

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

2.1. Needs Assessment of the Maternal and Child Health Population

2.1.1 Needs Assessment Process

Overview

During 2004 and 2005, in anticipation of the FY2006 Maternal and Child Health Block Grant (MCH BG) application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions, and professional judgment from those working in the field. The needs assessment process and resulting priorities are more fully described below and have been used to guide Ohio's MCH BG-funded activities and grant applications for 2005-2006.

Process to Establish Title V FFY 2006 MCH Needs and Priorities

Planning for the 2006 MCH needs assessment started in October 2003 with an evaluation of the previous needs assessment by the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) chiefs (Division chief, seven Bureau chiefs, and the DFCHS Medical Consultant.) An evaluation tool was developed to assess what went well and what could have been done differently given the experience with the previous five-year needs assessment conducted in 1999/2000. Major changes recommended to the process for the 2006 needs assessment included the following:

- Determine better way to include outside partners.
- In regard to priority setting, use more "gut" reactions instead of number scores and select fewer priorities that are data driven.
- Allow more time for intervention and implementation planning, including a review of "best/promising/evidence-based" practices.
- Build evaluation into each phase of the needs assessment.

The DFCHS MCH BG and Needs Assessment Coordinator attended a regional federal Maternal and Child Health Bureau-sponsored training on Needs Assessment in St. Louis in February 2004. Many ideas on how to involve partners and how to structure the prioritization process were gained at that training and were incorporated into the Ohio process.

Model for the Needs Assessment: The Ohio needs assessment was based on the community needs assessment model developed by ODH through collaboration with local health departments. That process was documented in *Ohio's Public Health Plan*, released in 1997. The 9-step process is illustrated as a community needs assessment "wheel." Steps 1 through 6 represent the needs assessment phase, steps 7 through 8 are the planning phase, and step 9 is evaluation. The Ohio plan recognizes the need to do analytical studies to ascertain root causes of problems and includes a data analysis agenda

to be carried out in the years between the needs assessments required for the MCH Block Grant. The data analysis/research agenda is outlined in section 3.2.2.

Data Collection: DFCHS chiefs decided to put less emphasis on data collection this cycle since so much time was spent on it in 1999/2000. The charge was to update data indicators DFCHS

Community Health Improvement Cycle



already had in the previous MCH BG *Data Collection Plan* and to spend less time seeking out new data. More emphasis was to be placed on planning interventions since that step was shortchanged in the previous Needs Assessment due to time limitations.

In addition to updating secondary data, primary data (qualitative) were collected through a survey of local public health providers and focus groups of families of Children with Special Health Care Needs (CSHCN). The survey and focus groups are listed below.

- *Local Public Health Providers:* A survey was sent electronically to all local health districts, Child and Family Health Services Projects and WIC projects requesting feedback on progress in regard to the top 10 priorities identified in the last Maternal and Child Health Needs Assessment (2001). They were also asked four questions designed to elicit their opinions about other health issues that affect families and children in their communities.
- *CSHCN Focus Groups:* In collaboration with the Foundation for Accountability's Child and Adolescent Health Measurement Initiative, ODH and the Ohio Department of Job and Family Services conducted nine statewide focus groups of parents/caregivers of CSHCN who were enrolled both in the Title V Children

with Medical Handicaps program and Medicaid. The purpose of the Ohio Medical Home Focus Group Project was to learn how to improve services for CSHCN and increase access to health care that functions as a medical home.

Partners: DFCHS chiefs recommended that outside partners or stakeholders have a higher level of involvement in the FY 2006 needs assessment than in the previous cycle. Stakeholders were chosen to meet in four population groups consistent with 1) how MCH BG funds are required to be divided: 30 percent for CSHCN; 30 percent for children and adolescents; and 40 percent for all other activities, including mothers/infants; and 2) a parallel needs assessment being conducted for early childhood for the Bureau of Early Intervention Services' State Early Childhood Comprehensive Systems planning grant.

Thus there were four external stakeholder groups:

- Women's Health, Birth Outcomes, and Infant Health
- Early Childhood (aged 28 days to five years)
- School Age and Adolescents (aged five to 21 years)
- CSHCN

Potential stakeholders were identified from the MCH Advisory Committee and by asking each DFCHS Bureau chief and their designees to supplement the MCH Advisory Committee list with other partners representing their issue/population area. This resulted in four lists of 25-30 names from other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers. A letter of invitation was sent to each stakeholder candidate, asking them to participate in a kickoff meeting and two other meetings to discuss and prioritize issues. Stakeholders self-selected themselves into a group that interested them. There were a total of about 20 external stakeholder participants in each group – some participating in just one meeting and some in all.

Prioritization Methods and Meetings: Prioritization was accomplished in two phases.

Phase 1

Phase 1 included the work of the four stakeholder groups, who provided input through a series of meetings and electronic communications with the DFCHS, beginning with a kickoff meeting in July, 2004. At this meeting, DFCHS staff presented stakeholders with an overview of the MCH Needs Assessment, Ohio's process, and timeline. Participants were given lists of indicators for each of the four issue groups for which data were available. They were instructed to review materials and provide feedback about indicators or issues that were omitted, redundant or no longer necessary. At this time, an overview of the Q-sort process was also given and dates were set for the four issue groups' first meetings. Stakeholders were asked to use the Q-sort process as a way to begin identifying priorities for their issue areas. The Q-Sort methodology is a technique for identifying priorities among competing needs by sorting needs into groups of the most important to the least important.

After receiving feedback from stakeholders, DFCHS staff compiled a comprehensive list of health indicators, with data and other background information as available. The list of indicators was sent to each of the participants with instructions for completing a Q-sort of

the issues/indicators. Participants were instructed to return their individual Q-sorts for analysis by ODH personnel in late August 2004. This was considered the *first round of prioritization*. Stakeholders were asked to consider the impact or importance of the issue, the susceptibility to intervention and the practicality of monitoring and addressing the need in designating priority levels for each issue/indicator.

Needs with good agreement among stakeholders were to be set aside as high, medium, or low. The needs that merited discussion were those for which there was not good agreement.

The four issue groups met in September and early October 2004 to review the data and Q-sort analysis summaries. During these facilitated (an outside, contracted facilitator was used) *second round of prioritization*, one-day meetings, most of the groups examined the issues in which there was more variation in responses. Participants also identified other issues that were then included in the group discussions. In some groups, issues were combined to create a more comprehensive issue. This aided in reducing the number of issues and indicators to a more manageable list. Participants then were asked to prioritize the issues for their group by placing a sticker next to the issues they felt were most important. In most cases, issues not receiving any votes were then omitted from the list for subsequent consideration. During this round of prioritization, participants were asked to consider the importance of the issue; feasibility would be considered at a later step. At the conclusion of this round, participants were asked what types of information would be helpful to them in determining the ability of ODH to impact an issue. This additional data/information was then provided to participants prior to the next round of prioritization.

The *third round of prioritization* for each of the issue groups occurred between late October and early December 2004. One-day meetings were held for each of the four stakeholder groups. Beginning with the priority ranking of the second round, the facilitator introduced the tasks for the day using the first issue as a model. Participants were asked to generate possible solutions within strategy/approach/solution areas outlined on a provided worksheet. Group members were then asked to vote for the solutions they felt were of the highest priority and that ODH could address. Group members were next asked to rate the top two solutions with regard to effectiveness, efficiency (including cost), and acceptability using a response set of low, medium, and high. Participants then re-examined the priority of the issues based on the feasibility of the solutions provided using a High (3), Medium (2), Low (1) response set. In some issue groups, new rankings of the priorities based on feasibility/promising practices emerged. These rankings were then forwarded to DFCHS for their use in selecting priorities.

Phase 2

Phase 2 included the deliberations of the DFCHS administrators (mostly DFCHS Division and Bureau Chiefs), who began a series of meetings in mid-December 2004 to prioritize and discuss issues identified by the stakeholder groups. From these priorities, they would recommend ten priorities for the MCH BG and suggest new state performance measures. Prior to the first meeting, each of the Chiefs reviewed the

priorities identified by the four stakeholder groups and identified their individual top 10 issues. Next, a rough analysis was conducted. For this analysis, each issue identified as a priority by a chief was scored with a point system devised by the contracted facilitator. Using the issues that received the most points as a starting place for discussion, the chiefs felt some of the issues were correctly identified, but wanted to tweak some of the phrasing and ensure the issues were comparable. After identifying the top ten priorities, the next step in this process was to examine the state performance measures and national performance measures in the current MCH BG to determine if they mapped to the new list; if they were worded in the manner the Chiefs wanted for the BG application; and whether they were still appropriate.

Next, the Chiefs decided to examine each performance measure for its appropriateness for the current issue, wording, and the data sources that could be used to measure the issue. Finally, since more than 10 potential new state performance measures were identified, some were omitted after discussion of the importance, relevance, and the ability of ODH to do something about it.

The results of the prioritization process are reported in Section 4.B.

Once the priority health issues were identified, the DFCHS workgroups undertook a process to identify the need for services at different levels of the pyramid in order to address these needs. The results of this process are reported in Section 4.B.

2.1.2 Needs Assessment Content

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

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

A. Demographic

A.1 Geographic Description

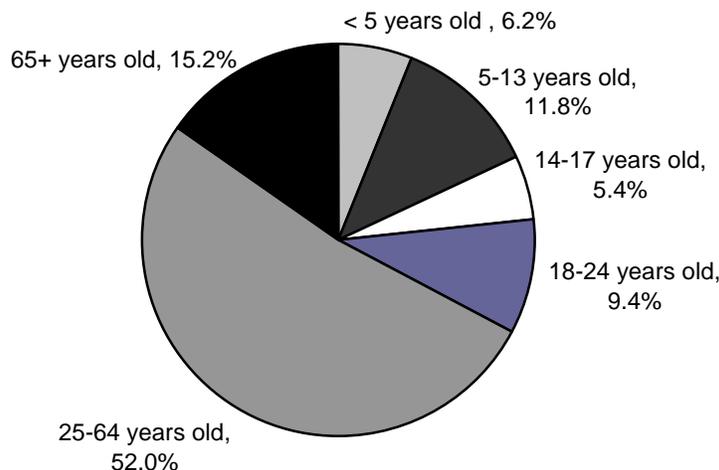
Ohio has a land area of 40,953 square miles and is divided into 88 counties. Ohio has no geographical barriers; its accessibility has been perhaps the key factor in its growth. A well-developed interstate highway system interconnects the state: interstate highways 70, 76, 80, and 90 run east and west,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

A.2 Population

Overall: The 2003 estimated population of Ohio was 11,435,798, giving the state a population density of 279.2 people per square mile.¹ Ohio ranks as the seventh most populous state among the fifty states and the District of Columbia. By 2030, Ohio is projected to remain the seventh most populous state, with an estimated 12.3 million people.² Between 2000 and 2030, the state expects to gain 254,617 people through migration.³

Females in Ohio accounted for 51.3 percent of the total population in 2003. Twenty-five to 64- year-olds make up 52 percent of the female population. Women age 65 years and over comprised 15.2 percent of the female population. Females 18-24 years of age make up 9.4 percent, females 5 to 13 years of age make up 11.8 percent and females younger than five make up 6.2 percent of the female population.

Ohio Female Population by Age, 2003



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

Geographic Distribution: An estimated 81.1 percent of the population in Ohio resides in metropolitan areas. The ten counties with the largest populations are Cuyahoga, Franklin, Hamilton, Montgomery, Summit, Lucas, Stark, Butler, Lorain, and Mahoning. The Ohio Family Health Survey categorized the 88 counties as metropolitan (12), suburban (17), rural non-Appalachian (30), and Appalachian (29).

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

² "Projected Population: County Totals," Ohio Department of Development, Office of Strategic Research, 27 January 2004, <http://www.odod.state.oh.us/research/FILES/P200/countytotals.pdf>, 1.

³ Ohio Department of Development, Office of Strategic Research (JH), March, 2003.

Race/Ethnicity: Since 1990, Ohio has had an increase in ethnic minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origin, accounted for 15 percent of Ohio's net growth since 1990. Likewise, since 1990, the black population accounted for 29 percent of Ohio's net growth. The three largest groups of Asian populations in Ohio are of Indian, Chinese, and Korean origin. In 2000, 2.2 percent of Ohio's population was composed of persons identifying themselves as being of two or more races.⁴

In 2003, 85.4 percent of the population was white, 11.7 percent was black, 1.4 percent was Asian or Pacific Islander, and 0.2 percent was Native American and Alaskan Native. These groups may also include Hispanics who made up 2.0 percent of the population.⁵ The relative percentages of different racial/ethnic groups are not projected to change significantly by 2030.

Age: Ohio's age distribution has gone through a fundamental change in the past 10 years. The first half of the baby-boom generation has moved into empty-nester household stage. The 65 and over age group has experienced the slowest growth in three decades due to inclusion of smaller WWII veteran and Great Depression cohorts. Gaining only 3.2 percent growth statewide, growth in the under-18 age group is limited to areas of larger total population growth. Ohio births have declined from the baby boom high of about 243,000 in 1957 to just over 147,000 in 2002.⁴

In 2000, the population of children through age 21 was 3,536,123, representing 31 percent of the total population.⁶ Youth as a percentage of the state population is projected to continue to decrease. This trend is consistent with the national trend.

A.3 Birth Rate

Overall: According to Ohio Department of Health Vital Statistics, the crude birth rate decreased slightly from 13.4/1,000 total population in 1999 to 12.9/1,000 total population in 2002. The number of resident live births in 2002 was 147,832.⁷ Unwed mothers accounted for approximately 35 percent of the live births in 2002. The number of white resident live births in 2002 was 121,956 with 34,934 (28.6 percent) being to unwed mothers. The number of black resident live births in 2002 was 22,513 with 16,830 (74.8 percent) being to unwed mothers.

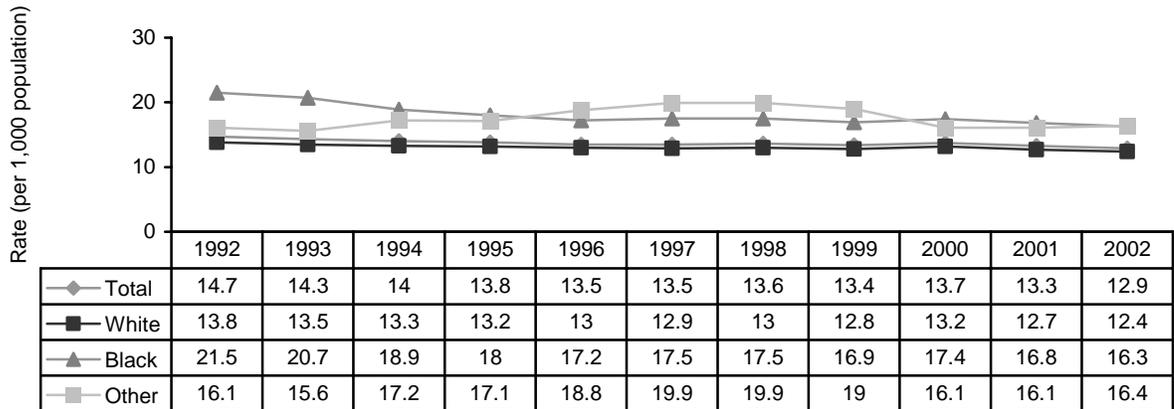
⁴ "Ohio 2000 Demographic Profile: Charting the Change, May 2001," Ohio Department of Development Office of Strategic Research, Population Series.

⁵ Population Division, U.S. Census Bureau.

⁶ U.S. Census Bureau, Census 2000.

⁷ Vital statistics, Annual County birth summary, 2002, Ohio Department of Health, Center for Vital and Health Statistics.

Ohio Rate of Live Births by Race, 1992 - 2002

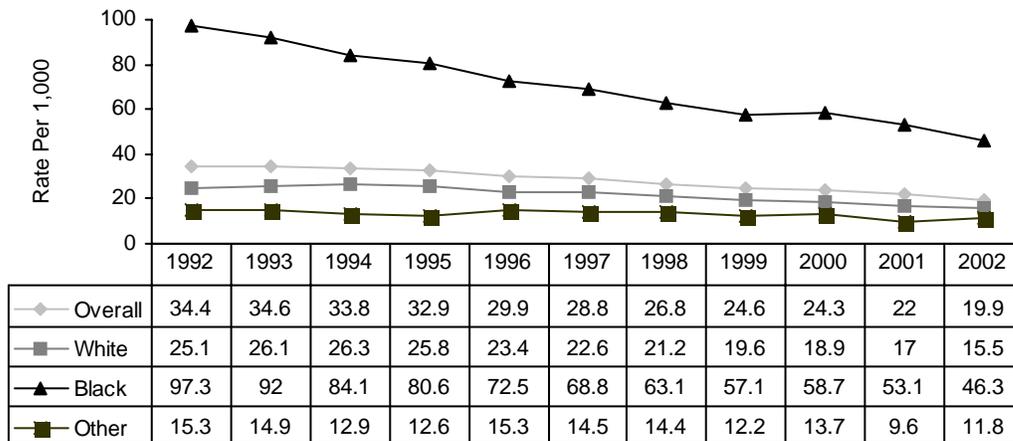


Data Source: Ohio Vital Statistics

Teen: Ohio teenage mothers (ages 15 to 17 years) had a birth rate of 19.9 per 1,000 live births in 2002. The U.S. teen birth rate in 2002 was 23.2 per 1,000 live births. For the same year, the birth rate in Ohio was three times higher for black teens age 15 through 17 years (46.3/1,000) than for white teens age 15 through 17 (15.5/1,000). Ohio's teen birth rate ranks 26th among the 50 states for teens between 15 and 17 years of age. Ohio's teen birth rate parallels the national trend. The U.S. teen birth rates have shown a significant decline since 1991. The birth rate among teens ages 15 to 17 years has decreased from 38.6/1,000 in 1991 to 23.2/1,000 in 2002. Ohio's birth rate among teens ages 15 to 17 years has also decreased since 1992 from 34.4/1,000 to 19.9/1,000 in 2002.⁸

⁸ Ibid; Ohio Teen Birth Rate by Race: Age 15-17; 1992-2002, Ohio Department of Health Data Warehouse.

Ohio Teen Birth Rate by Race: Age 15-17, 1992 - 2002



Data Source: Ohio Vital Statistics

A.4 Family Characteristics

Overall: Ohio has 4,445,773 total households. A household consists of all the people who occupy a housing unit. A household may include the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. There are two major categories of households, "family" and "non-family". Sixty-seven percent of Ohio households are family households; approximately 47 percent of family households include children under the age of 18 years. Seventy-six percent of family households are married-couple families; the rest are single-parent households (24 percent).⁹

Families Headed by Single Parents: Twenty-four percent of all family households in Ohio are single-parent households. Approximately 67 percent of these single-parent households are female householders with no husband present. The percentage of births to single mothers has increased from 34.0 in 1997 to 35.3 in 2002.¹⁰ The number of single mothers in Ohio has increased 2.5 times since 1960, to 536,878 in 2000.¹¹ In Ohio, 74.8 percent of all black births were to single mothers whereas 28.6 percent of all white births were to single mothers according to 2002 records.¹²

⁹ U.S Census Bureau, Census 2000.

¹⁰ Ohio Vital Statistics.

¹¹ "Ohio 2000 Demographic Profile: Charting the Change, May 2001"; U.S Census Bureau, Census 2000.

¹² Ohio Vital Statistics.

A. 5 Economic Indicators

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

Labor Force: The percentage of Ohio women who work continues to increase, with nearly 61 percent of the female civilian population over age 16 participating in the labor force in 2002, up from 57 percent in 1992. The percent of women in the labor force is projected to continue to increase over the next 10 years.

Ohio Labor Force Estimates*: 1992, 2000, 2012				
	Civilian Noninstitutional Population 16 and over	Civilian Labor Force	Labor Force Participation Rate	Share
1992				
Total	8,341,000	5,489,000	65.8%	100.0%
Male	3,970,000	2,996,000	75.5%	54.6%
Female	4,371,000	2,494,000	57.1%	45.4%
Nonwhite	898,000	550,000	61.2%	10.0%
2002				
Total	8,701,000	5,828,000	67.0%	100.0%
Male	4,133,000	3,058,000	73.9%	52.4%
Female	4,568,000	2,772,000	60.7%	47.6%
Nonwhite	1,182,000	781,000	66.1%	13.4%
2012				
Total	9,258,000	6,239,000	67.4%	100.0%
Male	4,457,000	3,261,000	73.2%	52.3%
Female	4,801,000	2,978,000	62.0%	47.7%
Nonwhite	1,537,000	1,055,000	68.6%	16.9%

*Data for 1992 and 2002 are from annual issues of the Geographic profile of employment and unemployment, U.S. Department of Labor, Bureau of Labor Statistics; BLMI projections for 2012

Education: Ohio Asian women lead in pursuing higher education with 51.2 percent holding at least a bachelor's degree compared with 20 percent of non-Hispanic white women, 12 percent of black women, and 15.6 percent of Hispanic women. For the younger age groups—ages 25 to 34—the educational levels of women are higher than men. Roughly 27 percent of women in this age group have completed college compared with 24.8 percent of men.¹³

Poverty Levels: In 2003, 12.1 percent of Ohioans were living below the federal poverty level. This is slightly lower than the national rate of 12.4 percent. The poverty level, however, varies greatly by county. The five counties with the highest poverty rates were

¹³ National Center for Education Statistics <http://nces.ed.gov/help/sitemap.asp>

Athens (27.4 percent), Vinton (20.0 percent), Meigs (19.8 percent), Scioto (19.3 percent), and Lawrence (18.9 percent). The five counties with the lowest poverty rates were Delaware (3.8 percent), Warren (4.2 percent), Geauga (4.6 percent), Union (4.6 percent), and Medina (4.6 percent).

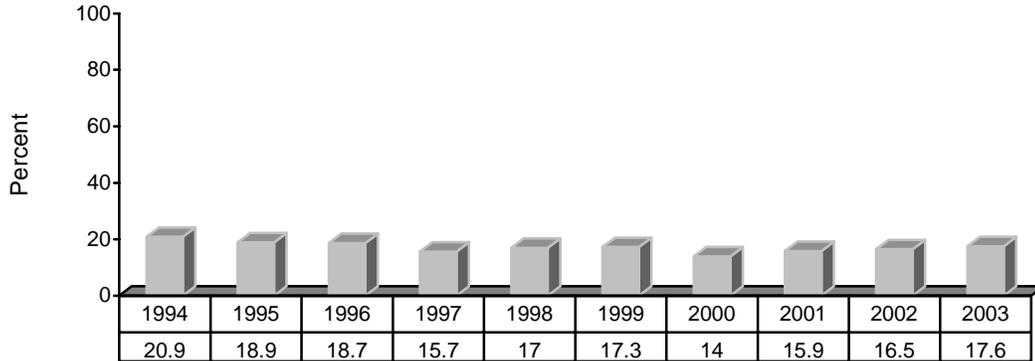
Within metropolitan areas, the average poverty rate for Ohio cities was 18.9 percent, compared to 6.5 percent for areas outside of the central cities. Eight central cities had poverty rates greater than 20 percent: Cleveland (26.3 percent), Bowling Green (25.3 percent), Kent (25.2 percent), Youngstown (24.8 percent), Dayton (23.0 percent), Lima (22.7 percent), Cincinnati (21.9 percent), and Steubenville (20.4 percent). The counties with the highest poverty rates are located in Appalachian Ohio. Two-thirds of Ohio's poor are white, yet this racial group has the lowest poverty rate—8.2 percent in 2000. The poverty rate was 26.5 percent for blacks, 12.9 percent for Asian and Pacific Islanders, and 20.3 percent for Hispanics.

The risk of poverty varies by the type of household in which people live and whether they have children. Families with children are at greater risk of being poor than families with no children. Among married couples or families headed by a man with no spouse present, those with children had poverty rates less than 8 percent in the last four censuses. The risk among families headed by a woman with no spouse present is much larger. Those with no related children had poverty rates only one-third to one-fifth the rates of those with at least one child. The age groups now characterized by higher-than-average poverty rates are children (ages 0 to 17 years). The higher poverty rate for children may be partly explained by the larger proportion of one-parent families.

Children are the poorest people in Ohio: 17.6 percent of children 19 and younger lived below the poverty level in 2003. The poverty rate for the total population decreased from 1994 (14.2 percent) through 2003. Overall, the rate for children 19 and younger decreased from 1994 (20.9 percent) through 2003. Of the 280,116 families currently estimated to be below the poverty level, 79.1 percent of those families have related children younger than 18 years of age. There were 161,526 families with female head of households that fell below the federal poverty level in 2003. Approximately ninety percent of families with female head of households had related children 18 years of age and younger.¹⁴

¹⁴ U.S. Census Bureau, American Community Survey Office, last revised Thursday September 09, 2004.

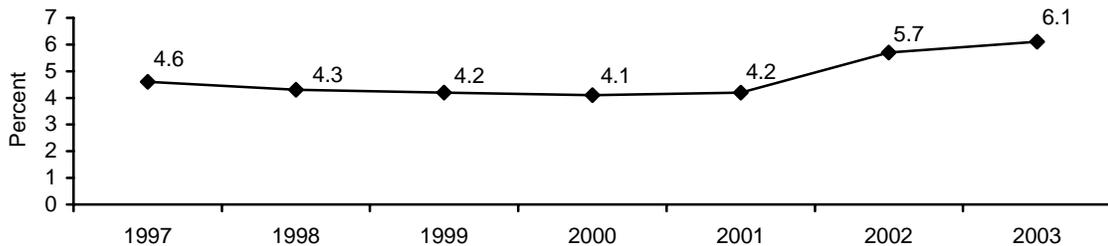
Ohio Poverty Level Ages 0 - 19, 1994-2003 (Estimated)



Data Source: U.S. Census

Unemployment: The unemployment rate in Ohio was 6.3 percent in October 2004, which was higher than the national average of 5.5 percent for the period. Since October 2003, Ohio's unemployment rate has risen slightly, which is inconsistent with the national trend. Since October 2003, the nation's unemployment rate has continued to decrease. Ohio's unemployment rate has continually increased since 1994 from 5.5 to 6.1 percent in 2003.¹⁵

Ohio Unemployment Rate, 1997 - 2003



Data Source: Ohio Department of Job and Family Services, Bureau of Labor Market Information

Food Stamp Recipients: In 2003, Ohio had 273,000 family households receiving food stamps. The total monthly issuance of food stamp benefits was \$68,265,000. Approximately 50 percent of participating family households had children and 35.4 percent were single parent households. The distribution of participating households by poverty status based on gross countable income as a percentage of the poverty guideline was: 36 percent of participating households had a poverty status of 50 percent or below, 52.8 percent had a poverty status of 51 percent to 100 percent, and 11.2 percent of the

¹⁵ Ohio Department of Job and Family Services, Bureau of Labor Market Information, prepared in cooperation with the Bureau of Labor Statistics, U.S. Department of Labor.

households were classified as having a poverty status of 101 percent or more. The number of white Ohio households receiving food stamps in 2003 was 223,000 or 60.1 percent of all recipients of food stamps; black households receiving food stamps in 2003 was 121,000 or 32.7 percent; and Hispanic households receiving food stamps was 10,000, or 2.8 percent. The distribution of participants by age for 2003 was: 17.6 percent preschool age children, 31.5 percent school age children, 42.8 percent non-elderly adults, and 8.1 percent elderly adults. In 2003, the average monthly number of recipients receiving Food Stamps was nearly 900,000. The average monthly issuance was \$85.00.¹⁶

Welfare Recipients: In 1996, the U.S. Congress eliminated the Aid to Families with Dependent Children program and replaced it with the federal Temporary Assistance for Needy Families (TANF) program. Ohio created two separate programs from within TANF: Ohio Works First (OWF) and Prevention, Retention and Contingency (PRC). Ohio Works First is a state-supervised, county-administered program that provides time-limited cash assistance to needy families with (or expecting) children. This assistance provides work, training and other support services they need to attain permanent self-sufficiency while meeting the family's on-going needs. PRC is a county-administered, state-supervised program that provides on-going services and non-recurring short-term benefits to promote self-sufficiency.¹⁷

As of June 2004, there were over 194,000 individual TANF recipients in the state of Ohio. Of these recipients, Ohio averaged about 194,000 cash assistance participants per month (OWF) of which 41,000 were child-only cases. Medicaid eligibility is aligned with OWF eligibility so all participants have access to quality health care.¹⁸

Children and Adults on Public Insurance: In 2004, children and adults in Ohio relied primarily on employment-based insurance for health services access. About 1.8 million (64 percent) of Ohio children and 5.3 million adults (63 percent) received coverage though a present or former employer or through a relation with job-based coverage. The proportion of Ohioans without health insurance has fallen since 1998 from 11.2% to 10.7%. The uninsured in Ohio are primarily adults. Approximately 12 percent of Ohio adults, just over 1 million people, lack health insurance. Only about 5 percent of children fewer than 18 years of age, by contrast, lacked health insurance coverage, or fewer than 200,000 individuals. Ohio Medicaid covered nearly 800,000 low-income or disabled children, over 27 percent of all children in Ohio.¹⁹

Racial disparities in source of coverage are apparent among children. Although not significantly more likely than white children to be uninsured, over half of black children rely on Medicaid coverage, compared to just over 20 percent of white children. White

¹⁶ Ohio Job and Family Services, 2003 Annual Report Accomplishments; "Characteristics of Food Stamp Households: Fiscal year 2003," United States Department of Agriculture Food and Nutrition Service 2004, Report No. FSP-04-Char.

¹⁷ Temporary Assistance to Needy Families (TANF) Program State Title IV-A Plan, Ohio Department of Job and Family Services, October 1, 2004.

¹⁸ www.jfs.ohio.gov/0001infocenter.stm#reports/.

¹⁹ <http://www.jfs.ohio.gov/ohp/reports/documents/OhioInsuranceCoverage.pdf>.

children are twice as likely as black children to be covered by job-based insurance. Job-based coverage for children increases and Medicaid coverage declines with age of the child. Medicaid covers one-third of all newborns, while that coverage declines to less than one fourth of 13-17 year olds ²⁰

See further discussion of Health Insurance Coverage issues Section 2.1.2.3, A.1

Ohio Medicaid Coverage in 2003			
Age Group	Total Population	Medicaid Eligible	Percent Medicaid
0-4	740,300	335,598	43.3%
5-18	2,235,616	689,698	30.9%
19-44	4,133,101	539,301	13.0%
45-64	2,810,010	165,022	5.9%
65-84	1,320,372	110,255	8.4%
85+	196,400	41,766	21.3%
Total	11,435,799	1,881,640	16.5%
Male	5,566,215	784,861	14.1%
Female	5,869,584	1,096,779	18.7%
White	9,567,713	1,246,987	13.01%
Black	1,316,803	560,761	42.6%
Hispanic	232,448	56,998	24.5%

Data Source: http://www.jfs.ohio.gov/ohp/bhpp/reports/omr2005/OMR_SFY_2003.pdf (data from 2003)

B. Maternal and Infant Health Status

B.1 Mortality

Infant Mortality

Description: Infant mortality is the death of an infant under one year of age. The leading causes of infant death in Ohio are disorders related to congenital anomalies, short gestation, and Sudden Infant Death Syndrome (SIDS).

