no resources available
- 2 = resources moderately available
- 3 = resources highly available

Acceptability

- 1 = not perceived as a health problem; any effort to address it would be opposed
- 2 = not perceived as a health problem; efforts to address it would not be opposed
- 3 = recognized as a health problem; any effort to address it would be opposed
- 4 = recognized as a health problem; efforts to address it would not be opposed
- 5 = recognized as a health problem; efforts to address it would be welcomed

MCH Issues/ Problems Facing Region	Extent (High incidence/ prevalence)	Trends Increasing	Severe Conse- quences	In HP 2010	Resources Available	Accepta bility to citizens	Total
Low Birthweight	4	4	4	3	3	5	23
Infant Mortality	4	2	5	3	3	5	22
Vision Impairments	2	3	3	1	1	4	14
Adolescent Pregnancy	4	4	4	3	2	4	21

Scoring Method

Extent

- 1 = low incidence or prevalence

- 2 = moderate incidence or prevalence in some subgroups
- 3 = moderate incidence or prevalence in all groups

4 = high incidence or prevalence in some subgroups
 5 = high incidence or prevalence in all subgroups

Trends Increasing

1 = rapid decrease in past 5 years
 2 = moderate/slow decrease in past 5 years
 3 = no change in past 5 years
 4 = moderate/slow increase in past 5 years
 5 = rapid increase in past 5 years

Severity of Consequences

1 = not life threatening
 2 = slightly debilitating to individuals or society
 3 = moderately debilitating to individuals or society
 4 = life threatening or debilitating to individuals or society
 5 = life threatening and debilitating to individuals and society

Healthy People 2010

1 = not tracked by MCHB

2 = subset of an objective for the nation, tracked by MCHB

3 = main focus of an objective for the nation, tracked by MCHB

Resources Available

1 = no resources available
 2 = resources moderately available
 3 = resources highly available

Acceptability

1 = not perceived as a health problem; any effort to address it would be opposed
 2 = not perceived as a health problem; efforts to address it would not be opposed
 3 = recognized as a health problem; any effort to address it would be opposed
 4 = recognized as a health problem; efforts to address it would not be opposed
 5 = recognized as a health problem; efforts to address it would be welcomed

Perinatal Needs/ Problems Facing Region	Extent (High incidence/prevalence)	Trends Increasing	Severe Consequences	In HP 2010	Resources Available	Acceptability to citizens	Total

Possible Solutions to an Identified Perinatal Health Need

Perinatal Health Need: _____

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	Short/Long Term	Effective	Resources	Total
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			
	<input type="checkbox"/> Short <input type="checkbox"/> Long			

Do you have a realistic choice of solutions for this need? **Yes / No**

If you answered “no”, what priority is this need now that you’ve considered solutions? (higher, lower)

Do you need to reconsider this need being one of the top 3 needs? _____

Finalized Needs Worksheet
Perinatal Needs Assessment
(To be returned to LA-OPH)

Name _____
Region # _____

1. State your established vision/goals for the Perinatal population in your region.

2. List the identified Perinatal health needs based on the current existing health status data.

3. For Health Services by Region” place and “X” to all that apply.

Services	Present within Region	Present within all Parishes in Region	Not Present	Easy Accessibility*	Moderate Accessibility	Poor Accessibility
Pregnancy Testing						
Prenatal Care						
Home Visiting						
Adequate high risk prenatal care & delivery services						
Health Education/ Counseling (WIC only)						
Violence/Substance use/Mental Health Assessment						
Violence/Substance use treatment & intervention//Mental Health Services (referral opportunities)						
HIV Counseling & Testing						
Sleep Position & Sleep Environment Education						
Family Planning						
Breast feeding Promotion						

*Accessibility: Waiting time to appointment.

6. In order for your needs assessment data to become a successful evaluation of the current health needs, outside input is required. Please list all of the outside input used (sources/partners/individuals/organizations) and their comments.

**Louisiana Office of Public Health
Maternal and Child Health Program**

**Perinatal Needs Assessment 2005 Summary
By Region**

Table of Contents

Introduction	4
OPH Regional Map	5
Orleans Parish	6
<i>Vision</i>	6
<i>Identified Perinatal Health Needs/Issues</i>	6
<i>Services/Accessibility</i>	7
<i>Top 3 Perinatal Needs</i>	8
<i>Activities to Address Needs</i>	8
Region I	11
<i>Vision</i>	11
<i>Identified Perinatal Health Needs/Issues</i>	11
<i>Services/Accessibility</i>	12
<i>Top 3 Perinatal Needs</i>	12
<i>Activities to Address Needs</i>	12
Region II	15
<i>Vision</i>	15
<i>Identified Perinatal Health Needs/Issues</i>	15
<i>Services/Accessibility</i>	16
<i>Top 3 Perinatal Needs</i>	17
<i>Activities to Address Needs</i>	17
Region III	20
<i>Vision</i>	20
<i>Identified Perinatal Health Needs/Issues</i>	20
<i>Services/Accessibility</i>	21
<i>Top 3 Perinatal Needs</i>	21
<i>Activities to Address Needs</i>	21
Region IV	23
<i>Vision</i>	23
<i>Identified Perinatal Health Needs/Issues</i>	23
<i>Services/Accessibility</i>	24
<i>Top 3 Perinatal Needs</i>	25
<i>Activities to Address Needs</i>	25
Region V	26
<i>Vision</i>	26
<i>Identified Perinatal Health Needs/Issues</i>	26
<i>Services/Accessibility</i>	27
<i>Top 3 Perinatal Needs</i>	27
<i>Activities to Address Needs</i>	27

DRAFT

Region VI	.....	29
<i>Vision</i>	.....	29
<i>Identified Perinatal Health Needs/Issues</i>	.....	29
<i>Services/Accessibility</i>	.....	30
<i>Top 3 Perinatal Needs</i>	.....	30
<i>Activities to Address Needs</i>	.....	31
Region VII	.....	33
<i>Vision</i>	.....	33
<i>Identified Perinatal Health Needs/Issues</i>	.....	33
<i>Services/Accessibility</i>	.....	34
<i>Top 3 Perinatal Needs</i>	.....	34
<i>Activities to Address Needs</i>	.....	35
Region VIII	.....	36
<i>Vision</i>	.....	36
<i>Identified Perinatal Health Needs/Issues</i>	.....	36
<i>Services/Accessibility</i>	.....	37
<i>Top 3 Perinatal Needs</i>	.....	37
<i>Activities to Address Needs</i>	.....	38
Region IX	.....	40
<i>Vision</i>	.....	40
<i>Identified Perinatal Health Needs/Issues</i>	.....	40
<i>Services/Accessibility</i>	40
<i>Top 3 Perinatal Needs</i>	41
<i>Activities to Address Needs</i>	41

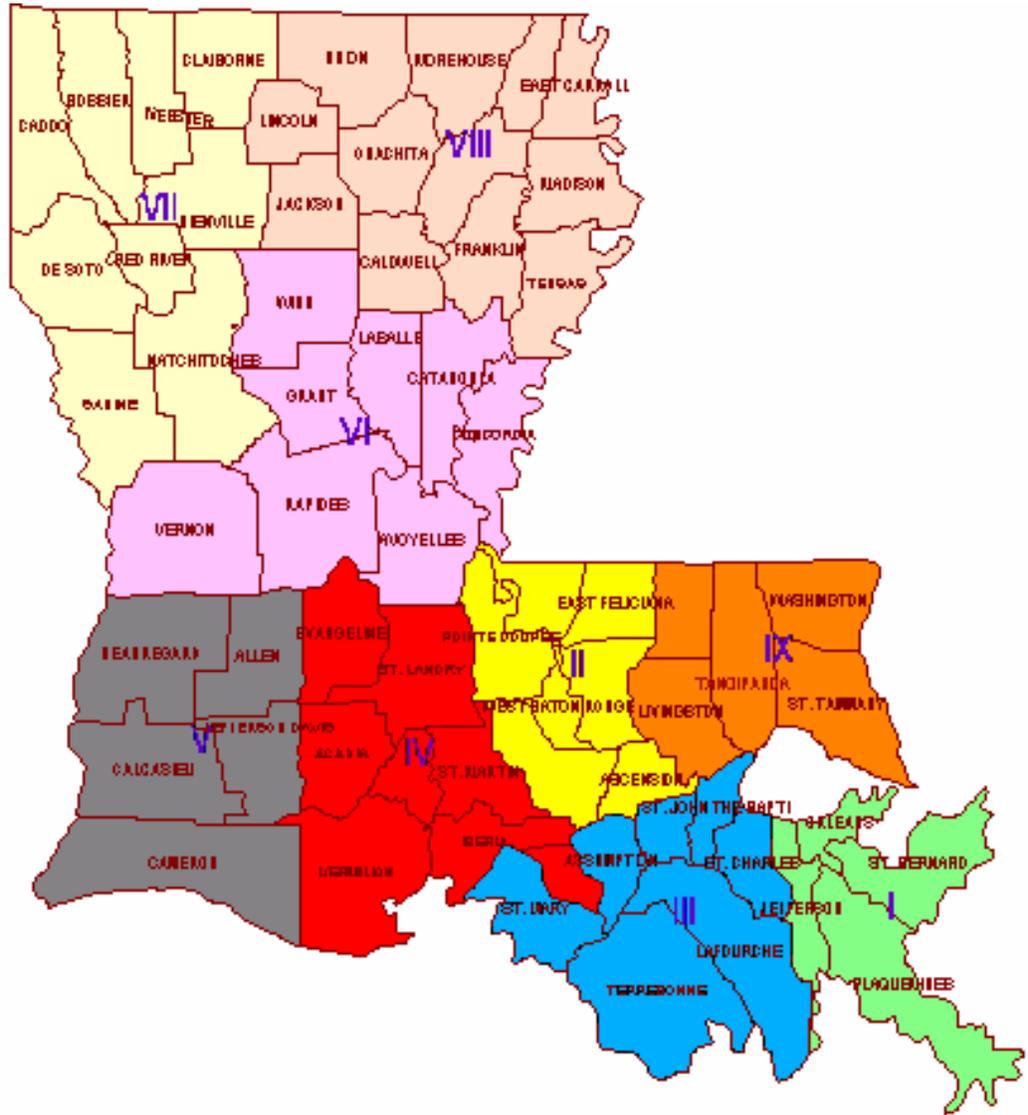
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Introduction

The Title V Maternal and Child Health (MCH) Block Grant is a federal government grant which provides approximately \$15 million to fund MCH services throughout Louisiana through the Office of Public Health's MCH Program. Every five years, State Title V agencies are required to conduct a comprehensive needs assessment to identify state MCH priority needs, arrange programmatic and policy activities around these priorities needs and develop measures to monitor the success of their efforts.

The Perinatal Needs Assessment 2005 Summary by Region describes the needs and health status of the perinatal population, infants (less than 1 year), and women of child bearing age (15-44 years) for each of the nine public health regions in Louisiana in addition to Orleans Parish.

Office of Public Health Regional Map



Region I- Jefferson Parish, Orleans Parish, Plaquemines, St. Bernard
Region II- Ascension Parish, East Baton Rouge, East Feliciana Parish, Iberville Parish, Point Coupee Parish, West Baton Rouge Parish, West Feliciana Parish
Region III- Assumption Parish, Lafourche Parish, St. Charles Parish, St. James Parish, St. John Parish, St. Mary Parish, Terrebonne Parish
Region IV- Acadia Parish, Evangeline Parish, Iberia Parish, Lafayette Parish, St. Landry Parish, St. Martin Parish, Vermilion Parish
Region V- Allen Parish, Beauregard Parish, Calcasieu Parish, Cameron Parish, Jeff Davis Parish
Region VI- Avoyelles Parish, Catahoula Parish, Concordia Parish, Grant Parish, LaSalle Parish, Rapides Parish, Vernon Parish, Winn Parish
Region VII- Bienville Parish, Bossier Parish, Caddo Parish, Claiborne Parish, Desoto Parish, Natchitoches Parish, Red River, Parish, Sabine Parish, Webster Parish
Region VIII- Caldwell Parish, E. Carroll Parish, Franklin Parish, Jackson Parish, Lincoln Parish, Madison Parish, Morehouse Parish, Ouachita Parish, Richland Parish, Tensas Parish, Union Parish, West Carroll Parish
Region IX- Livingston Parish, St. Helena Parish, St. Tammany Parish, Tangipahoa Parish, , Washington Parish

ORLEANS PARISH

Vision: The vision for the Orleans Parish perinatal population is to enhance, improve and optimize perinatal outcomes and healthcare and to reduce healthcare disparities.

The goals are as follows:

- Identify and prioritize perinatal needs, including strengthening data resources
- Develop a broad-based understanding of the needs
- Design, implement, and monitor culturally sensitive and community based programmatic and policy activities to address needs
- Collaborate with community partners and political leaders to address the needs of the region.

Perinatal Periods of Risk Analysis (PPOR):

Orleans Parish Rate

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	5.0 Maternal Health/Prematurity		
1500g+	2.0 Maternal Care	1.7 Newborn Care	2.9 Infant Health

PMR= 11.6

*Excess Mortality

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	2.4 Maternal Health/Prematurity		
1500g+	0.7 Maternal Care	0.5 Newborn Care	1.8 Infant Health

Excess PMR= 5.4

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> • Increase percentage of African American women entering prenatal care in first trimester • Increase adequacy of prenatal care from 80% to 90% • Increase access to prenatal care • Coordinated prenatal services • Psychosocial/ mental health risk assessments (including postpartum depression) and treatment • Reduce perinatal substance abuse • Optimize women’s health and nutrition (pre- and post-conceptual) 	<ul style="list-style-type: none"> • Reduce the percentage of African American women delivering VLBW babies • Reduce the percentage of African American women delivering pre-term • Reduce racial disparity in the infant mortality rate from 2.4:1 to 1:1 (Black:White)

	<ul style="list-style-type: none"> • Reduce mortality in babies born weighing <1500gm • Improve access to women’s health services and family planning • Expand health care coverage and enrollment for Medicaid/LaMOMS • Increase WIC services • Increase transportation accessibility • Monitor changes in prenatal care usage • Monitor trends in mortality through data collection and surveillance 	
<p style="text-align: center;">Infant Health</p>	<ul style="list-style-type: none"> • Promote breastfeeding • Promote “Back to Sleep” to reduce SIDS related deaths • Promote safety • Improve consumer and healthcare provider access to and delivery of educational information, respectively • Expand health care coverage and enrollment for Medicaid/LaCHIP • Examine SIDS circumstances through FIMR • Monitor trends in SIDS through data analysis 	<ul style="list-style-type: none"> • Decrease mortality for normal birth weight babies dying between 28 and 365 days of age

Services/Accessibility:

All services are available within Orleans parish. Pregnancy testing, WIC health education and counseling, HIV counseling and testing, sleep position and environment education, and breastfeeding promotion education are all easily accessible in Orleans parish. There is moderate access to violence, substance abuse and mental health assessment, high risk prenatal care and delivery services, prenatal care, and home visiting. Treatment and interventions for violence, substance abuse, and mental health have poor accessibility.