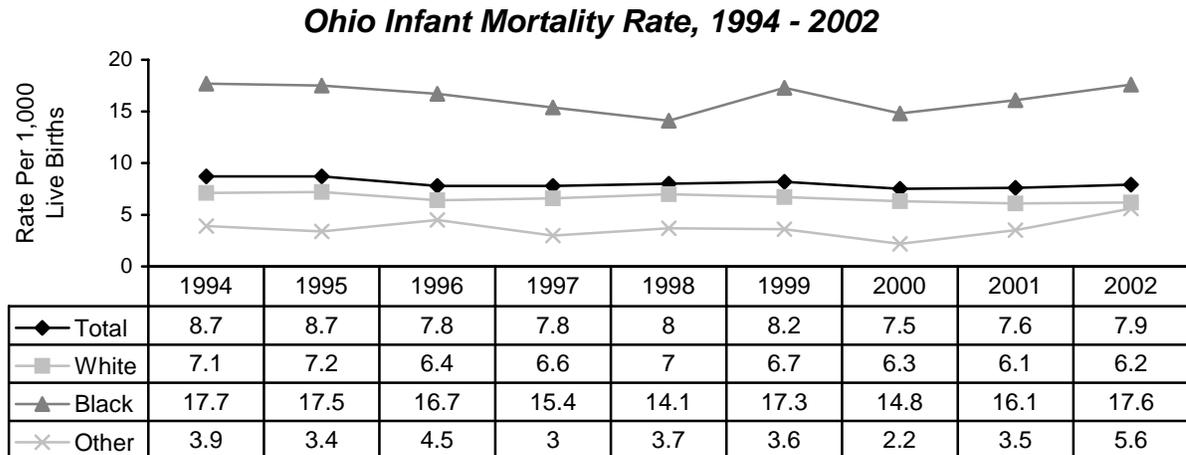
Quantitative Data: The infant mortality rate (IMR) is the number of deaths per 1,000 live births in a given year. In 2002, 1,170 infants in Ohio died before they reached their first birthday. This represents an IMR of 7.9, which is higher than the national rate of 7.0. The Ohio rate is higher than the Healthy People 2010 target rate of 5.0. The rate has decreased since 1994, when it was 8.7. The leading cause of infant mortality in the state of Ohio in 2002 was congenital malformations, deformations, and chromosomal abnormalities (233 infant deaths). Disorders related to short gestation and low birth weight, not elsewhere classified, resulted in the second highest number of infant deaths (182). Sudden Infant Death Syndrome caused 104 infant deaths in 2002.²¹

Racial/Ethnic Disparities: The 2002 IMR for black infants was nearly three times the rate for white infants (17.6 compared to 6.2). This disparity is consistent with national

²⁰ <http://www.jfs.ohio.gov/ohp/reports/documents/OhioInsuranceCoverage.pdf>

²¹ Ohio Vital Statistics.

data. Paralleling the national trend, the black IMR in Ohio between 1994 and 1998 had been declining. In 1999, however, there was a significant rise in the black IMR in Ohio, from 14.1 in 1998 to 17.3. A slight decrease in black IMR occurred in 2000, but otherwise the IMR has continued to rise. The white IMR has varied. From 1996 to 1998, the white IMR rose steadily; from 1998 to 2001 it slightly dropped each year. From 2001 to 2002 there was a 0.1 increase in the white IMR.²²



Data Source: Ohio Vital Statistics

Perinatal Mortality

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

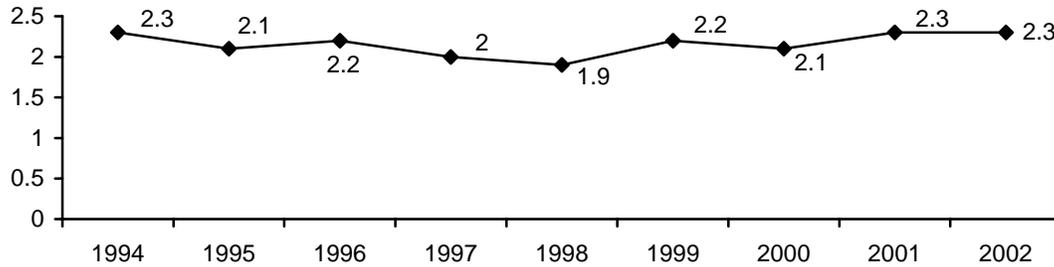
Quantitative Data: In Ohio, the perinatal mortality rate is the number of fetuses/infants who die during the perinatal period per 1,000 live births and fetal deaths in a given year. This definition is different from the national definition and the Healthy People 2010 (HP2010) definition, making comparisons difficult. In Ohio, fetal death is defined as death of a product of conception of at least 20 weeks gestation prior to its complete expulsion or extraction from its mother (including induced abortions). In 2002, the perinatal mortality rate was 8.1. From 1995 to 1998, the rate declined; in 1999 the rate had a slight increase from the previous year (10.9 to 11.2). From 1999 to 2000, the rate decreased again, and in 2001 the rate slightly increased (9.7 to 10.5). From 2001 to 2002 the rate decreased from 10.5 to 8.5.²³

²² Ibid.

²³ Ibid.

Racial/Ethnic Disparities: In 2001, Ohio’s black/white perinatal mortality ratio was 2.3. This compares to a ratio of 2.2 for the nation. Trends for the Ohio ratio of black/white perinatal mortality remained stable, only increasing from 2.1 in 1991 to 2.3 in 2001. This trend paralleled the nation’s trend. However, the Healthy People 2010 goal of a ratio of 1 between black and white perinatal mortality rates has not been met.²⁴

Ohio Ratio of Black Perinatal Mortality Rate to White Perinatal Mortality Rate



Data Source: Ohio Vital Statistics

Neonatal Mortality

Description: Neonatal mortality is the death of an infant under the age of 28 days. Nearly two-thirds of all infant deaths occur during the neonatal period. The leading causes of neonatal deaths are disorders related to short gestation and low birth weight (LBW), congenital anomalies, respiratory distress syndrome, and complications of pregnancy.

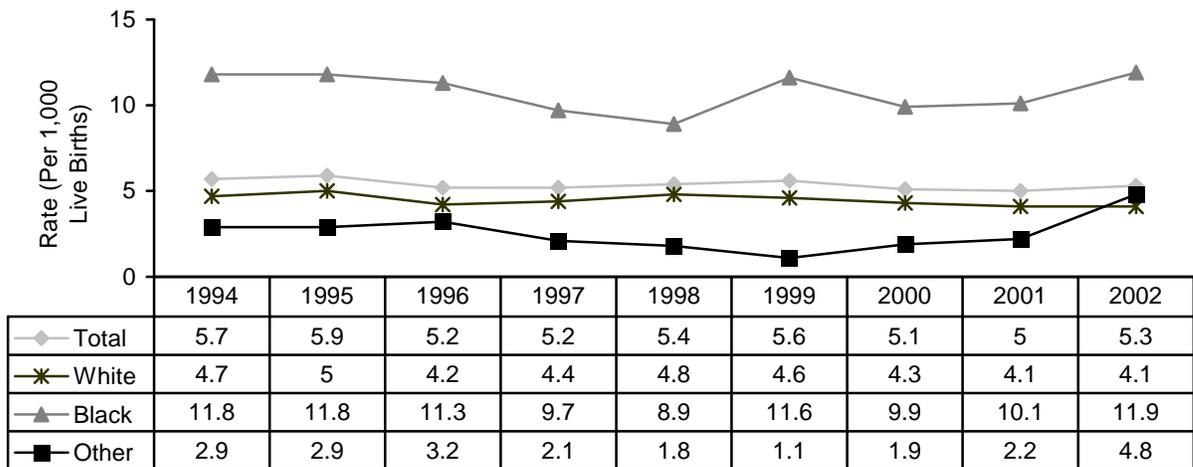
Quantitative Data: The neonatal mortality rate (NMR) is the number of infants who die during the neonatal period per 1,000 live births in a given year. In 2002, there were 790 neonatal deaths in Ohio. The NMR was 5.3, which was higher than the national rate of 4.5. The Ohio rate also is higher than the Healthy People 2010 target rate of 3.3. Ohio’s three-year average rate is 5.2.²⁵

Racial/Ethnic Disparities: The 2002 neonatal death rate for black infants was nearly three times the rate for white infants (11.9 compared to 4.1). This disparity is consistent with national data.

²⁴ Ibid.

²⁵ Ibid.

Ohio Neonatal Death Rate by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Postneonatal Mortality

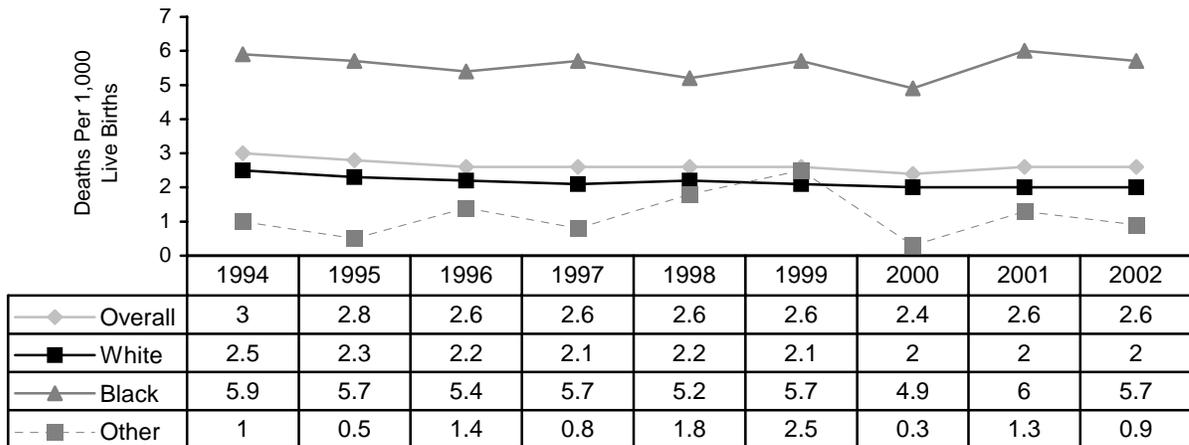
Description: Postneonatal mortality is the death of an infant from age 28 days to less than one year old. One-third of infant deaths occur during the postneonatal period. After the first month SIDS is the leading cause of infant mortality, accounting for about one-third of all deaths during the postneonatal period. The causes of SIDS are unknown, but risk factors include maternal smoking, drug use, teenage birth, and infections late in pregnancy.

Quantitative Data: The postneonatal mortality rate is the number of infants who die during the postneonatal period per 1,000 live births in a given year. In Ohio, 380 postneonatal deaths occurred in 2002. Ohio's postneonatal mortality rate was 2.6, which was higher than the national rate of 2.3. Ohio's three-year average postneonatal mortality rate is 2.5. Both of these rates are higher than the Healthy People 2010 goal of 1.2.²⁶

Racial/Ethnic Disparities: Blacks had a postneonatal mortality rate of 5.7 in 2002 while whites had a postneonatal mortality rate of 2.0. This trend is consistent with the U.S. trends. Although the postneonatal mortality rate has significantly decreased from 1994, there still exists a disparity between races.

²⁶ Ibid.

Ohio Postneonatal Mortality Rate by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Maternal Mortality

Description: The most commonly used definition of a pregnancy-related (maternal) death was developed by the World Health Organization (WHO): “A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.”

Quantitative Data: Based on the above definition, Ohio reported 11 maternal deaths in 2002 for a maternal mortality rate of 7.4/100,000 live births. This is higher than the Healthy People 2010 target rate of 3.3. These deaths were determined using ICD-10 codes in the “O” range in the cause of death fields or elsewhere on death certificates. Each death was matched to the corresponding birth or fetal death certificate when possible. Seven of the deaths were to white women, 3 to blacks and 1 to other race (Asian). Eight deaths were linked to a birth or fetal death certificate; the remaining three occurred in early pregnancy. The 11 deaths occurred in nine different counties.

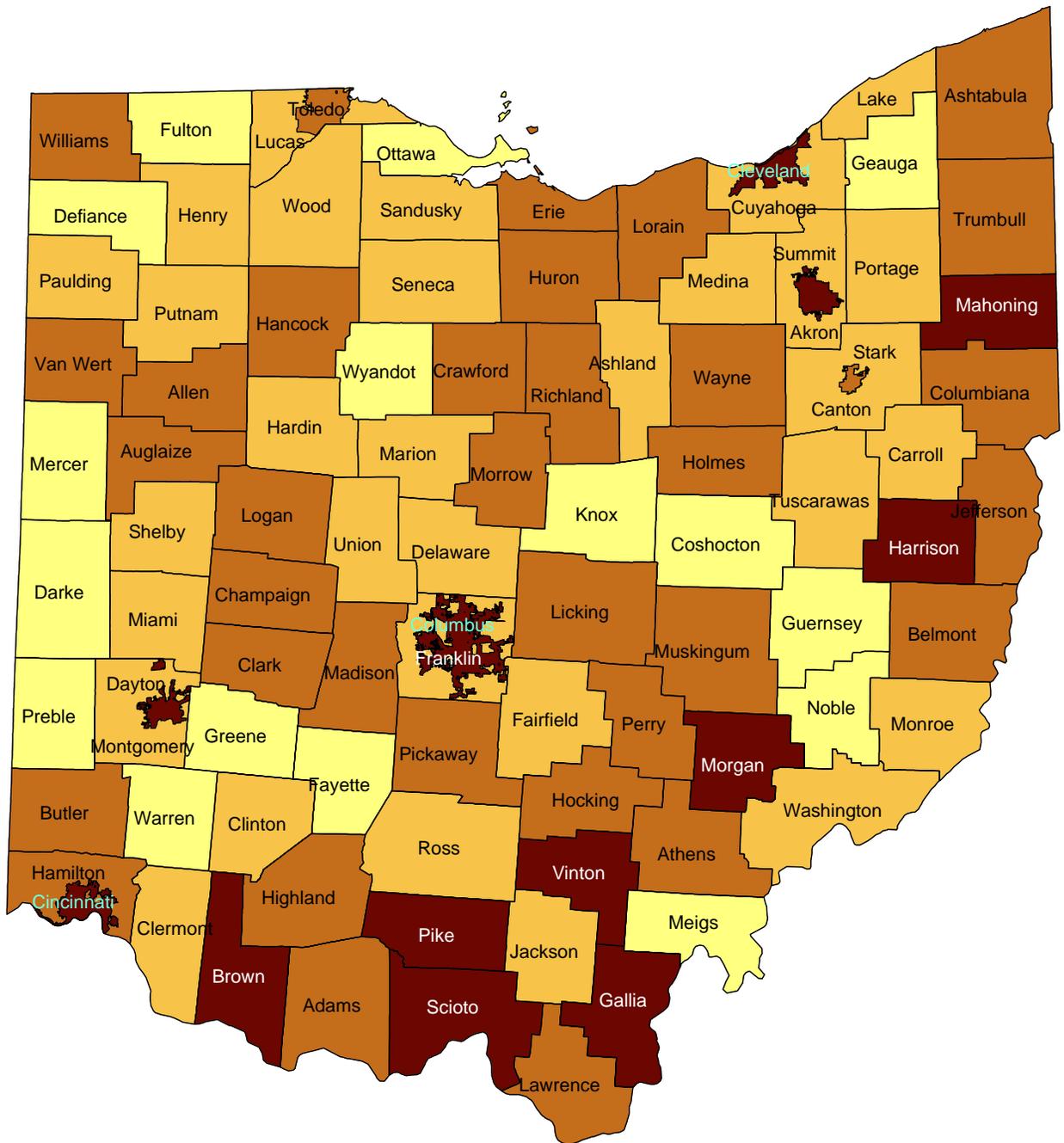
In 1986, the Centers for Disease Control and Prevention/American College of Obstetricians and Gynecologists Maternal Mortality Study Group expanded the definition, extending the time interval between termination of pregnancy and death from 42 days to one year. They also introduced two new terms to differentiate between deaths from any cause related to or aggravated by pregnancy and those that were incidental to pregnancy.

- *A pregnancy-associated death* is the death of any woman, from any cause, while pregnant or within one calendar year of termination of pregnancy, regardless of the duration and site of the pregnancy.

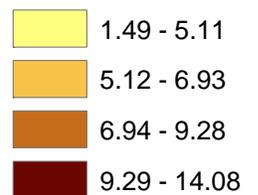
- *Pregnancy-related deaths* are a subset of pregnancy-associated deaths. In addition to occurring within one calendar year of termination of pregnancy, pregnancy-related deaths result from 1) complications of the pregnancy itself, 2) the chain of events initiated by the pregnancy that led to death, or 3) aggravation of an unrelated condition by the physiologic or pharmacological effects of the pregnancy that subsequently caused death.

Racial/Ethnic/Age Disparities: In an attempt to identify all women ages 13-49 who died within one year of giving birth, Ohio Vital Statistics computer-matched death data to birth data. While some cases may have been missed due to adoptions and lack of other information, 35 additional cases were found and sent to the National Center for Health Statistics. No analyses of these cases have been done. Ohio does not have a Maternal Mortality Surveillance System.

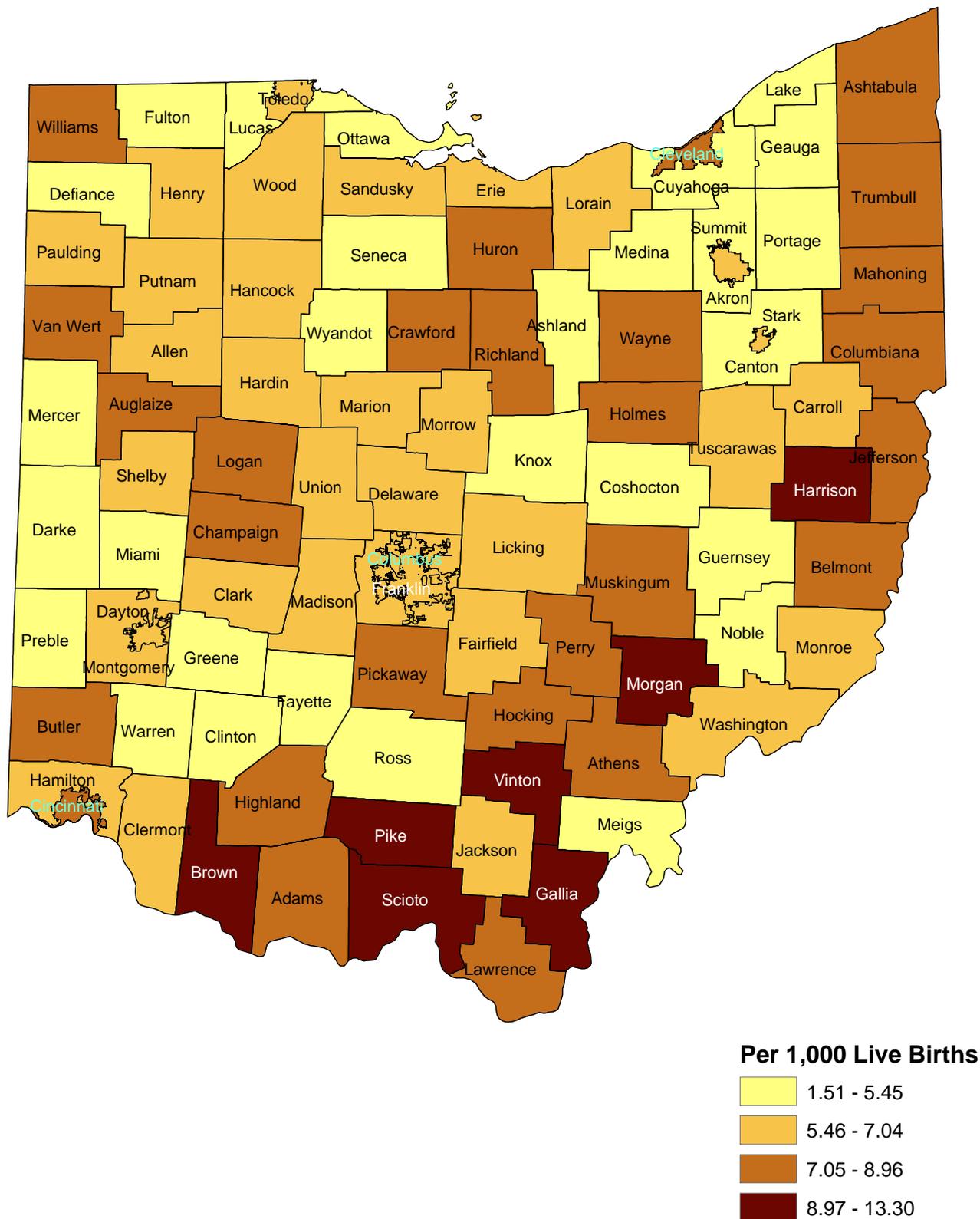
1998 – 2002 Ohio Infant Mortality Rate (Per 1,000 Live Births)



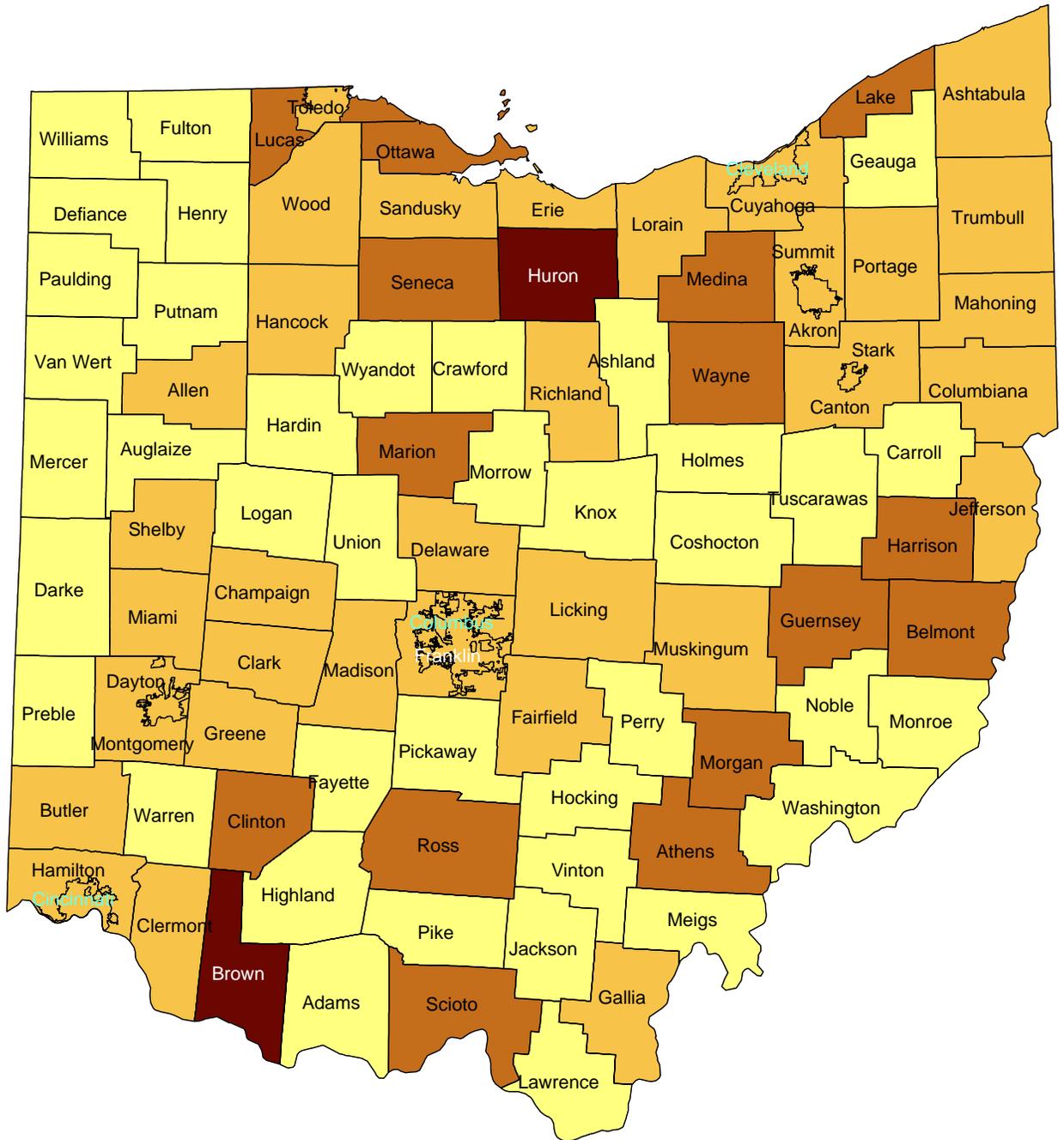
Per 1,000 Live Births



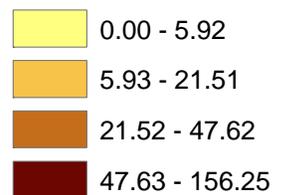
1998 – 2002 White Infant Mortality Rate (Per 1,000 Live Births)



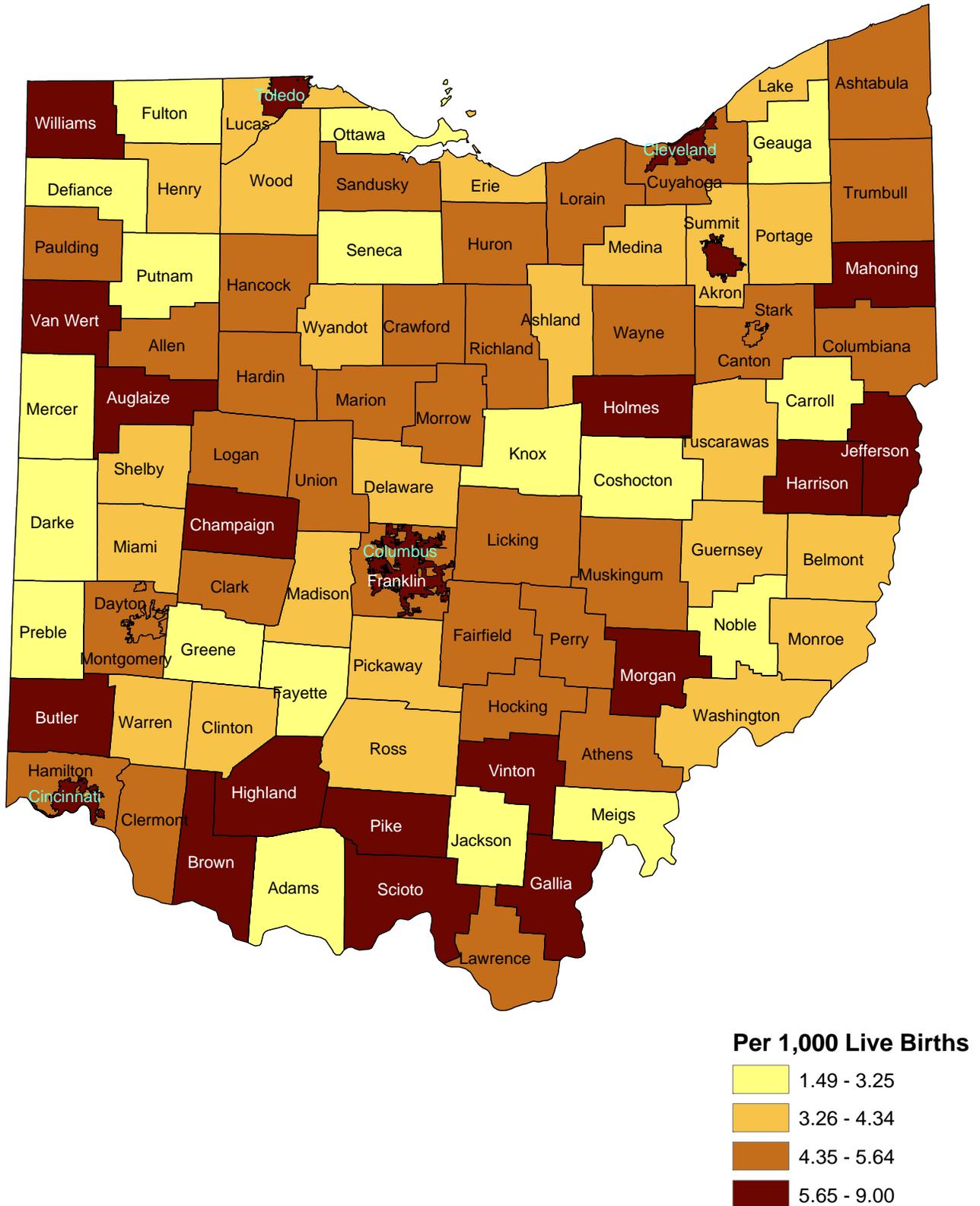
1998 – 2002 Black Infant Mortality Rate (Per 1,000 Live Births)



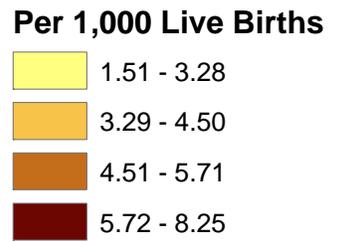
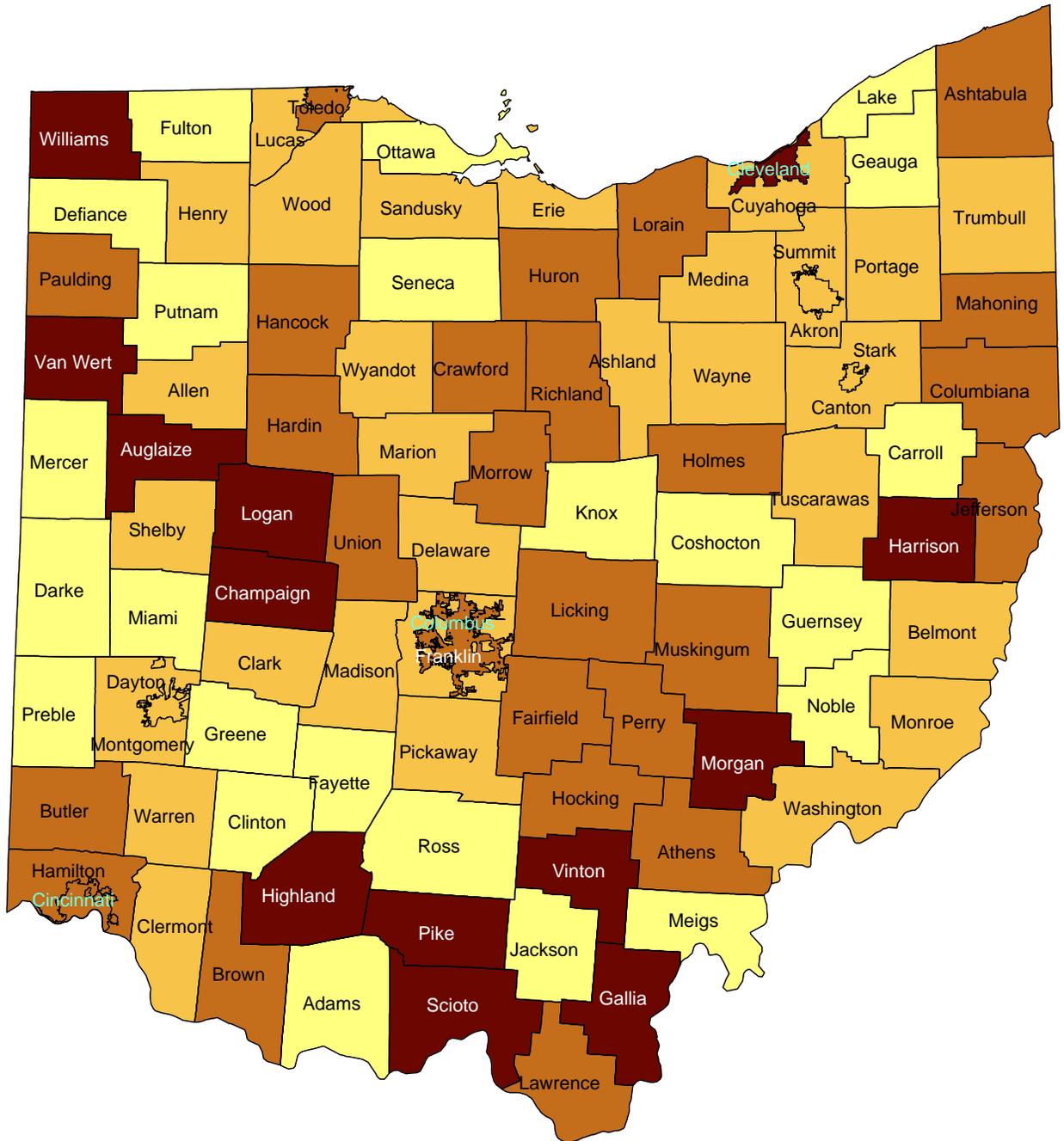
Per 1,000 Live Births



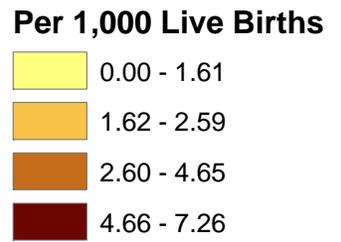
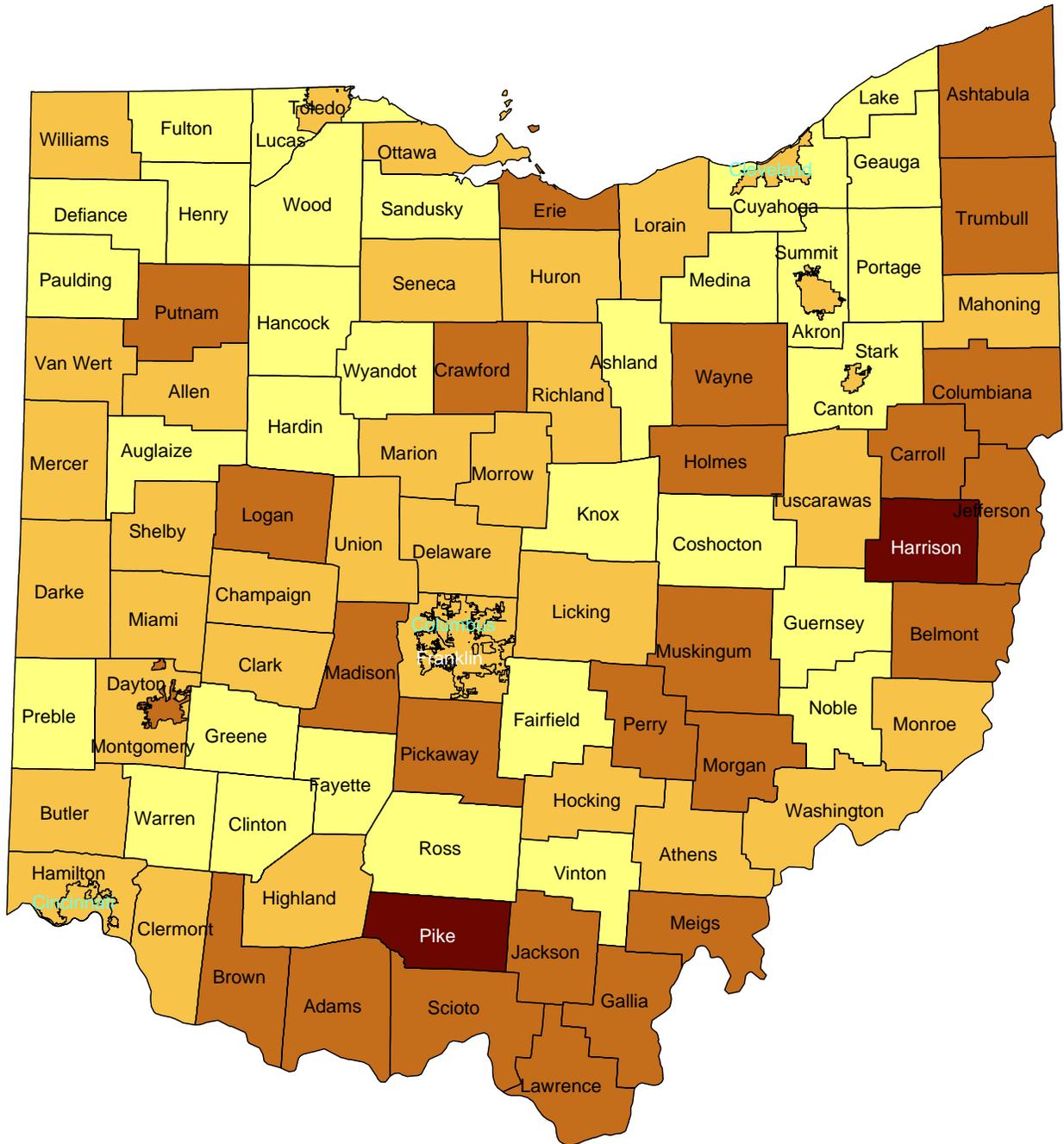
1998 – 2002 Ohio Neonatal Mortality Rate (Per 1,000 Live Births)



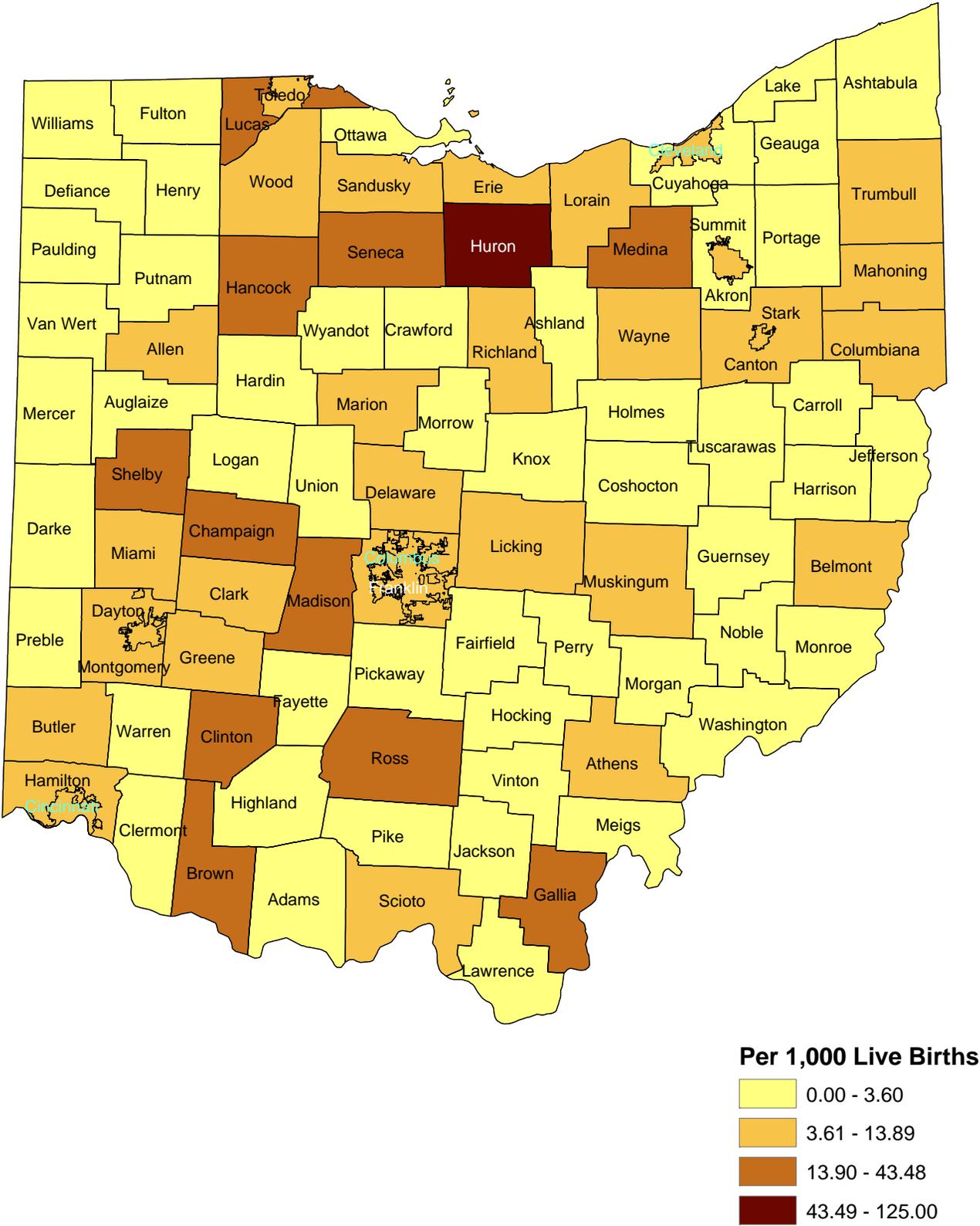
1998 – 2002 White Neonatal Mortality Rate (Per 1,000 Live Births)



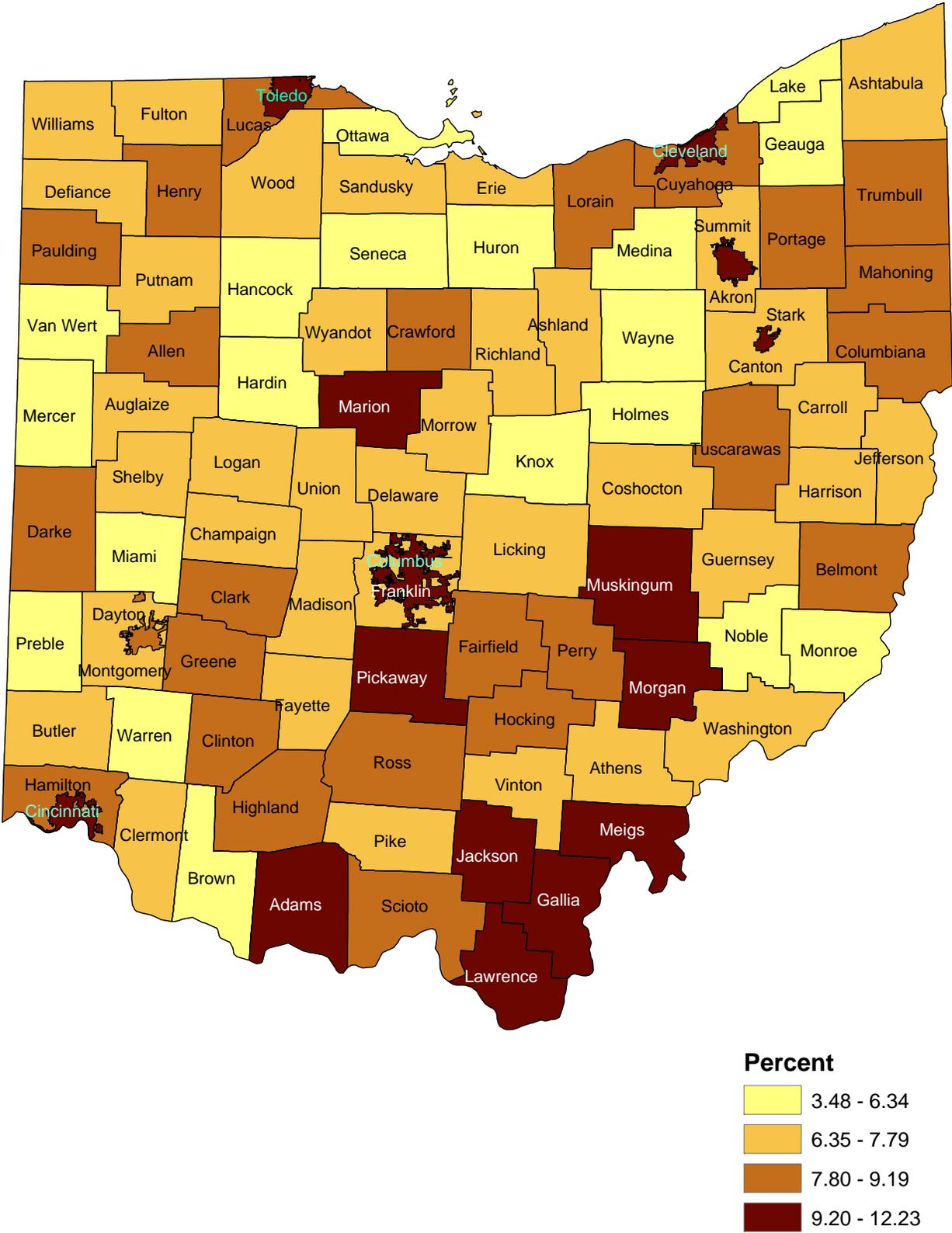
1998 – 2002 White Postneonatal Mortality Rate (Per 1,000 Live Births)



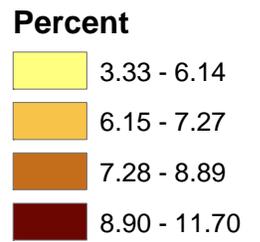
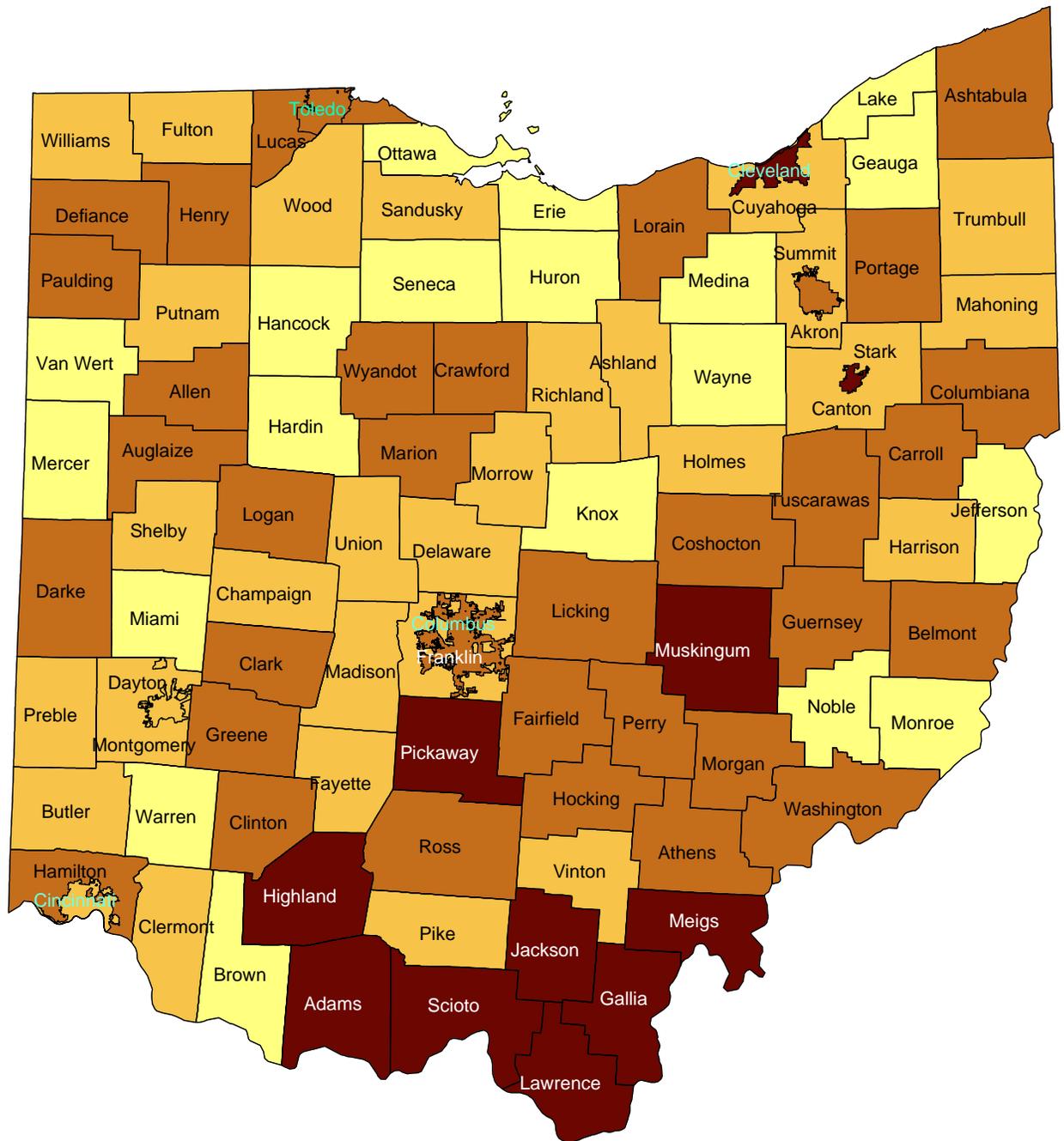
1998 – 2002 Black Postneonatal Mortality Rate (Per 1,000 Live Births)



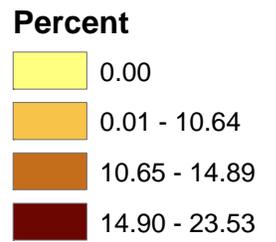
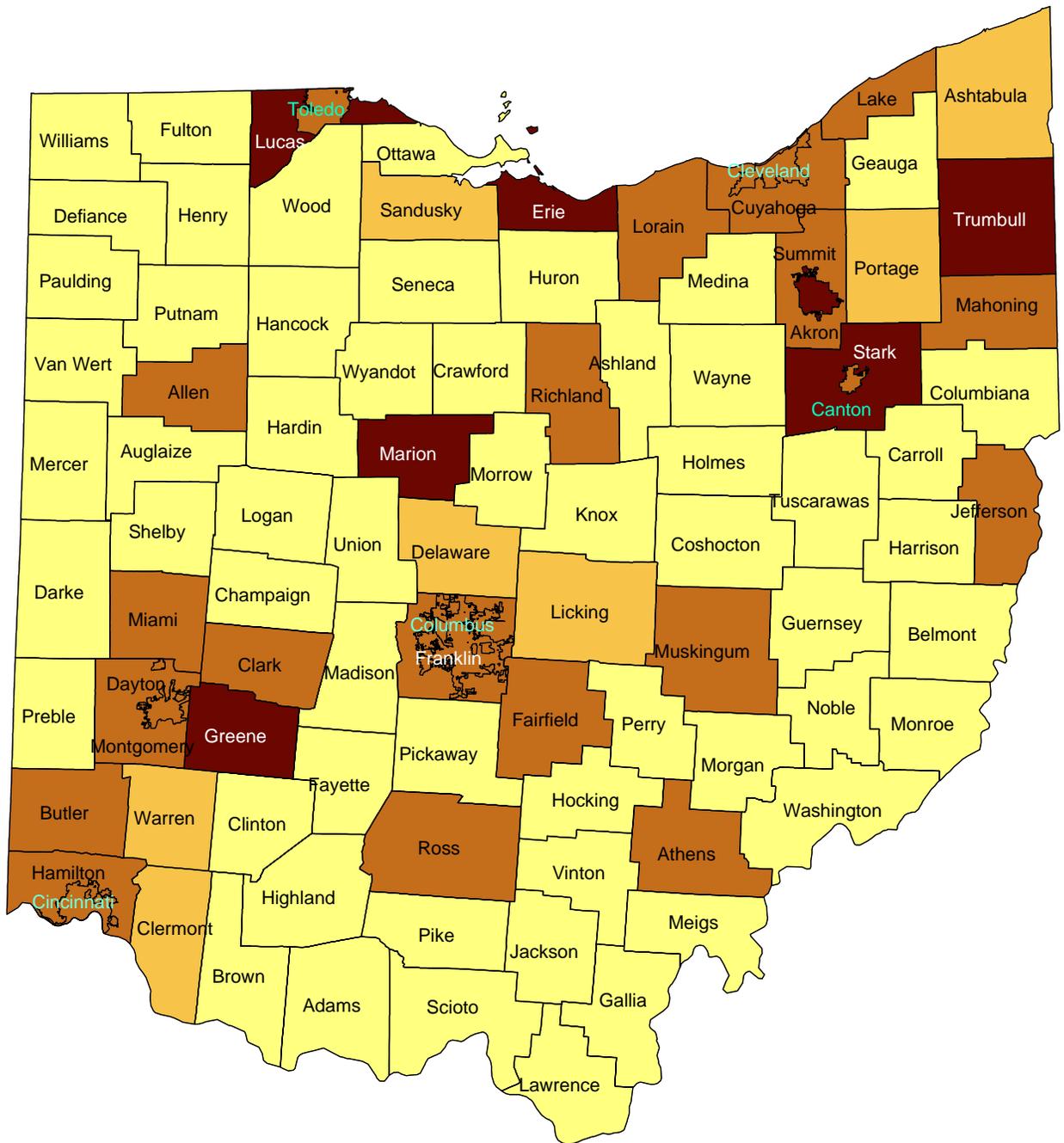
2002 Ohio Percent of Low Birth Weight (< 2,500 Grams)



2002 White Percent of Low Birth Weight (< 2,500 Grams)



2002 Black Percent of Low Birth Weight (< 2,500 Grams)



B. 2 Morbidity

Low Birth Weight

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

Maternal Risk Factors: Factors associated with increased risk of LBW include: minority status, poverty, low level of educational attainment, prior LBW history, low pre-pregnancy weight, multiple births, vaginal infections, domestic violence, and smoking. Nationally, in 2002, 12 percent of infants born to women who smoked during pregnancy were LBW compared with 7 percent of births to non-smokers.²⁷

Quantitative Data: LBW is defined as the percentage of infants born with birth weight < 2500g in a given year. In Ohio in 2002, the rate was 8.3, higher than the national rate of 7.8.²⁸ The Healthy People 2010 target rate of 5.0 percent has not yet been met. The trend in Ohio parallels the national trend. Ohio's LBW has increased since 1994 from 7.5 to 8.3 in 2002, while the nation's LBW rate has also risen, from 7.3 in 1994 to 7.8 in 2002.²⁹

Racial/Ethnic Disparities: In Ohio, the white rate of LBW has increased from 6.4 in 1994 to 7.3 in 2002. Rates among blacks have also increased slightly from 13.6 in 1994 to 13.9. Blacks had an average percentage of LBW infants that was 2.0 times higher than whites during the period of 1994 to 2002, which parallels national data.³⁰

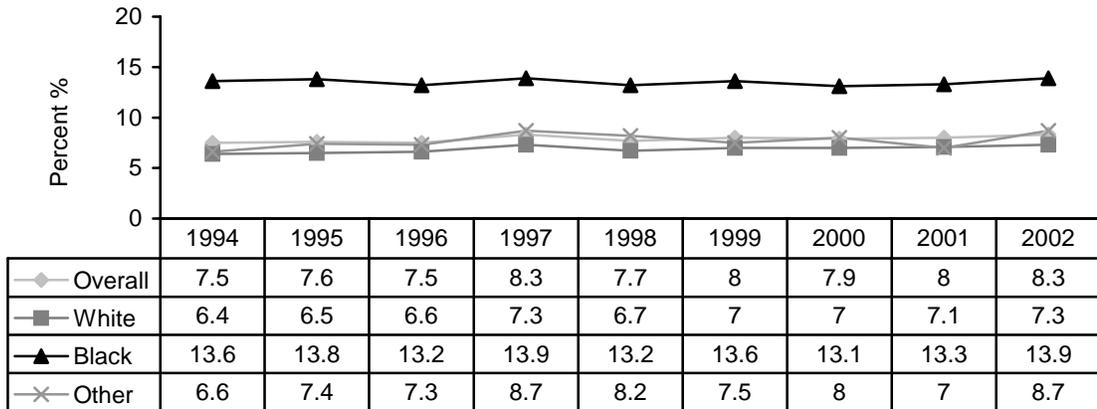
²⁷ National Vital Statistics Report Volume 52, number 10, December 17, 2003.

²⁸ Ibid.

²⁹ Ohio Vital Statistics.

³⁰ Ibid.

Ohio Percent of Low Birth Weight Live Births by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Age Disparities: The highest rate of LBW is among women 45 and over. The rate for this group has decreased from 18.8 in 2001 to 16.2 in 2002. The next age groups with the highest LBW rates were adolescents less than 15 years of age (12.8), teens 15 to 17 years (10.6), women 40 to 44 years (10.5), and women 18 to 19 years (9.8). Women within the age range of 20 to 39 had an average LBW rate of 8.2. Overall, women 25 to 34 have had the lowest LBW rate over time.³¹

Very Low Birth Weight

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

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

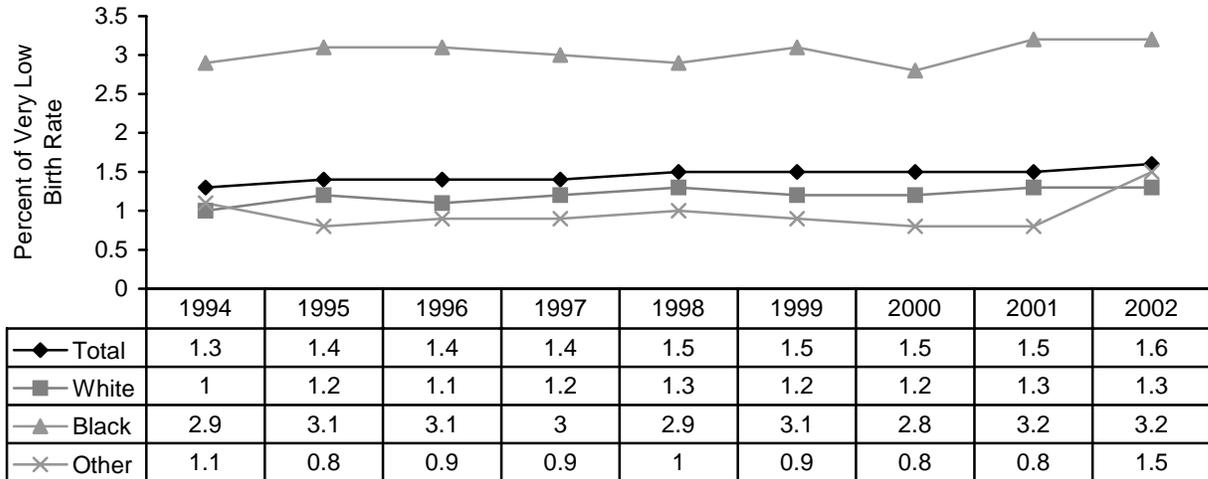
Quantitative Data: The VLBW rate is the percentage of infants born with birth weight < 1500g in a given year. In Ohio in 2002, the rate was 1.6 percent. This was higher than the

³¹ Ohio Vital Statistics.

national rate of 1.5 in 2002³² and higher than the HP 2010 target rate of 1.0 percent. The rate increased from 1994 (1.3 percent) through 2002.³³

Racial/Ethnic Disparities: Blacks in Ohio had an average rate of very low birth weight infants that was 2.6 times higher than whites during the period of 1994 to 2002. In 2002, whites in Ohio had a VLBW rate of 1.3, while blacks had a VLBW rate of 3.2.³⁴

Ohio Percent of Very Low Birth Rate by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Age Disparities: The highest rate of VLBW in Ohio is among teens under the age of 15 years. The rate for these teens decreased from 3.2 in 2001 to 3.0 in 2002. The rate for women over 45 years of age has fluctuated from the highest VLBW in 1997, with a rate of 6.2, to the lowest VLBW in 2000 (0.8). Women 25 to 34 years have consistently had the lowest VLBW rate overall. This age group's VLBW rate in 2002 was 1.6.³⁵

Preterm Births/Birth Outcomes

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

³² National Vital Statistics Report Volume 52, number 10, December 17, 2003

³³ Ohio Vital Statistics.

³⁴ Ibid.

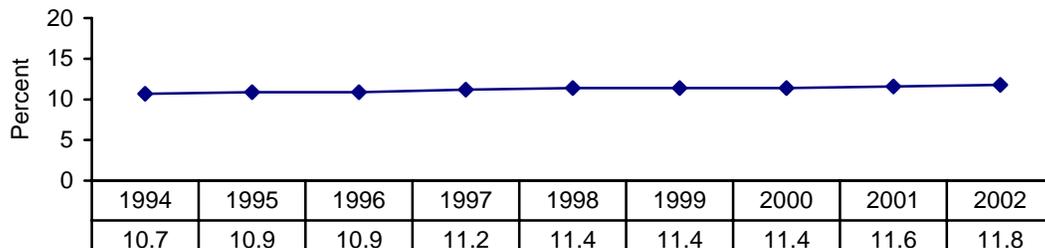
³⁵ Ibid.

Quantitative Data: About 12 percent of babies in the United States are born preterm every year. Of those, the majority (84 percent) are born between 32 and 36 weeks of gestation. About 10 percent are born between 28 and 31 weeks of gestation, and about 6 percent are born at less than 28 weeks of gestation. In 2002, 1 in 8 babies (12.2 percent of live births) were born preterm in Ohio. This is higher than the HP target of 7.6. The rate of preterm births between 1992 and 2002 increased approximately 14 percent. In Ohio in 2002, 2.1 percent of live births were very preterm, 10.2 percent were moderately preterm and 87.8 percent were not preterm.³⁶

Racial/Ethnic Disparities: In 2002, the rate of preterm births in Ohio was highest for black infants (16.9 percent), followed by Native Americans (13.1 percent), Hispanics (12.4 percent), whites (11.1 percent), and Asians (10.0 percent).

Age Disparities: Maternal age is a risk factor for preterm births, with higher preterm birth rates found among the youngest and oldest mothers in the U.S. Ohio's preterm average birth rates during 2000-2002 paralleled the national averages, with mothers age 40 and older having the highest rate (14.6 percent), followed by mothers under age 20 (13.8 percent), ages 30-39 (11.9 percent), and ages 20-29 (11.6 percent).³⁷

Ohio Preterm Births, 1994 - 2002



Data Source: Ohio Vital Statistics

Sexually Transmitted Infections and Perinatal Transmission of HIV

Description: Sexually transmitted infections are risk factors for adverse perinatal outcomes such as miscarriage, ectopic pregnancy, stillbirths, preterm delivery, newborn illness and death. The majority of pediatric (under age 13 years) AIDS cases result from transmission during the perinatal period (before or during birth). The number of new cases of pediatric AIDS due to perinatal transmission has declined by 54.2 percent nationally since 1993. A major factor in this decline is the increasing use of zidovudine treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV-positive pregnant women.

³⁶ National Center for Health Statistics, final natality data. Retrieved February 9th, 2005, from www.marchofdimes.com/peristats.

³⁷ Ibid.

In 1995, routine voluntary HIV testing and counseling for all pregnant women was recommended.

Quantitative Data: The rate of chlamydia among women in Ohio in 2002 was 506.1 cases per 100,000 women, compared to an overall rate of 455.4 cases per 100,000 women in the United States. In 2002, the rate of gonorrhea among women in Ohio was greater than the national rate, 204.5 and 125.3 per 100,000 women respectively. During 1998 through 2002 the average rate of syphilis among women in Ohio was lower than the national average rate, .07 and 1.7 cases per 100,000 women respectively. The Ohio 1998 through 2002 average rate of congenital syphilis was lower than the national average. Ohio's 1998 through 2002 average rate of cases per 100,000 live births was 3.1 compared to the overall rate of 18.3 cases of congenital syphilis per 100,000 live births in the United States.³⁸

Racial/Ethnic Disparities: A statistically significant disparity exists when examining the percent of Ohio women living with HIV by race. In 1998, 10.3 percent of Ohio's female population was black, yet 53.9 percent of the women living with HIV/AIDS in Ohio were black. Hispanic women are over-represented among HIV/AIDS cases as well, making up one percent of the Ohio female population and over six percent of Ohio females living with HIV/AIDS in 1998.

Neural Tube Defects

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

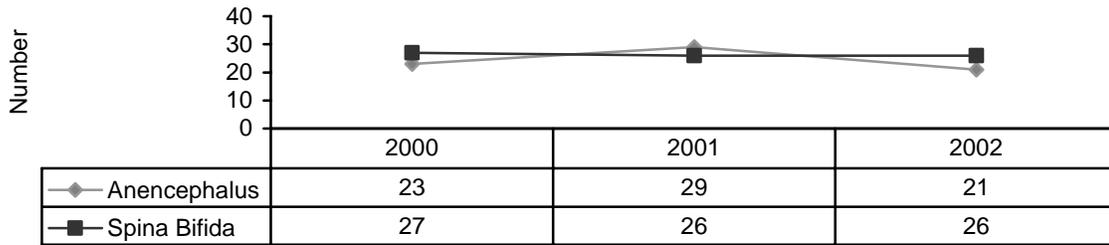
Quantitative Data: After a significant increase in the overall spina bifida rate in the United States from 1992 to 1995, there was a significant decline from 1995 to 1999. However, the rate did not continue to decline; from 1999 to 2002 the spina bifida rate remained constant. The rates, however, for 1999 through 2002 were significantly lower than the rate in 1997. The overall rate for spina bifida in the United States of in 2002 was 20.1 per 100,000 live births.