Orleans Parish Services	Available in Parish	Accessibility*		
		Easy	Moderate	Poor
Pregnancy Testing	X	X		
Prenatal Care	X		X	
Home Visiting	X		X	
Adequate high risk prenatal care & delivery services	X		X	
Health Education/ Counseling (WIC only)	X	X		
Violence/Substance use/Mental Health Assessment	X		X	
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X			X
HIV Counseling & Testing	X	X		
Sleep Position & Sleep Environment Education	X	X		
Family Planning	X			X
Breast feeding Promotion	X	X		

Top Three Perinatal Needs:

1. *Mental Health Services*
2. *Substance Abuse Services*
3. *Early Access to Prenatal Care*

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Activities to Address Needs:

1. Mental Health Services

Short Term	<ul style="list-style-type: none"> • Healthcare provider education – screening for illness/risk factors, treatment options, and available referral sources • Patient education - treatment options and compliance • Increase screening for risk factors and/or illness • Increase screening for postpartum depression (before discharge from hospital and at two week follow-up visit) • Increase treatment of acute/chronic mental illness • Coordinate existing outpatient mental health services with prenatal visits • Consolidate resource options into a patient/provider reference manual • Social Service monitoring
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Long Term	<ul style="list-style-type: none"> • Community education of available treatment resources • Increase number of inpatient treatment facilities • Increase reimbursement and funding for inpatient and outpatient treatment • Resource development • Legislature to address funding/reimbursement • Partnerships with Mental Health Association, the Office of Mental Health, and local mental health providers to enhance existing services and to increase detection of mental illness and utilization of existing services
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2. Substance Abuse Services

Short Term	<ul style="list-style-type: none"> • Healthcare provider education – screening for risk factors/abuse, treatment options, available referral sources • Patient education – abstinence, fetal affects, treatment options • Increase screening for risk factors and referrals for treatment • Increase prenatal health education on fetal affects of substance abuse • Coordinate existing outpatient treatment services with prenatal visits • Consolidate resource options into a patient/provider reference manual • Social Service monitoring • Increase utilization of existing prevention/treatment programs
Long Term	<ul style="list-style-type: none"> • Community education on the fetal affects of substance abuse and available treatment options/resources • Inpatient treatment programs • Increase reimbursement and funding for inpatient and outpatient treatment programs • Resource development • Legislature to address funding/reimbursement • Partnerships state and local substance abuse prevention and treatment programs to enhance existing services and to increase detection of mental illness and utilization of existing services • Increase community outreach programs • Monitor incidence/prevalence through data collection

3. Early Access to Prenatal Care

<p>Short Term</p>	<ul style="list-style-type: none"> • Increase pregnancy screens for early detection of pregnancy • Increase access – coordinate care, transportation • Community education of existing services available for diagnosing pregnancy and initiating early prenatal care, such as family planning clinics and City of New Orleans Health Clinics • Increase community awareness and utilization of existing support programs, such as Great Expectations • Address barriers to scheduling provider appointments • Increase number of available providers • Educate females (including adolescents) on importance of early prenatal care
<p>Long Term</p>	<ul style="list-style-type: none"> • Expand health care coverage and enrollment for Medicaid/LaMOMS • Increase availability of and reimbursement for transportation to prenatal visits • Funding for more family planning services (to address pre- and post-conceptual health, preventive services, detection of pregnancies, treatment of acute gynecological infectious diseases, education, coordination of prenatal care, mental health and substance abuse screenings, treatment, referrals, etc.) • Increase number of available providers • School educational programs • Monitor prenatal care entry and adequacy through data collection and analysis – examine barriers to early entry

Participants for Region Needs Assessment:

New Orleans Health Department/LSUHSC
 LA OPH MCH / New Orleans Health Department
 Tulane University MCH
 Planned Parenthood
 New Orleans Health Department
 Perinatal Enrichment LSUHSC
 Great Expectations
 Region I Medical Director

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 Robert Sevalia
 Cassandra Youmans, MD

REGION I

Mission: DHH/OPH Metropolitan Region I seeks to improve the health outcomes of women and infants in the state of Louisiana by decreasing the incidence and prevalence of very low birth weight babies and by providing access to high quality complementary, primary, prenatal and postnatal care services that address the global health, wellness, and individual social needs of our women and infants. We further seek to modify maternal risk factors through education that targets the preconceptional health of women.

Vision: DHH/OPH Metropolitan Region I will be recognized nationally as a leading advocate for women and infant health and as a provider of the highest quality in health care services through a multidisciplinary approach to care that addresses each individual's needs. Region I envisions a strategic expansion of the scope of available services to bridge persistent gaps present in the intervention efforts provided to women and children, which will result in a reversal of the increasing incidence and prevalence of low birth weight babies and infant mortality in the state of Louisiana.

Perinatal Periods of Risk Analysis (PPOR):

Region I Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	4.3 Maternal Health/Prematurity			500-1499g	1.7 Maternal Health/Prematurity		
1500g+	2.2 Maternal Care	1.6 Newborn Care	2.7 Infant Health	1500g+	0.9 Maternal Care	0.4 Newborn Care	1.6 Infant Health
PMR= 10.8				Excess PMR= 4.7			

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Increase access to prenatal care Decrease maternal risk factors Improve preconceptional health 	<ul style="list-style-type: none"> Reduce the number of VLBW babies
Infant Health	<ul style="list-style-type: none"> Reduce the number of SIDS cases Improve access to medical home 	

Services/Accessibility:

All services are available within the region and in every parish except, home visiting and adequate high risk prenatal care & delivery services. Accessibility is rated as easy or moderate for all services except Violence/Substance use/Mental Health assessment, treatment and intervention (referral opportunities), which are rated as poor.

Region I Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X		X	
Home Visiting	X			X	
Adequate high risk prenatal care & delivery services	X	Only Orleans		X	
Health Education/ Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X	X			X
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X	X			X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X		X		
Family Planning	X	X	X		
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs

1. *Reduce the number of Very Low Birth Weight Babies*
2. *Reduce the number of Sudden Infant Death Syndrome*
3. *Improve Access to Medical Homes*

Activities to Address Needs:

1. Reduce the number of Very Low Birth Weight Babies

Short Term	<ul style="list-style-type: none"> • Expansion of pre and postnatal case management services, i.e. Great Expectations, Nurse Family Partnership, McFarland Institute, Healthy Families, Partners for Healthy Babies, etc. • High quality prenatal care and postnatal care • Smoking, drug, and alcohol cessation programs • Proper nutrition/special formula clinics • Monitoring and expanding data collection systems such as PRAMS-Pregnancy Risk Assessment Monitoring System
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Long Term	<ul style="list-style-type: none"> • Community Care • LaCHIPS • LaMOMS • Community and State Health Centers-Children Special Health Services, Early Steps, and Kid Med • Proper nutrition/special formula clinics • Continued monitoring of health indicators through strong surveillance systems
------------------	---

2. Reduce the number of Sudden Infant Death Syndrome

Short Term	<ul style="list-style-type: none"> • SIDS Prevention-outreach and education programs for sleep position, common myths, parental education and awareness, and environmental education • Pediatric and women’s health and wellness services are readily available in parish and community health centers- members of PATH • Children’s Hospital of New Orleans, MCLNO, Oschner and Tulane Children’s Hospital • LSU/Children’s of New Orleans partnership in Tiger Clinics • FIMR monitoring of SIDS circumstances and trends.
Long Term	Same as short term

3. Improve Access to Medical Homes

Short Term	<ul style="list-style-type: none"> • PATH- Partnership for Access to Health Care (DHH/OPH, MCLNO, City of New Orleans, St. Thomas, EXCELth, Inc., and Catholic Charities) has combined to form a network of collaborating clinics which provide various direct primary and other health and wellness programs that are available to the community on a sliding scale based on federal poverty guidelines for family income. The coordination of these available services should be strengthened to provide a strong community infrastructure of available health services
Long Term	Same as short term

Participants for Region Needs Assessment:

Region I Medical Director
 Region I Administrator
 New Orleans MCH Epidemiologist
 Region I Epidemiologist
 Nurse Supervisor, Orleans Women’s Clinic
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REGION II

Vision: Our efforts to address feto-infant mortality must focus on the reduction of racial disparities that exist between the white and black birthing populations in the Region 2 service area. Our prevention strategy will address the particular issues of maternal health (pre-conceptionally, prenatally, and postnatally), prematurity/pre-term births, and infant health by directing our efforts to reduce the percentage of unintended pregnancies with particular focus on reducing the number of births to teens, to reduce maternal risk factors associated with poor birth outcomes, to improve family planning access and use, and to reduce the number of injury-related fatalities and unexplained deaths among infants in the post-neonatal period.

Perinatal Periods of Risk Analysis (PPOR):

Region II Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	5.0 Maternal Health/Prematurity			500-1499g	2.4 Maternal Health/Prematurity		
1500g+	2.1 Maternal Care	1.7 Newborn Care	2.1 Infant Health	1500g+	0.8 Maternal Care	0.5 Newborn Care	1.0 Infant Health
PMR= 10.8				Excess PMR= 4.7			

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Reduce the number of Low Birth Weight (LBW)/Very Low Birth Weight (VLBW) babies. Reduce the number of Pre-term Births. Improve pre-conception Health <ul style="list-style-type: none"> - Reduce smoking before pregnancy - Increase Folic acid intake before pregnancy - Reduce alcohol and substance use before pregnancy Reduce the number of unintended pregnancies <ul style="list-style-type: none"> - Teen Birth Rates - Family Planning – Child 	<ul style="list-style-type: none"> Reduce maternal partner violence (intimate partner violence)

	<p>Spacing</p> <ul style="list-style-type: none"> • Reduce the burden of Maternal Risk Factors <ul style="list-style-type: none"> - Reduce teen pregnancy - Reduce maternal smoking - Reduce maternal substance use (alcohol/drugs) - Reduce the amount of inadequate or no prenatal care - Reduce/improve treatment of maternal infection (HIV/STD/BV) • Improve Family Planning Access <ul style="list-style-type: none"> - Reduce teen births - Increase birth/child spacing 	
<p style="text-align: center;">Infant Health</p>	<ul style="list-style-type: none"> • Promote Safe Infant Sleeping <ul style="list-style-type: none"> - Reduce SIDS rates - Reduce Co-sleeping risk behavior - Reduce Suffocation/Overlay deaths • Promote Breastfeeding especially among minorities • Continue and expand Injury Prevention promotion efforts <ul style="list-style-type: none"> - Increase Child restraint use - Reduce Child abuse - Reduce Child neglect 	<ul style="list-style-type: none"> • Continue increasing access/connection of infants & moms to Medical Homes

Services/Accessibility:

All services are available in within Region II. Only Home visiting, Adequate high risk prenatal care & delivery services, and Violence/Substance use/Mental health assessment/treatment referrals were not available in all parishes. There is moderate access to Pregnancy testing, Prenatal care, Violence/Substance use/Mental health assessment, Family Planning, and Breastfeeding promotion. Adequate high risk prenatal care & delivery services and Violence/Substance use Treatment & Intervention/Mental services were rated as having poor accessibility to the public.

Region II Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X		X	
Prenatal Care	X	X		X	
Home Visiting	X		X		
Adequate high risk prenatal care & delivery services	X				X
Health Education/ Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X			X	
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X				X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X		X	
Breast feeding Promotion	X	X		X	

Top Three Perinatal Needs:

1. *Reduce Preterm and LBW births*
2. *Address multiple maternal risk factors- unintended pregnancies, the high number of teen births (especially among black women), maternal violence (intimate partner violence), and maternal infection (STDs, HIV, and BV).*
3. *Direct efforts to further reduce SIDS deaths and other unintentional injuries leading to death including suffocation deaths (co-sleeping).*

Activities to Address Needs:

1. Reduce Preterm and LBW births

Short Term	<ul style="list-style-type: none"> • Family Planning Waiver for increased access to women of childbearing age (for postnatal population enhancing child spacing) • Implement 4P's Plus Substance Abuse Screening Tool in Public and Private Sectors • Increase accessibility to smoking cessation programs
Long Term	<ul style="list-style-type: none"> • Work with school based health centers (teen births, contraception, etc.) • Work with child care issues (removing a barrier for pregnant mothers to attend prenatal clinic while removing the concern for having someone to look after children during appointment times)

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	<ul style="list-style-type: none"> • Provide community outreach and education on reducing risk factors/behaviors and promoting access to available services • Promote STD/HIV/BV screening in all OB care practices; ensure adequate treatment (disease control/partner treatment when applicable; test for eradication when applicable)
--	--

2. Address multiple maternal risk factors- unintended pregnancies, the high number of teen births (especially among black women), maternal violence (intimate partner violence), and maternal infection (STDs, HIV, and BV).

Short Term	<ul style="list-style-type: none"> • Increase Healthy Start service population • Family Planning Waiver for increased access to women of childbearing age (for postnatal population enhancing child spacing) • Implement 4P’s Plus Substance Abuse Screening Tool in Public and Private Sectors • Best Start – psychosocial maternal-infant attachment – intense intervention model
Long Term	<ul style="list-style-type: none"> • Work with school based health centers (teen births, contraception, etc.) • Work with child care issues (removing a barrier for pregnant mothers to attend prenatal clinic while removing the concern for having someone to look after children during appointment times) • Provide community outreach and education on reducing risk factors/behaviors and promoting access to available services • Promote STD/HIV/BV screening in all OB care practices; ensure adequate treatment (disease control/partner treatment when applicable; test for eradication when applicable)

3. Direct efforts to further reduce SIDS deaths and other unintentional injuries leading to death including suffocation deaths (co-sleeping).

Short Term	<ul style="list-style-type: none"> • Further epidemiologic studies on racial disparities in birth outcomes and infant deaths • Improving accessibility and outreach of breastfeeding promotion
Long Term	<ul style="list-style-type: none"> • Further epidemiologic studies on racial disparities in birth outcomes and infant deaths • Improving accessibility and outreach of breastfeeding promotion

Participants for Region Needs Assessment:

LSU – Healthy Start Program Analyst/Evaluator
 Woman’s Hospital – FIMR Medical Director
 Healthy Start – Healthy Start enrollment
 Healthy Start --FIMR Analyst
 LSU-NO E.K. Long Med. Ctr.

Andrew Curtis, Ph.D.
 Alfred Robichaux
 Vivian Richards Gettys
 Ragan Canella
 W. Robert Pace, M.D.

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Woman's Hospital-Breast feeding
School-Based Health Centers-EBR Parish Schools
OLOL Children's Hospital
Nurse Family Partnership
Earl K. Long Medical Center/
LSUHSC Midcity Pediatric Clinic
Capitol Regional Office

Helene Kurtz
Sue Catchings
Roberta Vicari, M.D.
Karen Mills, R.N.
Stewart Gordon, M.D.

Stephen Henry
Jamie Roques, M.D
Marilyn Reynaud
Chery Ewing

REGION III

Mission: Our goal is to decrease our feto-infant mortality rate.

Perinatal Periods of Risk Analysis (PPOR):

Region III Rate

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	4.6 Maternal Health/Prematurity		
1500g+	2.0 Maternal Care	1.7 Newborn Care	3.2 Infant Health

PMR= 11.4

***Excess Mortality**

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	2.0 Maternal Health/Prematurity		
1500g+	0.7 Maternal Care	0.5 Newborn Care	2.1 Infant Health

Excess PMR= 5.3

* The excess perinatal (feto-infant) mortality rate represents the number of deaths avoided if you could get your population to the best scenario.

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Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> • Reduce unintended/unplanned pregnancies • Increase access to family planning • Improve pre-conceptual maternal health • Decrease maternal risk factors • Reduce the number of LBW and Pre-term Births • Increase screening and treatment for violence, substance abuse, and mental health • Smoking cessation programs • Nutrition education • Obesity and Diabetes education 	<ul style="list-style-type: none"> • Decrease the number of teen pregnancies/births • Transportation system • Housing environment assistance
Infant Health	<ul style="list-style-type: none"> • Increase education on sleep position and environment • Injury prevention awareness 	

Services/Accessibility

All services are present in the region and in each parish except home visiting, high risk prenatal care and delivery services, and treatment and intervention for violence, substance use, and mental health. There is moderate accessibility to health education and counseling for WIC participants. Accessibility is poor for home visiting, and violence, substance use, and mental health assessment, treatment and intervention.