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

The decline in neural tube defect rates may be due in part to a 1996 Food and Drug Administration mandate requiring all breads and grains sold in the U.S. be fortified with folic acid by January 1998.

³⁸ Ibid.

Ohio Neural Tube Defects, 2000 - 2002



Data Source: Ohio Vital Statistics

B. 3 Contributing Factors

Unintended Pregnancy

Description: Unintended pregnancies include births that were not wanted at the time of conception (mistimed), births that were not wanted at all at conception, and abortions. Unintended pregnancies resulting in live births are associated with delayed entry into prenatal care, poor maternal nutrition, cigarette smoking, and alcohol and other drug use. Some unhealthy behaviors, such as delayed entry into prenatal care, may be related to the time frame in which women discovered the pregnancy. In Ohio, however, among women who are similar in race, age, education, marital status, and Medicaid receipt, pregnancy intent does not appear to influence whether a woman has poor pregnancy outcomes or engages in unhealthy behaviors.³⁹

Quantitative Data: In 2001, 144,688 women delivered a live infant in Ohio; of those, 58,874 (41 percent) of the pregnancies were unintended. This means that 59 percent of the pregnancies were intended, which is lower than the HP 2010 goal of 70 percent of pregnancies are intended.⁴⁰

Racial/Ethnic Disparities: In 2001, whites had 118,494 deliveries of live infants in Ohio. Thirty-five percent of these pregnancies were unintended. Of the 22,220 births of live infants to black women in Ohio in 2001, 70 percent of the pregnancies were unintended.⁴¹

Age Disparities: In Ohio, unintended pregnancies are most common among the younger age groups: 15,373 women under age 20 delivered a live infant in 2001; 83 percent of whom became pregnant unintentionally.

Cigarette Smoking During Pregnancy

Description: Cigarette smoking during pregnancy has been shown to increase the risk of spontaneous abortion, bleeding during pregnancy, other pregnancy complications, and

³⁹ ODH, Ohio PRAMS, 2000.

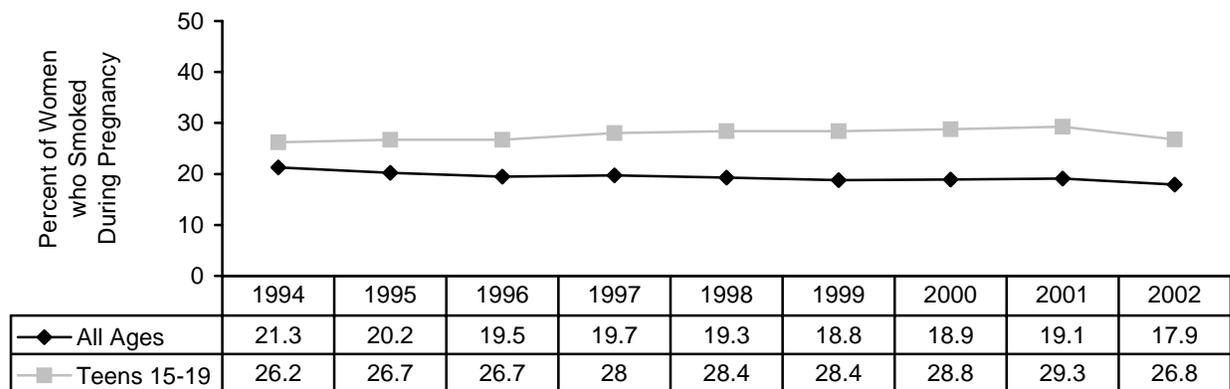
⁴⁰ Ibid.

⁴¹ Ibid.

low birth weight. In addition, smoking during pregnancy has been associated with Sudden Infant Death Syndrome (SIDS) and other negative effects on child health and development. One major concern with accurate interpretation of this type of data is underreporting of smoking behavior.

Quantitative Data: In 2002, 11.4 percent of U.S. mothers smoked during pregnancy, compared to nearly 17.9 percent of Ohio mothers. Ohio ranks among the 10 states with the highest rates of smoking during pregnancy. In Ohio, rates of smoking during pregnancy are highest among younger women and among women with less education. These trends are similar to those found in the U.S. overall. Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) data showed that in 2001, 27.2 percent of mothers smoked in the 3 months prior to pregnancy, 17.5 percent smoked during the last 3 months of pregnancy, and 23.8 percent were smoking in the early post-partum period.

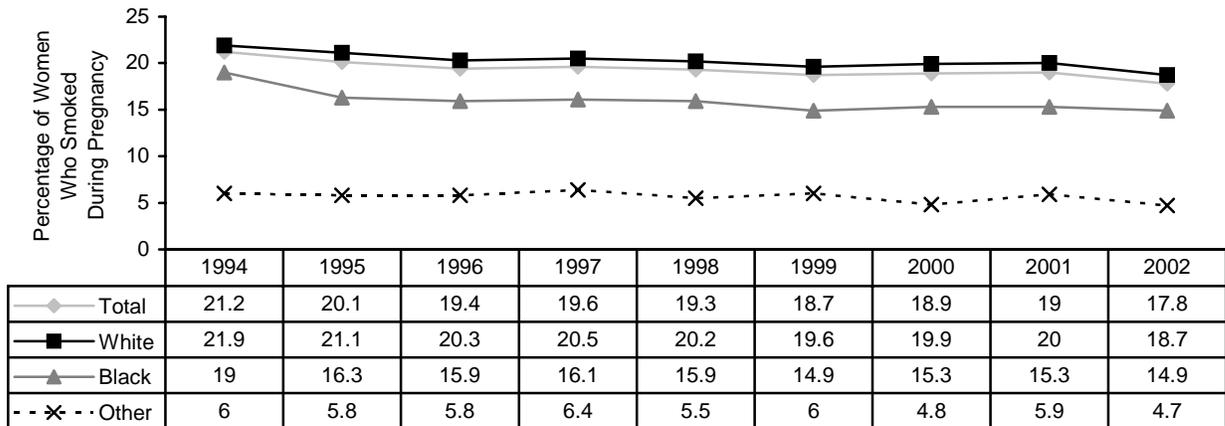
Ohio Percentage of Mothers Who Smoked During Pregnancy by Age, 1994 - 2002



Data Source: Ohio Vital Statistics

Racial/Ethnic Disparities: Since 1994 the percent of white and black mothers who smoked during pregnancy has steadily decreased. In 2002, 18.7 percent of white mothers smoked, whereas only 14.9 percent of black mothers smoked.

**Percentage of Ohio Mothers Who Smoked During Pregnancy
by Race, 1994 - 2002**



Data Source: Ohio Vital Statistics

Alcohol Use During Pregnancy

Description: The use of alcohol during pregnancy is the leading cause of preventable defects and developmental disabilities. Heavy alcohol use during pregnancy is a risk factor for poor pregnancy outcomes, in particular Fetal Alcohol Spectrum Disorders (FASD), which consists of growth abnormalities, central nervous system function abnormalities, and facial characteristic abnormalities. Fetal Alcohol Effects consist of less severe effects in the same three areas. One major concern with accurate interpretation of this type of data is underreporting of alcohol use during pregnancy.

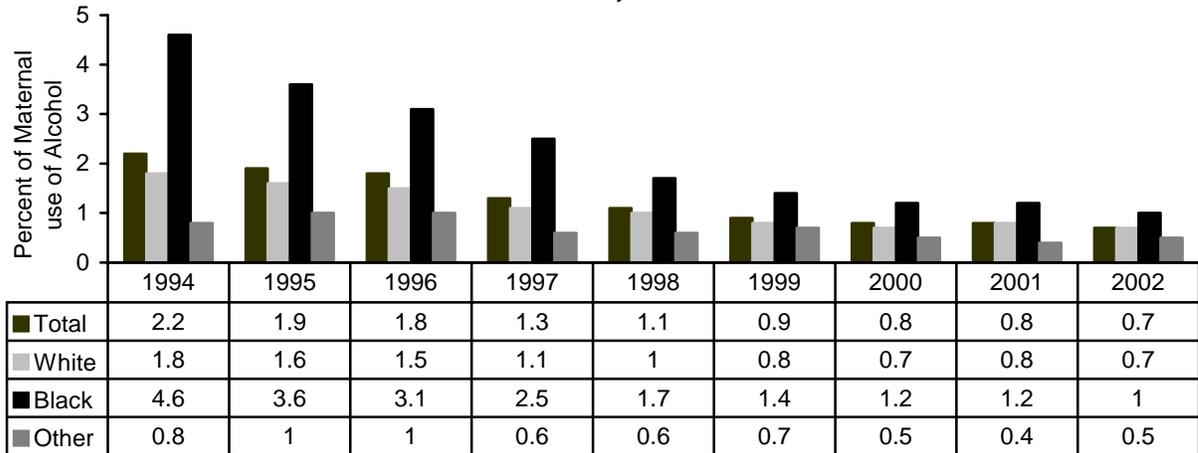
Quantitative Data: Ohio Vital Statistics data, which reports any alcohol use during the pregnancy, disclosed that 0.7 percent of mothers use alcohol during pregnancy. Reports of alcohol use during the last three months of pregnancy from the Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) are higher than U.S. Vital Statistics levels. Ohio PRAMS data for 2001 showed that 5.9 percent of mothers reported alcohol use in the last three months of pregnancy.

The 2002 Pregnancy Nutrition Surveillance System (CDC), which assesses low income pregnant and postpartum women who receive WIC benefits, identified that 11.4 percent of low-income women enrolled in WIC reported drinking alcohol three months prior to their pregnancy. Also in 2002, the Pregnancy Nutrition Surveillance System (CDC) identified that only 0.4 percent of women report drinking alcohol in the last three months of their pregnancy.

Racial/Ethnic Disparities: Black mothers using alcohol during pregnancy has continued to decline since 1994, reaching its lowest point since 1994 in 2002 at 1 percent. Although only 1 percent of black mothers use alcohol during pregnancy this is still above the

percentage of white (0.7 percent) or Hispanic (0.8 percent) mothers using alcohol during pregnancy.

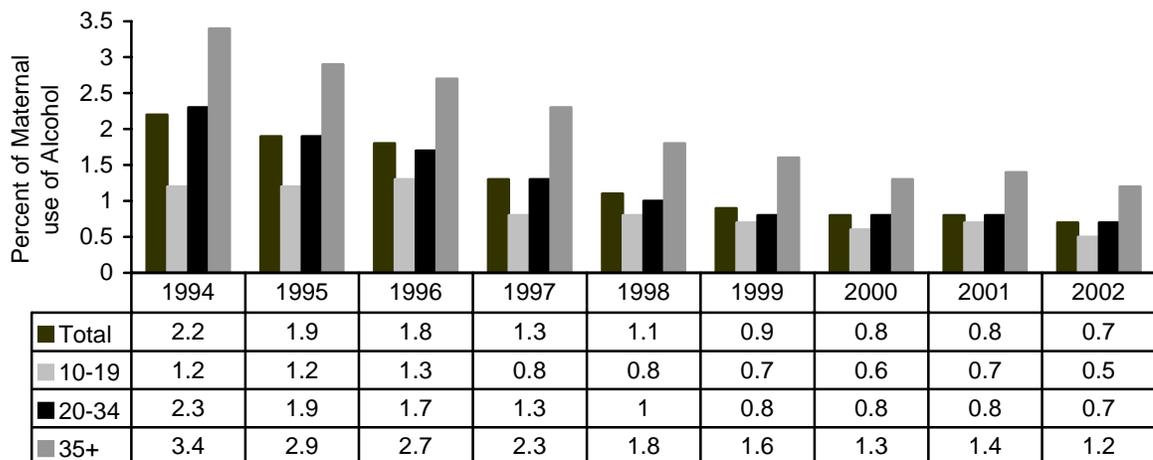
Ohio Percent of Maternal Use of Alcohol During Pregnancy by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Age Disparities: The percent of mothers who use alcohol during pregnancy has continued to decline since 1994 for all age groups. However, mothers 35 and over have persistently reported the highest percent since 1994. In 2002, only 0.5 percent of mothers age 10 to 19 years old and 0.7 percent of mothers between 20 and 34 years of age used alcohol during pregnancy, where 1.2 percent of mothers 35 years of age and over used alcohol during pregnancy.

Ohio Percent of Maternal Use of Alcohol During Pregnancy by Age, 1994 - 2002



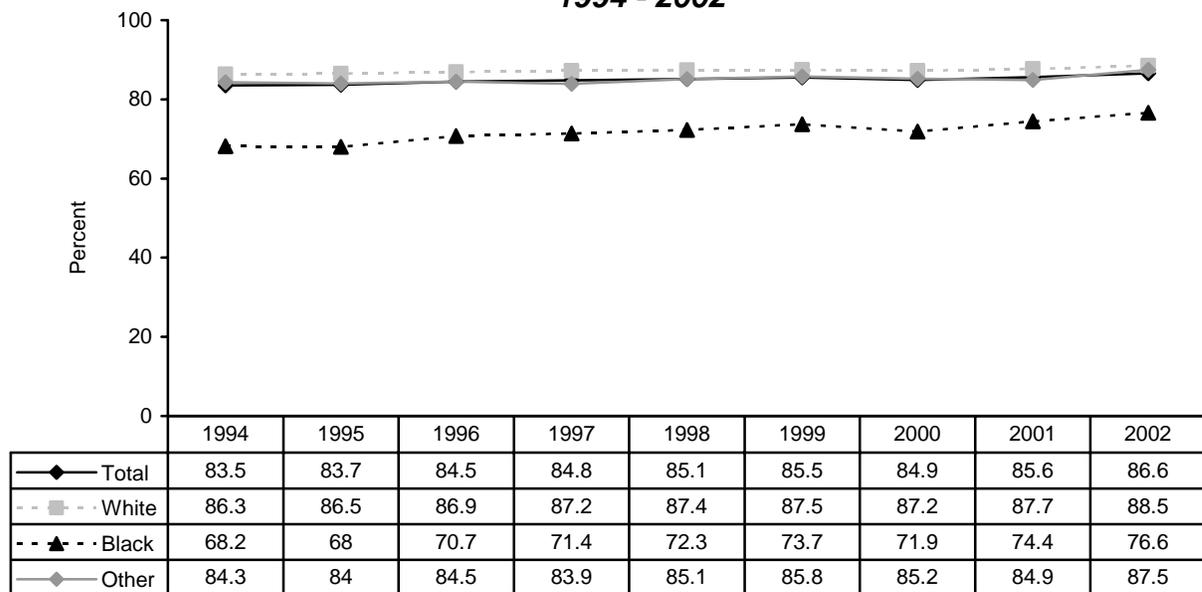
Data Source: Ohio Vital Statistics

Prenatal Care

Description: The use of timely, high-quality prenatal care can help to prevent poor birth outcomes, especially by providing counseling to women who are at high risk of using alcohol, tobacco, and other drugs. The percentage of women who receive first trimester prenatal care has steadily increased since 1990 for all population groups. According to Ohio Vital Statistics, adolescents, black women, and low-income women remain less likely to enter care early and to receive adequate care.

Quantitative Data: First Trimester Prenatal Care: The rate of first trimester prenatal care is defined as the percentage of births to women who received prenatal care in the first trimester. In Ohio in 2002, this rate was 86.6 percent compared to the National rate of 83.4. The 2001 rate was 85.6. These rates were lower than the Healthy People 2010 target rate of 90 percent. The rate increased from 1994 (83.5 percent) through 2002. This is similar to the national trend.⁴²

Ohio Women Receiving First Trimester Prenatal Care by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

Racial Disparities: First Trimester Prenatal Care: Among births to whites, the rate increased from 86.3 percent in 1994 to 88.5 percent in 2002. The rate among births to blacks increased from 68.2 percent in 1994 to 76.3 percent in 2002. The rate among births to other races increased from 84.3 percent in 1994 to 87.5 percent in 2002.⁴³

In comparison to overall 2001 U.S. statistics, Ohio had a higher rate of mothers receiving prenatal care in the first trimester (85.6 compared to 83.4). Parallel to the overall

⁴² Ohio Vital Statistics.

⁴³ Ibid.

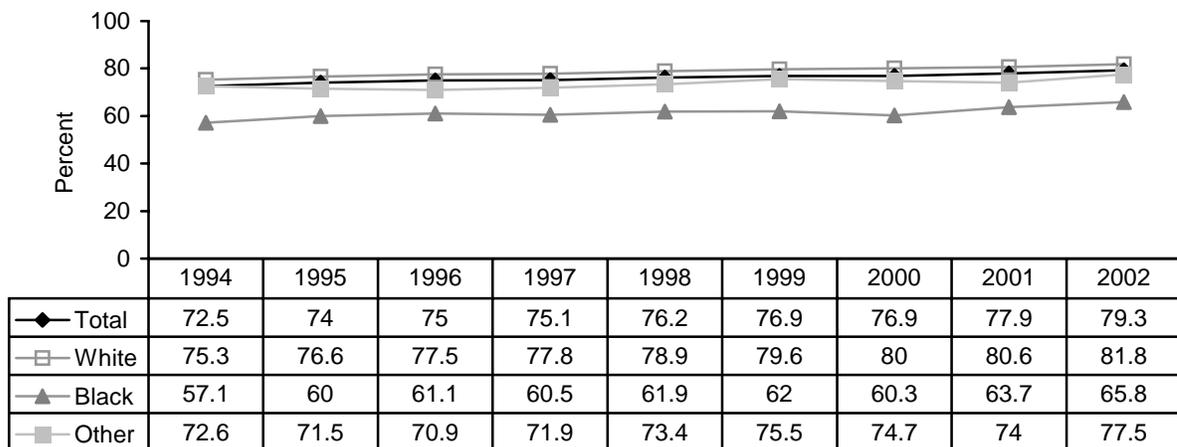
percentage, white mothers had a slightly higher percentage of first trimester prenatal care in Ohio compared to the nation. (87.7 compared to 85.2). Blacks in Ohio had a similar percentage of women receiving prenatal care in the first trimester than the national percentage (74.4 compared to 74.5). There is a disparity between the percentages of black and white infants born to women receiving prenatal care in the first trimester, with blacks being about 16 percent lower than whites during the period of 1992 to 2002. This disparity was slightly higher than the nation's 13 percent between 1990 and 2001.⁴⁴

Age Disparities: First Trimester Prenatal Care: In Ohio from 1994 through 2002, all of the maternal age groups showed an increase in early prenatal care. Teen mothers were less likely to receive prenatal care in the first trimester. The proportion rose with maternal age until the late 30s, when it declined slightly.⁴⁵

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

Kotelchuck Index Age Disparity: An age disparity exists for mothers 10 to 19 years of age. The Kotelchuck index for mothers 10 to 19 years of age was 68.9, whereas 20 to 34 year olds had a Kotelchuck index of 80.2, and mothers 35 years and above had a Kotelchuck index of 82.7.

Ohio Kotelchuck Index (Adequate and Adequate Plus Prenatal Care) by Race, 1994 - 2002



Data Source: Ohio Vital Statistics

⁴⁴ Ibid.

⁴⁵ Ohio Vital Statistics.

Birth Spacing

Description: Birth intervals of less than 18 months are associated with adverse maternal and child outcomes. A relationship exists between short birth intervals and preterm births, very low birth weight, low birth weight, and small size for gestational age.

Birth/pregnancy intervals are measured in three ways: 1) Birth-to-birth interval – the period between two consecutive live births, from birth date to birth date 2) Birth-to-conception interval – the period between a live birth or stillbirth and the conception of the next pregnancy, and 3) Interpregnancy interval – the period from conception of the first child to conception of the next.

Quantitative Data: In 2002, 90,527 births were preceded by a previous live birth, representing 61 percent of all live births. Birth spacing was calculated by number of months between the month of current birth and the month of last live birth. Of these 90,527 births, 13.5 percent of Ohio infants were born less than 18 months after their mother's previous live birth.

Racial/Ethnic Disparities: In 2002, 16.9 percent of black mothers had births that were preceded by a previous live birth of less than 18 months. Thirteen percent of white mothers had births that were preceded by a previous live birth in less than 18 months.

Age Disparities: A greater percentage of teen mothers experience birth intervals of less than 18 months. In 2002, 33.8 percent of Ohio mothers 10 to 19 years of age had births that were preceded by a previous live birth of less than 18 months. Approximately 14 percent of mothers 20 to 34 years of age had births that were preceded by a previous live birth in less than 18 months. Only 8.7 percent of women 35 years and older who gave birth in 2002 had births that were preceded by a previous live birth in less than 18 months.

Nutrition/BMI

Description: Body Mass Index (BMI) is a measure of weight for height expressed as $\text{wt (kg) / ht (m}^2\text{)}$ before the woman became pregnant. The BMI cut-off values specified by the Institute of Medicine (IOM) in 1990 are commonly used to classify women as underweight, normal weight, overweight, and obese prior to pregnancy. Maternal weight gain, also called gestational weight gain, refers to the amount of weight gained from conception to delivery. In 1990 the IOM published recommended weight gain amounts based on prepregnancy BMI for optimal infant health. Maternal weight gain is based on prepregnancy weight status and is considered to be a major determinant of birth weight as well as infant mortality and morbidity.

- *Underweight* is defined as BMI below 19.8 prior to pregnancy. The lower a woman's weight-for-height or BMI the more likely she is to be undernourished. Women who are underweight prior to pregnancy are at a higher risk for having a low birth weight infant, fetal growth problems, perinatal mortality and other pregnancy complications. (IOM, 1996)
- *Normal weight* is defined as a BMI between 19.8 and 26.0.

- *Overweight*: is defined as a BMI greater than 26.0 up to 29.0. Being overweight prior to pregnancy is a risk factor for postpartum weight retention of prenatal weight gain. (IOM, 1996)
- *Obese* is defined as a BMI greater than 29.0. Obese women are at greater risk of delivering an infant much larger than normal weight for their developmental age and experiencing shoulder dystocia and other complications (IOM, 1996). Obese women are also more likely to develop gestational diabetes.

Weight	Pre-Pregnancy BMI	Recommended Total Weight Gain (lb)
Underweight	<19.8	28–40
Normal weight	19.8–26.0	25–35
Overweight	> 26.0–29.0	15–25
Obese	>29	At least 15

Data Source: IOM 1996

Quantitative Data: The Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) data shows a statistically significant increase between 1999 (18.9 percent) and 2001 (21.7 percent) in the percentage of mothers reporting a pre-pregnancy BMI > 30 (obese).

The 2003 Pregnancy Nutrition Surveillance (CDC) Summary of Health Indicators Report, which assesses low income pregnant and postpartum women receiving WIC benefits, stated that 43 percent of all Ohio women with live births who are enrolled in WIC were of normal weight. Thirty percent of all Ohio women enrolled in WIC with live births were obese, and 14 percent each were overweight or underweight. The percent of women enrolled in WIC with live births in 2003 having ideal maternal weight gain was 27.8 percent. The percent of women enrolled in WIC with live births in 2003 having less than ideal maternal weight gained was 23.8 percent. The percent of women enrolled in WIC with live births in 2003 having greater than ideal weight gain was 48.4 percent.

B.4. Priority Issues for Maternal and Infant Health

MCH Stakeholder Identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the Maternal and Infant Health group. A summary of the group discussion is listed under each to help define the issue. A list of group members can be found at the end of this report.

1. Access to Health Care: Lack of health insurance was given as a major cause of access problems. Some disparities in access to care appear to have a regional basis. The number of uninsured individuals and families have continued to increase and the number of undocumented workers is steadily increasing with no source of payment for health care. Even people with insurance have increasing costs and are forced to make choices about coverage resulting in the selection of inferior coverage. An emerging issue in Ohio also

affecting access to maternal health care is that many obstetricians are no longer delivering babies due to the cost of malpractice insurance.

2. Preterm Birth and Low Birth Weight (LBW): The technological advances that have occurred in the past twenty years have improved health care in general; however, preterm births is one in which there has been little improvement. While technology has greatly advanced the care of infants born pre-term (neonatal intensive care units), there remains a need to look at interventions earlier in the prenatal period. One in 8 babies born in Ohio is preterm or LBW; this number is even greater among minority populations.

3. Preconception/Family Planning/Unintended Pregnancy/Genetic Referrals and Services: Intentional pregnancy and having a medical home is related to better prenatal care and positive birth outcomes. Good health related behaviors and inter-conceptional care lower pregnancy related risk factors. Issues related to newborn screening, genetics referrals, and services and programs to help children with metabolic conditions other than PKU and sickle cell anemia were also identified.

4. Neonatal/Perinatal Mortality: These are high priorities due to racial disparities.

5. STDs/HIV/Hepatitis: These were identified as a high priority because of the number of new cases each year and because there is a large racial disparity. The female minority population is the fastest growing population with STD infections.

6. Nutrition and Overweight: These are a high priority considering the negative health effects associated with obesity.

7. Smoking: There are known links between smoking and preterm birth and low birth weight.

8. Interconceptional Care: Good health care between pregnancies lowers risk factors for poor pregnancy outcomes.

9. Mental Health Issues: These issues (including stress and the need for emotional support) were identified as a priority issue. Access to mental health treatment is a serious problem.

10. Teen Births: This is a priority because birth outcomes in teenage pregnancies are poorer than among older age groups. A distinction was made between preventing teen pregnancy and improving birth outcomes for teens.

Local Agency Identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects and WIC projects requesting feedback on progress in regard to the top ten priorities identified in the last Maternal and Child Health Needs Assessment (2001). Survey respondents were asked to identify issues from 2001 that remain high-priority issues in 2005. They were also asked four questions designed to elicit their opinions about other health issues that affect families

and children in their communities. The following are their top concerns for maternal and infant health issues:

Continuing Top Issues from Last Needs Assessment (2001)

1. Low Birth Weight
2. Teen Birth
3. Teen Sex and its Consequences
4. Infant Mortality
5. Neonatal Mortality

Other Concerns Added in 2005

1. Access to Care
2. Smoking
3. Breastfeeding
4. Mental Health
5. Poor Outcomes
6. Domestic Violence

C. Early Childhood Health Status

C.1 Mortality

Overall Mortality Ages 1 through 4

Description: Nationally, the mortality rate for children ages 1-4 was 33.3 per 100,000 in 2002.⁴⁶ Injuries (intentional and unintentional) accounted for 40.4 percent of deaths.⁴⁷ Unintentional injuries accounted for about 27 percent of all deaths in children aged 1-4 in Ohio in 2000-2002. The leading causes of death from injury for children ages 1 through 4 are as follows: (1) motor vehicle crashes, (2) accidental exposure to smoke, fire, and flames, (3) accidental drowning and submersion, (4) other and unspecified transport injuries.⁴⁸

Quantitative Data: The overall death rate for children aged 1-4 years in Ohio in 2002 was 26.4, lower than the national rate of 33.3 and approaching the Healthy People 2010 goal of 25/100,000.⁴⁹ The mortality rate for this age group has declined since 1994, when the rate was 40.9/100,000.

Racial/Ethnic Disparities: The mortality rate for children aged 1-4 years has decreased for all population subgroups since 1995. While the percentage of decrease was greater for blacks than whites, the mortality rate for blacks remains much higher than for whites.

⁴⁶ CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hus/hus04trend.pdf#035>, 165.

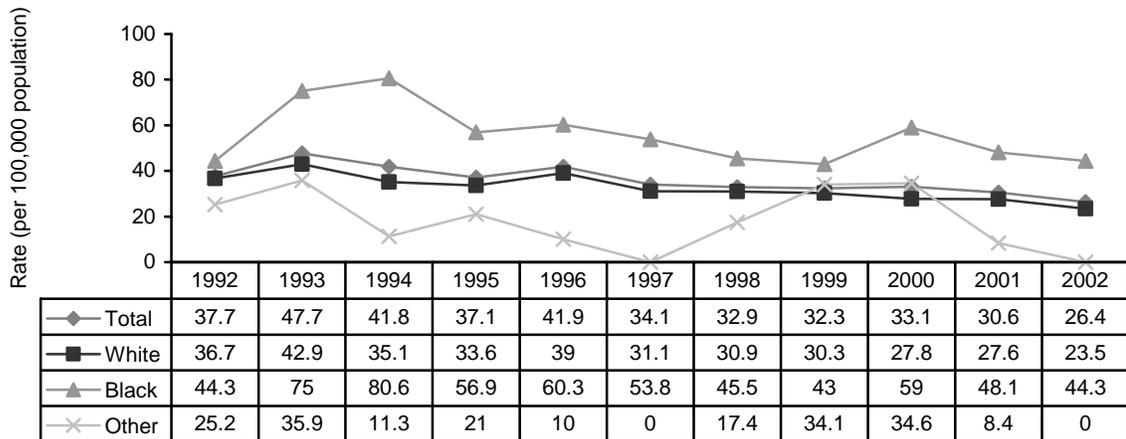
⁴⁷ CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hus/hus04trend.pdf#035>, 158.

⁴⁸ Ohio Vital Statistics.

⁴⁹ Ibid.

Death rates for Native Americans and Alaska Natives are comparable to black mortality rates.⁵⁰

Ohio Mortality Rate Ages 1 - 4, 1992 - 2002



Data Source: Ohio Vital Statistics

Mortality Due to Motor Vehicle Crashes

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

Quantitative Data: Children aged 1 through 4: The motor vehicle accident injury mortality rate for Ohio was 2.4; this rate is based on a three year average (2000-2002)⁵¹. In 2002, children aged 1 through 14 had a mortality rate for MV accidents of 3.0/100,000, lower than the national three year average (2000-2002) of 3.6/100,000, and higher than the HP 2010 target rate of 2.1.⁵²

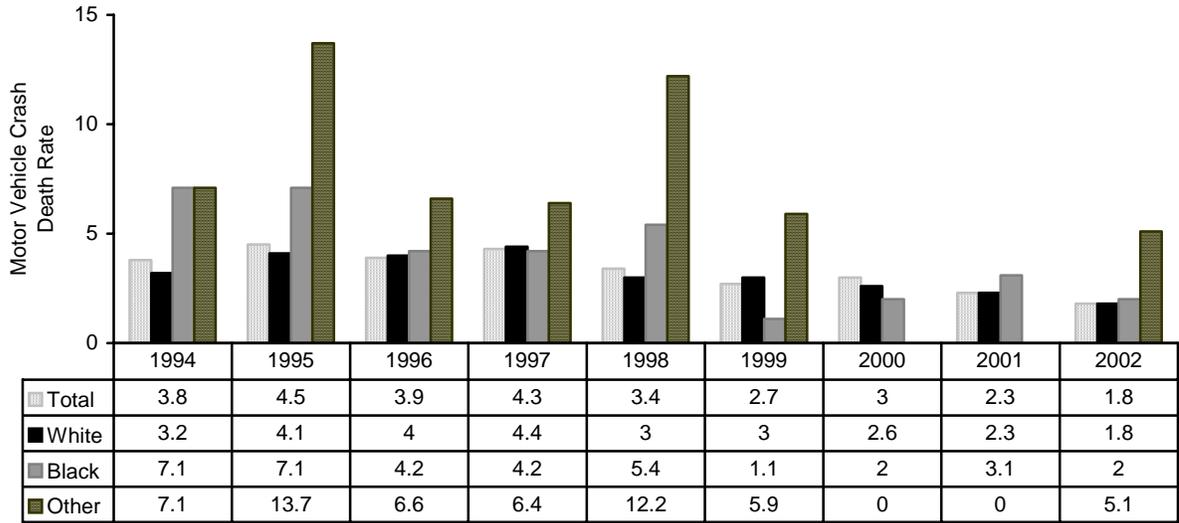
Racial/Ethnic Disparities: There is a very slight disparity in MV accident death rates between whites and blacks, 1.8 and 2, respectively.