Region III Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X	X		
Home Visiting	X				X
Adequate high risk prenatal care & delivery services	X		X		
Health Education/ Counseling (WIC only)	X	X		X	
Violence/Substance use/Mental Health Assessment	X	X			X
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X				X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X	X		
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs

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1. *Reduce Unintended pregnancies*
2. *Increase sleep position awareness and injury prevention awareness*
3. *Increase screening and treatment for violence, mental health, and substance abuse*

Activities to Address Needs:

1. Reduce Unintended pregnancies

Short Term	<ul style="list-style-type: none"> • Promote family planning (Resource health fair)
Long Term	<ul style="list-style-type: none"> • Increase accessibility of family planning and community awareness of family planning

2. Increase sleep position awareness and injury prevention awareness

Short Term	<ul style="list-style-type: none"> • Contact Linda Savoie concerning injury prevention, etc, and her resources for car seats, cribs, etc
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Long Term	<ul style="list-style-type: none"> • Increase education throughout the entire region about multiple things – smoking in pregnancy, folic acid pre-pregnancy, birth control to increase inter-pregnancy interval, resources for car seats, cribs, etc, access to bus tickets for appointments, breastfeeding classes, parenting classes, etc., no co-sleeping.
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3. Increase screening and treatment for violence, mental, and substance abuse

Short Term	<ul style="list-style-type: none"> • Educate local health providers about available resources on issues of substance abuse, and screening for psychosocial issues
Long Term	<ul style="list-style-type: none"> • Increase screening for mental/substance abuse, • Increase long-term in-house treatment/recovery • Increase local funding

Participants for Region Needs Assessment:

Region III FIMR Team

TADAC

Partners for Healthy Babies

Community Injury Prevention

Office of Mental Health

Children’s Coalition

Tim Butler

Nelia Hoffman

Linda Savoie

Albert Stibe

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REGION IV

Vision: To decrease our fetal/infant mortality rate by implementing strategies to increase access to care through outreach activities and mobile clinics.

Perinatal Periods of Risk Analysis (PPOR):

Region IV Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	4.1 Maternal Health/Prematurity			500-1499g	1.5 Maternal Health/Prematurity		
1500g+	2.0 Maternal Care	1.5 Newborn Care	2.5 Infant Health	1500g+	0.7 Maternal Care	0.3 Newborn Care	1.4 Infant Health
PMR= 10.1				Excess PMR= 4.0			

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> • Increase access to care • Transportation to services • Education to identify pre-term labor signs • Private medical doctors care improved follow up • Provide counseling: nutrition etc. • Education on the importance of preventive care • Decrease environmental stressors • Decrease number of adolescent pregnancies • Increase spacing between pregnancies • Decrease fragmented care • Private medical doctors not accept presumptive eligibility • Prenatal care 	<ul style="list-style-type: none"> • Poverty • Lower education • Lack of family support • Domestic violence • Drug/alcohol/smoking • Inadequate housing • High risk: obesity, Diabetes • Sexually transmitted diseases • Maternal depression • Working poor • Rural parishes

Infant Health	<ul style="list-style-type: none"> • Increase access to care • Transportation to services • Private medical doctors care improved follow up • Provide counseling: nutrition etc. • Education on the importance of preventive care • Decrease environmental stressors • Decrease number of adolescent pregnancies • Increase spacing between pregnancies • Decrease fragmented care • Lack of follow up for NICU discharges 	<ul style="list-style-type: none"> • Poverty • Lower education • Lack of family support • Domestic violence • Drug/alcohol/smoking • Inadequate housing • Maternal depression • Working poor • Rural parishes • Availability of pediatricians
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Services/Accessibility:

All services are present within the region. Home visiting, adequate high risk prenatal care and delivery services, violence/substance use/mental health assessment, intervention, and treatment are not available in all parishes. Accessibility is easy for all services except adequate high risk prenatal care and delivery services (transportation issues), violence/substance use/mental health assessment, intervention, treatment where access is moderate. Home visiting is accessible when the criteria is met.

Region IV Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X	X		
Home Visiting	X	3 of 7	X		
Adequate high risk prenatal care & delivery services	X			X	
Health Education/ Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X			X	
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X			X	
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X	X		
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs

1. *Increase the number of women getting early and adequate prenatal care*
2. *Substance Abuse/Maternal Depression*
3. *Education on the Importance of Infant Preventative Care*

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Activities to Address Needs:

1. Increase the number of women getting early and adequate prenatal care

Short Term	<ul style="list-style-type: none"> • Educate public about importance of PNC • Partnership with private sector/case management
Long Term	<ul style="list-style-type: none"> • Mobile prenatal clinics

2. Substance Abuse/Maternal Depression

Short Term	<ul style="list-style-type: none"> • Coordinate (LSU) Social Worker Students to do internship in health units.
Long Term	<ul style="list-style-type: none"> • Expand EDSS outside of Lafayette parish • Mental health services with mobile prenatal clinics

3. Education on the Importance of Infant Preventative Care

Short Term	<ul style="list-style-type: none"> • Partner with hospitals for home visits/home evaluations prior to discharge for high risk infants • Social worker/case management for infants not eligible for NFP
Long Term	<ul style="list-style-type: none"> • Educate pediatricians/MDs/PCP on being medical home for high risk (post NICU) infants

Participants for Region Needs Assessment:

Our Lady of Lourdes Hospital
 LSUMC, LGMC, WCH- Early Intervention Coordinator
 University of Louisiana, at Lafayette- Health Infomatics
 SWLAHEC- Tobacco Control Coordinator
 The Family Tree- Social Worker
 LSUMC
 LGMC
 WCH
 Office of Public Health- Nurse Family Partnerships
 Office of Public Health

Dr. Ken Brown
 Donna Broussard
 Philip Caillouet
 Jennifer Burris
 Yasmin Welch
 Lauren Haygood, RN
 Karen Rue, RN
 Leona Boullion, RN
 Patricia McNeill, RN
 Barbara Hebert, RN

REGION V

Vision: Overall, to reduce the high numbers of fetal/infant deaths in Calcasieu Parish as well as Region 5 using community resources and dedicated members. Ensure the health and future of our moms, babies and families by maximizing healthcare resources available and educating the community to utilize these resources in a timely manner.

Perinatal Periods of Risk Analysis (PPOR):

Region V Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	5.3 Maternal Health/Prematurity			500-1499g	2.7 Maternal Health/Prematurity		
1500g+	2.1 Maternal Care	2.1 Newborn Care	2.9 Infant Health	1500g+	0.8 Maternal Care	0.9 Newborn Care	1.8 Infant Health
PMR= 12.5				Excess PMR= 6.4			

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> • Preconceptional health <ul style="list-style-type: none"> - Reduce unintended pregnancies - Increase early & adequate prenatal care • Low birth weight <ul style="list-style-type: none"> - Increase access to family planning - Decrease smoking among pregnant women - Increase nutrition education • Decrease prematurity 	<ul style="list-style-type: none"> • Maternal Risk (Domestic Violence) • Teen Births (15-19) Calcasieu (blacks)
Infant Health	<ul style="list-style-type: none"> • Sleep Position Education 	

Services/Accessibility:

Only home visiting and adequate high risk prenatal care & delivery services were not available in all parishes of Region V. Home visiting services in region V were only available in Calcasieu and Beauregard parishes. Calcasieu parish is the only parish which has adequate high risk prenatal care & delivery services. Family planning services were easily accessible in all parishes except Calcasieu, where it was moderately accessible. Home visiting and Violence/substance use treatment & intervention/mental health service referrals were rated as poorly accessible.

Region V Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X	X		
Home Visiting	X				X
Adequate high risk prenatal care & delivery services	X		X		
Health Education/Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X	X	X		
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X	X			X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X	X		
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs:

1. *Preconceptional Health*
2. *Low Birth Weight*
3. *Maternal Risk Factors*

Activities to Address Needs:

1. Preconceptional Health

Long Term	<ul style="list-style-type: none"> • Educate leaders to inform others of the importance of PNC • Offer preconceptional health, smoking, and nutrition classes • Educate peer trainers to be mentor-like member of the community. • Utilize educational institutions especially McNeese University.
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2. Low Birth Weight

Short Term	<ul style="list-style-type: none"> • Early CHAMP Applications • Provide Medicaid representatives to be housed at the Calcasieu Parish Health Unit to quicken turnaround for Medicaid Applications
Long Term	<ul style="list-style-type: none"> • Preconception classes – FP clinics, Private medical doctors • Smoking cessation classes for pregnant women • Expand NFP program • Prenatal care available to rural communities and in the rural communities • Nutrition classes that are aimed at reducing nutritional myths for pregnant women.

3. Maternal Risk (domestic violence)

Long Term	<ul style="list-style-type: none"> • Incorporate education about anger management, domestic violence, etc. into health curriculum in middle school through high school. • Make education about maternal risk factors available to young adults by taking it to them through churches. • Collaborate with the Women’s Shelter for information and strategy development.
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Participants for Region Needs Assessment:

- LSU Medical
- Women’s Health
- DHH-OPH- Region V Medical Director
- Office of Community Services
- WCCH-local Hospital Health Educator
- Parish Health Unit
- Christus St. Patrick’s
- Prevent Child Abuse Louisiana
- Home Health Care 2000
- Lake Charles Housing Authority
- DHH-Community Care
- Zeta Phi Beta Sorority, Inc.
- Stork’s Nest
- Resident Advisory Council
- Lighthouse Ministries
- School Aged Moms (SAM)
- Nurse Family Partnership
- Injury Prevention Coordinator

REGION VI

Vision: To determine reasons for lack of or delayed entry into Prenatal Care for pregnant women in this region, particularly Black women aged 20 to 34. Decrease disparity between black and white population in relation to fetal and infant mortality rate and adequate prenatal care. Increase access to and participation in Family Planning programs within the region.

Perinatal Periods of Risk Analysis (PPOR):

Region VI Rate

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	4.7 Maternal Health/Prematurity		
1500g+	2.2 Maternal Care	2.1 Newborn Care	2.3 Infant Health

PMR= 11.3

***Excess Mortality**

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	2.1 Maternal Health/Prematurity		
1500g+	0.9 Maternal Care	0.9 Newborn Care	1.2 Infant Health

Excess PMR= 5.2

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Improve education in schools on Preconceptional health Improve knowledge of services available Increase access to prenatal care Increase early and continuous participation in PNC Improve patient perceptions of PNC Improve transportation to PNC Increase access to family planning Improve follow-up of family planning Decrease unintended pregnancies Medical care planning (discharge planning) community care Expansion of NFP to include PNC classes 	

Infant Health	<ul style="list-style-type: none"> • Increase availability of Pediatric Care for Medicaid patients • Increase number of women who breastfeed • Increase immunization coverage • Decrease number of SIDS cases • Increase referral to Nurse Family Partnership 	
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Services/Accessibility:

Pregnancy testing, family planning services, health education and breastfeeding promotion are available in all parishes of the region VI. All other services are available within the region but not in every parish. Violence, substance use and mental health assessment and treatment is poorly accessible in region VI. All other services have moderate accessibility except pregnancy testing which is easily accessible in region VI.

Region VI Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X			X	
Home Visiting	X			X	
Adequate high risk prenatal care & delivery services	X			X	
Health Education/ Counseling (WIC only)	X	X		X	
Violence/Substance use/Mental Health Assessment	X				X
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X				X
HIV Counseling & Testing	X			X	
Sleep Position & Sleep Environment Education	X			X	
Family Planning	X	X		X	
Breast feeding Promotion	X	X		X	

Top Three Perinatal Needs:

1. Prenatal Care

- a) Adequate Prenatal Care-Early entry, continuous participation*
- b) Patient perceptions related to PNC – access, sensitivity, etc*
- c) Access to PNC: Transportation, Traveling PNC clinic/Bus*

2. Infant Health

- a) Availability of Pediatric Care for Medicaid patients*

- b) *Breastfeeding promotion*
- c) *Immunizations*
- d) *SIDS prevention*

3. *Family Planning*

- a) *Access to Services*
- b) *Follow-up*
- c) *Unintended pregnancies*

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Activities to Address Needs:

1. Prenatal Care

Short Term	<ul style="list-style-type: none"> • Focus Group to determine perceptions related to Prenatal Care • Networking to ensure communication and knowledge about services provided to pregnant women
Long Term	<ul style="list-style-type: none"> • Education related to importance of prenatal care including signage on bus benches, city buses, and public service announcements • Decrease impact of Lack of Transportation as barrier to Prenatal Care Plan: Equip Bus as Prenatal Clinic that travels to variety of communities in Parish (with potential for expansion into region) providing regular Prenatal Care – Education, WIC, check-ups, Medicaid and other social services as necessary

2. Infant Health

Short Term	<ul style="list-style-type: none"> • Focus Group to determine perceptions related to Infant Health such as Back-to-Sleep/Co-Sleeping and Immunizations
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3. Family Planning

Short Term	<ul style="list-style-type: none"> • Focus Group to determine perceptions related to Family Planning • Networking to ensure communication and knowledge about services provided to women of child bearing ages
Long Term	<ul style="list-style-type: none"> • Education in schools directed at Pre-Conceptual Health • Education directed toward Family Planning that reduces Unintended pregnancies • Education related to family planning including signage on bus benches, city buses, and public service announcements

Participants for Region Needs Assessment:

Shepherd Center Ministries
 Stork's Nest
 Rapides Foundation
 March of Dimes

Victim's Advocacy Groups
Early Steps
Obstetrician- Gynecologists
Neonatologists
Pediatricians
Family Practitioner
Pathologist/Coroner
MCH nurses
Nurse practitioners
LSUHSC Huey P Long Hospital
LSUHSC Family Practice Residency Training Program and Clinic
Rapides Regional Medical Center
CHRISTUS St Frances Cabrini Hospital

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REGION VII

Vision: Decrease the Infant and Perinatal mortality rate in Region VII to or below the state average.

Perinatal Periods of Risk Analysis (PPOR):

Region VII Rate

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	6.7 Maternal Health/Prematurity		
1500g+	2.4 Maternal Care	1.7 Newborn Care	2.5 Infant Health

PMR= 10.8

***Excess Mortality**

Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	4.1 Maternal Health/Prematurity		
1500g+	1.1 Maternal Care	0.5 Newborn Care	1.4 Infant Health

Excess PMR= 7.2

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Increase access to prenatal care prior to Medicaid enrollment Education about prenatal health Social Services assessment Expand NFP and prenatal care throughout region Increase access to PNC Increase the number of women accessing prenatal care in the first trimester Awareness, education, and networking of providers to available resources Community education Increase access to dental care Provide access to mental health and substance abuse programs Increase access to and education of medications 	<ul style="list-style-type: none"> Access to transportation Rural Parishes

Infant Health	<ul style="list-style-type: none"> • Access to a state wide medical record system 	<ul style="list-style-type: none"> • Access to transportation • Rural Parishes
	<ul style="list-style-type: none"> • Client advocacy in the community (i.e. peer outreach workers) • Community education programs • Social Services assessment • Awareness, education, and networking of providers to available resources • Access to a state wide medical record system 	

Services/Accessibility:

All services are available within the region but not within each parish. Accessibility of home visiting was rated as easy only when provided by Northwest Louisiana Coalition (NWLC). Health education and counseling for WIC participants was also easily accessible. All other services were rated as moderately accessible except family planning, which is rated as poorly accessible.

Region VII Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X			X	
Prenatal Care	X			X	
Home Visiting	X		X(NWLC only)		
Adequate high risk prenatal care & delivery services	X			X	
Health Education/ Counseling (WIC only)	X		X		
Violence/Substance use/Mental Health Assessment	X			X	
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X			X	
HIV Counseling & Testing	X			X	
Sleep Position & Sleep Environment Education	X			X	
Family Planning	X				X
Breast feeding Promotion	X			X	

Top Three Perinatal Needs:

1. *Maintain and expand NFP and prenatal care throughout region VII*
2. *Increase the number of women receiving prenatal care in the first trimester*

3. *Develop and implement community maternal child advocacy program*

Activities to Address Needs:

1. Maintain and expand NFP and prenatal care throughout region VII

Short Term	<ul style="list-style-type: none"> Expand NFP and prenatal care to Bossier Parish Provide prenatal care prior to Medicaid coverage
Long Term	<ul style="list-style-type: none"> Expand NFP and prenatal care to all parishes in Region VII Provide lactation and breast feeding specialists in Region VII

2. Increase the number of women receiving prenatal care in the first trimester

Short Term	<ul style="list-style-type: none"> Expand NFP and prenatal care to Bossier Parish Provide prenatal care prior to Medicaid coverage
Long Term	<ul style="list-style-type: none"> Expand NFP and prenatal care to all parishes in Region VII Provide transportation to and from medical appointments

3. Develop and implement community maternal child advocacy program

Short Term	<ul style="list-style-type: none"> Develop community maternal child advocacy program
Long Term	<ul style="list-style-type: none"> Provide Peer leaders in high risk areas to promote maternal child community advocacy Implement community maternal child advocacy program Provide emergency infant supplies Provide infant care education Begin Breast feeding promotion Educate teens prior to pregnancy Provide lactation and breast feeding specialists in Region VII

Participants for Region Needs Assessment:

- | | |
|--|------------------|
| LSUHSC-S Family Practice Medicine | Joan Landry |
| Willis Knighton Health System | Gaye Hill |
| Shreveport Bossier Community Renewal | Shelley Lester |
| Office of Public Health | Jerre Perry |
| Shreveport Housing Authority | Donzetta Kimble |
| Shreveport Housing Authority | Linda Henry |
| Shreveport Community Health Institute | Murray Lloyd |
| AHEC/ Health Start | Barbara Joseph |
| Northwestern State University School of Nursing | Sally Cook |
| Unity Way of North Louisiana | Joe Pierce |
| LSUHSC- S Department of Pediatrics | Yvonne Mitchell |
| State Office of Addictive Disorders | Trudie Abner |
| Northwest Louisiana Coalition of Health for Women & Children | Linda Brooks |
| Northwest Louisiana Coalition of Health for Women & Children | Angela Brossett |
| Northwest Louisiana Coalition of Health for Women & Children | Wendi Barnett |
| LSUHSC-S Department of OB/GYN | Dr. Steve London |
| Community Health Columnist | Emily Metzgar |

REGION VIII

Vision: Our goal is to reduce the overall fetal and infant mortality rate by up to 7.5 deaths per 1,000 live births and fetal deaths over the next five years by focusing efforts toward the development of activities and strategies to intervene in the types of death most in need of improvement: maternal health and prematurity and infant health. We envision a perinatal population that will become increasingly more informed about their options and services available, the importance of preconceptional and prenatal health, and how to appropriately ensure their infants' health and safety. In addition to implementing the activities and strategies outlined in this needs assessment, progress toward these goals will be aided through the activities of an operational Fetal Infant Mortality Review process and expansion region-wide of the Nurse-Family Partnership.

Perinatal Periods of Risk Analysis (PPOR):

Region VIII Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	6.4 Maternal Health/Prematurity			500-1499g	3.8 Maternal Health/Prematurity		
1500g+	2.6 Maternal Care	1.5 Newborn Care	3.1 Infant Health	1500g+	1.3 Maternal Care	0.3 Newborn Care	2.0 Infant Health
PMR= 13.6				Excess PMR= 7.5			

* Excess mortality is the number of deaths in your population compared to a reference group. The excess perinatal (feto-infant) mortality rate represents the number of deaths that could be avoided if your population had the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Reduce STD prevalence in women of childbearing age Adequate routine prenatal testing/care Adequate transportation to family planning Increase awareness of and use of folic acid Decrease difficulties in scheduling family planning appointments 	<ul style="list-style-type: none"> Teen pregnancies Substance abuse Mental health needs

Infant Health	<ul style="list-style-type: none"> • Increase injury prevention/safety awareness (Inappropriate use of cribs/co-sleeping, safe sleep environment) • Knowledge and education regarding injury prevention • Knowledge regarding/Availability of medical homes 	<ul style="list-style-type: none"> • Inadequate parental/caretaker supervision • Inadequate provider participation in Medicaid • Lack of initiation/support of breastfeeding
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Services/Accessibility:

Home visiting, high risk prenatal care and delivery services, and treatment and assessment of violence, substance use, and mental health are the only services not available in all parishes, although they are available within the region. All services are easily accessible except home visiting, violence, substance use, and mental health assessment and treatment. Home visiting and assessment for violence, substance use, and mental health are moderately accessible while treatment for violence, substance use, and mental health is poorly accessible.

Region VIII Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X	X		
Home Visiting	X			X	
Adequate high risk prenatal care & delivery services	X			X	
Health Education/Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X			X	
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X				X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X	X		
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs:

1. *Reduce STD prevalence in women of childbearing age*
2. *Increase adequate prenatal testing and care*
3. *Injury prevention/Safety Awareness*

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4. *Reduce the number of Adolescent Pregnancies*

Activities to Address Needs:

1. Reduce STD prevalence in women of childbearing age

Short Term	<ul style="list-style-type: none"> • Community awareness and/or media campaigns regarding STDs • Easier access to and education regarding correct use of Condoms • Early STD testing
Long Term	<ul style="list-style-type: none"> • Education through school system about STDs • School based health clinics in middle schools in each parish

2. Increase adequate prenatal testing and care

Short Term	<ul style="list-style-type: none"> • Van transportation for prenatal care patients- increase funding for existing agencies • Work with DHH to identify location for eligibility workers to issue LaMOMS card, reducing wait
Long Term	<ul style="list-style-type: none"> • Decentralized high-risk pre-natal care- utilization of health units • Community based education through school system about importance of prenatal care, adolescent health

3. Injury prevention/Safety Awareness

Short Term	<ul style="list-style-type: none"> • Train more service providers in car seat safety • More education regarding appropriate parental/caretaker supervision • Offer educational sessions in high schools on personal/family safety and health
Long Term	<ul style="list-style-type: none"> • Offer High School semester or quarter course on personal/family safety and health • Community awareness and/or media campaigns regarding injury prevention

4. Reduce the number of Adolescent Pregnancies

Short Term	<ul style="list-style-type: none"> • Community awareness and/or media campaigns regarding adolescent pregnancies • Collaboration among agencies that work with adolescent pregnancy to provide health and sex educational programs • Offer educational sessions in high schools on personal/family safety, health and sex
Long Term	<ul style="list-style-type: none"> • Education about adolescent pregnancy in schools- create safe and drug free schools • Education through school system about adolescent health

Participants for Region Needs Assessment:

Better Health for the Delta
Bridges of Ouachita
DSS- Office of Family Support
East Carroll Parish OFS
Even Start
Families Helping Families
Glenwood Regional MC
Jackson Public Health Unit
LA Early Childhood Support Services
LA Office of Addictive Disorders
LA Office of Community Services
LA Office of Public Health
LA Tech University
LBCH - Sellers Maternity Home
Life Choices PRC
LSU Ag Center
LSU-HSC Monroe
March of Dimes
Mental Health Center
NELA HEC
North Monroe Medical Center
Nurse Family Partnership
Ouachita Parish Media Center
Ouachita Parish Medicaid
Our House
Prevent Child Abuse Louisiana
Salvation Army
St. Francis Medical Center
The Childrens Coalition
The Extra Mile
University of Louisiana Monroe
Woman's Clinic of Monroe

DRAFT

REGION IX

Vision: Envision hiring a FIMR Coordinator and starting a FIMR group to evaluate needs of perinatal population in Region IX.

Perinatal Periods of Risk Analysis (PPOR):

Region IX Rate				*Excess Mortality			
Birth Weight	Fetal	Neo-natal	Post Neonatal	Birth Weight	Fetal	Neo-natal	Post Neonatal
500-1499g	3.2 Maternal Health/Prematurity			500-1499g	0.6 Maternal Health/Prematurity		
1500g+	1.8 Maternal Care	1.9 Newborn Care	2.2 Infant Health	1500g+	0.5 Maternal Care	0.7 Newborn Care	1.1 Infant Health
PMR= 9.1				Excess PMR= 3.0			

* The excess perinatal (feto-infant) mortality rate represents the number of deaths avoided if you could get your population to the best scenario.

Identified Perinatal Health Needs/Issues:

PPOR Category	Needs	Issues
Maternal Health/ Prematurity	<ul style="list-style-type: none"> Increase availability of high risk OB care Early and continuous PNC Appropriate weight gain during pregnancy Reduce maternal health risks 	<ul style="list-style-type: none"> Transportation Availability of Medicaid providers Lack of providers for high risk OB care
Infant Health	<ul style="list-style-type: none"> Medical homes Education on sleep position and safe sleep environment Injury prevention 	<ul style="list-style-type: none"> Increase number of women who breastfeed Availability of Medicaid providers

Services/Accessibility:

Home visiting and high risk PNC and delivery services are the only services that are not available in every parish, although they are available within the region. Pregnancy testing, health education and counseling, HIV counseling and testing, sleep position/environment education, and breastfeeding promotion are easily accessible. Family planning services are only moderately accessible in Region IX. Poorly accessible services within the region are prenatal care, home visiting, high risk PNC and delivery, and assessment and treatment for violence, substance use, and mental health.

Region IX Services	Available in Region	Available in All Parishes	Accessibility*		
			Easy	Moderate	Poor
Pregnancy Testing	X	X	X		
Prenatal Care	X	X			X
Home Visiting	X				X
Adequate high risk prenatal care & delivery services	X				X
Health Education/ Counseling (WIC only)	X	X	X		
Violence/Substance use/Mental Health Assessment	X	X			X
Violence/Substance use Treatment & Intervention/Mental Health Services (referrals)	X	X			X
HIV Counseling & Testing	X	X	X		
Sleep Position & Sleep Environment Education	X	X	X		
Family Planning	X	X		X	
Breast feeding Promotion	X	X	X		

Top Three Perinatal Needs:

1. *Create a FIMR coalition to evaluate perinatal needs in Region IX*
2. *Increase Access to medical homes*
3. *Increase access to high risk obstetric care*

Activities to Address Needs:

1. Create a FIMR coalition to evaluate perinatal needs in Region IX

Short Term	<ul style="list-style-type: none"> • Hire FIMR Coordinator for Region IX to bring together people and resources • Recruit FIMR members and hospitals
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2. Increase Access to medical homes

Short Term	<ul style="list-style-type: none"> • Bring access issues to the attention of the Regional Health Care Reform Consortium • Recruit and educate providers who accept Medicaid
Long Term	<ul style="list-style-type: none"> • Increase access to transportation • Community education- public awareness • Increase prenatal care through Healthy Start (Family Roads)

3. Increase access to high risk obstetric care

Long Term	<ul style="list-style-type: none"> • Start a Family Roads type center for high-risk OB care • Recruiting providers • Medical home strategies
------------------	---

Participants for Region Needs Assessment:

Office of Public Health Staff
St. Tammany Parish Hospital
Nurse Family Partnership Staff

Availability and Access of Services

	Orleans	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Region 7		Region 8		Region 9	
	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access	All Parishes	Access
Pregnancy Testing	Easy	X	Easy	X	Moderate	X	Easy	X	Easy	X	Easy	X	Easy		Moderate	X	Easy	X	Easy
Prenatal Care	Moderate	X	Moderate	X	Moderate	X	Easy	X	Easy	X	Easy		Moderate		Moderate	X	Easy	X	Poor
Home Visiting	*Moderate	X	Moderate		Easy		Poor		Easy		Poor		Moderate		Easy		Moderate		Poor
Adequate high risk prenatal care & delivery services	Moderate		Moderate		Poor	X	Easy		Moderate		Easy		Moderate		Moderate		Moderate		Poor
Health Education/ Counseling (WIC only)	Easy	X	Easy	X	Easy		Moderate	X	Easy	X	Easy	X	Moderate		Easy	X	Easy	X	Easy
Violence/ Substance use/ Mental Health Assessment	Moderate	X	Poor		Moderate		Poor		Moderate	X	Easy		Poor		Moderate		Moderate	X	Poor
Violence/ Substance use Treatment & Intervention/ Mental Health Services (referrals)	Poor	X	Poor		Poor		Poor		Moderate	X	Poor		Poor		Moderate		Poor	X	Poor
HIV Counseling & Testing	Easy	X	Easy	X	Easy	X	Easy	X	Easy	X	Easy		Moderate		Moderate	X	Easy	X	Easy
Sleep Position & Sleep Environment Education	Easy	X	Easy	X	Easy	X	Easy	X	Easy	X	Easy		Moderate		Moderate	X	Easy	X	Easy
Family Planning	Poor	X	Easy	X	Moderate	X	Easy	X	Easy	X	Easy	X	Moderate		Easy	X	Easy	X	Moderate
Breast Feeding Promotion	Easy	X	Easy	X	Moderate	X	Easy	X	Easy	X	Easy	X	Moderate		Moderate	X	Easy	X	Easy

* Home visiting in Orleans Parish is delivered by Great Expectations

Top Priority Needs by Region

	Orleans	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Mental Health										
STD/HIV/BV										
Preconceptional Health										
Unintended Pregnancies										
Adolescent Births										
PNC- Early										
PNC-Adequate										
PNC-Transportation										
High Risk OB Care										
Low Birth Weight										
Breastfeeding										
Immunizations										
Injury Prevention (environment)										
SIDS (sleep position/ sleep environment)										
Medical Homes										
Infrastructure in Region										

Top Three Priority Needs by Region

Orleans	<ul style="list-style-type: none"> • Mental Health Services • Substance Abuse Services • Early Access to Prenatal Care
Region 1	<ul style="list-style-type: none"> • Reduce the number of Very Low Birth Weight Babies • Reduce the number of Sudden Infant Death Syndrome • Improve Access to Medical Homes
Region 2	<ul style="list-style-type: none"> • Reduce Preterm and LBW births • Address multiple maternal risk factors- unintended pregnancies, the high number of teen births (especially among black women), maternal violence (intimate partner violence), and maternal infection (STDs, HIV, and BV). • Direct efforts to further reduce SIDS deaths and other unintentional injuries leading to death including suffocation deaths (co-sleeping).
Region 3	<ul style="list-style-type: none"> • Reduce Unintended pregnancies • Increase sleep position awareness and injury prevention awareness • Increase screening and treatment for violence, mental health, and substance abuse
Region 4	<ul style="list-style-type: none"> • Increase the number of women getting early and adequate prenatal care • Substance Abuse/Maternal Depression • Education on the Importance of Infant Preventative Care
Region 5	<ul style="list-style-type: none"> • Preconceptional Health • Low Birth Weight • Maternal Risk Factors
Region 6	<ul style="list-style-type: none"> • Prenatal Care- Adequate Prenatal Care-Early entry, continuous participation; Patient perceptions related to PNC – access, sensitivity, etc; Access to PNC: Transportation, Traveling PNC clinic/Bus • Infant Health- Availability of Pediatric Care for Medicaid patients; Breastfeeding promotion; Immunizations; SIDS prevention • Family Planning- Access to Services; Follow-up; Unintended pregnancies
Region 7	<ul style="list-style-type: none"> • Maintain and expand NFP and prenatal care throughout region VII • Increase the number of women receiving PNC in the first trimester • Develop and implement community maternal child advocacy program
Region 8	<ul style="list-style-type: none"> • Reduce STD prevalence in women of childbearing age • Increase adequate prenatal testing and care • Injury prevention/Safety Awareness • Reduce the number of Adolescent Pregnancies
Region 9	<ul style="list-style-type: none"> • Create a FIMR coalition to evaluate perinatal needs in Region IX • Increase Access to medical homes • Increase access to high risk obstetric care

Priority Need	# of Regions listing	Regions
Maternal Health		
Mental Health Services	5	O,2,3,4,5
Maternal Risk Factors: STD/HIV/BV	2	2,8
Preconception health	1	5
Unintended Pregnancies	3	2,3,6
Adolescent Births	2	2,8
Prenatal Care		
Early Access	4	O,4,6,7
Adequate Care	3	4,6,8
Transportation to PNC	1	6
High Risk OB Care	1	9
Low Birth Weight		
	3	1,2,5
Infant Health		
Breastfeeding	1	6
Immunizations	1	6
Injury Prevention (sleep position)	3	2,3,8
SIDS	3	1,2,6
Preventive Care	1	4
Medical Homes		
	3	1,6,9
Infrastructure in Region		
Expand NFP throughout region	1	7
MCH Advocacy Program	1	7
FIMR Coalition	1	9

Summary

The most frequently reported need by regions was for mental health services and treatment. Types of services mentioned were depression related services, substance use, and domestic violence. Mental health services were also listed as the least accessible service by the regions. The next most frequently reported need was to increase the number of women accessing prenatal care during their first trimester and the accessing of adequate prenatal care. Other commonly cited needs were to increase the availability of medical homes, increase education on sleep position and sleep environment, increase access to family planning and decrease the number of low birth weight babies. Two of the regions listed a need for the creation of a coalition to improve their region's ability to address the populations' perinatal needs.