⁵⁰ CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hus/04trend.pdf#035>.

⁵¹ Ohio Vital Statistics.

⁵² WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

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

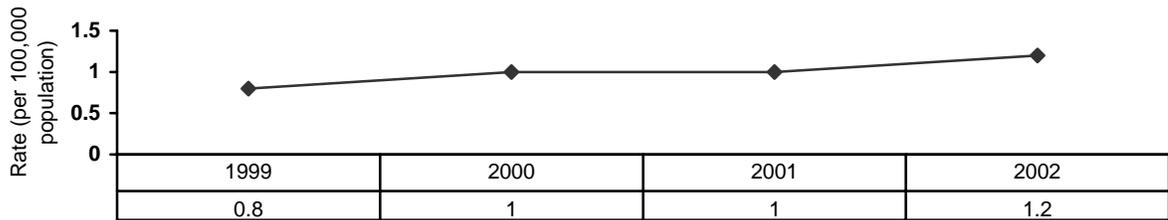


Data Source: Ohio Vital Statistics

Mortality Due to Child Abuse

The death rate for children ages 1 – 4 years due to child abuse increased slightly between 1999 and 2002. There were 5 deaths in 1999, 6 deaths in both 2000 and 2001 and 7 deaths in 2002.

Ohio Death Rate (per 100,000 population) Ages 1-4 Due to Child Abuse

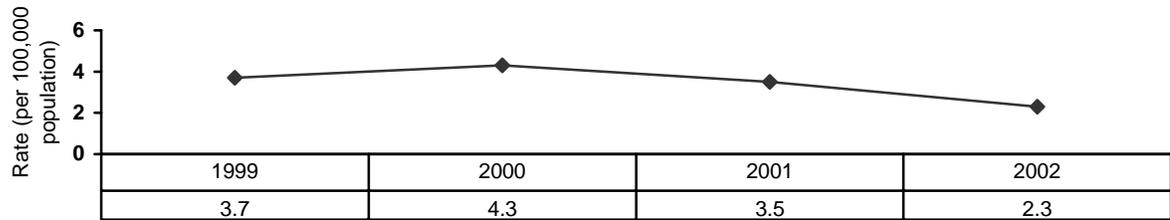


Data Source: Ohio Vital Statistics

Mortality Due to Fire and Burns

Deaths due to fire and burns among children 1 – 4 years of age decreased slightly between 1999 and 2002. There were 22 deaths in 1999, 26 in 2000, 21 in 2001 and 14 in 2002.

Ohio Death Rate (per 100,000 population) Ages 1 - 4 Due to Fire/Burns



Data Source: Ohio Vital Statistics

C. 2 Environmental—Morbidity

Elevated Blood Lead Levels

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

Quantitative Data: In Ohio in 2003, 4.2 percent of all children aged 0-72 months screened for elevated blood lead levels were found to have levels in excess of 10 micrograms per deciliter. This continued a trend of decline in percentage of screened children with high levels, down from 5.1 percent in 2002, 6.2 percent in 2001, and 7.1 percent in 2000.⁵³ If the same rate of decrease is maintained, Ohio will meet the Healthy People 2010 goal of eliminating blood lead levels in excess of 10 mcg/dl by 2007.

⁵³ "Childhood Lead Poisoning," Ohio Department of Health, http://www.odh.ohio.gov/Data/Lead_Poison/lead1.htm.

Asthma

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

Quantitative Data: It is estimated that 6.1 million U.S. children under 18 years of age currently have asthma of which 4.2 million suffered from an asthma attack or episode in 2002. Asthma is the third leading cause of hospitalization among U.S. children under the age of 15 and it is the leading cause of chronic illness among children. Most children have mild to moderate problems and their illness can be controlled by treatment at home. For some children the illness becomes a formidable problem causing numerous visits to the hospital emergency room. In 1999, 658,000 U. S. pediatric emergency room visits were due to asthma. The estimated annual rate for United States emergency room visits among children 5 years old or younger is 137.1 per 10,000 persons. Asthma accounts for 14.6 million lost school days in the United States in 2002. It is the leading cause of school absenteeism attributed to chronic conditions.⁵⁴

Second Hand Smoke

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

Quantitative Data: Each year in the United States, 280 children actually die from respiratory illness caused by secondhand smoke; and another 300 children suffer from injuries caused by smoking-caused fires. Children with asthma have more frequent and more severe asthma attacks because of exposure to secondhand smoke, which is also a risk factor for the onset of asthma in children who did not previously have symptoms.⁵⁵ Ohio 2001 PRAMS data show that 18.9 percent of mothers reported their baby spent time in a room with someone who is smoking.

⁵⁴ National Center for Health Statistics. Raw Data from the National Health Interview Survey (Analysis by the American Lung Association) and American Journal of Public Health, March 1992, Vol. 82, No. 3

⁵⁵ "Second Hand Smoke is Dangerous to Children," Tobacco Free Ohio, 2004
<http://www.tobaccofreeohio.org/contentfiles/child.pdf>

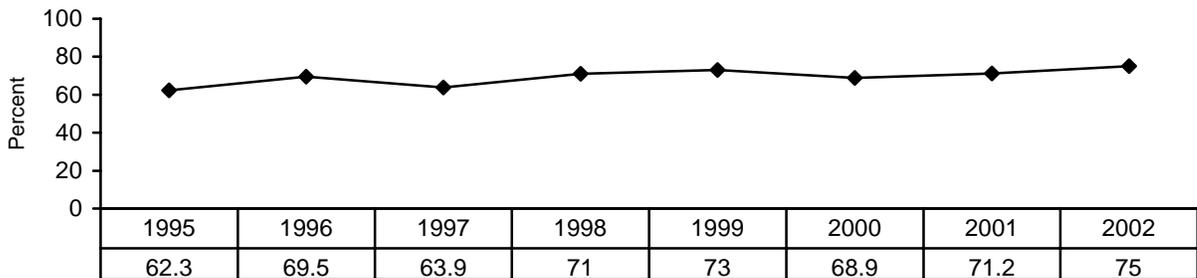
C. 3 Infectious Diseases—Morbidity

Vaccine-Preventable Diseases

Description: Widespread vaccination of children has resulted in decreases in morbidity and mortality due to vaccine-preventable diseases. An HP 2010 objective for vaccine-preventable diseases is the elimination of congenital rubella syndrome, diphtheria, measles, mumps, polio, rubella, tetanus, and invasive disease caused by *Haemophilis influenzae* type b (Hib).

Quantitative Data: In Ohio in 2002, 75 percent of children aged 19 to 35 months had received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, H. influenza and hepatitis B (series 4:3:1:3:3). This is comparable to the national rate of 77.5 percent, but below the HP 2010 goal of 90 percent.⁵⁶ In 2002, there were 398 cases of pertussis reported in children 0 – 19 in Ohio, with 58 percent occurring in children less than 4 years of age. In addition, there were 15 cases of *Haemophilis influenzae*, five cases of mumps, and one case of measles reported in 2002.⁵⁷

**Immunization Coverage (series 4:3:1:3:3)
Children Ages 19-35 Months Ohio 1995-2002**



Data Source: State Immunization Registry, National Immunization Survey (NIS), CDC, NCHS and National Immunization Program (NIP), Ohio Vital Statistics and Bureau of Census population estimates

C. 4 Injuries—Morbidity

Nonfatal Motor Vehicle Injuries in Children

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

⁵⁶ Maternal and Child Health Block Grant Core Performance Measure 7, prepared by ODH DFCHS, BHSIOS, Research & Evaluation, BHSIOS@odh.ohio.gov, 9/04

⁵⁷ “Reported Cases of Notifiable Diseases by Age in Years, Ohio 2002,” Ohio Department of Health, http://www.odh.ohio.gov/Data/Inf_Dis/idann/Idsum02/02age.pdf.

Quantitative Data: Children aged 1-4: In 2003, the rate of nonfatal injuries due to transport accidents was 725/100,000 nationally.⁵⁸ In Ohio, the rate was 936/100,000.⁵⁹

Child Abuse and Neglect

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

Quantitative Data: According to Child Maltreatment 2002, published by the Administration for Children and Families in the Department of Health and Human Services, the rate of substantiated incidences of child maltreatment in the U.S. was 12.5/1,000. Ohio had a rate higher than the national rate, at 17.4/1,000. This is also higher than the HP 2010 goal of reducing maltreatment of children to 11.1/1,000. In Ohio, over half of the victims of child maltreatment (54 percent) suffered from neglect, while 23 percent were victims of physical abuse and 16 percent suffered sexual abuse (2002 data). Males and females suffer abuse at roughly the same rates, with females accounting for 52 percent of victims in 2002. Younger children are more frequently the victims of maltreatment, with the rate of victimization of children 0-3 in Ohio in 2002 at 21.5/1,000 and decreasing in every older age group.⁶⁰

The same source reports 2.5/100,000 fatalities as a result of child maltreatment in Ohio in 2002, compared with 1.98/100,000 nationally.⁶¹ The HP 2010 goal for fatalities from child maltreatment is 1.5.

Racial/Ethnic Disparities: Black children have the highest rate of abuse in Ohio at 35.2/1000 (2002 data), followed by Native Americans at 17.7. The white maltreatment rate was 13.7, while the Hispanic rate was 7.6.⁶²

⁵⁸ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁵⁹ Calculated from ODP data available at <http://www.publicsafety.ohio.gov/publicat/HSY7606/HSY7606-2003.PDF> with number of injury by age group divided by population estimates available at <http://www.census.gov/popest/states/asrh/tables/SC-EST2003-02/SC-EST2003-02-39.pdf>.

⁶⁰ "Child Maltreatment 2002; Administration of Youth and Families, <http://www.acf.hhs.gov/programs/cb/publications/cm02/cm02.pdf>.

⁶¹ Ibid.

⁶² Ibid.

C. 5 Nutrition—Morbidity

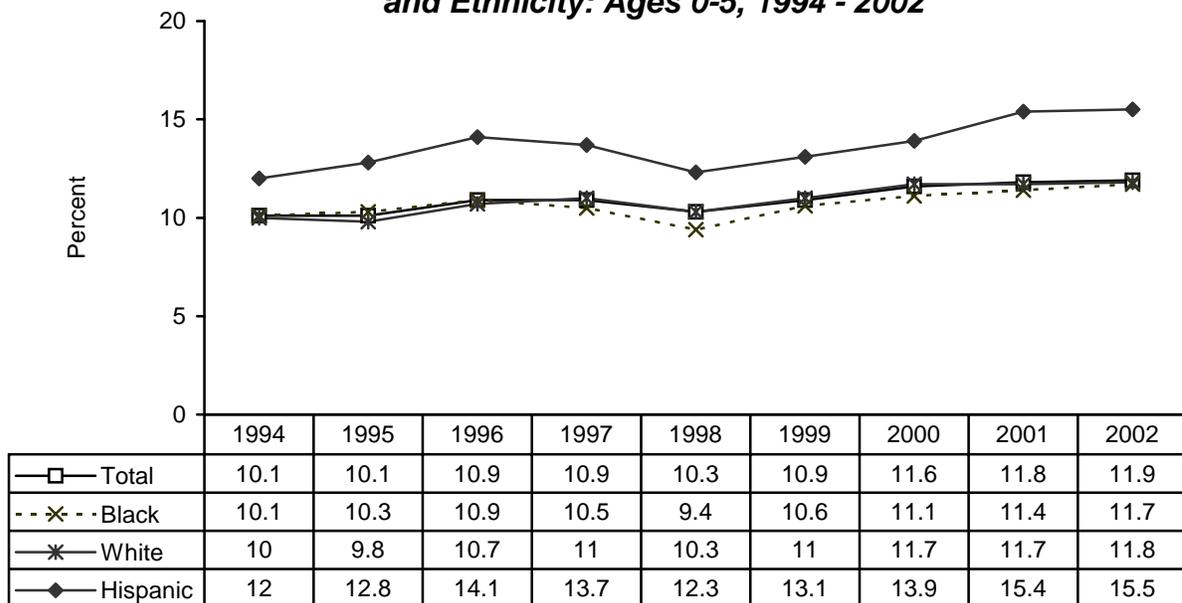
Overweight in Children Younger than 5 Years

Description: Overweight is defined as a weight-for-height above the 95th percentile of the National Center for Health Statistics age-and-sex-specific weight-for-height reference population. The health problems associated with childhood overweight and obesity include high blood pressure, high cholesterol, glucose intolerance, orthopedic disorders, and psychosocial disorders. In addition, longitudinal studies show that overweight in childhood is associated with overweight in adulthood, which is a recognized health risk. Contributing factors to overweight include high body mass index of parents, low family income, eating a high proportion of calories from fat and long hours of watching television.

Quantitative Data: According to the 2003 Pediatric Nutrition Surveillance System (CDC), which assesses children aged 0 to 5 years in families who are at less than 185% of the federal poverty level and who receive WIC benefits, 12.5 percent of low-income Ohio children enrolled in WIC were overweight, about the same as the national rate of 13 percent.⁶³ Ohio does not collect population-based data on childhood overweight.

Racial/ethnic disparities: Hispanic children are more likely than whites or blacks to be overweight.

Ohio Percent of Overweight Low-Income Children by Race and Ethnicity: Ages 0-5, 1994 - 2002



Data Source: Pediatric Nutrition Surveillance System (PedNSS)

⁶³ “2003 Pediatric Nutrition Surveillance, National, Table 6D” CDC, http://www.cdc.gov/pednss/pednss_tables/pdf/national_table6.pdf.

Anemia

Description: Anemia, defined by a low hemoglobin concentration or a low hematocrit level, is often used as an indicator of iron deficiency, the most common nutritional deficiency in the world. Iron deficiency is associated with developmental delays and behavioral disturbances in children. In addition to iron deficiency, anemia can be caused by other nutritional deficiencies (e.g., folate or vitamin B12 deficiency); hereditary defects in red blood cell production (e.g., thalassemia and sickle cell disease); recent or current infection; and chronic inflammation. Anemia is declining among low-income children as a result of increased iron intake during infancy; therefore, anemia is becoming less predictive of iron deficiency and more strongly associated with other underlying illnesses.

Quantitative Data: As reported in the 2003 Pediatric Nutrition Surveillance System (CDC), 14.2 percent of low income Ohio children less than 5 years old receiving benefits from WIC had anemia as defined by low hemoglobin/low hematocrit, higher than the national rate of 12.8 percent. Rates of anemia have been decreasing nationally, down from 14.5 percent in 1998.⁶⁴

Racial/Ethnic Disparities: Nationally, blacks had a higher rate of anemia (19 percent) than whites (10.4 percent), with Hispanics falling in between (11.9 percent).⁶⁵ The racial disparity in Ohio is similar to national data.⁶⁶

Age Trends: Ohio children less than 11 months old have the highest rates of anemia at 16.2 percent. The rate falls slowly over each successive one-year period, with children 48-59 months having the lowest rate of 8 percent.

C. 6 Nutrition—Contributing Factors

Breastfeeding

Description: Breastfeeding is an important contributor to overall infant health, as human breast milk presents the most complete form of nutrition for infants.

Quantitative Data: According to the Ross Mother's Survey, in 2002, the percentage of Ohio mothers who breastfed their infants at hospital discharge was 63.7 percent, lower than the national percentage of 70.1. This survey also reported that low income infants (i.e., on WIC) were breastfed at a lower rate, with 58.8 percent nationally and 49.4 percent of Ohio infants breastfed at hospital discharge.⁶⁷

⁶⁴ "2003 Pediatric Nutrition Surveillance, National, Table 6D" CDC, http://www.cdc.gov/pednss/pednss_tables/pdf/national_table6.pdf.

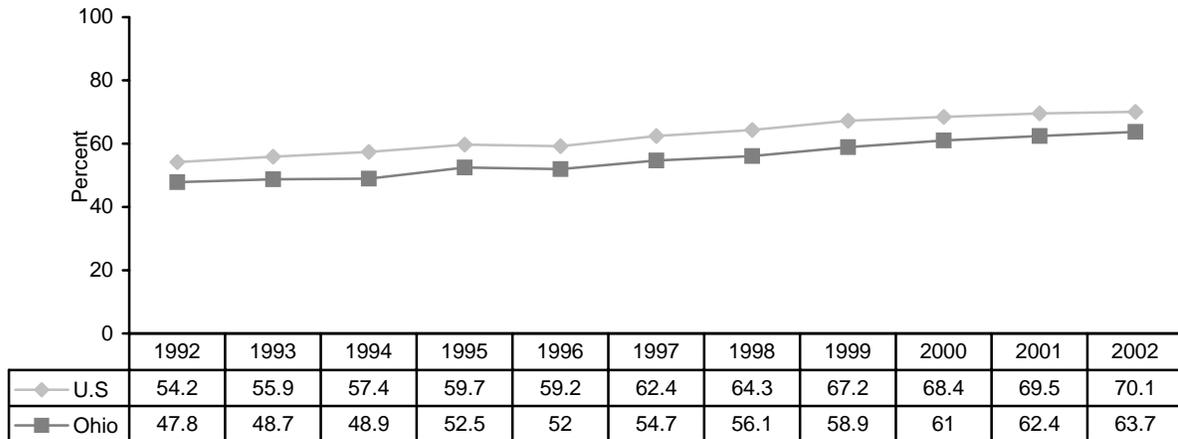
⁶⁵ "2003 Pediatric Nutrition Surveillance, National, Table 8D," CDC, http://www.cdc.gov/pednss/pednss_tables/pdf/national_table8.pdf.

⁶⁶ "2002 Pediatric Nutrition Surveillance, Ohio," Ohio Department of Health, <http://www.odh.ohio.gov/data/pednss/PedPPT.pdf>.

⁶⁷ Mother's Survey, Ross Products Division, Abbot Laboratories, http://www.ross.com/images/library/BF_Trends_2002.pdf

Racial/Ethnic Disparities: Nationally, white children had the highest percentage of breastfeeding at hospital discharge, at 73.4 percent, followed by Hispanics at 70.7 percent and blacks at 53.9 percent.⁶⁸

Ohio and U.S. Percent of Mothers who Breastfed Their Infants at Hospital Discharge, 1992-2002



Data Source: Ross Mother's Survey

C.7. Priority Issues for Early Childhood

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

1. **Access to Health Care:** The problem involves both lack of affordable health insurance and the limited availability of providers who accept Medicaid. Finding a medical home is sometimes difficult for Medicaid clients as providers perceive them as more likely to be “no shows” and therefore are reluctant to accept them as patients. Care is especially difficult to find for vision, dental and hearing needs.

2. **Comprehensive Services:** Oral, vision, and hearing services were identified as priorities under the broader issue of access to comprehensive services. For example, the limited availability of dentists who take Medicaid prevents many individuals from receiving adequate dental or oral health. Access to comprehensive services also included immunizations.

⁶⁸ Ibid.

3. Infant and Child Mortality: Racial/ethnic disparities make infant and child mortality a high priority. The problem is getting worse, not better, especially in the 0-28-day-old population.

4. Child Care and Development: Quality of child care is as important as access to child care. This issue impacts family employment, health, and learning.

5. Mental Health Issues and Child Abuse: Screening of children with behavioral and mental health needs is not done on a wide-scale, statewide basis. Mental health is linked to later abuse issues, to mothers' drug and alcohol use, and to lead poisoning. There is a need to ensure that treatment occurs when a need is identified.

6. Childhood Injuries: These were identified as a priority issue because racial disparities are so dramatic.

7. Overweight and Obesity: The long-term implications associated with childhood overweight is a concern and has more of an impact on the health care system as they reach adulthood. Obesity has a strong relationship to traditional adult onset diseases. Prevention issues can be addressed with this age group.

8. Environmental issues of Lead Poisoning, Asthma, and Second-Hand Smoke: These were combined as a priority. There is a high prevalence of childhood lead poisoning in Ohio and racial disparities are evident.

Local Agency Identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects and WIC projects requesting feedback on progress in regard to the top ten priorities identified in the last Maternal and Child Health Needs Assessment (2001). Survey respondents were asked to identify issues from 2001 that remain high-priority issues in 2005. They were also asked four questions designed to elicit their opinions about other health issues that affect families and children in their communities. The following are their top concerns for the early childhood population:

Continuing Top Issues from Last Needs Assessment (2001)

1. Overweight
2. Oral Health
3. Postneonatal Mortality
4. Infant Mortality
5. Child Mortality
6. Child Mortality due to Motor Vehicle Crashes

Other Concerns Added in 2005

1. Access to Care
2. Nutrition
3. Parenting Skills
4. Immunization

D. School Aged Children and Adolescent Health Status

D.1 Mortality

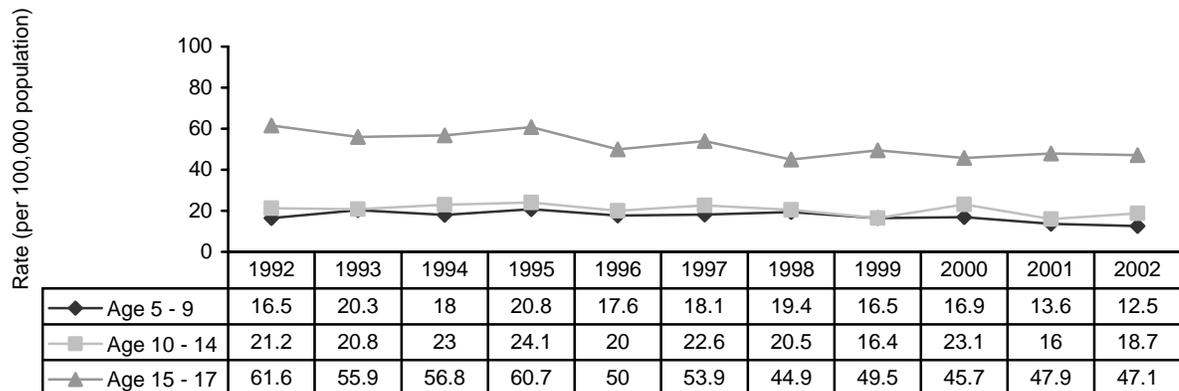
Overall Mortality, Ages 5 through 14

Description: In 2002, the national mortality rate for children in this age group was 17.4 per 100,000, and injuries accounted for 40 percent of all deaths in children ages 5 through 14 in 2002.⁶⁹

In Ohio, unintentional injuries accounted for 36.8 percent of all mortality in this age group in the years 2000-2000.⁷⁰ Motor vehicle crashes were by far the leading cause of death from accidental injury, accounting for 57 percent of fatalities, followed by accidental drowning and submersion, accidental exposure to smoke, fire, and flames, and other and unspecified non-transport accidents.

Quantitative Data: The overall death rate for children aged 5 through 14 in Ohio was 15.7 per 100,000, lower than the national figure and coming very close to HP 2010 targets of 14.3 for children ages 5-9 and 16.8 for children ages 10-14. Mortality among this segment of the population has also been decreasing since 1994, when the rate was 20.3/100,000.⁷¹

Ohio Mortality Rate Ages 5 - 17, 1992 - 2002



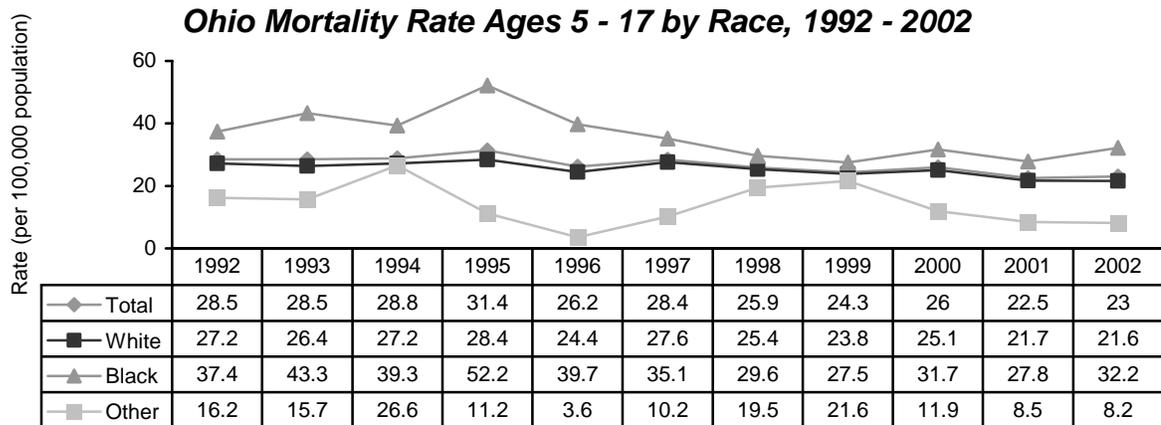
Racial/Ethnic Disparities: In Ohio, blacks have a higher mortality rate in this age group than whites, while the rate for Native Americans falls in between that of blacks and whites and the rate for Asian Americans is lower than that of whites. The mortality rate has decreased for all population subgroups since 1995. While the percentage of decrease was greater for blacks than whites, the mortality rate for blacks remains much higher than for whites. Death rates for Hispanics are comparable to whites in this age group. Death

⁶⁹ CDC NCHS chart book <http://www.cdc.gov/nchs/data/has/has04trend.pdf#035>, 165, 158.

⁷⁰ Ohio Vital Statistics.

⁷¹ Ibid.

rates for Native Americans and Alaska Natives are higher than white rates, but lower than black rates.⁷²



Overall Mortality, Ages 15 through 19

Description: In 2002, the mortality rate for adolescents in this age group was 67.8 per 100,000. Nationally, injury, both intentional and unintentional (accidental) was the leading cause of death, accounting for 46.6 percent of all deaths in that age group (note: the data reported are for 15-24 year olds).⁷³ Mortality rates from injury in Ohio are worse than the US rate, with 68.5 percent of all deaths of 15-24 year olds from 2000-2002 resulting from unintentional injury, homicide, or suicide. Other leading causes of death in this age group are malignant neoplasm followed by diseases of the heart.⁷⁴

Quantitative Data: The overall mortality rate for the 15-24 year age group in Ohio was 71.2 per 100,000 in 2002. This rate has remained fairly stable since 1994.⁷⁵

Racial/Ethnic/Gender Disparities: There is a striking gender disparity in death rates among this age cohort; the death rate for males 15-24 was 117.3 in 2002, while for females the rate was 43.7/100,000.⁷⁶ As is true for each of the other age groups mentioned in this report, black rates were much higher than whites, especially among males. For instance, in 2002 the death rate for black males 15-24 was 172.6, compared with 109.7 for white males. Disparities, while present, were less striking among females, with the death rate for black females 54.4, compared with 42.4 for white females. Blacks have the highest death rates of all races/ethnicities, and Asian Americans the lowest.⁷⁷

⁷² National vital statistics report, vol. 53 no. 5, Oct. 12,2004, http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_05acc.pdf.

⁷³ Ibid.

⁷⁴ Ohio Vital Statistics.

⁷⁵ Ibid.

⁷⁶ CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hus/hus04trend.pdf#035>.

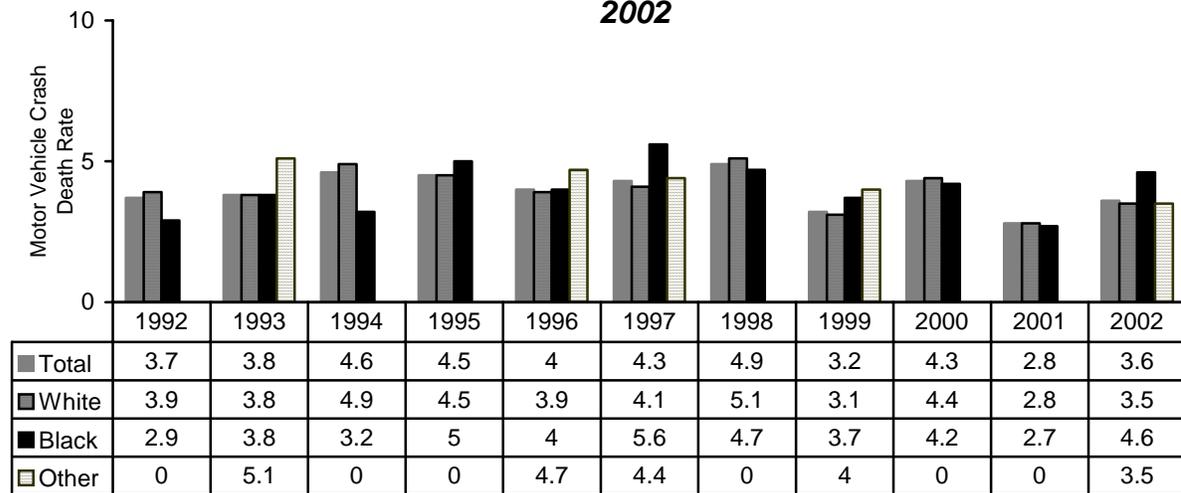
⁷⁷ Ibid.

Mortality Due to Motor Vehicle Crashes

Description: Injury is the leading cause of death in children and youth. Motor vehicle (MV) crashes are the leading cause of mortality from injury, accounting for nearly 60 percent of all injury deaths among children age 5-14, and 76 percent of injury deaths for 15-24 year olds.⁷⁸

Quantitative Data: Children aged 5 through 14: In Ohio in 2002, the mortality rate for MV accidents was 3.6/100,000 for this age group, the same as the national three year average of 3.6/100,000, and higher than the Healthy People 2010 target rate of 2.1.⁷⁹

Ohio Motor Vehicle Crash Death Rates (per 100,000 population) For Children Aged 5-14 Years Old by Race, 1992 - 2002



Data Source: Ohio Vital Statistics

Youth ages 15-19: In 2002, the mortality rate for MV accidents in children aged 15-19 was 24.7/100,000. This rate is lower than the national rate of 27.4, and higher than the HP 2010 target of 9.0.⁸⁰

Racial/Ethnic/Gender Disparities: There is a gender disparity in rates of death by MV accident, with males having a higher rate across all age groups, with the most striking disparity in the 15-19 year old group, with males (32.6) double the rate of females (16.4).⁸¹ Racial and ethnic disparities are less apparent for this cause of death.

⁷⁸ Ohio Vital Statistics.

⁷⁹ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁸⁰ Ibid.; CDC NCHS chart book, <http://www.cdc.gov/nchs/data/hus/hus04trend.pdf#035>

⁸¹ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>

Suicide Deaths and Suicide Attempts

Description: In Ohio in the years 2000-2002, over 13 percent of deaths in the 15-24 year old age group were due to suicide. The mortality rate for suicide has slowly decreased, at 9.5/100,000 for 2000-2002, compared with 11.1/100,000 in 1994-1996.⁸²

Quantitative Data: Suicide deaths: In 2002, the rate of suicide deaths in 15-19 year olds in Ohio was 6.2/100,000. This rate is lower than the national rate of 7.4 for this age group, and approaches the HP 2010 target rate of 6.0/100,000.⁸³

Suicide attempts: According to the 2003 Ohio Youth Risk Behavior Survey (YRBS), 12 percent of teens in grades 9 through 12 reported that they had attempted suicide one or more times in the past 12 months.⁸⁴ This percentage is higher than that reported in the 1999 Ohio Survey (8 percent), and also higher than the percentage (8.5 percent) reported in the national 2003 YRBS Survey data.⁸⁵

Racial/Ethnic/Gender Disparities: In the 15 to 19 year old age group, suicide mortality rates were higher in whites (6.6/100,000) than blacks (4.4) in Ohio in 2002, although the rate for blacks should be viewed with caution because of the low number of deaths (five deaths reported). The rates for males were much higher than for females (10.0 to 2.3). Again, the rate for females reflects a low number of deaths (nine deaths reported) and should be viewed with caution.⁸⁶ Slightly more females (12.8 percent) than males (10.8 percent) in Ohio reported attempted suicide in 2003.⁸⁷ Nationally, the percentage of attempted suicides was higher in Hispanics (10.6 percent) than either blacks (8.4 percent) or whites (6.9 percent).

D. 2 Infectious Diseases—Morbidity

Chlamydia in Adolescents Ages 15 through 19

Description: Chlamydia is the most common sexually transmitted disease (STD). STD rates are highest among the teenage population, especially females. Ohio ranked 9th out of all states in cases of chlamydia according to 2003 data.⁸⁸

Quantitative Data: The rates of chlamydia in adolescents aged 15-19 years old in Ohio is rising. In 2003, the overall rate was 1,982/100,000, up from 1,696 in 2001 and 1,944 in

⁸² Ohio Vital Statistics.

⁸³ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁸⁴ Ohio Youth Risk Behavior Survey.

⁸⁵ "CDC Youth Risk Behavior Surveillance-United States, 2003," <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm>.

⁸⁶ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

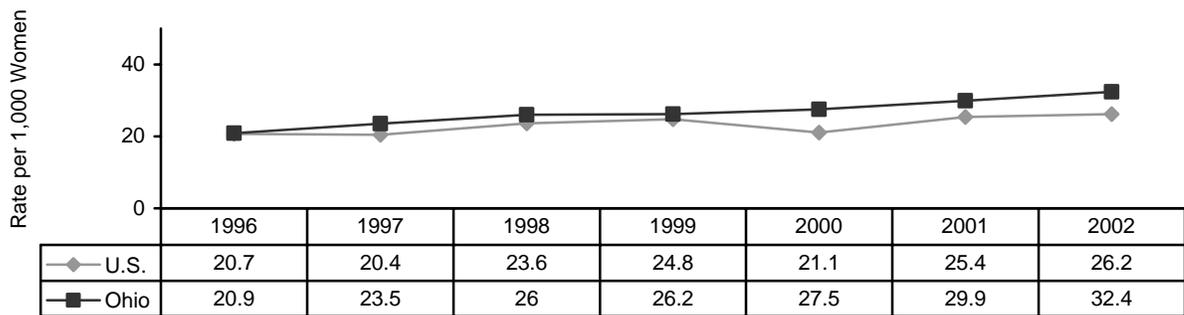
⁸⁷ "CDC Youth Risk Behavior Surveillance-United States, 2003," <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm>.

⁸⁸ "STD Surveillance 2003, Table 2. Chlamydia," CDC, <http://www.cdc.gov/std/stats/tables/table2.htm>.

2002. However, this prevalence of 2 percent is lower than the HP 2010 objective of 3 percent. Reported rates among females are much higher than males because women are more likely to be symptomatic and seek treatment. In 2003, the rate of chlamydia in females' ages 15-19 years old was 3,477/100,000, compared with 501/100,000 for males.⁸⁹

Racial/Ethnic/Gender Disparities: As noted above, rates of chlamydia are considerably higher in females than males, across all races and ethnicities. Rates are higher for blacks and Hispanics than for whites.

Chlamydia Rate (per 1,000 Women) Ages 15 - 19 U.S. and Ohio, 1996 - 2002



Data Source: Ohio Vital Statistics, CDC

AIDS

Description: Nationally, the rate of HIV/AIDS diagnosed in adults and children over the age of 13 was 14.7/100,000 in 2003. Women made up over 25 percent of new diagnoses. The national rate for adolescents aged 13-19 was 1.4.⁹⁰

Quantitative Data: As of June 30, 2004, there were 95 adolescents 13-19 years of age living with HIV/AIDS in Ohio, a rate of 8.3/100,000 (not equivalent to the incidence rate or diagnosis with HIV/AIDS). This population accounts for 1 percent of all diagnosed HIV/AIDS cases in Ohio. Eighty percent of persons living with HIV/AIDS were male.⁹¹

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

⁸⁹ Ohio Vital Statistics.

⁹⁰ CDC NCHS chart book, [http://www.cdc.gov/nchs/data/04trend.pdf#035](http://www.cdc.gov/nchs/data/hus/04trend.pdf#035).

⁹¹ "Ohio HIV Statistical Summary, HIV Infection and AIDS Cases Diagnosed through June 2004," Ohio Department of Health, http://www.odh.state.oh.us/Data/Inf_Dis/HIVsum/hiv0604.pdf.

D. 3 Infectious Diseases—Contributing Factors

Teen Sexual Intercourse

Description: Sexual intercourse is defined as heterosexual vaginal intercourse. Sexual experience, and particularly age at first intercourse, represents a critical risk factor for pregnancy and sexually transmitted infections, including HIV/AIDS. Youths who begin having sex at younger ages are exposed to these risks over a longer time. Research has shown that youths who have early sexual experiences are more likely at later ages to have more sexual partners and more frequent intercourse.

Quantitative Data: The data for this health issue comes from the Ohio Youth Risk Behavior Survey. In 2003, 42 percent of teenagers in grades nine through 12 reported ever having sexual intercourse, down from 55 percent in 1993. Similarly, the number reporting first sexual intercourse before age 13 decreased to 6 percent in 2003, down from 11 percent in 1993.⁹²

Racial/Ethnic/Gender Disparities: Results of this question for the Ohio survey were not reported by race. Nationally, black teens (67.3 percent) were more likely to report ever having intercourse than whites (41.8 percent). Ninth grade females were less likely to report intercourse than males (22 percent compared to 36 percent), but roughly equal numbers of males and females reported intercourse in the later grades.⁹³

Age Disparities: In Ohio, more older adolescents report having had sexual intercourse than younger adolescents. In 2003, 29 percent of 9th graders reported ever having sexual intercourse, while 56 percent of 12th graders reported having intercourse.

D. 4 Injuries—Morbidity

Nonfatal Motor Vehicle Injuries

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

Quantitative Data: Children aged 5 - 14: In 2003, the rate of nonfatal injuries due to transport accidents was 1,213/100,000 nationally.⁹⁴ In Ohio, the rate was 936/100,000.⁹⁵

⁹² “2003 Ohio Youth Risk Behavior Survey, Sexual Behaviors,
<http://www.odh.state.oh.us/ODHPrograms/YouthRisk/Survey/sxbeh.pdf>.

⁹³ “Healthy Youth, Youth Online: Comprehensive Results, Ohio,” CDC, <http://apps.nccd.cdc.gov/yrbss/SelHealthTopic.asp?Loc=OH>.

⁹⁴ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁹⁵ Calculated from ODP data available at <http://www.publicsafety.ohio.gov/publicat/HSY7606/HSY7606-2003.PDF> with number of injury by age group divided by population estimates available at <http://www.census.gov/popest/states/asrh/tables/SC-EST2003-02/SC-EST2003-02-39.pdf>.

Youth aged 15 through 24: In 2003, the national rate of nonfatal injuries from this cause was 3,002/100,000.⁹⁶ In Ohio, the rate was lower than the national rate at 1,813/100,000. This rate is higher than the HP 2010 target rate of 953 for ages 16-20 and 21-24.⁹⁷

Racial/Ethnic/Age Disparities: The rate of motor vehicle related injuries is similar for males and females (3,034 for males and 2,965 for females). Blacks have a higher injury rate than whites, 3,132 compared to 2,422.⁹⁸ In Ohio, the age group with the highest number of injuries is 16-20 years, with a rate of 2,045/100,000, compared with 1,703 for 21-25 year olds and 936 for children aged 0-15.⁹⁹

D. 5 Nutrition—Morbidity

Overweight

Description: Overweight is defined as a weight-for-height above the 95th percentile of the National Center for Health Statistics age-and-sex-specific weight-for-height reference population. The health problems associated with childhood overweight and obesity include high blood pressure, high cholesterol, glucose intolerance, orthopedic disorders, and psychosocial disorders. In addition, longitudinal studies show that overweight in childhood is associated with overweight in adulthood, which is a recognized health risk. Contributing factors to overweight include high body mass index of parents, low family income, eating a high proportion of calories from fat and long hours of watching television.

Quantitative Data: In 1999-2000, about 16 percent of U.S. children aged 6-11 and 12-19 years of age were overweight (15.8 and 16.1 percent, respectively). This was an increase from the approximately 11 percent who were overweight in 1988-1994, and the 6.5 percent overweight in 1976-1980.¹⁰⁰ Ohio does not yet collect population-based data on children and adolescents except for self-reported data from YRBS for adolescents in grades 9-12. According to these self-reports, 10 percent of students were overweight in 1999, and increased significantly to 14 percent in 2003.

Racial/Ethnic Disparities: Nationally, among boys aged 6-19, Mexican Hispanics had the highest percentage of overweight in 1999-200, followed by blacks and whites.

⁹⁶ WISQARS injury mortality report, National Center for Injury Prevention and Control, CDC, <http://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

⁹⁷ Calculated from ODP data available at <http://www.publicsafety.ohio.gov/publicat/HSY7606/HSY7606-2003.PDF> with number of injury by age group divided by population estimates available at <http://www.census.gov/popest/states/asrh/tables/SC-EST2003-02/SC-EST2003-02-39.pdf>.

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

⁹⁹ Calculated from ODP data available at <http://www.publicsafety.ohio.gov/publicat/HSY7606/HSY7606-2003.PDF> with number of injury by age group divided by population estimates available at <http://www.census.gov/popest/states/asrh/tables/SC-EST2003-02/SC-EST2003-02-39.pdf>

¹⁰⁰ CDC NCHS chart book, [http://www.cdc.gov/nchs/data/04trend.pdf#035](http://www.cdc.gov/nchs/data/hus/04trend.pdf#035).

Among girls of this age, blacks had the highest percentage of overweight, followed by Mexicans and whites.¹⁰¹

D. 6 Oral Health Morbidity

Dental Caries

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

Quantitative Data: In Ohio, 63 percent of third grade students had an observable history of dental caries in 2003.¹⁰² This rate is higher than the HP 2010 goal of 42 percent.

Racial/Ethnic Disparities: In the Ohio Sentinel Schools study in 2003, a slightly lower percentage of black students (51 percent) had a history of dental caries than white students (60 percent).¹⁰³

Socioeconomic Disparities: In the 2003 Ohio Sentinel Schools Study, a higher percentage of children from lower income families, as determined by eligibility for school lunch programs, had a history of dental caries than children not eligible for the school lunch program (66 percent compared to 56 percent).¹⁰⁴

Untreated Dental Caries

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

Quantitative Data: In 2001-2002, 31 percent of Ohio third graders had untreated dental caries.¹⁰⁵ While not from exactly comparable populations, this is higher than the national

¹⁰¹ CDC NCHS chart book <http://www.cdc.gov/nchs/data/hus/04trend.pdf#035>.

¹⁰² "Sentinel Data, 1998-1999," Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

rate of 22.6 percent of children aged 6-17 according to 1999-2000 data.¹⁰⁶ Ohio's rate is higher than the HP 2010 target of 21 percent.

Racial/Ethnic Disparities: In 1998-1999, white and black children in Ohio had roughly comparable rates of untreated dental caries: 31 percent and 26 percent, respectively.¹⁰⁷

Socioeconomic Disparities: In 1998-1999, untreated dental caries were more prevalent in Ohio children eligible for free lunch programs (40 percent) compared to children ineligible for free lunch programs (25 percent).¹⁰⁸

D. 7 Oral Health—Contributing Factors

Protective Sealants in Third-Grade Children

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

Quantitative Data: In Ohio in 2001-2002, 41 percent of third grade students had received protective sealants on at least one permanent molar tooth.¹⁰⁹ This is higher than the national rate of 26 percent but slightly below the HP 2010 target of 50 percent.¹¹⁰

Racial/Ethnic Disparities: In national data, there are large disparities in protective dental sealants between black, Hispanic, and white children. Thirty-one percent of non-Hispanic white children had dental sealants, compared to 13 percent of non-Hispanic blacks and 17 percent of Mexican children aged 8-10.¹¹¹ In Ohio, while the discrepancy is not as great, it is still apparent, with 34 percent of white children having had sealants compared to 20 percent of black third graders.¹¹²

Socioeconomic Disparities: Children in poverty are less likely to have access to dental sealants. In the US, only 15 percent of children at or below the federal poverty level (FPL) received sealants, compared to 30 percent of children above the FPL. Racial and ethnic disparities are less apparent among poor children, ranging from 11 percent of Mexican children to 16 percent of non-Hispanic white children below the FPL having

¹⁰⁶ “Table 80. Untreated dental caries according to age, sex, race and Hispanic origin, and poverty status: United States, 1971–74, 1988–94, and 1999–2000,” CDC, <http://www.cdc.gov/nchs/data/has/has04trend.pdf#080>.

¹⁰⁷ “Sentinel Data, 1998-1999,” Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ “Table 2.11, Children and adolescents with dental sealants by age group and selected demographic characteristics,” The Third National Health and Nutrition Examination Survey (NHANES III) 1988-1994, National Center for Health Statistics, CDC, http://drc.nidcr.nih.gov/report/alltables.htm#2_1_1.

¹¹¹ Ibid.

¹¹² “Sentinel Data, 1998-1999,” Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>.

sealants.¹¹³ Again, Ohio data reflects the national rates, with 27 percent of third-graders eligible for school lunch programs receiving sealants.

Ability to Get Wanted Dental Care

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

Quantitative Data: Nationally, 74.3 percent of children aged 2-17 had at least one dental visit in the past twelve months.¹¹⁴ Ohio rates compare favorably with national rates, with 75 percent of third graders reporting a dental visit in the past year. Nineteen percent of these third-graders could not get dental care.¹¹⁵

Racial/Ethnic Disparities: In national data, Hispanics aged 2-17 were the least likely to have visited a dentist in the last year (62 percent) followed by blacks (70 percent) and non-Hispanic whites (79 percent).¹¹⁶ In Ohio, this disparity was not noted among third grade children, with 77 percent of whites and 74 percent of blacks reporting a dental visit within one year.¹¹⁷

Socioeconomic Disparities: Persons at or above the FPL (all ages) were more likely (71 percent) to report a visit to the dentist in the past year than those who were less than the FPL (51 percent).¹¹⁸ In Ohio, children not eligible for school lunch program were more likely to report a dental visit in the past year (81 percent) than children who were eligible for school lunch program (65 percent). Poor children were also more likely to report being unable to get care (33 percent) than non-poor children (10 percent).¹¹⁹

¹¹³ “Table 2.11, Children and adolescents with dental sealants...”, CDC, http://drc.nidcr.nih.gov/report/alltables.htm#2_1_1.

¹¹⁴ Table 79, CDC, <http://www.cdc.gov/nchs/data/hus/04trend.pdf#079>.
http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹¹⁵ “Sentinel Data, 1998-1999,” Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>.

¹¹⁶ “Table 7.1.1. Visits to a dentist during the past year among those aged 2 years and older,” CDC, http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹¹⁷ “Sentinel Data, 1998-1999,” Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>.

¹¹⁸ “Table 7.1.1. Visits to a dentist during the past year among those aged 2 years and older,” CDC, http://drc.nidcr.nih.gov/report/dqs_tables/dqs_7_1_1.htm.

¹¹⁹ “Sentinel Data, 1998-1999,” Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/oral/sentinel/sentgd3.pdf>.

D. 8 Substance and Tobacco Use—Contributing Factors

Tobacco Use

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

Quantitative Data: Data for this issue came from the Youth Risk Behavior Survey. In 2003, 22 percent of Ohio adolescents in the 9th through 12th grade reported that they smoked one or more cigarettes in the 30 days preceding the survey. This is the same as the rate reported nationally (21.9 percent)¹²⁰ and represents a significant decrease since 1999, when 40 percent of students reported use of cigarettes within the last 30 days.¹²¹ The Ohio rate falls short of the HP 2010 goal of 16 percent.

Racial/Ethnic Disparities: Racial and ethnic rates are not reported for 2003 Ohio YRBS data. In the national YRBS, a higher percentage of whites smoked cigarettes (25 percent) than either Hispanics (18 percent) or blacks (15 percent).¹²²

Gender Disparities: There was not a significant difference in the percentages of Ohio males and females who smoked.¹²³

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

MCH Stakeholder Identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the school-aged and adolescent health group. A brief summary of the group discussion is reported under each to help define the issue. A list of group members can be found at the end of this report.

1. **Access to Health Care:** Access to health care includes children without health insurance or Medicaid eligible children not receiving Medicaid services.
2. **Hearing and Vision:** The link between hearing, vision and learning makes this a high priority.

¹²⁰ “Youth Risk Behavior Surveillance --United States, 2003,” *Morbidity and Mortality Weekly Report* 53, May 21, 2004, CDC, <http://www.cdc.gov/mmwr/PDF/SS/SS5302.pdf>.

¹²¹ Ohio YRBS, <http://www.odh.state.oh.us/ODHPrograms/YouthRsk/Survey/tobacco.pdf>.

¹²² “Youth Risk Behavior Surveillance-United States, 2003,” CDC, <http://www.cdc.gov/mmwr/PDF/SS/SS5302.pdf>.

¹²³ “2003 Ohio Youth Risk Behavior Survey, Tobacco” Ohio Department of Health, <http://www.odh.state.oh.us/ODHPrograms/YouthRsk/Survey/tobacco.pdf>.

3. Sexual Behavior: “Abstinence only” is not working for all adolescents. Teen pregnancies are declining, but many resources have been used to make this impact. Sexually transmitted disease rates are rising.
4. Substance Use/Abuse: Substance abuse issues are closely linked to other risk factors such as HIV, STDs, and impaired driving. Parents hosting or condoning alcohol and drug use is also a problem.
5. Suicide: The fact that early intervention and prevention opportunities can have an impact makes suicide a high priority. There are strong links to alcohol, drug use, motor vehicle crashes, and other mental health issues.
6. Chronic Disease Prevention: Children with asthma and children who were overweight were of the greatest concern to the group. Parent education and school policy change are needed to help minimize the risk for both conditions. Links to tobacco use are strong for asthma.
7. Mental Health: As with suicide, the fact that early intervention and prevention opportunities can have an impact make mental health issues a priority. Mental health issues are strongly linked to suicide, alcohol, drug use, and motor vehicle crashes.
8. Motor Vehicle Crashes: Motor vehicle crashes continue to be the number one reason for death in children and adolescents. This is related to alcohol use, seatbelt use, and possibly linked to suicide.
9. Fatalities: Violence/violence prevention is an opportunity for collaboration with other agencies.
10. School Safety issues: Violence at schools is part of larger violence issue including weapon carrying and bullying.

Local Agency Identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects and WIC projects requesting feedback on progress in regard to the top ten priorities identified in the last Maternal and Child Health Needs Assessment (2001). Survey respondents were asked to identify issues from 2001 that remain high-priority issues in 2005. They were also asked four questions designed to elicit their opinions about other health issues that affect families and children in their communities. The following are their top concerns for school-aged children and adolescents:

Continuing Top Issues from Last Needs Assessment (2001)

1. Oral Health
2. Teen Birth
3. Teen Sex and its Consequences
4. Teen Tobacco Use
5. Child Mortality

6. Child Mortality due to Motor Vehicle Crashes
7. Adolescent Suicide

Other Concerns Added in 2005

1. Obesity
2. Mental Health
3. Substance Abuse
4. Violence

E. Children With Special Health Care Needs Health Status

E. 1 Morbidity

Prevalence of Children with Special Health Care Needs (CSHCN)

Description: Children with special health care needs are children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions, and require health and related services of a type or amount beyond that generally required by children.¹²⁴

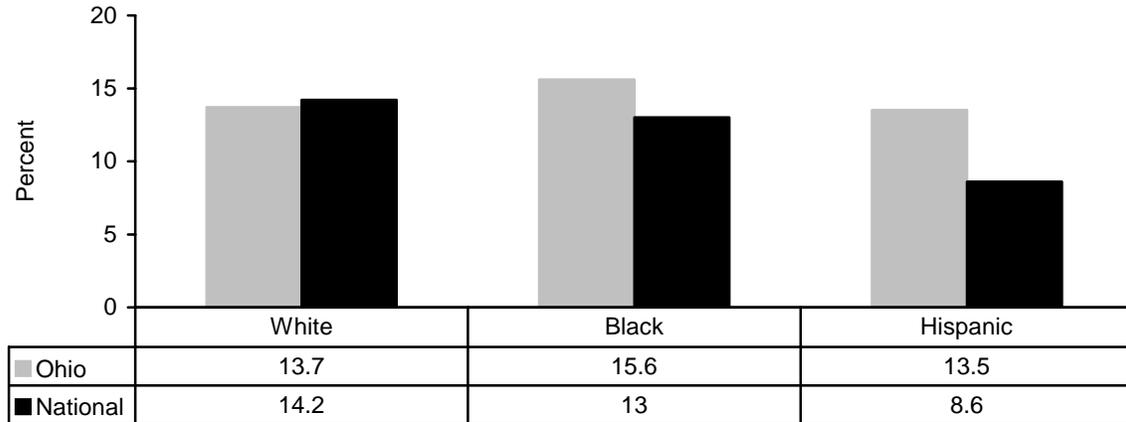
Quantitative Data: Ohio has approximately 402,800 CSHCN age 0-17 years. They comprise 13.9 percent of all Ohio children. Approximately 338,550 households have at least one child with special health care needs, comprising 22 percent of Ohio households with children. A greater proportion of CSHCN are in the older ages, reflecting an increased identification or development of special health needs as the child grows. There are more males (61 percent) with special health care needs compared to females (39 percent). Over half of the CSHCN are in families with income under 400 percent federal poverty level (FPL). In fiscal year 2003, the Bureau for Children with Medical Handicaps (BCMh) at ODH provided funding for services to 31,000 children with medically handicapping conditions. BCMh provided funding for diagnostic evaluations for 7,000 children at a cost of \$1.4 million, treatment services for 23,000 children at a cost of \$18.5 million and service coordination for 1,000 children at a cost of \$410,000.¹²⁵

Racial Disparities: In Ohio, prevalence of CSHCN is evenly distributed among races: Hispanic 13.5 percent, white 13.7 percent, and black 15.6 percent.

¹²⁴ Definition from Maternal and Child Health Bureau, U.S. Dept. Health and Human Services, and American Academy of Pediatrics.

¹²⁵ BCMh fact sheet, 2003, Ohio Department of Health.

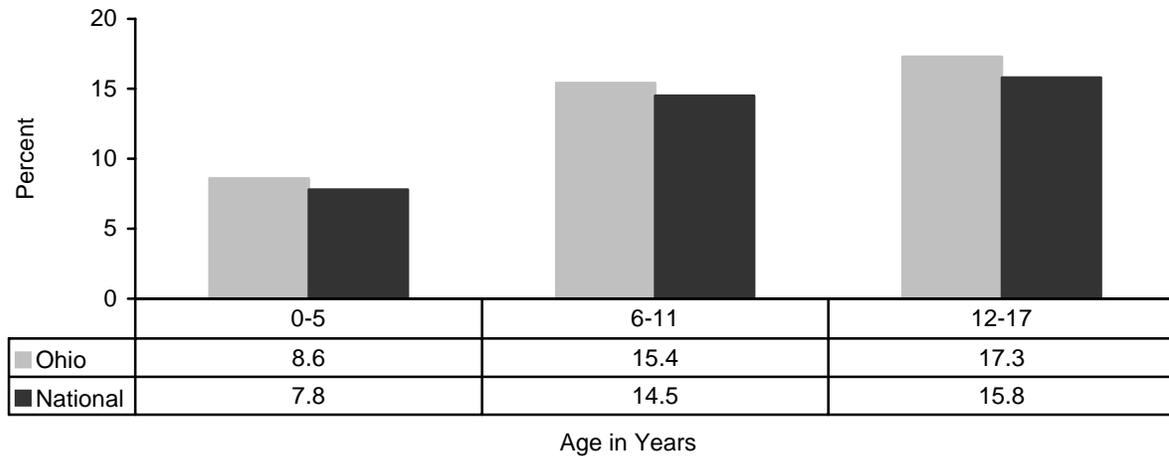
Ohio and U.S. CSHCN Prevalence By Race/Ethnicity, 2002



Data Source: National Survey of CSHCN, 2002

Age Disparities: Prevalence of CSHCN is disproportionately distributed among older age groups: children 0-5 years, 8.6 percent; children 6-11 years 15.4 percent; children ages 12-17, 17.3 percent.

Ohio and U.S. CSHCN Prevalence by Age, 2002



Data Source: National Survey of CSHCN, 2002

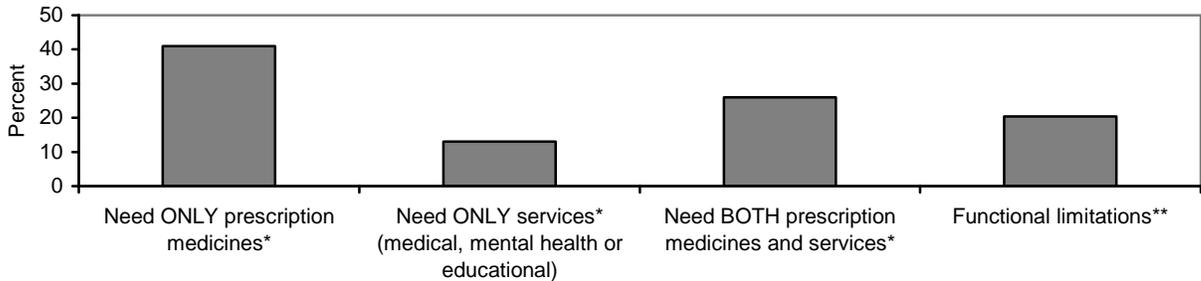
Prevalence of Congenital Anomalies

Description: Congenital anomalies are the leading cause of death in infants under 12 months of age. In Ohio, this translates to about 1,230 infant deaths each year. However, current state information is inadequate and the Ohio Department of Health is working to improve this. The Ohio Department of Health has convened the Birth Defects Advisory Council to develop a birth defects information system. A birth defects reporting form is

currently being field-tested and results will be used to develop trainings for mandated reporters when the system is implemented statewide.

Special Health Care Needs: In the National Survey of CSHCN, parents were asked to describe the special health care needs of their children. Forty-one percent said their children needed ONLY prescription medicines, while 21 percent reported functional limitations.

Ohio Special Health Care Needs, 2002



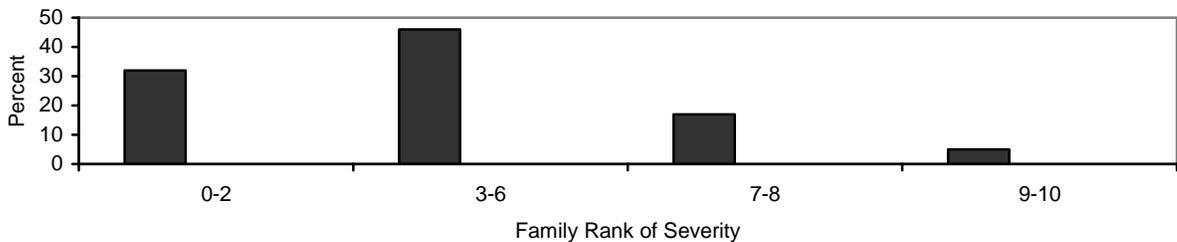
*No functional limitations

**Limited in ability to do things most children of the same age can do. This subgroup includes children with functional limitations who also need prescription medicines and/or more services.

Data Source: National Survey of CSHCN, 2002

Severity: Parents ranked their children’s conditions or problems on a scale from 0-10, with 10 as the most severe. Forty-six percent reported their children had moderate conditions or problems (rank 3-6), and 22% reported severe conditions or problems (rank 7-10).

Ohio CSHCN Severity of Condition, 2002



Data Source: National Survey of CSHCN, 2002

E. 2 Qualitative Data—Consumers and Key Informants

Consumer focus groups of parents of CSHCN were held in 2002. Nine groups were held representing 67 families and approximately 77 CSHCN enrolled in Medicaid and BCMH.

All of the CHSCN represented in the focus groups experienced on-going medical conditions, many of which were severe and/or disabling. Overarching themes include:

1. **Stress and crises:** Families described stress and overload with extended hospital stays, unexpected paperwork, and financial burdens while adapting to the child's health care needs, which prevented them from understanding information about services available. Families felt a lack of support and understanding, and experienced a vacuum of information and difficulty with the ever-changing stream of caseworkers and insurance staff.
2. **Families are the first and foremost experts about their children:** A number of parents recalled instances when health providers discounted their observations, requiring them to go to several providers before finding one who took their concerns seriously. Several participants described refusing medical advice that later proved to be inaccurate or incomplete.
3. **Navigating the insurance payment arrangements:** Confusion over complex insurance arrangements was nearly universal. Participants described a lack of clarity regarding the relationship between Medicaid and BCMH as well as private insurance.

E.3. Priority Issues for Children with Special Health Care Needs (CSHCN)

MCH Stakeholder Identified Issues: Through a series of individual and group prioritization by MCH stakeholders, the needs listed below (in priority order) were identified as priority issues within the Children with Special Health Care Needs Group. A summary of the group discussion is reported under each to help define the issue. A list of group members can be found at the end of this report.

1. **Access to Healthcare and Insurance** (Special Health Care Services): Less than 16 percent of children on SSI are receiving CSHCN services and a number of children not on SSI are being enrolled in the Bureau for Children with Medical Handicaps (BCMh). This is a high priority because it is difficult to get enrolled, especially for children from birth to three years. Even with payment systems, providers are not always available. Access to mental health is also needed because of concerns specific to CSHCN.
2. **Care Coordination/Medical Home:** The care system needs to be better organized and streamlined. This need increases as children grow older.
3. **Congenital and Genetic Services:** There is a need to increase the percentage of parents and CSHCN who have genetic counseling available to them. Early identification and treatment can prevent more serious problems. Sickle cell service availability was especially noted as an example of this.
4. **Transition to Adult Life:** Because of improved health care, more CSHCN are reaching adulthood and few providers are available to treat a 20 year old with multiple health needs. Economic issues are severe and aging parents create a burden of care issue.

Children's hospitals in the state have age restrictions even though they may be the most appropriate places for some care.

5. Special Health Care Services: Budget cuts, eligibility restrictions, and lack of transportation make provision problematic.

6. Mental Health Issues: Depression is a major issue with multi-handicapped teens. It affects many other areas (school, social relationships) and often goes unrecognized.

7. Medical Conditions and Services: These may be detected in birth screenings and may be of low severity when caught early. Problems include lack of transportation and lack of providers.

8. Impact on Family: The financial and emotional impact of providing for a special needs child are intense, affecting the family's ability to work, causing a higher than average divorce/separation rate among parents, which impacts the children. Also, problems in negotiating the system for desired services were identified.

Local Agency Identified Issues: A survey was sent electronically to all local health districts, Child and Family Health Services projects and WIC projects requesting feedback on progress in regard to the top ten priorities identified in the last Maternal and Child Health Needs Assessment (2001). Survey respondents were asked to identify issues from 2001 that remain high-priority issues in 2005. They were also asked four questions designed to elicit their opinions about other health issues that affect families and children in their communities. The following are their top concerns for CSHCN:

Continuing Top Issues from Last Needs Assessment (2001)

1. Gaps in CSHCN Services
2. Coordination of CSHCN Services
3. Lack of CSHCN Population-Based Data

Other Concerns Added in 2005

1. BCMH/State Funding Issues
2. Access to Community-Based Care
3. Spend Down/Cost Sharing/ Financial Support to Families
4. Access/Gaps in Service
5. Support Services

2.1.2.2. Direct Health Care Services

2.1.2.3 Enabling Services

The balance between the State's involvement in direct health care services and enabling services depends on the gaps that need to be filled. This can be a dynamic process that responds to changes in the economy (e.g., willingness of providers to treat Medicaid patients, health care benefits associated with employment) and public policy (e.g., Medicaid/SCHIP expansions, impact of managed care). The Ohio Department of Health has set strategic priorities for each of the last several years based on annual assessments of needs, wants, and resources. With significant reductions in state public health funding combined with potential or proposed cuts in federal funding this process is producing significant shifts in current and planned funding for maternal and child health. The department decided against across-the-board cuts at the time of earlier reductions, with priority to activities designed to stop disease spread. Over the past five years Title V and other federally funded initiatives have supported efforts to transform funded projects from direct care to other efforts designed to strengthen community resources for treatment, including local needs assessments, linkages with safety net providers, and targeting of health care provider placement programs. The Legislature has proposed a study commission to address the need for a comprehensive long-term funding solution to support treatment services for children with special health care needs.