Perinatal Health

SUBGROUP		ORGANIZATION
	Orleans Parish	New Orleans Health Department/LSUHSC LA OPH MCH / New Orleans Health Department Tulane University Maternal & Child Health Program Planned Parenthood Perinatal Enrichment LSUHSC Great Expectations (Healthy Start) Region I Office of Public Health Medical Director
	Region I	Region I Prenatal Nurse HIV/AIDS Perinatal Coordinator Nurse Family Partnership Region I Injury Prevention Coordinator Director of Orleans Parish Health Units
	Region II	LSU – Healthy Start Program Analyst/Evaluator LSU – Healthy Start Program Analyst/Evaluator Healthy Start --FIMR Analyst LSU-NO E.K. Long Med. Ctr. Woman’s Hospital-Breast feeding School-Based Health Centers-EBR Parish Schools OLOL Children’s Hospital Nurse Family Partnership Earl K. Long Medical Center/ LSUHSC Midcity Pediatric Clinic Capitol Regional Office
	Region III	Region III FIMR Team TADAC Partners for Healthy Babies Community Injury Prevention Office of Mental Health Children's Coalition
	Region IV	Our Lady of Lourdes Hospital LSUMC, LGMC, WCH- Early Intervention Coordinator University of Louisiana, at Lafayette- Health Informatics SWLAHEC- Tobacco Control Coordinator The Family Tree- Social Worker LSUMC LGMC WCH Office of Public Health- Nurse Family Partnerships Office of Public Health

Perinatal Health

Region V

LSU Medical
 Women's Health
 DHH-OPH- Region V Medical Director
 Office of Community Services
 WCCH-local Hospital Health Educator
 Parish Health Unit
 Christus St. Patrick's
 Prevent Child Abuse Louisiana
 Home Health Care 2000
 Lake Charles Housing Authority
 DHH-Community Care
 Zeta Phi Beta Sorority, Inc.
 Stork's Nest
 Resident Advisory Council
 Lighthouse Ministries
 School Aged Moms (SAM)
 Nurse Family Partnership
 Injury Prevention Coordinator

Region VI

Shepherd Center Ministries
 Stork's Nest
 Rapides Foundation
 March of Dimes
 Victim's Advocacy Groups
 Early Steps
 Obstetrician- Gynecologists
 Neonatologists
 Pediatricians
 Family Practitioner
 Pathologist/Coroner
 MCH nurses
 Nurse practitioners
 LSUHSC Huey P Long Hospital
 LSUHSC Family Practice Residency Training Program and Clinic
 Rapides Regional Medical Center
 CHRISTUS St Frances Cabrini Hospital

Region VII

LSUHSC-S Family Practice Medicine
 Willis Knighton Health System
 Shreveport Bossier Community Renewal
 Office of Public Health
 Shreveport Housing Authority
 Shreveport Community Health Institute
 AHEC/ Healthy Start
 Northwestern State University School of Nursing
 Unity Way of North Louisiana
 LSUHSC- S Department of Pediatrics
 State Office of Addictive Disorders
 Northwest Louisiana Coalition of Health for Women & Children
 LSUHSC-S Department of OB/GYN

Perinatal Health

Region VIII

Better Health for the Delta
 Bridges of Ouachita
 DSS- Office of Family Support
 East Carroll Parish OFS
 Even Start
 Families Helping Families
 Glenwood Regional MC
 Jackson Public Health Unit
 LA Early Childhood Support Services
 LA Office of Addictive Disorders
 LA Office of Community Services
 LA Office of Public Health
 LA Tech University
 LBCH - Sellers Maternity Home
 Life Choices PRC
 LSU Ag Center
 LSU-HSC Monroe
 March of Dimes
 Mental Health Center
 NELA HEC
 North Monroe Medical Center
 Nurse Family Partnership
 Ouachita Parish Media Center
 Ouachita Parish Medicaid
 Our House
 Prevent Child Abuse Louisiana
 Salvation Army
 St. Francis Medical Center
 The Childrens Coalition
 The Extra Mile
 University of Louisiana Monroe
 Woman's Clinic of Monroe

Region IX

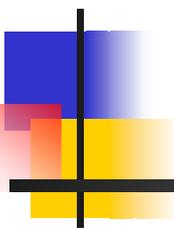
Office of Public Health Staff
 St. Tammany Parish Hospital
 Nurse Family Partnership Staff

Adolescent Health

Attorney Generals Office
Department of Social Services/Office of Community Service
Youth Empowerment Project
Office of Mental Health
Adolescent Health Initiative
Governor's Children's Cabinet
Federal Bureau of Investigation (FBI)
Law Enforcement
Medicaid
Office of Addictive Disorders
Abstinence Program
Community Mental Health
School Based Health Centers
Gay, Lesbian, Bisexual, and Transgender Youth
HIV AIDS
Office of Public Health

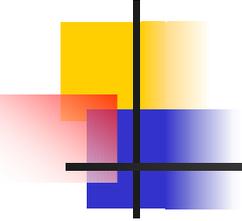
**Title V (MCH) Block Grant
Priority Setting Session Invitees**

Name	Title
Ananda Hall	Environmental Coordinator for Childhood Lead Poisoning Program
Bernadette Mills	State Injury Prevention Coordinator
Charlie Myers	Genetic Diseases Program Manager
Christi Stewart	Childhood Lead Poisoning Prevention
Christine Armand	Adolescent & School Health Program Coordinator
Connie Bouligny	Maternity Nurse Consultant
Connie Christoffer	Adolescent & School Based Health
Diana Echenique	Public Health Epidemiologist- CSHS
Dionka Pierce	PRAMS Coordinator
Elizabeth Black	Assist. MCH Administrator
Francoise Grossman-Kendall	Reproductive Health Training Coordinator
Genet Burka	Public Health Epidemiologist
Irene Schiavo	Adolescent & School Based Health
Jaime Slaughter	Public Health Epidemiologist
Janet Guidry	Nutritionist
Jean Takenaka	Child Health Med. Director
Jean Valliere	Mental Health Coordinator
Joan Wightkin	MCH Program Administrator
Joyce Mernin	Child Death Review Coordinator
Juan Acuna	MCH Epidemiologist
Karen Oretling	Oral Health Program Director
Karis Schoellmann	Health Ed/ Communications
Kay Webster	Birth Defects Registry Coordinator
Linda Pippins	CSHS Program Administrator
Linda Polfus	Public Health Epidemiologist
Lyn Kieltyka	Public Health Epidemiologist-Orleans Parish
Mary Craig	Maternity Program Nurse Coordinator
Maureen Daly	Adolescent School Health Initiative-Med. Director
Meaghan Cooper	Folic Acid Coordinator
Pamela Metoyer	Pediatric Nurse Consultant
Rhonda Smith	Childhood Lead Poisoning Prevention Coordinator
Rodney Wise	Maternity Med Director
Rohini Singh	Nurse Family Partnership
Sarah Martin	Safe Kids Coordinator
Sheri Sison	Fluoridation Coordinator
Susan Berry	CSHS Medical Director
Suzette Chaumette	Health Ed
Tanya Williams	Public Health Epidemiologist-PRAMS
Tracy Hubbard	Program Specialist-SIDS
Tri Tran	Public Health Epidemiologist
Trina Evans	Adolescent Health Initiative Program Specialist



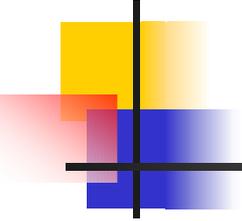
Oral Health Program Identified Priority Needs

Karen M. Oertling, RDH, MPH
Oral Health Program Director



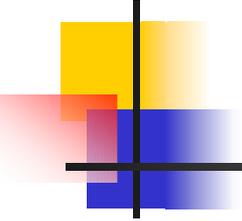
Priority Oral Health Needs

- Increase the number of dental providers treating Medicaid children and Medicaid eligible pregnant women to provide greater access to dental care. (Infrastructure Building)
- Increase the Medicaid reimbursement fees for dental providers to a level where dentists will participate in the program. (Infrastructure Building)



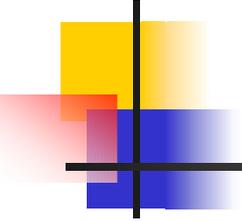
Priority Oral Health Needs

- Expand the dental practice act in Louisiana for dental hygienists to include general supervision in schools, public health clinics, head start programs, day care centers and rural health clinics. (Infrastructure Building)
- Increase the number of children who receive protective dental sealants through school based dental sealant programs. (Population-based Services)



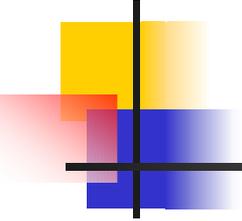
Priority Oral Health Needs

- Increase the number of Louisiana residents who receive the protective benefit of community water fluoridation. (Population-based Services)
- Increase the number of Medicaid eligible pregnant women who utilize the Expanded Dental Services Pregnant Women's Program with the intent to help reduce the preterm low birth weight rate in Louisiana. (Population-based Services)



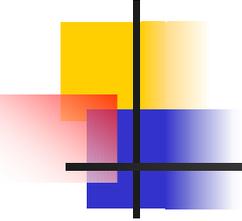
Priority Oral Health Needs

- Improve the oral health IQ of Louisiana residents through a multimedia campaign that targets the general population stressing the need for early dental intervention before problems occur. (Population-based Services)
- Improve oral health data collection so that oral health information can be obtained on all population groups that are consistent and comparable. (Infrastructure Building)



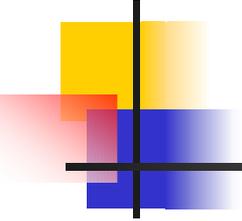
Top Three Priority Needs

- Increase the number of dental providers treating Medicaid children and Medicaid eligible pregnant women to provide greater access to dental care
- Increase the number of children who receive protective dental sealants through school-based sealant programs



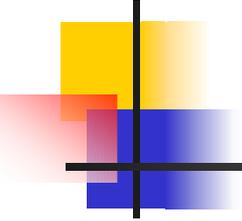
Top Three Priority Needs

- Expand the dental practice in Louisiana for dental hygienists to include general supervision in schools, public health clinics, head start programs, day care center and rural health clinics.



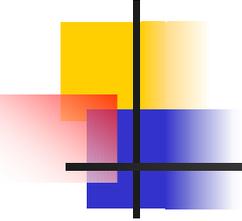
Why These Three?

1. Reoccurring themes from both oral health summits
2. Lack of dental providers accepting Medicaid patients problem in many regions (child health survey)
3. Analysis of Medicaid data revealed too few sealants being placed on 6-9 year old children



Current Performance Measures

- NPM-09 Percent of third grade children who have received protective sealants on at least one permanent molar.
- Change to percent of 6-9 year olds who have received protective sealants on at least one permanent molar. Rational: Available Medicaid data that can be analyzed.



Possible New Performance Measures

- Percent of dentists in Louisiana who bill Medicaid for dental services at or above \$10,000 per year. Rational: This data is available from Medicaid and gives a true picture of the # of dentists who really see Medicaid patients.

Child Health Needs Assessment

Age 1-14 years

Process Methodology Overview

- **Data/Statistical Review**
 - Child health related mortality, morbidity, demographic, and socioeconomic data compiled
 - Information from other Needs Assessments/reports reviewed
- **Community Stakeholder**
 - Regional workgroups reviewed US, state and local morbidity and mortality data to select top three priority needs for the region. Approximately 200 agencies participated statewide.
- **Provider Stakeholder**
 - Online survey to identify needs and activities in practice area. Approximately 157 provider respondent participation.
- **Child Health Needs Assessment Group**
 - 18 member group (OPH and City of New Orleans) used the tally method to prioritize identified needs.

Top Priority Child Health Needs

1. Ensure access to quality, comprehensive, coordinated care from quality providers.
2. Ensure access to quality, comprehensive mental health services.
3. Decrease child mortality and morbidity due to unintentional and intentional injuries.
4. Need for development of a comprehensive, quality database for collection of child health data.
5. Promote and increase family development, parenting skills and education.

Current Performance Measures Related to the Top Three Needs

- 1. Ensure access to quality, comprehensive, coordinated care from quality providers.**
 - NPM – #1(NB Screening), #7(Immunization), #13(Uninsured),and #14 (Medicaid eligible children receiving services)
- 2. Ensure access to quality, comprehensive mental health services.**
 - SPM - #3 (Child abuse and neglect)
- 3. Decrease child mortality and morbidity due to unintentional and intentional injuries.**
 - NPM - #10 (MVC deaths)

Changes in Performance Measures

- 1. Ensure access to quality, comprehensive, coordinated care from quality providers.**
 - Add a measure of quality
- 2. Ensure access to quality, comprehensive mental health services.**
 - % of parishes with programs that address mental health for young children (B–age 5) and their families – ECSS, NFP, Best Start **OR**
 - # (%) of young children referred for mental health services who received mental health services
- 3. Decrease child mortality and morbidity due to unintentional and intentional injuries.**
 - NPM - #10 (MVC deaths)
 - SPM - #3 (Child abuse and neglect)

State priorities for the Title V Block Grant, FFY 2004

CSHS Program

1. Access to pediatric sub-specialty care

Barriers include:

- Transportation
- lack of adequate reimbursement
- lack of sub-specialists
- mode of service delivery

2. Transition to adult services

3. Mental Health services

4. Dental Services



Sources of Data

- SLAITS data – national telephone survey
- CSHS Needs Assessment – conducted July 1, 2003 to June 30, 2004
 - 18 Focus groups with 127 families
 - 108 subspecialty physician interviews
 - 1159 primary care physician surveys
 - 528 subspecialty physicians surveys

#1. Access to pediatric sub-specialty care: Transportation

- Families explained how an unreliable, un-family friendly, inefficient transportation system impacts access to specialized care
- Physicians (108 specialist interviewed) stated that unreliable transportation for patients contributes to a high number of missed appointments and poor follow-up

Data source: CSHN Statewide Needs Assessment – Family Focus Groups

Access to pediatric sub-specialty care:

Lack of adequate reimbursement

- 84.2% of CSHCN had insurance coverage during the entire year prior to the interview (US 88.4%)
- 91.9% of CSHCN had public or private insurance at time of interview (US 94.8%)
- 82.6% said insurance usually or always met child's needs (US 85.5%)

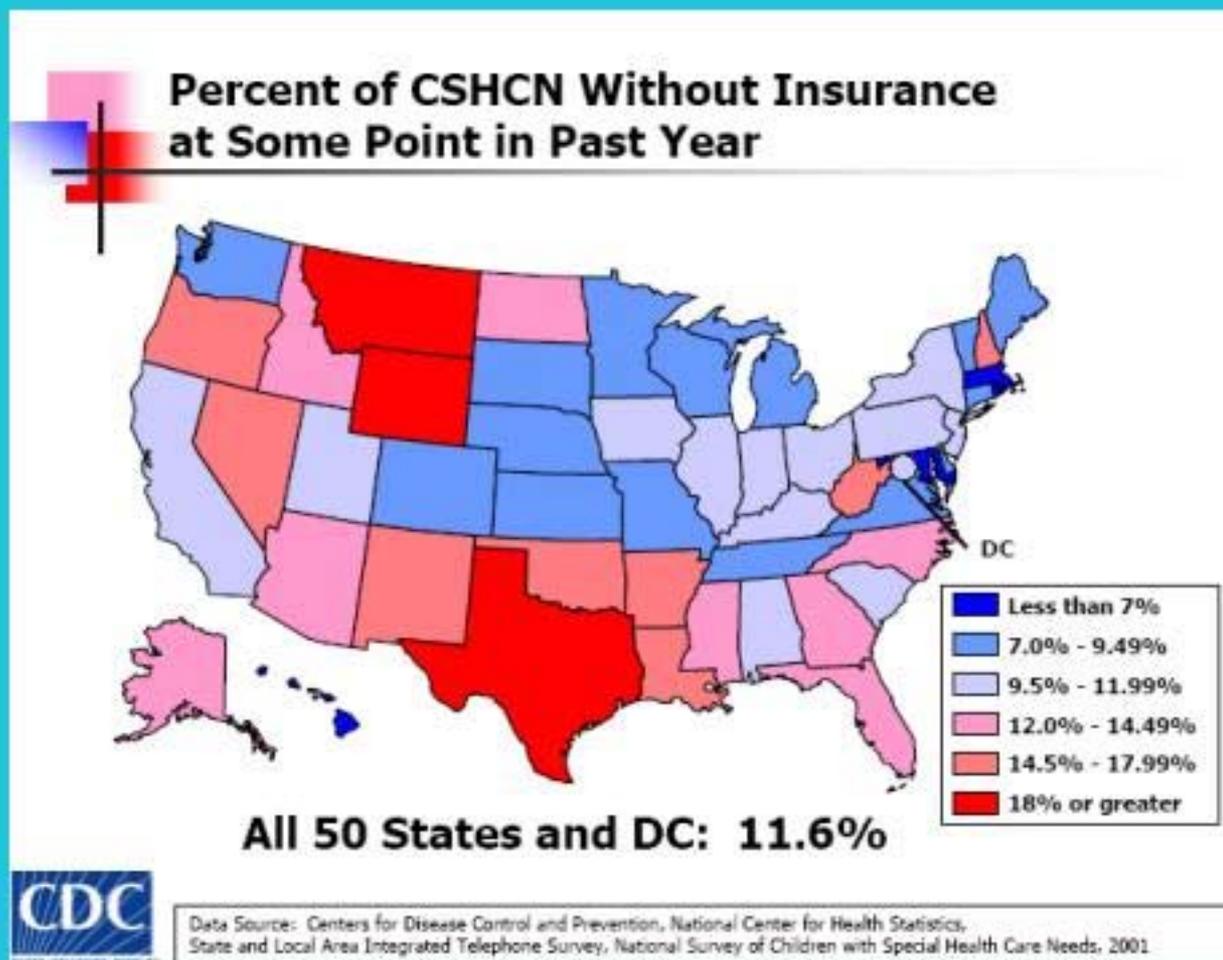
Maternal and Child Health Bureau 6 Core Outcomes. Data: SLAITS

Access to pediatric sub-specialty care:

Lack of adequate reimbursement

- 69.7% said costs not covered by insurance were usually or always reasonable (US 71.6%)
- 85.7% said insurance usually or always permitted child to see needed providers (US 87.8%)

Access to pediatric sub-specialty care: **Lack of adequate reimbursement**



LA: 15.8%

Access to pediatric sub-specialty care:
Lack of adequate reimbursement

Who Accepts Medicaid Among PCPs?

Type of PCP	Yes	No/ Unknown	Total
Pediatrician	203 (41.8%)	283	486
Family Practitioner/ General Practitioner	241 (41.3%)	343	584
Total	444 (42.8%)	626	1070

Data source: Needs Assessment Surveys

Access to pediatric sub-specialty care:
Lack of adequate reimbursement

Who Accepts Medicaid Among Specialist?

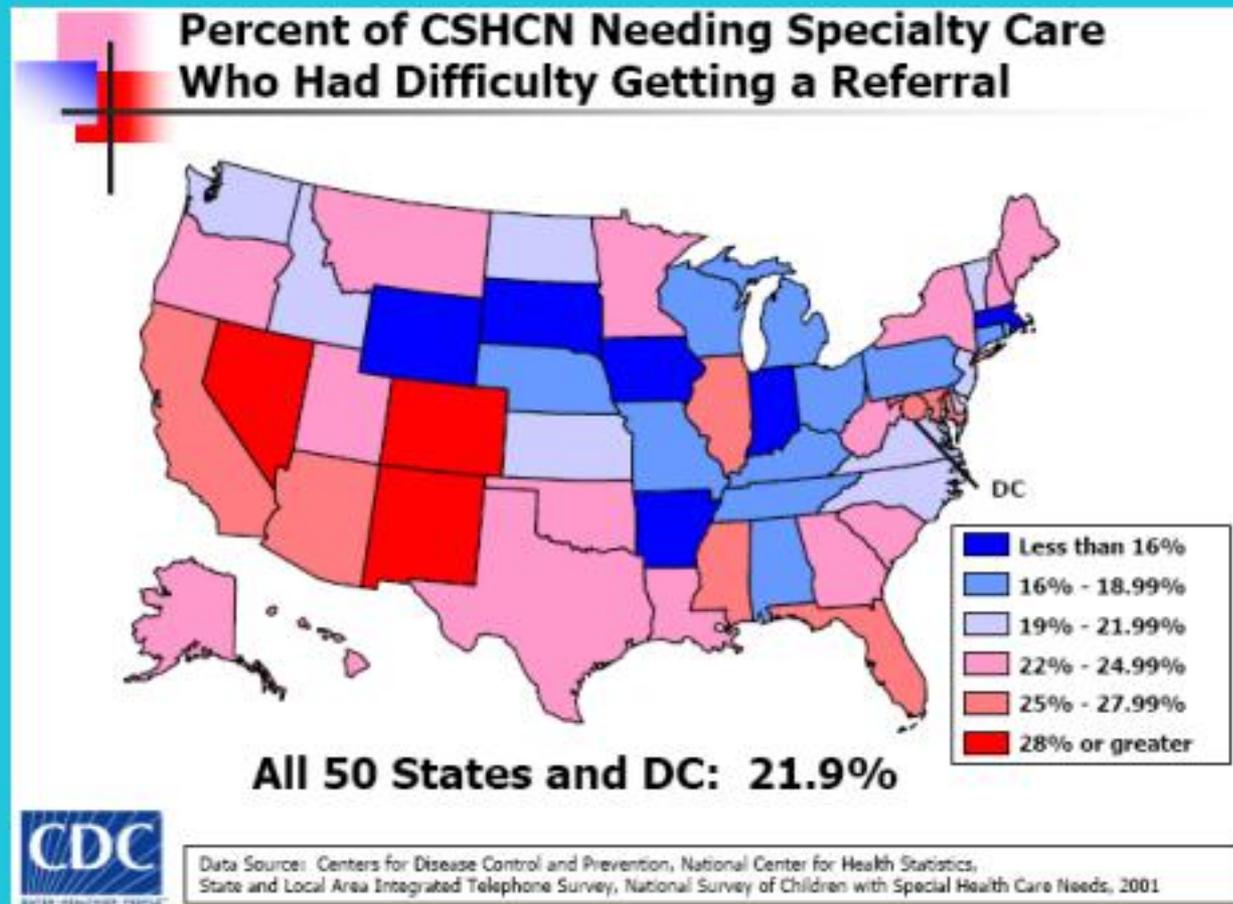
- Allergist/Immunologists 15 of 35
- Cardiologists 20 of 28
- Developmental/Behavioral Pediatricians 3 of 6
- Endocrinologists 6 of 11
- Gastroenterologists 10 of 14
- Geneticists 3 of 3
- Hematologist/Oncologists 11 of 19
- Infectious Disease Specialist 5 of 11
- Neonatologists 6 of 7
- Nephrologists 6 of 9
- Neurologists 14 of 29
- Ophthalmologists 43 of 54
- Otolaryngologist 26 of 83
- Pulmonologists 15 of 18
- Psychiatrists 14 of 48
- Surgeons 22 of 48
- Urologists 19 of 42

Access to pediatric sub-specialty care:

Lack of adequate reimbursement

- Specialists interviewed suggest increasing Medicaid reimbursement to improve access to care for CSHCN
- Many of the interviewed specialists said they can afford to serve children with Medicaid only because of their affiliation with a safety net, such as CSHS or LSUHSC
- Families in focus groups also mentioned the need for more primary care and specialty physicians to accept Medicaid reimbursement.

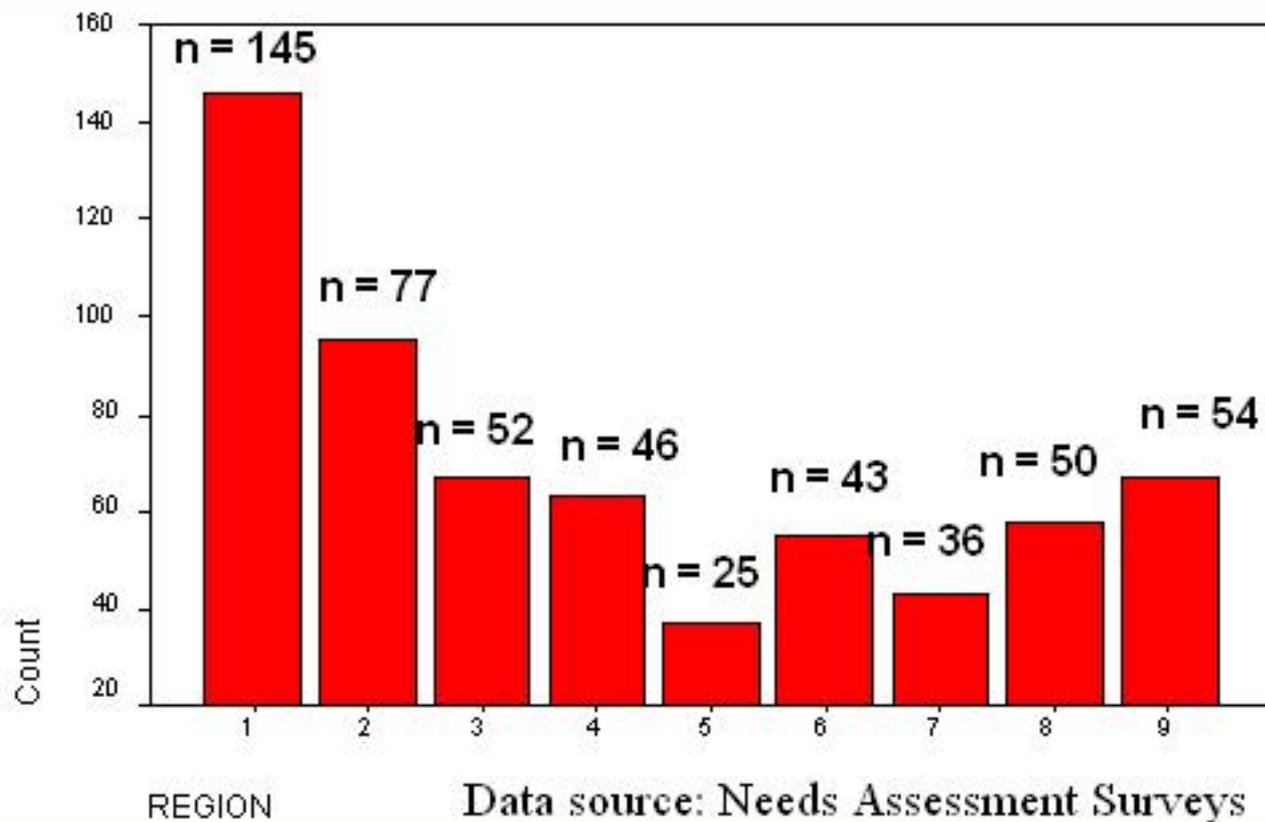
Access to pediatric sub-specialty care: **Lack of sub-specialists**



LA: 23.7%

Access to pediatric sub-specialty care: **Lack of sub-specialists**

Number of Sub-specialists by Region



Access to pediatric sub-specialty care:
Lack of sub-specialists

- Family focus groups mentioned lack of subspecialty care (hence, need for transportation)
- Families in regions 4, 5, 6, 7, 8, and 9 said they traveled out of state for specialty care

Data source: Needs Assessment Surveys

Access to pediatric sub-specialty care:
Mode of service delivery

68.8% of CSHCN of LA families report
community-based services systems are organized
so they can use them easily (US 74.3%)

Maternal and Child Health Bureau 6 Core Outcomes. Data: SLAITS

Access to pediatric sub-specialty care:
Mode of service delivery

Suggestions from sub-specialists:

- Maintain essential core elements of CSHS system
- Increase resources for CSHS personnel to adequately staff and retain professional level in each region
- Put more emphasis on case management

(Data source: Specialist Interviews)

Access to pediatric sub-specialty care:
Mode of service delivery

- Organize service delivery to meet regional needs (fewer specialists are willing to travel to remote areas)
- Increase provider participation
- Expand Eligibility
- Consider Centers of Excellence in NO, Baton Rouge, Shreveport

(Data source: Specialist Interviews)

Privatization

- “Privatization of CSHS is too lofty a goal to achieve without loss of services to some patients.”
- “The state has yet to admit/face the fact that there are very few docs who are willing to take Medicaid patients or CSHS kids, esp. if they are Medicaid. Unless that changes, privatizing doesn't seem like much of an option.”

State priorities for the Title V Block Grant, FFY 2004

CSHS Program

1. Access to pediatric sub-specialty care

Barriers include:

- Transportation
- lack of adequate reimbursement
- lack of sub-specialists
- mode of service delivery

2. Transition to adult services

3. Mental Health services

4. Dental Services



#2. Transition to adult Services for CSHCN

- **SLAITS:** #6 Youth with Special Health Care Needs will receive the services necessary to make transitions to all aspects of adult life including adult health care, and independence (LA 4.5% US 5.8%)
- Physicians interviewed had difficulty transitioning CSHSCN to providers of adult health care.

#3. Mental Health Services

- Mental Health was #8 of the Top Ten Needed Services for LA CSHSCN according to SLAITS data (22.52 %)
- Mental Health was #3 among top 10 Services Needed but Not Received for the LA CSHSCN according to SLAITS data (26.23 %)
- Mental health was a priority mentioned by both physicians and families in the Needs Assessment

#4. Dental or Oral Health

- Dental care was one of the Top Ten Needed Services for LA CSHSCN according to SLAITS data (73.28 %)
- Dental care was # 7 of top 10 Services Needed but Not Received for the LA CSHCN according to SLAITS data (13.55 %) Data source: SLAITS Analysis: Jaime Slaughter

State priorities for the Title V Block Grant, FFY 2004

CSHS Program

1. Access to pediatric sub-specialty care

Barriers include:

- Transportation
- lack of adequate reimbursement
- lack of sub-specialists
- mode of service delivery

2. Transition to adult services

3. Mental Health services

4. Dental Services



Are there any current performance indicators that address these needs?

- Three of the current national performance indicators address these needs
 - % families with adequate insurance
 - % families who report service systems are organized for easy use
 - % of CSHCN who received services necessary for transitioning to adult life

Would we change any performance indicators?

- Add to state performance measures:
“Percent of CSHCN ages 14-18 who have received transitioning services in a CSHS clinic”



A collection of symbolic objects is arranged on a light-colored surface. On the left, a portion of a chessboard with a checkered pattern and several chess pieces is visible. Below the chessboard, there are two ornate medals with star-shaped centers and intricate designs. A pair of round-rimmed glasses with thin frames lies horizontally across the middle. In the bottom left corner, a circular compass with a white face and black markings is partially visible. The background is a plain, light-colored surface.