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

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

A. Barriers and Systems/Programs to Address Them

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

A.1 Financial Barriers

Health Insurance Coverage

A major determinant of access to health care is the ability of a family to pay for care. Private and public health insurance are significant enabling factors. The 2004 Ohio Family Health Survey of nearly 40,000 households revealed that 10.7 percent (1.2 million) of Ohio residents had no health insurance. This is not significantly different from the 11.2 percent overall uninsured rate reported in 1998. However, from 1998 to 2004 the uninsured rate for children ages 0 through 17 declined significantly from 9.8 percent (280,000) to 5.4 percent (156,000), largely due to eligibility expansions in Ohio's Medicaid program. The child uninsured rate in Ohio is substantially lower than the 2003 national average of 11.4 percent for this age group¹²⁶, but higher than the HP 2010 target rate of 0 percent. Uninsured rates for Ohio children did not vary significantly by age group: 5.8 percent of children ages 13 through 17 were uninsured, versus 5.6 percent of children ages 6 through 12 and 4.8 percent of children under age 6. Among Ohio children with special health care needs, 4.4 percent were uninsured.

The uninsured rate for Ohio women ages 18 through 44 decreased slightly from 17.0 percent in 1998 to 15.7 percent in 2004. Among pregnant women, 12.7 percent were uninsured in 2004. Racial, age, and economic disparities in uninsured rates are apparent, particularly among adults. Women belonging to racial or ethnic minorities, young women, women from low-income families, and Appalachian women are at high risk of being uninsured. Nearly one-third (30.9 percent) of Hispanic women ages 18 through 44 were uninsured in 2004, as were 19.9 percent of Black women in this age group. In addition, 9.3 percent of Hispanic children were uninsured. Among women ages 18 through 24, 19.5 percent were uninsured. The percentage of low-income and Appalachian women ages 18 through 44 who were uninsured was 25.8 percent and 18.9 percent, respectively.¹²⁷ In addition, 8.4 percent of low-income children were uninsured.

Most uninsured Ohioans lack coverage because they do not think they can afford it or they cannot obtain insurance through work. About one-third (30.7 percent) of uninsured women ages 18 through 44 reported that they were without coverage in 2004 because it was too expensive or they could not afford it. Nearly half (47.6 percent) cited employment related reasons such as losing or changing jobs, working only part-time, or not being eligible for an employer's health plan. For uninsured children, 24.3 percent cited cost or affordability and 28.1 percent gave employment related reasons. Among uninsured children with special health care needs, 11.6 percent were reported to be without coverage because their child was not eligible for Medicaid. In addition, 12.5 percent of uninsured children near poverty (family income between 101 percent and 150 percent of poverty) were reported to be without coverage because the adult respondent thought the child was not eligible for Medicaid, despite the fact that children in this income group would meet the program's eligibility requirement.

¹²⁶ Source: 2004 Current Population Survey, U.S. Census Bureau

¹²⁷ Low-income women are defined as living families with annual income of 200% or less of the Federal Poverty Level.

Many uninsured Ohioans reported barriers to health care. Most (58.0 percent) of uninsured women ages 18 through 44 reported that they delayed or avoided obtaining health care because they were without coverage. In addition, 27.8 percent of uninsured women in this age group reported problems when trying to obtain health care. For uninsured children, 20.7 percent of adult respondents said they had delayed or avoided obtaining care for their child because s/he was uninsured. Furthermore, 10.3 percent reported problems trying to obtain health care for their child while uninsured.

The Medicaid Program and SCHIP

The Medicaid Program

The Medicaid program is the most significant source of payment for health care services for low-income Ohioans. The Ohio Department of Job and Family Services (ODJFS) is the single state agency in Ohio with responsibility for administering the health care needs of Medicaid eligible persons including the health care needs of childbearing women, infants, and children. As in other parts of the country, Ohio's Medicaid program is undergoing major changes as Medicaid spending outpaces the growth of state revenues.

In SFY 2004, Ohio Medicaid provided comprehensive health care coverage to:

- 1 million children, including 45 percent of children under age 5;
- 265,000 non-elderly adults and children with disabilities;
- Over 490,000 low income parents;

The Ohio Medicaid program offers two delivery systems: the Fee-For-Service (FFS) and Managed Health Care System via the Managed Care Plans (MCP). The FFS system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is delivered. Medicaid MCPs operate in 15 Ohio counties for the Healthy Start and Healthy Families population.

One of Medicaid's program categories is the Covered Families and Children (CFC) category of Healthy Start/Healthy Families that provide health care coverage for pregnant women and children who are not eligible for other Medicaid programs but meet the income guidelines for Healthy Families. It can provide assistance to pregnant women at any age, and infants, children and teens up to age 18.

Pregnant Women: Provides time-limited health care coverage to low-income pregnant women with family incomes at or below 150 percent of poverty. Coverage begins following confirmation of pregnancy and ends two months following birth. Ohio has not elected to exercise the option of presumptive eligibility for pregnant women. However, Ohio does have Expedited Medicaid – the criteria being proof of pregnancy with expected due date signed by a doctor or nurse and statement of income. A face-to-face interview is not required. In SFY03, 30.1 percent (42,759) of the Ohio's total births were covered by Medicaid.

Infants and Children: Healthy Start provides health care coverage for Children from birth through age 18 in families with incomes up to 200 percent FPL. Children in families with incomes at or below 150 percent PFL are eligible regardless of other health coverage. Children in families with incomes at 151-200 percent FPL are eligible only if they do not have creditable health coverage. Newborns are deemed eligible for 12 months if the mother was eligible for Medicaid at the time of birth, regardless of subsequent changes in the mother's income.

Ohio's State Health Insurance Plan for Children (SCHIP): As part of the Medicaid expansion of the Healthy Start program, Medicaid eligibility was increased for children up to 150 percent of FPL on January 1, 1998. In July 2000, Ohio further expanded Healthy Start under SCHIP. This expansion raised the income limit for eligibility up to 200 percent FPL. For this second SCHIP expansion, there was no complementary Medicaid expansion for the under-insured children, so children in this income range (151-200 percent FPL) are only eligible if they are uninsured.

Healthy Families: previously known as Low Income Families provides health care coverage to families (parents and children). The majority of families receiving Healthy Families coverage are working families. A smaller group receives Ohio Works First (OWF) cash assistance. On July 1, 2000, Healthy Families coverage was expanded to families earning up to 100 percent of the Federal Poverty Level (FPL).

Medicaid Managed Care

Medicaid Managed Care operates in 15 counties. There are three (3) categories of Managed Care counties: four counties are *mandatory* for Healthy Start eligibles; six counties are *preferred options* which means that Healthy Start eligibles are automatically enrolled in a managed care plan unless they choose to be in the FFS program; and five counties are *voluntary* counties which means that a Healthy Start eligible may choose to be in a MCP or in the FFS program. Those eligible through the aged, blind, and disabled categories remained on the FFS program

In March 2005, Medicaid managed care enrollment was 525,699 as compared to an enrollment of 252,902 in September 1999. Historically, 1997 through 2000 was a time when cash assistance and Medicaid eligibility were *delinked* as a result of welfare reform. As a result many lost their eligibility for cash assistance and were disconnected from Medicaid coverage. Between July 1997 and September 1999, the number of families eligible for Medicaid/Healthy Start dropped from 651,651 to 546,405, a decrease of 16 percent. This now compares to a total statewide Medicaid eligibles (MCP and FFS) of 895,215 with 45 percent HF/HS eligibles enrolled in MCPs.

Medicaid Administrative Claiming

ODH has been working with ODJFS and more recently with the Centers for Medicare and Medicaid Services (CMS) to implement the Medicaid Administrative Claiming

(MAC) program. Activities reimbursed as Medicaid administrative costs are not subject to the same rules and regulations that drive the delivery and reimbursement of Medicaid services. MAC in federal regulation is defined as activities that are "...necessary for efficient administration of the State Plan...". Historically, federal reimbursement has been provided for activities that increase access to Medicaid and that assist in improving the quality, appropriate usage, and effectiveness of services. These activities include outreach; referral, coordination and monitoring of Medicaid Services; and program planning, development and interagency coordination of medical services. Thus, Medicaid administrative claiming opportunities are logically focused in communities and among populations with the greatest disparity in health outcomes. MAC will allow ODH and its local partners to reinvest its reimbursements in community-based health-related programs.

Ohio Commission to Reform Medicaid

Ohio's budget bill (House Bill 95) called for the creation of the Ohio Commission to Reform Medicaid to evaluate the Medicaid program and make recommendations to Governor Bob Taft, the Speaker of the House, and the Senate President about reform and cost containment initiatives by January, 2005.

The Commission recently completed its tasks and provided recommendations with action steps to reform Medicaid. The commission recommended:

- Ohio's current Medicaid eligibility standards for low-income families and children, who represent 74 percent of the covered lives, but only 24 percent of costs, should be maintained.
- Expand the current full-risk managed care program to all Medicaid-covered families and children enrollees throughout Ohio.
- Implement outcome-based protocols that offer incentives, including but not limited to financial incentives, to constrain cost and improve health status through patient education and compliance, deployment of community health education and outreach workers, and coordination with public and private social service organizations to support adherence to those protocols.

Medicaid Cost Containment Strategies

The Executive Budget proposed for Medicaid for SFY 2006-2007 impacts to the MCH population are:

- Expand managed care statewide for Covered Families and Children. Over 1.2 million individuals will be covered by the end of FY 07.
- Reduce Medicaid eligibility for Healthy Families from 100 percent of FPL to 90 percent FPL. An estimated 25,000 people will lose coverage.
- Eliminate Medicaid covered dental services for adults (18 and over).
- Eliminate Medicaid covered vision services for adults (18 and over).

A.2 Lack of Availability of Providers

A lack of availability of health care resources, particularly for vulnerable populations, often results from geographic barriers and barriers within the very systems created to fill gaps (i.e., Medicaid). Although they have limitations, federally designated health

professional shortage areas (HPSAs) are a proxy for summarizing the availability of mostly private providers. Safety net resources attempt to fill the gaps in the private system.

Data Sources and Limitations

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

ODH has some data on advanced practice nurses and public health nutritionists by county. However, there are no standards against which to measure their availability. ODH does not have information on medical social workers, audiologists, occupational therapists, physical therapists, and speech-language therapists.

Primary Care HPSAs

Ohio has 76 federally designated primary care health professional shortage areas (HPSAs) distributed within 51 of its 88 counties. They include much of rural Ohio and parts of every major city in Ohio (Cleveland, Cincinnati, Toledo, Columbus, Dayton, Youngstown, Akron and Canton). The counties with the largest metropolitan areas (Cuyahoga [Cleveland], Franklin [Columbus] and Hamilton [Cincinnati]) have many Primary Care HPSAs, but they also have many Title V and non-Title V clinics to act as safety net providers. In the rural underserved areas of Ohio, the safety net varies from none, in counties such as Meigs and Morrow, to significant, in counties such as Pike and Lawrence.

Dental HPSAs

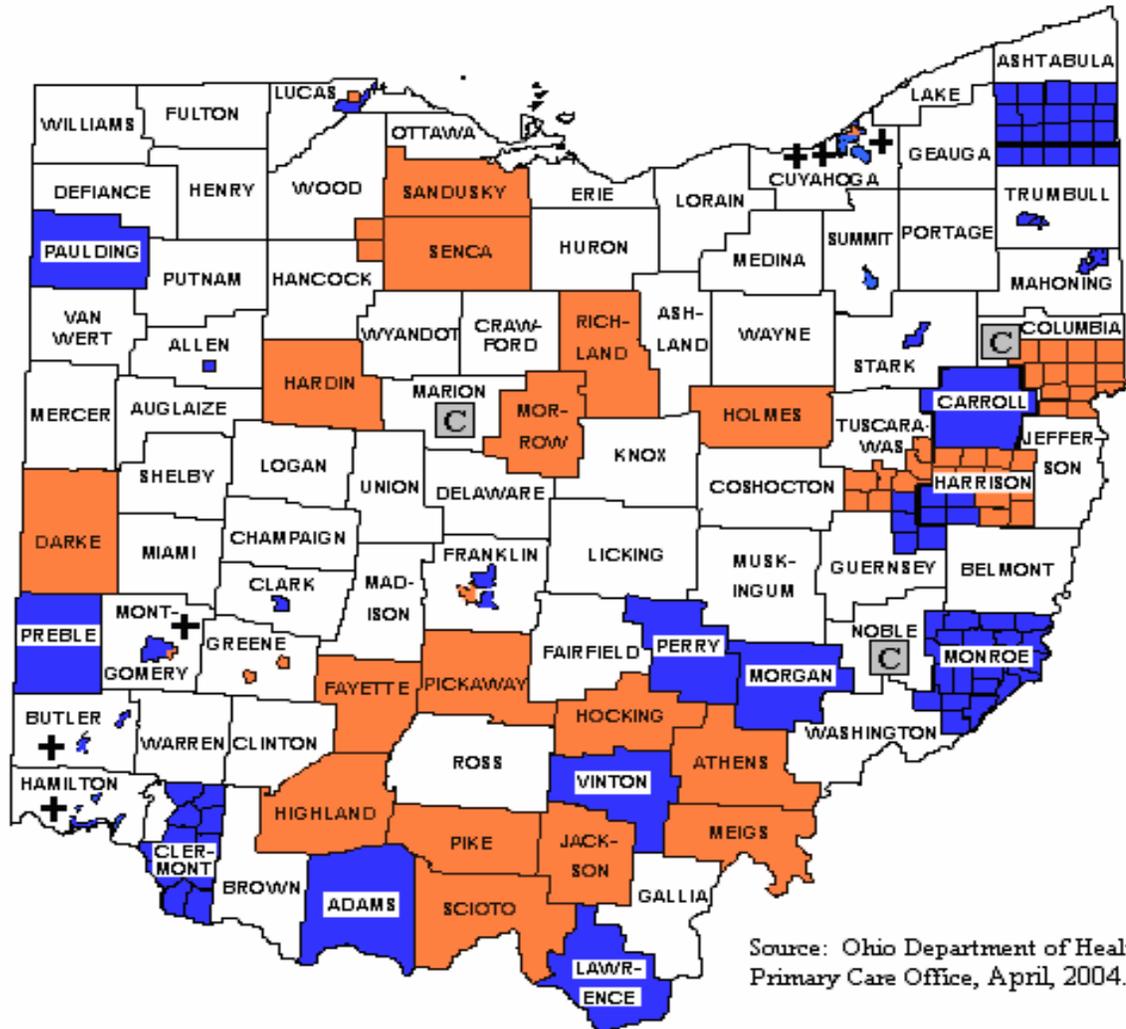
As with Primary Care HPSAs, Dental HPSAs represent only those that have applied. Other areas would likely qualify if they applied. The map illustrates the 45 Dental HPSAs, the dental care safety net programs, and the counties with the potential for shortage area designation. In addition, requests for 16 new Dental HPSAs have been made. The majority of Dental HPSAs have been identified for low-income population groups in both rural and urban areas.

Mental Health HPSAs

The same caveats on using HPSA data as a proxy for shortage areas apply to mental health care providers. Ohio has 16 Mental Health HPSAs. Thirteen geographic designations indicate a need for 19 psychiatrists to serve a population of more than

907,000 Ohioans. Of the 19 counties within these geographic designated areas, 12 are in the Appalachian region. The remaining three Mental Health HPSAs have been designated for facilities (one state prison and two state psychiatric hospitals).

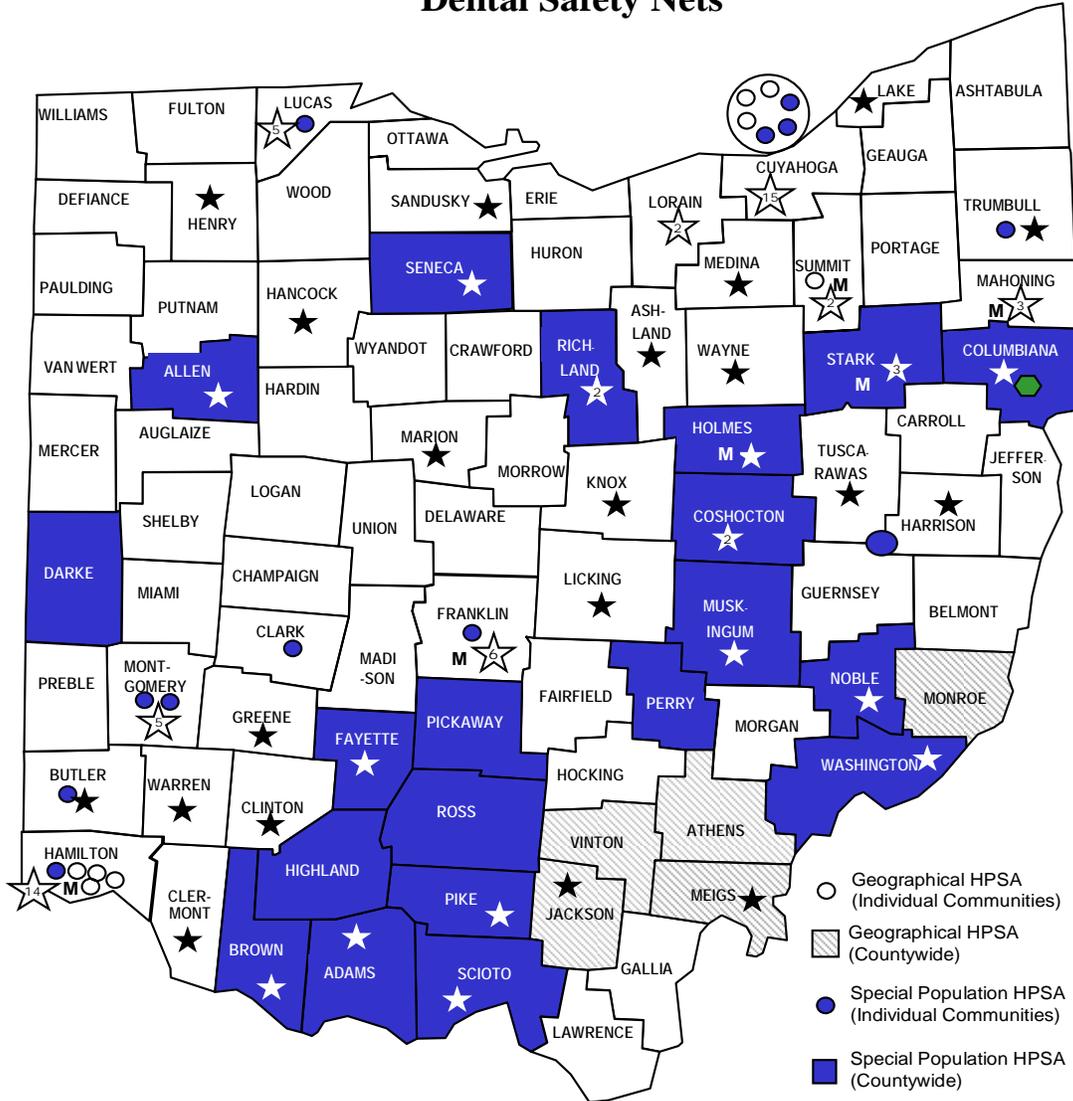
Ohio Primary Care Health Professional Shortage Areas



Source: Ohio Department of Health, Primary Care Office, April, 2004.

- Special Population HPSA
- Geographic HPSA
- C Correctional Facility HPSA
- + Facility HPSA

Dental Health Professional Shortage Areas And Dental Safety Nets



April, 2005

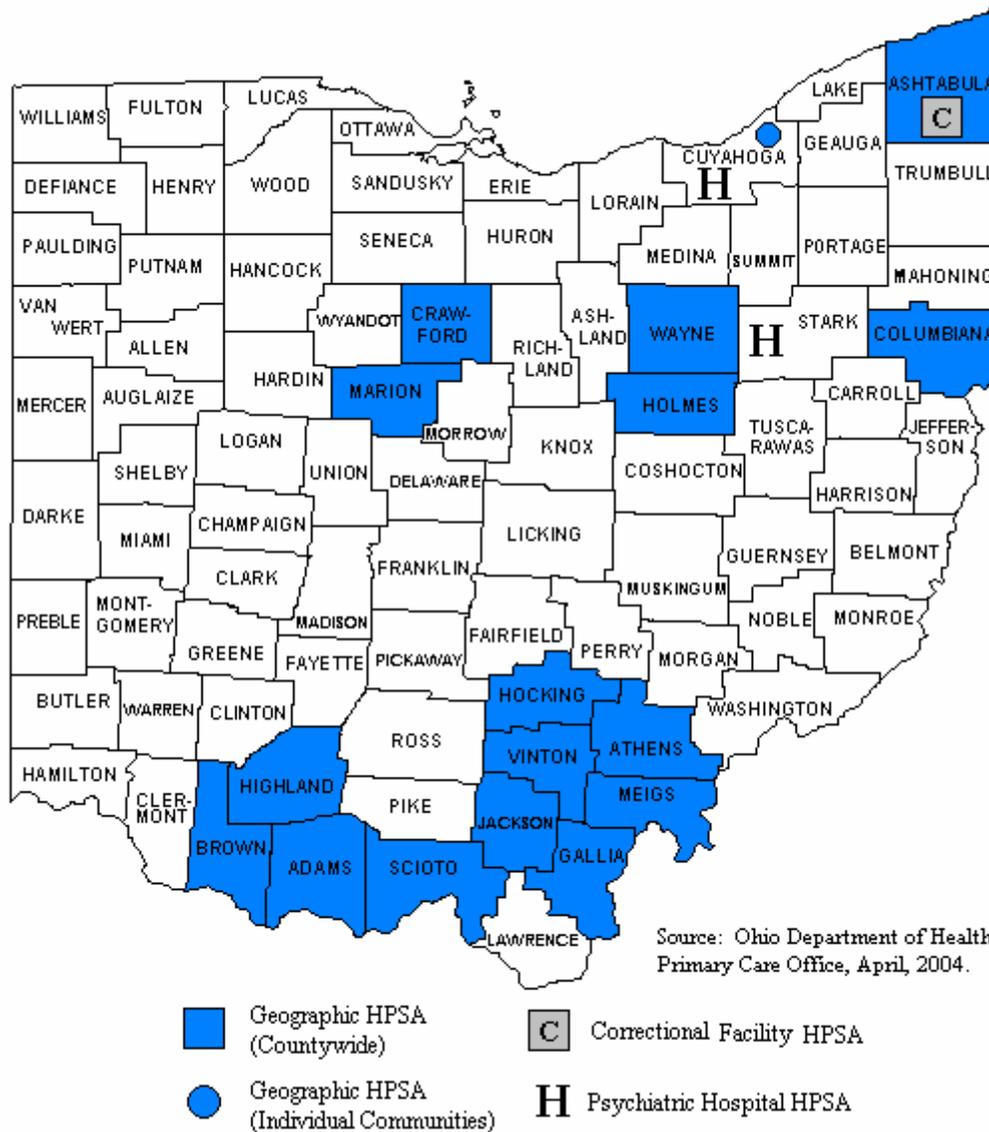
Ohio Department of Health, Bureau of Oral Health Services (614) 466-4180

<http://www.odh.ohio.gov/ODHPrograms/ORAL/dshort/HPSAmap.pdf>

L:\BOHS\Access\HPSA&-loan Reply\HPSA factsheets, brochures\Map with HPSA & SNs.ppt Rev. 4/1/05

- Geographical HPSA (Individual Communities)
- ▨ Geographical HPSA (Countywide)
- Special Population HPSA (Individual Communities)
- Special Population HPSA (Countywide)
- ◆ Facility designation
- ★ Safety Net Dental Clinic (a number inside the star indicates more than one clinic)
- M Mobile Dental Clinic

Ohio Mental Health Professional Shortage Areas



The Safety Net of Health Care Services

Even when people have Medicaid coverage, they still may have difficulty finding a private health care provider to serve them. Programs that serve as a safety net for vulnerable women and children are found in a variety of settings (e.g., local health departments, community health centers, hospitals, and other community agencies). Some safety net programs receive funding through DFCHS, sometimes originating from Title

V. ODH provides subsidies to FQHCs for uninsured care for children and pregnant women. ODH also sends dollars to FQHCs from tobacco funding for uninsured pregnant women and children to receive care. For many pregnant women and children who are low income, eligible for Medicaid, and uninsured or underinsured, programs administered by DFCHS serve as an important part of the safety net by providing enabling services or direct health care services. The most notable systems are the CFHS Program, The Ohio Infant Mortality Reduction Initiative (OIMRI), specialty clinics, and dental care clinics. Enabling services are also provided by the Help Me Grow program and the WIC program. A description of each follows.

Child and Family Health Services Program (CFHS) is a community-based program that uses a combination of federal, state, and local monies to offer public programs and services, including safety net clinical services to low income families and children in Ohio. The program is designed to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, and children. Currently 79 agencies in 80 counties (e.g., local health departments, hospitals, community action agencies and other nonprofit agencies) hold CFHS grants. CFHS provides for improved health outcomes for about 90,000 low income children and pregnant women; and family planning services to nearly 17,000 clients annually.

In FY2000, the CFHS program used the pyramid of MCH public health services to focus program efforts on assuring access to health care for uninsured and underinsured families in Ohio. For FY2006, ODH is refining this focus in order to make the CFHS program more accountable for the use of public monies, the assurance of quality of services, and the evaluation of activities. This refinement is necessary in light of the 25 percent reduction in funding resources over the past two years. CFHS projects will serve the priority populations of low-income children and families in racial and ethnic groups that are disproportionately affected by poor health outcomes; assure that measurable benchmarks are developed based in identified priorities; and provide services according to ODH standards and guidelines.

CFHS projects use their CFHS grant dollars to provide infrastructure, population-based, enabling and direct care programs and services. The Ohio Infant Mortality Reduction Initiative (OIMRI) will be incorporated into the CFHS grants in FY2006. There will be five components in the CFHS Program: 1) Community Health Assessment (required); 2) Child Health; 3) Family Planning; 4) Prenatal Health; and 5) OIMRI. The maximum funding a county can apply for will be determined by a formula similar to the one used to allocate funds for the MCH Block Grant. CFHS projects have been asked to re-evaluate their need to provide direct care services. DFCHS collaborated with the OSU School of Public Health and the National Association of City and County Health Officials to provide regional strategic decision making process workshops for CFHS projects.

The Ohio Infant Mortality Reduction Initiative (OIMRI) is a targeted perinatal service coordination program. OIMRI is an enabling service that will be incorporated into the CFHS program for FY2006 as described above. Currently the program funds twelve OIMRI projects that target those census tracts or neighborhoods with high-risk, low-

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

Pediatric Medical Specialty Clinics operate in 52 counties. The five types of clinics, Developmental, Hearing, Neurology, Orthopedic and Vision, improve access for low-income children to pediatric specialists in medically underserved areas. Both diagnosis and treatment services are provided through these itinerant clinics. These "safety net" clinics supplement the private practice system in providing access points for patients. The clinical services are provided through a contractual arrangement with providers and ODH. The itinerant clinics are based primarily in local health departments through a contractual agreement. Local Public Health Nurses assist families in applying for Medicaid and the Bureau for Children with Medical Handicaps and help families make follow-up appointments for other testing or surgery. The majority of the clinics are provided in Rural-Appalachian counties located in the southeastern region of the state due to lack of specialty providers.

Safety Net Primary Dental Care Clinics provide diagnostic, preventive, and treatment services primarily for people who cannot or will not access the private system, usually for reasons relating to payment. While the numbers often fluctuate, Ohio's 98 safety net primary dental care clinics currently include the following:

- 2 dental schools (plus 4 of their clinics and 1 mobile program for special populations);
- 17 city and county health department clinics;
- 19 hospital-based/linked programs;
- 24 FQHC clinics; and
- 30 other programs (e.g., United Way agencies, Community Action Agencies, homeless programs, church-affiliated and other volunteer programs);
- 3 free clinics

More than half (59%) of dental care safety net programs are in Ohio's eight most populous counties. The capacity of safety net dental clinics, in terms of the services they provide and the populations they serve, varies widely. The largest programs tend to be dental schools or hospitals, where Medicaid is accepted, but sliding fee schedules are rare. About half of safety net dental care programs have waiting lists to get initial appointments. Waits are typically one to three months, but some exceed six months.

School-based dental sealant programs served 41 counties and over 29,000 children in the 2003-04 school year. Of the State's 18 programs, 15 receive Title V funds from ODH. . ODH also combines Title V and state dollars to fund the OPTIONS program of referral coordinators (case managers) linking low-income and/or disabled individuals with dentists willing to provide discounted or donated care.

The Help Me Grow (HMG) program provides information, services and supports to pregnant women, new parents, and to infants and toddlers at risk for or with developmental disabilities and their families. HMG includes enabling and population based services including home visits to pregnant women, first time and teen moms, and which promote outreach to women to seek early prenatal care. While funding for HMG comes from sources other than the MCH BG, the program works collaboratively with the Title V funded programs to improve the health of infants, young children and their families.

The USDA funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as a Farmer's Market Nutrition program, provides highly nutritious foods, nutrition and breastfeeding education and support, immunization screening, and health care referral through local agencies to eligible individuals. WIC helps income-eligible pregnant, postpartum, and breastfeeding women, infants, and children who are at special risk with respect to physical and mental health due to inadequate nutrition, health care, or both. WIC works collaboratively on Title V initiatives for improving the health status of pregnant and breastfeeding women, infants and young children.

A.3 Qualitative Data on Health Services—Community Providers (Related to Maternal, Infant, Child, and Adolescent Issues)

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

Local public health providers (local health districts, Child and Family Health Services Projects and WIC projects) responded that health service issues included access to care, insurance, gaps in service, access to community-based care, access to specialty, mental health and dental providers, and support services.

**The need for additional funding for services at the local level* was expressed repeatedly, particularly for mental health services, dental care and community outreach dental programs, programs to address obesity, and successful prevention programs.

**Respondents requested more training and technical assistance*, especially in regard to provision of tools/curricula/to address: obesity in the birth through 18 population; child safety; anger management; bullying; discipline; sleep issues; be bed wetting; tobacco use and substance abuse; STDs and sexual experimentation.

**The State was urged to recognize that the differences between urban and rural communities warrant different solutions for each.*

B. Direct Care and Enabling Services for CSHCN

B.1 Coordination of the CSHCN Program

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

Public health nurses and the following individuals coordinate enabling services. The *Medical Review Nurses* stationed in the Columbus office of BCMH are responsible for case management. These nurses communicate with the BCMH Field Nursing Consultant, medical center staff, the child's family, the physician, and the PHN. The *specialty team service coordinator* is a clinical nurse specialist or social worker located in the tertiary medical center. The child's *managing physician* is responsible for maintaining a medical home and developing a medical treatment plan, coordinating the request of services needed by the child, and submitting the necessary reports to BCMH. BCMH works closely with the local PHN and Local Health Department to assure CSHCNs and their families have access to the local service coordination they need.

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

B.2 Systems Issues

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

In 2003 BCMH served, through its treatment program, approximately 26 percent of children in Ohio who receive SSI and who are under age 16 (9,357 of 35,544). The number of active BCMH treatment cases also on SSI was estimated by matching BCMH files with Medicaid Management Information System files from ODJFS to determine the number of children on BCMH receiving Medicaid for the Disabled. In Ohio, recipients of SSI are not automatically eligible for Medicaid.