Adolescent Health Needs Assessment

February 24, 2005

Office of Public
Health

ASHI

Process

- ◆ Research & data
- ◆ OPH Stakeholders (program managers)
- ◆ Refine data
- ◆ Statewide stakeholder meeting
 - Community/faith based orgs., MH, SBHC, JJ, law enforcement, DHH, DOE, Governors Program on Abstinence, GLBT youth
- ◆ Data presentation based on the 21 critical health objectives, 6 risk factors for adolescents
- ◆ Discussion/top needs





Top Priority Needs

Statewide Stakeholder Advisory Group (5)

- ◆ **Mental Health**
- ◆ **Substance Abuse**
- ◆ **Access to Health Care**
- ◆ **Domestic Violence/Child Abuse**
- ◆ **Obesity Prevention**

CHNA Provider Survey (3)

- ◆ **Mental Health**
- ◆ **Substance Abuse**
- ◆ **Access to Health Care**



**National Research
Supports Mental
Health and Substance
Abuse Prevention &
Tx as top adolescent
need**

- ◆ 7%-20% increase in MH disorders over past 20 yrs., 80% do NOT receive Tx
- ◆ Co-occurring conditions (21%); substance abuse (24%-30%)
- ◆ Physician support of MH services in schools
- ◆ Adolescents with access to SBHC MH services are 10x more likely to access MH care than those who do not have access to SBHC.



PC & MH



LA SBHC





Current Performance Measures

- ◆ NPM-16 Rate (100,000) of suicide deaths among youths aged 15-19
- ◆ NPM-08 The rate of birth (1,000) for teenagers aged 15-17
- ◆ **SPM-01 Percent of children enrolled in public school that have access to SBHC services**

Recommendation #1

- ◆ Keep current SPM





Recommendation #2

Mental Health

- ◆ **Priority Need:** Include adolescent access to MH services, including a system to measure mental health access in the State
- ◆ **State Performance Measures:**
 - Increase the number of licensed social workers in schools (not guidance counselors)
 - Decrease % youth feel hopeless/sad everyday/2 weeks, interrupts daily activities (YRBSS)



Recommendation #3

Substance Abuse

◆ **State Performance Measure:**

- Increase the # of 6-12 graders who report not using alcohol and/or illegal drugs in past 30 days (CTC)
- Increase the # of 9-12 graders who report not drinking at least one drink of alcohol in the past 30 days. (YRBSS)



Recommendation #4

Physical Activity/Nutrition

◆ State Performance Measure

- Increase # of 9-12 graders who report at least 30 min of activity of activity in past 7 days. (YRBSS)
- Increase # 9-12 graders reporting healthy diet (fruit, vegetable, milk intake past week) (YRBSS)
- Increase # of days 9-12 graders participate in PE; Increase # of 9-12 graders reporting at least 20 min of activity time in PE. (YRBSS)

Conclusion



- ◆ Add State Performance Measures for...
 - Mental Health
 - Substance Abuse
 - Physical Activity



Perinatal Needs Assessment



February 24, 2005

Process Methodology Overview

- **Data/Statistical Review**
 - Infant and Fetal related mortality, morbidity, demographic, and socioeconomic data compiled
 - FIMR Case Reviews (CRT)
- **Regional Perinatal Needs Assessment Group**
 - 9 OPH regions and City of New Orleans utilized the Perinatal Needs Assessment Template to identify regional perinatal needs.

Top Priority Perinatal Health Needs

1. Decrease fetal and infant mortality and morbidity through expansion of the FIMRI to all regions, increasing and supporting regional MCH coalition building, data sharing, community empowerment, and advocacy aimed at improving birth outcomes and the health of all mothers and children in Louisiana.



Top Priority Perinatal Health Needs

2. Ensure access to quality, comprehensive, coordinated care from quality providers through increased collaboration with other state agencies and programs such as HIV, STD, Family Planning, Tobacco Control, OAD, OMH.
3. Increase access to mental health and substance services for all pregnant and postpartum women



Current Performance Measures Related to the Top Three Needs

1. Decrease fetal and infant mortality and morbidity through expansion of the FIMRI to all regions, increasing and supporting regional MCH coalition building, data sharing, community empowerment, and advocacy aimed at improving birth outcomes and the health of all mothers and children in Louisiana.
- **SPM-11 Rate of infant deaths due to Sudden Infant Death Syndrome (per 1,000 births)**



Current Performance Measures Related to the Top Three Needs

2. Ensure access to quality, comprehensive, coordinated care from quality providers through increased collaboration with other state agencies and programs such as HIV, STD, Family Planning, Tobacco Control, OAD, OMH, Community Care (Medicaid).
 - **NPM-18: Percent of infants born to pregnant women receiving prenatal care in the first trimester**
 - **SPM-02: Percent of women in need of family planning services who have received such services.**
 - **NPM-17: Percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

Current Performance Measures Related to the Top Three Needs

3. Increase access to mental health and substance services for all pregnant and postpartum women
 - **SPM-07 Percent of women who use substances (alcohol and tobacco)**
 - **SPM-06 Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant**

Changes in Performance Measures

3. Increase access to mental health and substance services for all pregnant and postpartum women
 - **Add measure for screening pregnant women for substance abuse (alcohol, tobacco, and drugs).**
 - **Add measure for screening depression and domestic violence among perinatal population.**



**Improving the health of all
mothers and children!**



Priority Needs Initial Evaluation

Subgroup	Number	Health Need	1- Top Priority, definitely include as MCH Priority Need	2- Priority need, most likely include	3- Would like to debate, include if consensus	4- Most likely should not be included	5- Do Not Include, definitely not a priority
Oral Health	I	Increase the number of dental providers treating Medicaid children and Medicaid eligible pregnant women to provide greater access to dental care.	14 people	10 people	5 people		
Oral Health	II	Increase the number of children who receive protective dental sealants through school-based sealant programs.	6 people	15 people	6 people	3 people	
Oral Health	III	Expand the dental practice in Louisiana for dental hygienists to include general supervision in schools, public health clinics, head start programs, day care center and rural health clinics.	5 people	5 people	11 people	6 people	2 people
Child Health	IV	Ensure access to quality, comprehensive, coordinated care from quality providers.	14 people	12 people	2 people	1 person	
Child Health	V	Ensure access to quality, comprehensive mental health services.	17 people	9 people	2 people		
Child Health	VI	Decrease child mortality and morbidity due to unintentional and intentional injuries.	12 people	11 people	7 people	1 person	
CSHCN	VII	Access to pediatric sub-specialty care (transportation, adequate reimbursement, sub-specialists, mode of service delivery)	14 people	7 people	1 person	1 person	1 person
CSHCN	VIII	Transition to adult services	4 people	10 people	7 people	5 people	2 people
CSHCN	IX	Mental Health services	17 people	5 people	3 people	3 people	
Adolescent Health	X	Mental Health (access and receipt of adequate care)	21 people	6 people	1 person	1 person	
Adolescent Health	XI	Substance Abuse	9 people	20 people	4 people	1 person	
Adolescent Health	XII	Access to Health Care	15 people	8 people	4 people		
Perinatal Health	XIII	Decrease fetal and infant mortality and morbidity through expansion of the FIMRI to all regions, increasing and supporting regional MCH coalition building, data sharing, community empowerment, and advocacy aimed at improving birth outcomes and the health of all mothers and children in Louisiana.	14 people	9 people	9 people		
Perinatal Health	XIV	Ensure access to quality, comprehensive, coordinated care from quality providers through increased collaboration with other state agencies and programs such as HIV, STD, Family Planning, Tobacco Control, OAD, OMH.	13 people	11 people	7 people		
Perinatal Health	XV	Increase access to mental health and substance services for all pregnant and postpartum women.	22 people	8 people	2 people		

APPENDIX E

TABLES

TITLE

TABLES 1-----	Consensus of Key Elements of the Needs Assessment
TABLES 2-----	Accessible Medical Care for CSHCN by Region
TABLES 3-----	Average Enrollment of Early Intervention Providers by Region
TABLES 4-----	Access to Care
TABLES 5-----	Access to Care for CSHCN Who Use Medicaid as Reimbursement Source
TABLES 6-----	Distribution of Primary Care Providers Throughout Louisiana
TABLES 7-----	Distribution of Specialty Providers Throughout Louisiana

Consensus of Key Elements of the Needs Assessment

	Involved Physicians	Families	Recommendations
MOST VALUED			
Professional, knowledgeable regional staff	Invaluable resource; knows CSHS disorders management and community resources (Not working as well in Region 2; Region 1 staff may need to be more familiar with resources throughout State)	Usually mentioned as only people in entire state system that are truly helpful	<ol style="list-style-type: none"> 1. Maintain professional level of regional staff. 2. In-service staff in needed areas. 3. Maintain adequate staffing to serve needs of CSHCN exclusively. 4. If expand eligibility, expand care coordination services by qualified staff to families not meeting current income eligibility in already covered diagnostic categories.
MOST NEEDED			
Effective transportation system	Current system contributes heavily to high rate of missed appointments & poor follow-up care by families	Not a functional system	Explore creative, regionally directed transportation alternatives presented at October workshop.
Mental health resources	Wish they were there for children and families they see	Mentioned as often and as passionately as transportation	Consider providing any needed professional development to clinic social work staff so that they could provide counseling to families and children on an on-going basis.
FREQUENTLY REQUESTED			
Better patient education materials	Mentioned need for patients to understand more about importance of proper disease management	Asked for direction to written materials, DVDs, reliable Internet sites on diseases	Charge a work group (including family members) with development of materials and a list of resources.
Outreach to primary care physician offices re: CSHS services	Don't think enough MDs know about program	Think more families need to know about program	<ol style="list-style-type: none"> 1. Outreach efforts should be targeted as much to PCP office staff (business manager & nurse particularly) as to PCP. 2. Outreach contact must be made in person.

Accessible Medical Care for CSHCN by Region

DHH Region	PCPs open to CSHCN	Specialists open to CSHCN	Children with Disabilities 0-20 Years*
1 - New Orleans area	177 (1:170)	146 (1:206)	30,082
2 - Baton Rouge area	156 (1:124)	95 (1:203)	19,312
3 - Thibodaux area	82 (1:145)	67 (1:178)	11,928
4 - Lafayette area	114 (1:162)	63 (1:294)	18,498
5 - Lake Charles area	41 (1:211)	37 (1:233)	8,639
6 - Alexandria area	57 (1:159)	55 (1:165)	9,060
7 - Shreveport area	104 (1:134)	43 (1:323)	13,892
8 - Monroe area	88 (1:114)	58 (1:173)	10,050
9 - Mandeville area	102 (1:117)	67 (1:178)	11,959
Statewide	921 (1:145)	631 (1:211)	133,420

* Number estimated from United States Census

Average Enrollment of Early Intervention Providers by Region

Discipline	Providers/100 Enrolled State Average	Providers/100 Enrolled Regional Average	Enrolled in Early Steps	Licensed
Occupational Therapy				
Region 3	6.16/100	3.7/100	18	66
Region 5		4.3/100	11	45
Region 6		3.8/100	10	69
Region 7		4.3/100	14	156
Physical Therapy				
Region 6	4.87/100	3.4/100	9	100
Region 7		3.1/100	10	249
Region 8		3.3/100	12	132

Access to Care

Practice Type	Accepts Medicaid	No Medicaid OR Unknown	Total
Pediatrician	272 (53%)	241 (47%)	513
Family Practitioner / General Practitioner	331 (51.2%)	315 (48.8%)	646
Total	603 (52%)	556 (48%)	1159

Access to Care for CSHCN Who Use Medicaid as Reimbursement Source

Regions	PCPs open to CSHCN	PCPs open to CSHCN with Medicaid	Specialists open to CSHCN with Medicaid	Children with Disabilities, 0-20 years*
1 – New Orleans area	177	115 (10%)	130	30,082
2 – Baton Rouge area	156	79 (7%)	68	19,312
3 – Thibodaux area	82	37 (3%)	44	11,928
4 – Lafayette area	114	87 (7.5%)	22	18,498
5 – Lake Charles area	41	18 (1.5%)	21	8,639
6 – Alexandria area	57	33 (3%)	26	9,060
7 – Shreveport area	104	42 (4%)	41	13,892
8 – Monroe area	88	47 (4%)	19	10,050
9 – Mandeville area	102	63 (5%)	38	11,959
Statewide	921	521(45%)**	409	133,420

*Number estimated from the United States Census 2000 data

**521 PCPs out of 1159 PCPs Statewide

Distribution of Primary Care Providers Throughout Louisiana (N=1159)

DHH Region	Pediatricians	Family Practitioners	General Practitioners	Total
1 – New Orleans area	134	54	20	208
2 – Baton Rouge area	93	89	22	204
3 – Thibodaux area	46	60	9	115
4 – Lafayette area	52	65	23	140
5 – Lake Charles area	16	42	1	59
6 – Alexandria area	24	53	0	77
7 – Shreveport area	58	78	2	138
8 – Monroe area	36	66	1	103
9 – Mandeville area	54	57	4	115
Statewide	513	564	82	1159

* Estimated response rate = 96.3 %

Distribution of Specialty Providers Throughout Louisiana (N=528)

Specialty	Physicians per Specialty	Indicated Accepted Medicaid Reimbursement
Otolaryngology	83	26
Ophthalmology	54	43
Orthopedics	49	22
Psychiatry	48	14
Surgery	48	22
Urology	42	19
Allergy/Immunology	35	15
Neurology	29	14
Cardiology	28	20
Hematology/Oncology	19	11
Gastroenterology	14	15
Other Specialty	12	10
Endocrinology	11	6
Infectious Disease	11	5
Nephrology	9	6
Neonatology	7	6
Developmental/Behavioral Pediatrics	6	3
Genetics	3	3

APPENDIX F

INTRODUCTION TO BRIEF GENERAL ACCESS SURVEY FOR PRIMARY CARE PHYSICIANS

INTERVIEW CONTENT FOR SPECIALTY PHYSICIANS

Statewide Needs Assessment Family Sessions Script

INTRODUCTION TO

BRIEF GENERAL ACCESS SURVEY FOR PRIMARY CARE PHYSICIANS

- Thank you for your interest in the Statewide Needs Assessment of Medical and Related Health Care Providers for the Delivery of Comprehensive, Coordinated Care for Children with Special Health Care Needs.
- Children's Special Health Services in Department of Health and Hospitals Office of Public Health is charged with developing a long range strategic plan to address the needs of **children with special health care needs** in Louisiana.
- **Your responses to this brief questionnaire are vital for the coordination and enhancement of medical services for children with special health care needs in Louisiana.**
- The following assessment will require a certain level of knowledge about the physician's practice in the areas of reimbursement sources and patient characteristics such as age and diagnosis. **Please identify the appropriate person in your practice or clinic to complete the questions.**
- Please return this survey to us via the email address from which it was sent, that is: mkimbrel@lsuhsc.edu or by faxing to Maxine Kimbrell at (504) 599-1896.

**BRIEF GENERAL ACCESS SURVEY FOR PRIMARY CARE
PHYSICIANS**

Physician Name: _____
Last Name *First Name*

Primary Clinic or Practice Name:

Street Number & Name *City* *Zip Code*

Other clinic locations in which physician practices:

Site 1: Address

Street Number & Name *City* *Zip Code*

Site 2: Address

Street Number & Name *City* *Zip Code*

1. The job title that best matches my role in the physician's practice is:

(1) Physician (2) Nurse (3) Nurse Practitioner
 (4) Physician Assistant (5) Office Manager (6) Billing Staff

If other than physician, please give your name

Last *First*

2. I am providing information on the practice of a:

(1) Family Practitioner (2) General Practitioner (3) Pediatrician

3. About what percentage of your current patients are covered by **private insurance**?

(1) 0 % (2) 1 – 25 % (3) 26 – 50% (4) 51 – 75% (5) > than 75%

4. About what percentage of your current patients are covered by **Medicaid or Community Care**?

(1) 0 % (2) 1 – 25 % (3) 26 – 50% (4) 51 – 75% (5) > than 75%

5. Is your practice open to new patients? (1) Yes (2) On a limited basis
(3) No

6. If your practice is open to patients on a limited basis only (2) above, please answer **Yes or No** to the following statements.

New patients may be enrolled if they are:

a. **New to the practice** AND are covered by **private insurance**.

Yes No

b. Siblings (up to age 18) in an **established family** with the practice AND are Yes
 No covered by **private insurance**.

c. Siblings (up to age 18) in an **established family** with the practice Yes
 No **regardless of reimbursement source (e.g., Medicaid/Community Care, self pay).**

d. Patients (up to age 18 years) covered by Medicaid or Community Care Yes
 No **cannot** be enrolled as the physician's practice is **currently serving the negotiated maximum** of Community Care patients.

7. If your practice participates in **Community Care**, please note which areas of care you have arranged to be provided outside your practice through contract or other arrangement.

(1)None (2) Immunizations (3) Developmental Screening

(4) Immunizations & Developmental Screening

For questions 8-10, children with special health care needs (CSHCN) will refer to:

*****children in your practice with developmental, behavioral, or medical needs or problems that are chronic and significant enough to warrant a referral to a specialist (including therapeutic, educational, or psychological) for consultation or management of problem.**

*****Examples of typical diagnoses for CSHCN include children with developmental delay, cerebral palsy, Down syndrome, genetic disorders, severe diabetes, severe respiratory distress, heart disease, seizure disorders, spina bifida, cystic fibrosis, hearing loss, cleft lip/palate, significant behavioral or emotional disturbance, and autism.**

*****Please note that children with autism or other developmental concerns significant enough to warrant a referral to a specialist such as a therapist or special educator are included as CSHCN.**

8. About what percentage of the physician's pediatric practice are **children with special health care needs (CSHCN)**?

(1) 0 % (2) 1 –10 % (3) 11 – 25% (4) 26 – 50% (5) > than 50%

9. Is your practice open to **new CSHCN**? (1) Yes (2) On a limited basis (3) No

10. If your practice is open to new CSHCN on a **limited basis** only (2) above, please answer **Yes or No** to the following statements.

New CSHCN patients may be enrolled if they are:

a. **New to the practice** AND are covered by **private insurance**. __Yes
__No

b. Siblings who need special health care (up to age 18) in an **established** __Yes
__No **family** with the practice AND are covered by **private insurance**.

c. Siblings who need special health care (up to age 18) in an **established** __Yes
__No **family** with the practice **regardless of reimbursement source**
(Medicaid/Community Care, self pay).

d. **CSHCN** Patients (up to age 18 years) covered by Medicaid or Community __Yes
__No Care **cannot** be enrolled as the physician's practice is **currently**
serving the **negotiated maximum** of Community Care patients.

e. The physician uses **individual discretion** in enrolling new **CSHCN** __Yes
__No children in the practice.

If yes to the above statement, is the enrollment discretion based on any of the following?

1. The nature and severity of the child's condition __Yes
__No

2. Reimbursement options __Yes
__No

3. Other _____

If you are administrative staff reporting on a primary care practice, you have completed the survey! **__THANK YOU**. Please provide the following supplemental questions to the practicing physician.

Through the Early Intervention Institute of Louisiana State University Health Sciences Center, we are collecting general accessibility information on physician practices throughout the State in the initial stage of the study of accessibility, utilization, needs, resources associated with providing care to children with special health care needs.

All identifiable information on this survey will be held in confidence by the LSUHSC Early Intervention Institute and Children's Special Health Services. The collected data will be used only for

the purposes of the study, and will not be released to anyone other than the project staff without the consent of the individual physician. Aggregate data will be used to create a computer generated map of providers by specialty and practice patterns using Geographic Information System (GIS) in order to fully describe the range of services available to children with special health care needs in all areas of the State.

Please return the survey via email to mkimbrel@lsuhsc.edu or fax to Maxine Kimbrell at (504) 599-1896.

Thank you again for your participation in the Statewide Needs Assessment of Medical and Related Health Care Providers for Children with Special Health Care Needs. For the physician reporting on your own practice, please take 5 minutes to respond to the following supplemental questions regarding resources for Children with Special Health Care Needs (CSHCN) in your community.

Physician Name: _____

Last Name

First Name

Primary Clinic or Practice Zip Code : _____

SU1. I would be willing to serve CSHCN or more CSHCN if I had the following supports:

- a. increased reimbursement rates for CSHCN Yes No
- b. additional staff support, either internal or external to my practice Yes No
- c. access to case management services Yes No
- d. training or technical assistance in areas such as care of gastro tubes, catheterization techniques, or referral to community resources for CSHCN & their families. Yes No
- e. access to subspecialty advice Yes No
- f. other (please specify) _____ Yes No

SU2. About what percentage of your practice are children with mental health needs (i.e. social, emotional, or behavioral) characterized as significant/severe feeding disruptions, sleeping disruptions, non-compliance or aggressiveness, separation fear or anxiety, or excessive sadness or crying?

(1) 0 % (2) 1 –10 % (3) 11 – 25% (4) 26 – 50% (5) > than 50%

SU3. If a family in your practice needs any of the following for a child under age 6, there are available resources in your community to which you can refer for effective assistance:

- a. Mental health needs as defined above in question 12 Yes No
- b. Family support to address difficult issues Yes No

- | | | |
|--|------------------------------|-----------------------------|
| c. Parenting issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Health insurance for the child < 6 years of age | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Safe, quality child care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

 THANK YOU for completing this survey.

Through the Early Intervention Institute of Louisiana State University Health Sciences Center, we are collecting general accessibility information on physician practices throughout the State in the initial stage of our study of accessibility, utilization, needs, resources associated with providing care to children with special health care needs.

All identifiable information on this survey will be held in confidence by the LSUHSC Early Intervention Institute and Children’s Special Health Services. The collected data will be used only for the purposes of the study, and will not be released to anyone other than the project staff without the consent of the individual physician. Aggregate data will be used to create a computer generated map of providers by specialty and practice patterns using Geographic Information System (GIS) in order to fully describe the range of services available to children with special health care needs in all areas of the State.

Please return the survey via email to mkimbrel@lsuhsc.edu or fax to Maxine Kimbrell at (504) 599-1896.

Thank you again for your participation in the Statewide Needs Assessment of Medical and Related Health Care Providers for Children with Special Health Care Needs.

INTERVIEW CONTENT FOR SPECIALTY PHYSICIANS

Date: _____ Time: _____ Interviewer: _____

Category

: _____ Safety Net Practice Private Practice Both

MD _____ Specialty Type: _____

Name:

Locations:

Frequency:

I. ORGANIZATION OF SPECIALTY PRACTICE RE: CSHCN

"We wanted to interview you because you are one of the few practices in LA that have been able to successfully combine providing quality care for CSHCN with a busy practice. We believe that your ideas on how you have accomplished this will be VERY helpful as CSHS crafts a long range plan to support health care for CSHCN." "We will start picking your brain by gathering information about how your current practice is set up in reference to CSHCN."

Q1. "First, tell me about how CSHCN get into your practice." (Note: if necessary, prompt to get information on:

For Referral Source, list specialty & practice type rather than name. Categorize as private or safety net practices

For Access, record open-ended responses noting barriers to practice access & associated factors.

Note Community Care restrictions vs. private insurer restrictions

Standard procedure vs. MD discretion in talking new patients.

Adequacy: is amount of contact information adequate or not.

Method: Faxed records, phone calls. Who imparts info (MD, nurse, care coordinator, family, other).

Frequency: Referral only or on-going exchange of information.

Barriers to adequate communication with referral source, if inadequate.

Q2. "What makes it more likely that you would be able to take a patient OR not? (Note: if necessary, prompt with private insurance coverage for your services, relatively slow time at hospital, referring physician is a respected colleague, network or non-networking patient, reimbursement, etc.)

Record enabling factors for new patients and barriers to access.

"Next few question deal with how you have organized your practice to care for CSHCN."

Q3. " About what percentage of your practice (or about how many) are CSHCN?"

Record & check against response on Brief General Access Survey for Specialists.

Q4. " Have you organized your practice for CSHCN differently than for other patients? If yes, How so?" (Note: if necessary, prompt with 1 certain day a week set aside for those more involved patients, longer times allotted for individual appointments, participation in "safety net" clinics, involvement of office staff as care coordinator).

Record open-ended responses, especially note frequency of participation in safety net practices; different appointment schedule. use of office staff for care coordination.

YES NO

Q5. " Can you accept into your practice every CSHCN that calls your office or Do you feel you have to limit the

number of CSHCN in your practice?” (Note: could your prompt with “Why do some docs say MD discretion for whether the practice is open to new CSHCN?”).

Record open-ended responses, especially note factors that cause an MD to impose limit, factors that allow an MD to have no limit, if applicable, strategies to maintain the limit.

YES NO

Q6. “What do you think is average waiting time for an appointment with your for CSHCN?”

Record open-ended responses.

II. ORGANIZATION OF SYSTEM OF CARE IN LA RE: CSHCN

NOTE: These questions are the main focus of the interview

“The next set of questions asks your opinions regarding the current “system provided resources for CSHCN (basically what and who do you rely upon to assist you in caring for these children), what is missing from the current “system”, and how the system can be improved.”

Q7. “What resources do you personally rely upon in providing the care you provide to CSHCN.” (Note: if necessary, prompt with CHSC Clinic, LSUHSC Clinic, respected community provider for a certain diagnostic group, a nurse, social worker, etc.)

Record open-ended responses.

Q8. “How adequate do you think those resources are? Are there barriers to accessing them?.” (Note: if necessary, prompt with frequency, location, ability to contact, personnel, etc.)

Record open-ended responses.

Problem with CSHS is that MD loses control if pt is referred to CSHS for orthodonture services (Note: MD is not board certified plastic surgeon so can't be used by CSHS?)

Q9. “What resources would you like to see available to you in order to continue or improve the care you provide to CSHCCN?” (Note: if necessary, prompt with assistance w/reimbursement/paperwork, local clinic for a diagnostic group, etc.).

Record open-ended responses.

Q10. “What changes in the system would need to occur, if any, for you to be able to care for more CSHCN? What do you see as barriers?” (Note: if necessary, prompt with paperwork different, practice not set up for time, reimbursement struggles, no back up in other specialists, medical home services, etc.).

Record open-ended responses.

Q10a. “Is there any difference in the reimbursement process for different funding sources or your office’s interactions with these funding sources (insurance, Medicaid) that acts as a barrier to your ability to see CCHCN with Medicaid?”

Record specific clinics mentioned and any comments or attitudes.

Q11. “Are you aware of medical clinics in your area that are supported by Children’s Special Health Services?”

YES NO

yes, list specific clinic and identify CSHS or another clinic.

Q12. “Do you have a working relationship with any clinics in your area or another area of the state?”

Record open-ended responses.

Q13. “What needs to happen to have specialty physicians such as yourself participate in a statewide system of care for CSHCN?”

Record open-ended responses. Record willingness to travel, note specific distance or locations, or willingness to travel for specific reasons.

Q13a. “How could you participate in that system of care?”

Record open-ended responses.

Q13b. “Would you be willing to travel to other parishes/regions?”

Record open-ended responses.

Q13c. “How far from your main practice settings are you willing to travel?”

Record open-ended responses.

Q13d. “Would you be willing to participate in a telemedicine model?”

Record open-ended responses.

Q14. “If you could offer any suggestions to CSHS personnel as they craft or refine a model for a statewide System of care for CSHCN, what would they be?”

Additional Notes:

**La DHH/OPH CSHS - LSUHSC Early Intervention Institute
Statewide Needs Assessment Family Sessions Script**

Introduction:

Thank You for taking time out of your busy schedules to join us today. We are here to discuss the health services available for **children with special health care needs** in Louisiana.

Children’s Special Health Services in the Louisiana Department of Health and Hospitals Office of Public Health is in the process of developing a revised plan to meet the needs of **children with special health care needs (CSHCN)** in Louisiana. Children’s Special Health Services has asked the Early Intervention Institute staff at LSU Health Sciences Center to conduct a needs assessment that will help Children’s Special Health Services develop the revised plan. As part of the needs assessment project, we have gathered information from physicians and other health care professionals who provide care to children with special health care needs. We also are interested in gathering information from families about their experiences in obtaining care for their child (children) with special health care needs. That is why we are interested in talking with all of you. We are conducting these sessions to collect information from families about obtaining care for a child with special health care needs. We will talk about such things as how easy it is to find health care providers for your child and your experiences with services for your child with special health care needs. We also would like your ideas about whether and how services should be changed.

ALL information obtained from this session will be held in strictest confidence by the LSUHSC Early Intervention Institute and Children’s Special Health Services (CSHS). The information we collect tonight will be reported in summary form only and will be used only for this project. The information collected will not be released to anyone other than CSHS without the consent of the parent(s) or legal guardian.

GUIDING QUESTIONS TO BE USED DURING FAMILY SESSIONS

Accessibility:1. Please share your experiences finding medical services in your community to meet

your child’s health care needs, including finding primary care and specialty physicians, therapists, etc.? [Additional prompts: Do you have to travel outside of your local area to find medical care for your child? How long do you usually wait to see the doctor? How much time do you spend with the doctor during your visit?]

2. How does the way in which you pay for your child’s medical care affect the type of care your child receives? (Additional prompts: Is it more difficult to find a medical provider without health insurance or with a specific type of insurance?)

Coordinated Care:

3. Who is responsible for keeping track of all the medical services your child needs? Is it you, someone in your family, your doctor, or office staff?

4. In your experience, how well does your doctor or other medical provider communicate with other physicians and services providers that your child sees? (Additional prompts: Does the amount of communication vary depending on whether the doctor is communicating with school personnel, Early Steps staff, social services, or other medical services?)

CSHS Specific Questions:

5. Are you familiar with services provided through LA Office of Public Health Children Special Health Services? If so, please tell us about your experience using these services; please include any suggestions to improve these services.

6. Is accessing special needs services for your child difficult? What things make it difficult to get special health services for your child?

7. What things in your community make it easier to get special health services for your child?

8. Does your child or your family have any needs that have not been or are not being met by the health service providers in your community?

Family-centered: 9. How much is your family included in the decision-making process regarding your child's medical care?

Compassionate Care: 10. Do you feel comfortable discussing your feelings and concerns to your child's medical care providers and are your questions regarding your child's care answered by the providers or office staff?

Current Structure of Services For Child's Special Health Care Services:

11. What sources do you use most often to pay for your child's medical care? (e.g., Private Insurance Carrier, Medicaid, LACHIP, Out of pocket, Other) (Only ask if this information has not become apparent during the earlier discussion.)

12. Does your child currently have a primary care physician, specialist physician or nurse etc. who provides your child's ongoing medical and well-child care? How did you locate this provider?

13. Please describe the location(s) where your child receives special health care services. (Only ask if this has not been covered during early discussions.)

**La DHH/OPH CSHS - LSUHSC Early Intervention Institute
Statewide Needs Assessment Family Sessions**

Facilitators should complete information in the aggregate for families who participated in the session.

Region in Which Session was Conducted _____

Number of families who participated in session _____

Range and mean age of children with special health care needs whose families participated in the session. Range = _____ to _____.

Mean age = _____ (calculate by asking each family to share their child's age, sum all ages reported, and divide by the number of ages provided)

List the special health care diagnosis/condition of the child whose family member participated in the session [DO NOT INCLUDE ANY NAMES OF CHILDREN OR FAMILIES, JUST LIST DIAGNOSES/CONDITIONS]. If a condition is named more than once by different family members, please indicate (e.g., Autism = 2):

List the number of families by race/ethnic status who participated in the session:

- _____ White Non-Hispanic
- _____ Hispanic
- _____ African American
- _____ Native American/American Indian/Alaskan Native
- _____ Asian
- _____ Bi-racial
- _____ Middle Eastern
- _____ Other