Uninsured CSHCN Served by Title V Nearly 11 percent of the children enrolled on the BCMH treatment program in SFY 1999 had no other source of health care coverage for the entire year. Between SFY 1996 and 1999, the number of uninsured children enrolled for BCMH treatment services decreased from 3,983 to 1,763, a decrease of 55.7 percent. This was due in large part because of the expansion of Healthy Start/SCHIP in 1998. Since 2002 this number has remained stable and the number of uninsured on the BCMH Treatment Program is now 1,320. The Bureau continues to closely monitor these children and assist them in any way possible to obtain other third party coverage. Counties having the highest numbers of uninsured children receiving BCMH treatment services are, in rank order, Geauga, Franklin, Hamilton, Holmes, Cuyahoga, Trumbull, and Summit.

Medical Home Every child with a special health care need should have an identifiable medical home. According to the American Academy of Pediatrics (AAP), a medical home has the following components: accessible care, family-centered care, continuing care, comprehensive care, coordinated care, compassionate care, and culturally competent care. In addition, the managing physician of a medical home is a trusted, well-trained pediatrician or other physician who can manage and facilitate all aspects of pediatric care. A HP 2010 objective is to increase the proportion of persons who have a specific source of ongoing care. State baseline data against which improvement can be measured are not yet available. ODH is working with the Ohio Chapter of the AAP to develop a network of medical homes for CSHCN.

BCMh addressed one of the components of the definition of a medical home—accessible care. In 2000, BCMH surveyed a sample of the families it serves to estimate the percentage of CSHCN who had a medical home and to learn about the quality of care. Of 590 surveys, 307 (52 percent) were returned. Almost all (294 families or 96 percent) responded that their child had a regular doctor or clinic for routine health care. The majority of these (83 percent) had been going to the same provider for at least one year; most (70 percent) had seen the same provider for at least three years. Nearly all of the respondents (95 percent) were able to get an appointment with the doctor or clinic within one to two days. Many (95 percent) indicated that the doctor or clinic answered all their questions regarding their child's health in ways that were clear and easy to understand always or most of the time.

BCMh continues to work closely with the Ohio Chapter of the AAP on all Medical Home issues. The Bureau is in the process of developing a web Based educational tool on The Medical Home for CSHCN for Ohio Physicians. The Bureau is working with the Cincinnati Children's Hospital to support a State-Wide "Special Needs Resource Directory for CSHCN". The Web address is www.cincinnatichildrens.org/special-needs.

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

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

Genetic Evaluation and Counseling Services

In 1999, ODH established the Regional Comprehensive Genetic Center (RCGC) electronic database, although aggregated data from the centers are available for previous years as well. RCGCs funded by ODH are required to submit data on individuals (without identifiers) they serve as well as data on the education activities they conduct. Although the data remains fairly consistent over the past years, there are some trends noted that reflect population trends and the economic climate in Ohio. There continues to be a slight increase in the number of adults (non-prenatal) served in genetic clinics which may be due to emerging information that many adult onset chronic diseases may have a genetic component. The number of Ohioans presenting to genetics clinics with insurance has decreased, also reflecting Ohio's economic situation. Other ODH systems that collect data related to genetics include the following: electronic birth certificates, which include data collection of some specific birth defects; the Behavioral Risk Factor Surveillance System, which asks women of childbearing age about their knowledge of the use of folic acid and the prevention of neural tube defects; and the Pregnancy Risk Assessment Monitoring System (PRAMS), which collects data on what women of childbearing age know about folic acid and the prevention of NTDs, history of birth defects in women of childbearing age, and alcohol use during pregnancy. In addition, ODH is currently developing a comprehensive birth defects information system that will include reported data collection on children with birth defects, as well as referrals to services to assure that children are linked to medical and other support systems. As genomic medicine becomes more mainstream, the ODH genetics program continues to integrate a genetics component in other public health programs such as cancer, cardiovascular health, universal newborn hearing screening, expanded newborn metabolic screening and promoting preconception health in family planning and prenatal programs.

B.3 Qualitative Data on Health Services—Community Providers and Consumers (Related to CSHCN)

Below is a summary of perceived needs related to CSHCN health services issues as reported by:

Medical Home focus groups composed of caregivers of CSHCN responded that these were important health issues: navigating insurance payment systems; having to work with providers who discounted their expertise as experts in the care of their children;

getting incomplete or inaccurate medical advice; lack of support; and dealing with stress and crisis related to their child's condition.

*Regarding *service coordination*, families stated that they would like to know where and whom to call for help. They wanted information and help in accessing services, but they did not want to be controlled. Parents complained that many service providers were coming into their homes but were not helping them to coordinate the services they needed.

*The *need for information* was repeatedly mentioned. Most parents stated that their primary source of information about health care was word of mouth from other parents. Parents recommended the publication of a resource book of available services.

*Participants reported these *systems barriers*: too much paperwork, difficulty in understanding the application processes, and delays and denials due to paperwork

Focus Groups of parents of children with birth defects were held in 2004 to provide input into the development of Ohio's birth defects information system. Parents overwhelmingly recommended that they would like to receive information about their child's disorder and programs they may be eligible for as soon as possible after the diagnosis. Other recommendations included a mechanism for linking parents of children with special health care needs to other parents for much needed emotional support and expertise in navigating health care and service program systems; as well as feedback on family-friendly wording on program brochures.

Local public health providers (local health districts, Child and Family Health Services Projects and WIC projects) responded that health service issues included access to care, insurance, gaps in service, access to community-based care, access to specialty, mental health and dental providers, and support services.

*In regard to funding for specialized services, there is a serious need that requires a state level solution. Help Me Grow is not funded well enough to offer what some families need and BCMH cuts greatly increase the burden to families, especially as health care insurance continues to cut coverage

C. Priority Access Concerns

The State has identified the following concerns regarding access to health care and health-related services. The needs assessment process incorporated data required to measure the MCH Block Grant performance and outcome measures, and the health status indicators that were being developed by the federal MCH Bureau. These are organized by the four levels of the pyramid.

C.1 Concerns for the Maternal and Infant Population

For all of the following, the concern relates to deficits in the specified item.

Direct Health Care Services

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

Enabling Services

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

Population-Based Services

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

Infrastructure Building Services

1. Information and training for providers on the following:
 - * Factors contributing to low and very low birth weight
 - * Culturally competent practices
 - * Identifying populations at risk for poor birth outcomes
 - * Identifying populations at risk for mental and behavioral health problems
 - * Adult obesity
2. Quality data and information for policy development and program planning on the following:
 - * Smoking among pregnant women
 - * Access to early prenatal care, including high-risk
 - * Adequacy of prenatal care
 - * Effective outreach strategies
 - * Education needs of prenatal providers
 - * Availability of high-risk prenatal services
3. Information for legislators, policymakers, and MCH stakeholders on risk factors

contributing to low birth weight and the effect of preconceptional, interconceptional and prenatal care on birth outcomes

4. Understanding among prenatal service providers of the barriers to care that pregnant women face

C.2 Concerns for the Child and Adolescent Population

Direct Health Care Services

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

Enabling Services

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

Population-Based Services

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

Infrastructure Building Services

1. Information and training for providers on the following:
 - * Pediatric overweight
 - * Oral health status, oral health resources, and access to dental care
 - * Blood lead screening policy
 - * Vision assessment
 - * Screening and referral

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

C.3 Concerns for the CSHCN Population

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

Direct Health Care Services

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

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

Enabling Services

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

Infrastructure Building Services

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

2.1.2.4 Population-Based Services

Population-based services for the MCH population center on screening, immunization, community water fluoridation, and outreach/education.

A. Screening

Blood Lead Levels The percentage of children with elevated blood lead levels has decreased from 7.8 percent in 2000 to 4.2 percent in 2003. The CY 2003 data from the STELLAR database and the Medicaid Claims and Eligibility databases were matched. Of the approximately 108,000 children in STELLAR, there were 67 percent matched in the Medicaid system. This demonstrates lead screening of 42 percent of one year olds and 36 percent of two years olds enrolled in Medicaid. There was a 3.5 percent increase in the in the one and two year old lead testing rate from calendar year 2002.

Vision All children enrolled in Ohio schools are screened for abnormal visual acuity at each of the following grade levels: kindergarten, 1, 3, 5, 7, and 9. The percent of Ohio children in kindergarten and first grade failing a vision screen was 7.3 in 2003.

Hearing The Ohio Revised Code mandates that all newborns in hospital nurseries be assessed for risk for hearing loss and referred for hearing testing when identified with risk factors. In July 2004, the birthing hospitals in Ohio began screening all newborns for hearing loss prior to hospital discharge. Each newborn is screened using a physiologic test and results are reported to the parents and newborn's primary care provider. Babies who do not pass the two-part screen are referred to the regional infant hearing program (nine regional projects) for follow-up and In July 2004, the birthing hospitals in Ohio began screening all newborns for hearing loss referral to the HMG program if a hearing loss is confirmed. Ohio anticipates that approximately 400-500 infants with hearing loss will be identified each year through this process. In 2003, 39.9 percent of newborns were screened for hearing before hospital discharge. This percentage is expected to rise considerably for 2004 and beyond.

B. Population-Based Preventive Services

Immunization Coverage Through Age 2: In Ohio, children entering regulated child day care centers, Head Start, or kindergarten are required to be fully immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. Children entering kindergarten must receive hepatitis B immunizations. Students must have a second MMR vaccine before entering seventh grade. Head Start also requires immunization against hepatitis B and HIB. In 2003, 82.3 percent of children completed the recommended series of childhood immunizations for ages 19 through 35 months. This rate is **lower** than the HP 2010 target rate of 90 percent. The rate increased overall by nearly 13 percent from 1999 (73.0 percent) through 2003.

Lead Screening: In 2003, local health departments collaborated with neighborhood groups, housing agencies and Community Action agencies to increase awareness of childhood lead poisoning in targeted neighborhoods (including supplies/instructions for cleaning). Each local agency receives a list of locations participating in the HEPA Vacuum loaner program; families are provided with an instructional video tape with the vacuum. In-services to staff and lead screenings of children enrolled in Head Start programs were done in many communities.

Community Water Fluoridation Thanks to a 1969 fluoridation law, 90 percent of Ohioans on community water systems receive optimally fluoridated water. Efforts to bring fluoridated water to the remaining 10 percent are ongoing, but successes are relatively few and far between.

C. Community Outreach/Education

Help Me Grow Since its inception in 1995, the Help Me Grow program has developed as Ohio's communication umbrella for many wellness programs. Help Me Grow increases public awareness about important issues such as prenatal and infant care, early child development, child safety, lead poison prevention, positive parenting, child abuse prevention, and foster care and adoption opportunities.

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

SCHIP Outreach Population-based strategies included the following: DFCHS funded projects provided assistance to consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services. All BCMH applications are screened for potential Healthy Start/Healthy Family eligibility. DFCHS funded projects provided assistance to consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services. About 41% of local CFHS funded projects identified Medicaid enrollment as a priority and provided over 400 hours of Combined Programs Application assistance and over 3,708 hours of care coordination. Local Help Me Grow programs informed families about the Healthy Start program.

2.1.2.5 Infrastructure Building Services

Infrastructure building services, the base of the MCH pyramid, are largely the assessment and policy development core functions identified by the Institute of Medicine in 1988. These functions are built on coordination and collaboration at all levels of government, and with the private and not-for-profit sectors.

A. Community Assessment and Planning

CFHS Program Plan Through its FY 2006 application process for Child and Family Health Services (CFHS) grants, the Ohio MCH BG process was used to narrow the focus of the CFHS areas of investment. The amount of each CFHS program award was influenced by the applicant's community health assessment and planning process based on the nine-step *Ohio's Public Health Plan* model. Applicant agencies were limited to

strategies that addressed the MCH BG priority topics. Applicant agencies were required to develop strategies based on best practices research with clear, measurable benchmarks for each strategy. CFHS projects were asked to re-evaluate their need to provide direct care services. Each applicant agency was required to describe how it would measure the effectiveness of the programs and services funded with the grant award. DFCHS collaborated with the OSU School of Public Health and the National Association of City and County Health Officials to provide regional strategic decision making process workshops for CFHS projects. In addition, to support and empower local agencies in each of the steps of the community health assessment and planning process, BCFHS provided regional training sessions. Technical assistance also was provided to those agencies requesting additional assistance.

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

To monitor progress toward meeting the Title V oral health performance measures, BOHS instituted an annual survey of 25 sentinel schools that were found to be highly representative of the 336 Ohio elementary schools selected for the 1998-99 county-specific survey. The sentinel schools approach will be evaluated after the 2004-05 data have been analyzed.

Through the HRSA-funded State Oral Health Collaborative Systems (SOHCS) grant, BOHS is developing an oral health surveillance system to describe need at the community level. This assessment of need will be combined with an instrument that BOHS has developed to assess community readiness for taking action on oral health issues. The resulting matrix will serve to prioritize counties for BOHS technical assistance.

Survey of BMI Status in Third Graders

A population based survey of BMI status of Ohio third graders was conducted to determine county specific baseline BMI data for third graders in Ohio. The survey was done on that same sample of third graders used for the oral health survey described above.

Child Fatality Review

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

members from ODH, Public Safety, law enforcement, child care advocates, coroners groups and other interested parties to share information and develop prevention strategies.

B. Coordination and Collaborative Relationships

Coordination of State Activities with Programs Implemented Under Title V and Related Federal Grant Programs DFCHS is responsible for the administration of the following closely related programs: (1) BCFHS administers the CDC Childhood Lead Poisoning Prevention Program; the Title X program; and services for women of childbearing age, infants, and children, particularly those who are low income or lack access to health care. (2) The Bureau of Community Health Services and Systems Development (BCHSSD) administers the Primary Care and Rural Health Services Section, which identifies underserved areas of the state and attempts to place health care practitioners in those areas; the Black Lung Program; the SEARCH program that recruits health care provider students to work in underserved areas and the Ryan White Title II Program which provides funding for health care, medications and support systems to approximately 7,500 HIV+ Ohioans. (3) BCMH administers diagnostic, treatment, and service coordination services for CSHCN, and the State's Genetic Services Program, Sickle Cell Services Program, Metabolic Formula, and Birth Defects Information System (BDIS). (4) BEIS administers several programs serving young children (primarily birth to three) and their families. The Help Me Grow program provides information, services and supports to pregnant women, new parents, and to infants and toddlers at risk for or with developmental disabilities and their families. BEIS also administers the Healthy Child Care Ohio grant for health consultation by registered nurses to child care providers; the Newborn Infant Hearing Program; and the State Early Childhood Comprehensive Systems Grant. (5) The Bureau of Nutrition Services (BNS) administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); and the Farmers Market Nutrition Program. (6) BOHS develops and implements programs to prevent oral diseases and to improve access to primary dental care for underserved Ohioans.

Title V and Title XIX Intergovernmental Collaboration The interagency agreement between ODH Title V and ODJFS Title XIX is in place and is updated every two years. The DFCHS Medical Director sits on the Medicaid Medical Advisory Committee for the ODHS, and on the Executive Committee for that group.

ODH and ODJFS collaborated on the implementation of the second round of the Family Health Survey (OFHS) to address data gaps. ODJFS funded the project and ODH provided technical assistance. Approximately 40,000 telephone interviews were conducted in 2004 to gather data on risk factors, health status, unmet need, access to care, and health insurance status.

The DFCHS Division Chief serves on the ODJFS Children's Trust Fund Board and BCFHS coordinates with the Trust Fund on activities related to the CFR program, including the preparation and publishing of the CFR annual state report.

In 2005 the Community Access Program funded by the Primary Care Bureau of HRSA provided the infrastructure to develop and pilot a Medicaid Administrative Claiming plan for the state which will provide a sustainable funding source for local health departments to continue to provide enabling services to vulnerable MCH populations.

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

Other Intergovernmental Collaboration DFCHS has developed agreements and cooperative arrangements with many State agencies, including the Departments of Mental Retardation and Developmental Disabilities, Alcohol and Drug Addiction Services, Rehabilitation and Corrections, Job and Family Services, and Education. DFCHS also has forged links with the University Affiliated Programs, the Cincinnati Center for Developmental Disorders (CCDD) and the Nisonger Center. CCDD and the Nisonger Center also house the MCH Bureau funded (Title V) Interdisciplinary Leadership Education Excellence in caring for Children with Neurodevelopmental and Related Disabilities training programs, which have close ties to DFCHS. The DFCHS also collaborates with Ohio's two MCHB funded Healthy Start Projects in Cleveland and Columbus.

Intergovernmental and Interorganizational Collaboration The Ohio Family and Children First Initiative is a partnership among the State's social service, education, and health systems. The goal is to ensure that all children enter school ready to learn. This partnership is critical because no single system has the resources or capacity to meet this goal alone. The Family and Children First Cabinet Council provides oversight of the Initiative. Members of the Cabinet Council include the State Superintendent of Schools, and the Directors of the Departments of Alcohol and Drug Addiction Services, Mental Retardation and Developmental Disabilities, Budget and Management, Job and Family Services, Youth Services, Mental Health, Aging, and Health.

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

- 1) The BCMH Medical Advisory Committee works with the Ohio Chapter of the AAP (OC/AAP) on the Children with Disabilities Subcommittee. This subcommittee is made up of members from the private sector and several state agencies and deals with social and educational issues of CSHCN in addition to medical issues. The ODH DFCHS participates with the OC/AAP in the development of a long term strategic plan targeting mental health concerns for children and adolescents. The

DFCHS Medical Director chairs the physician group which advises ODH on the recruitment of providers to participate in the statewide immunization registry. She also serves as liaison between ODH and the OC/AAP in regard to the immunization education program for physicians and nurses.

- 2) The BCFHS Bureau Chief attends Ohio Section of ACOG quarterly meetings to share information from ODH and to assure that pregnant women have early and adequate prenatal care.
- 3) MCH BG funds support regional perinatal teams that are housed in tertiary medical centers and provide technical assistance to local hospitals. In addition, children's hospitals, March of Dimes, Ohio Hospital Association, and Children's Defense Funds are represented on the MCH Council.

BCMh has partnered with children's medical centers and pediatric specialists to continuously develop and refine standards of care, to meet emerging health and technological needs, and to facilitate the collaboration of health care providers and public programs, such as those housed in ODJFS. Public health nurses promote family-centered, community-based, coordinated care. They link the tertiary care center team coordinator, local service providers, and families to develop a comprehensive plan that addresses the unique needs of the child and family.

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

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

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

Collaboration with The Ohio State University School of Public Health The Bureau of Child and Family Health Services collaborated with the OSU School of Public Health and the National Association of City and County Health Officials (NACCHO) to provide regional strategic decision making process workshops for CFHS projects. Title V staff

have also provided formal internships to students enrolled in the School of Public Health. Various Title V staff have assisted in teaching didactic components of classes within several colleges at OSU.

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

A. Provider Education

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

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

Lead Poisoning Prevention The Pediatric Lead Assessment NETwork (PLANET) pilot training program was implemented in SFY 1999 to increase the awareness and knowledge of health care providers about the health effects of lead poisoning, sources of lead, and Ohio's screening guidelines for high-risk populations. The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) funded 4 Lead Regional Resource Centers (Seneca Co., Cincinnati, Cleveland and Mahoning Co.) that provided education on nutrition, assisted in outreach initiatives and coordinated screening efforts. The Statewide Lead Education Committee met quarterly to plan and develop program strategies to educate/increase awareness and improve physician compliance with screening/follow-up. OCLPPP provided promotional ideas/technical assistance to sub-grantees during Lead Awareness Week.

Prenatal Smoking Cessation

The "5 A's" (Ask, Advise, Assess, Assist and Arrange) are considered best practice for treatment of tobacco use and dependence. In 2001, a survey of Ohio obstetricians and gynecologists was conducted to assess their experiences, opinions and clinical practices regarding smoking and pregnancy. The Ohio ACOG survey clearly showed that prenatal providers are not implementing all components of the "5A's". Most providers understand that tobacco use during pregnancy is a problem and ask (99%) their pregnant patients about tobacco use and advise (98%) them to quit, however; they are not systematically assessing the willingness of their pregnant patient to quit (65%), providing them assistance with cessation (52%), or arranging to follow-up throughout the pregnancy (76%). The survey further revealed that prenatal providers viewed smoking

cessation as one of the most important health care services they could provide but that they sometimes lack the skills, tools and infrastructure to support their efforts. The Prenatal Smoking Cessation Program has provided training to more than 500 prenatal care providers.

Vision Screening Checklist In an effort to facilitate early identification and referral for vision problems in young children (ages birth to three), 31 statewide training sessions on the use of a vision screening checklist has been conducted for over 700 Help Me Grow service coordinators. After a successful pilot project in early 2005, it was determined that the checklist “Taking a Look!” should be utilized statewide by service coordinators in the Help Me Grow program beginning July 2005. This project has been a collaborative effort with the Bureau of Early Intervention Services and a group of educators serving young children who are blind or visually impaired.

School Nursing Consultation: DFCHS school nurse consultants provide continuing education opportunities through annual and regional statewide conferences for the population of approximately 1200 school nurses throughout the state. Regional trainings to Ohio school nurses are provided on topics such as HIPPA, Bioterrorism, SARS and current school based mental health programs. Additional technical assistance and training is delivered to school nurses through the development of web based continuing education modules. ODH “Guidelines on BMI for Age” were developed to help local health departments and schools collect this information accurately. DFCHS collaborated with the ODH Homeland Security Program and has received funds to develop school based training for emergency preparedness in schools. Through these school nurses, the information provided in the conferences has the potential to reach and affect all of the two million Ohio school children and their families.

2.2 Selection of State Priority Needs/Needs Assessment Summary

See Supporting Documents – Form 14 and Section IV A.& B. – Priorities, Performance and Program Activities.

The process for creating the ten Title V priority needs for Ohio’s FFY 2006 MCH Block Grant application was based on the process used to identify the ten priority needs for the FFY 2001 application. The 2000 needs assessment used a community needs assessment model developed by ODH through collaboration with local health departments. The 9-step process, which was documented in *Ohio’s Public Health Plan*, released in 1997, is illustrated as a community needs assessment “wheel.” Steps 1 through 6 represent the needs assessment phase, steps 7 through 8 are the planning phase, and step 9 is evaluation. Participants in the 2000 needs assessment included ODH staff as well as outside stakeholders. The ten priority needs identified in 2000 were 1) to reduce the child and adolescent mortality rate; 2) to reduce the incidence of low birth weight; 3) to reduce the infant mortality rate; 4) to reduce the percentage of children and adolescents who are overweight; 5) to reduce the percentage of teens in grades 9 through 12 who have sexual intercourse; 6) to implement policies and strategies to facilitate coordination of services for CSHCN; 7) to eliminate gaps in services for CSHCN; 8) to reduce the percentage of

children and adolescents who require oral health care and do not receive it; 9) to reduce the percentage of teens who use tobacco; and 10) to establish and maintain population-based data for Children with Special Health Care Needs (CSHCN).

This year, ODH MCH Program staff reviewed the process and the results of the 2005 needs assessment in order to develop a new list of the top ten needs for Ohio's Title V Program. An evaluation of the prior needs assessment resulted in the decision to include more outside partners; to improve the priority-setting process; and to allow more time for intervention and implementation planning. Secondary data from the previous five year needs assessment were updated and primary data (qualitative) were collected through a survey of local public health providers (local health districts, WIC clinics, and Child and Family Health Services clinics) and focus groups of families of CSHCN. Priority recommendations from four external stakeholder groups: 1) Women's Health, Birth Outcomes, and Infant Health; 2) Early Childhood (aged 28 days to five years); 3) School Age and Adolescents (aged five to 21 years); and 4) CSHCN were the basis for the discussion and selection of the final ten priority needs. (See Section 2.1.1, Needs Assessment Process, for a complete discussion of the entire needs assessment process.) The new priority needs are as follows: 1) to improve birth outcomes; 2) to assure quality screening, identification, intervention, care coordination and medical home; 3) to assure access to comprehensive preventive and treatment services for individuals and families, including CSHCN; 4) to promote age-appropriate nutrition and physical activity; 5) to improve oral health and access to dental care; 6) to enhance social/emotional strengths of families; 7) to increase collaboration and coordination of programs for families through partnerships and data integration; 8) to incorporate racial/ethnic/cultural health equity in all activities; 9) to decrease substance abuse and addiction, including tobacco; and 10) to promote sexual responsibility and reproductive health.

Several of the needs identified as priority areas for the 2000 needs assessment continue to be priorities. Birth outcomes, including infant mortality and low birth weight; coordination of services for CSHCN; gaps in services for CSHCN; and access to oral health services for children and adolescents remain as important focus areas for the Title V program. Improving birth outcomes is more of a priority than ever, as Ohio's infant mortality and low birth weight rates have increased and are worse than the nation. Ohio continues to see large disparities in birth outcomes between the white and black populations. Services for CSHCN that are coordinated and comprehensive (no gaps) remain a challenge in a climate of decreased funding, inadequate insurance coverage, provider shortages and access to care issues. Continuing access problems for children in need of oral health care services keep this issue as a high priority in the Title V program.

Many other needs that were high priority in the last needs assessment continue to be priority needs, but were replaced with broader, more comprehensive needs statements. Instead of overweight as the priority, age-appropriate nutrition and physical activity is the new priority, with reduction of child and adolescent overweight the state performance measure that will be addressed through nutrition and physical activity. Instead of reducing teen smoking, the new priority has been broadened to decrease substance abuse and addiction, including tobacco. Instead of reducing the percentage of teens in grades 9

through 12 who have sexual intercourse, the new priority is to promote sexual responsibility and reproductive health; and instead of reducing the incidence of low birth weight and reducing the infant mortality rate, the new priority is to improve birth outcomes. Instead of implementing policies and strategies to facilitate coordination of services for CSHCN, the new priority is to increase collaboration and coordination of programs for families through partnerships and data integration.

Two priorities were replaced. Reducing the overall child and adolescent mortality rate is being addressed very comprehensively through Ohio's mandated Child Fatality Review (CFR) program. The program has a full-time coordinator and epidemiology support. There is a local CFR team in each of Ohio's 88 counties. These teams are required to review all child deaths to children under the age of 18 years and to make recommendations to prevent subsequent deaths. Population based data for CSHCN was replaced as a priority because the data needs are met by the National CSHCN Survey (SLAITS) and by the Ohio Family Health Survey, which has added questions related to CSHCN concerns.

Several new areas have emerged as priorities. Across all population groups, access to care and to insurance was the highest of needs, thus the priorities to assure quality screening, identification, intervention, care coordination and medical home; and to assure access to comprehensive preventive and treatment services for individuals and families, including CSHCN. Concerns about mental and social/emotional health of the entire MCH population arose in all discussions of unmet need. This resulted in the priority to enhance social/emotional strengths of families. This priority will be addressed in strong partnership with the Ohio Department of Mental Health. All stakeholder groups emphasized the importance of reducing disparities, thus the priority to incorporate racial/ethnic/cultural health equity in all activities.

Stakeholder Participants in the ODH Five Year Maternal and Child Health Needs Assessment

Women's Health, Birth Outcomes, and Newborn Health

Kathy Boersma, Community Action Health Services, Marietta
Karen Boester, Ohio Dept. of Job & Family Services, Columbus
Claire Boettler, Cuyahoga Co. Board of Health, Cleveland
Donna Bush, Ohio Dept. of Job & Family Services, Columbus
Ram Chandrashekar, Newborn Screening Section, Bureau of Public Health Labs
Rosemary Chaudry, Ohio State University College of Nursing, Columbus
Cynthia Creek, Mt. Carmel Hospital West, Columbus
Nancy Cunningham, March of Dimes, Columbus
Linda DiPasquale, Summa Health, Akron
Pat Handel, Cincinnati Health Dept., Cincinnati
Sheila Hiddleston, Clark Co. Combined Health District, Springfield
Benita Jackson, OSU School of Public Health, Columbus
Gail Johannes, OSU Medical Center, Columbus
John Kinsel, Good Samaritan Hospital, Dayton
John Ladd, March of Dimes, Cleveland
Nancy Leslie, Children's Hospital, Cincinnati
David Merriman, Cleveland Healthy Families Health Start Program, Cleveland
Tammy Nelson, REACH, Portsmouth
Carole Rogers, Family Planning Consultant, Columbus
Nancy Shapiro, Delaware City County General Health District, Delaware
Carolyn Slack, Columbus City Health Department, Columbus
Annemarie Sommer, Columbus Children's Hospital Genetics, Columbus
Sanford Starr, Ohio Dept. of Alcohol and Drug Addiction Services, Columbus
Carol Ware, Ohio Dept. of Job & Family Services, Columbus
Susan Wiley, Children's Hospital Medical Center, Cincinnati
Darlene Zangara, Ohio Resource Center on Deafness, Columbus

Early Childhood

Erin Joyce Brandt, Children's Defense Fund Ohio, Columbus
Donna Bush, Ohio Dept. of Job & Family Services, Columbus
Jesse Cannon, Ohio Family & Children First, Columbus
John DUBY, Akron Children's Hospital, Akron
James Duffee, Rocking Horse Children's Health Center, Springfield
Margie Eilerman, Sidney-Shelby County Health Department, Sidney
Terrie Hare, Ohio Dept. of Job & Family Services, Columbus
Barbara Haxton, Ohio Head Start Association, Dayton
Marla Himmeger, Ohio Dept. of Mental Health, Columbus
Margaret Hulbert, United Way of Greater Cincinnati, Cincinnati
Mike Kessler, Rocking Horse Children's Health Center, Springfield
Alicia Leatherman, Ohio Child Care Resource and Referral Association, Columbus
Sally Pedon, Ohio Dept. of Job & Family Services, Columbus
James Scott, Ohio Dept. of Education, Columbus

Chris Stoneburner, Build Ohio, Columbus
Amy Swanson, Voices for Cleveland's Children, Cleveland
Olivia Thomas, Columbus Children's Hospital, Columbus
Mike Thomasgard, Columbus Children's Hospital, Columbus
Diane Vanauker, Clark County Combined Health District, Springfield
Sherry Williams, Ohio Eye Care Coalition, Columbus
Theresa Wukusick, Sisters of Charity Foundation of Canton, Canton

School Age and Adolescent

Judy Andrews, Clark Co. Combined Health District, Springfield
Robert Brown, Columbus Children's Hospital, Columbus
Barb Bungard, Ohio PTA
Paul Casamassimo, Columbus Children's Hospital, Columbus
Debbie Chambers, Ohio Department of Alcohol and Drug Addiction Services, Columbus
Rick Cornett, Ohio Optometric Association, Columbus
Carolyn Givens, Ohio Department of Alcohol and Drug Addiction Services, Columbus
Diana Medlock, Montgomery Co. Combined Health District, Dayton
Iris Meltzer, Akron Children's Hospital Medical Center, Akron
Nan Migliozzi, Ohio Department of Health, Ohio
Pam Minard, Westerville Audiology and Hearing Aid Services
Robert Murray, Ross Labs and Columbus Children's Hospital, Columbus
Kay Reitz, Assistant Deputy Director, Ohio Department of Mental Health
Linda Scovern, Healthy Ohioans Coordinator, Ohio Department of Health
Jan Stine, Tobacco Program, Ohio Department of Health
Hermine Willey, Ohio Coalition for Hearing Health Awareness

Children with Special Health Care Needs

Todd Baker, Ohio Optometric Association
Roberta Bauer, Cleveland Clinic Children's, Cleveland
Andrew Carter, Association of Ohio Children's Hospitals
Yolanda Holler, Akron Children's Hospital, Akron
Eileen Kasten, Children's Medical Center, Dayton
Robin Kyman, Parent, Beachwood
Sonny Oppenheimer, Cincinnati Center for Developmental Disorders, Cincinnati
Ruthann Pfau, Children's Medical Center, Dayton
Kim Reilly Primecare of SE Ohio, Zanesville
Chris Rizzo, MetroHealth Medical Center
Betsy Schmaltz, Camelot Women's Health Center, Columbus
Robert Stone, Pediatrics of Akron, Inc.
Kay Treanor, Ohio Developmental Disabilities Planning Council, Columbus
Carol Ware, Ohio Dept. of Job and Family Services, Columbus
Gail Whitelaw, Ohio State University, Columbus
Sara Winter, Pediatric Academic Association