



OHIO DEPARTMENT *of* HEALTH
Living Healthier, Living Better



ANNUAL REPORT

2009-2010
Combined State Fiscal Years

**Combined Annual Report
State Fiscal Years 2009 –2010**

OHIO DEPARTMENT OF HEALTH

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Suggested Citation

Ohio Department of Health. Combined Annual Report State Fiscal Years 2009–2010.
Columbus, OH; December 2010.

Online:

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State of Ohio

Ted Strickland
Governor

Alvin D. Jackson, M.D.
Ohio Department of Health
Director

Acknowledgments

This report was written and designed by the ODH Office of Public Affairs staff.

The Office of Public Affairs would like to thank the dedicated staff in the many offices and bureaus at ODH who provided the information included in this report.

We are particularly grateful for the leadership provided by Dr. Michele Shipp in making this project possible. Special thanks also go to Robert Jennings, Lisa Klancher, Jennifer House, Shannon Libby, Tom Wilcox and Tessie Pollock.

OHIO DEPARTMENT *of* HEALTH

Living Healthier, Living Better



To Protect and Improve the Lives of all Ohioans

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Letter from the Director

Dear Governor Strickland and My Fellow Ohioans:

It is with great pleasure that I submit the combined Annual Reports of the Ohio Department of Health (ODH) for State Fiscal Years 2009 and 2010. This report provides a comprehensive overview of Ohio's state-level public health accomplishments, strategic initiatives, innovative strategies, and revenues and expenses generated during the past two fiscal years.

When I was appointed director of ODH in 2007, I was excited and humbled by the opportunities and challenges to make a significant impact in improving the health of Ohio's 11.5 million residents. As a physician, I could think of no greater calling than to be asked to serve as Ohio's Doctor.

I am particularly proud to share through this report the actions taken each day by our nearly 1300 employees who ensure Ohioans live longer, healthier and more productive lives. These dedicated, and in many cases unnoticed, public servants are driven by the desire to achieve ODH's vision of "Optimal Health for All Ohioans."

Over the past several years, Ohio's public health system has faced many challenges including infectious disease outbreaks, increases in foodborne illnesses, the H1N1 pandemic, an explosion of prescription drug abuses, increasing health disparities and bedbug infestations just to name a few. While these are difficult issues to overcome even in the best of times, ODH and its public health partners confronted these threats in the midst of the most devastating economic crisis since the Great Depression.

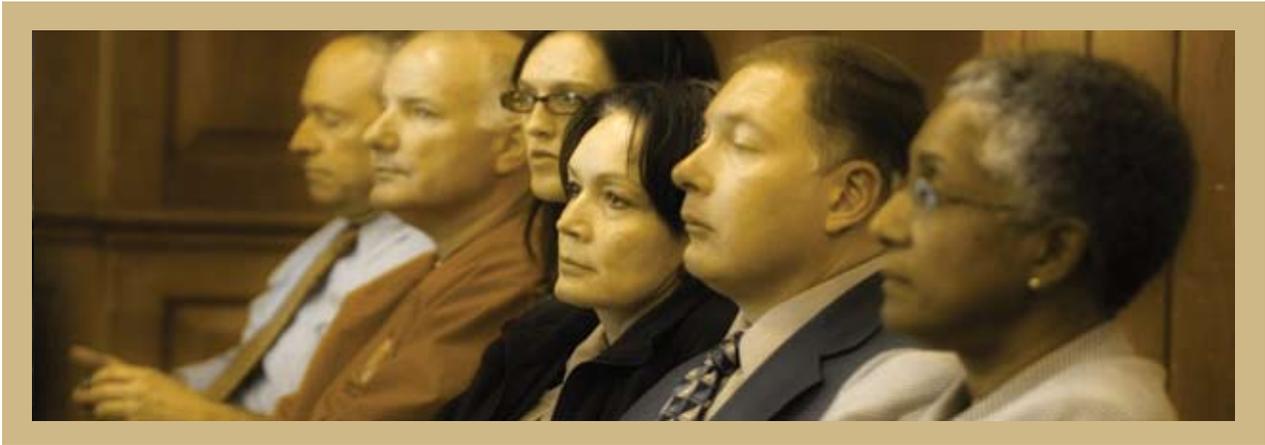
Through it all, Ohio's public health system once again proved its value to the public both in terms of efficiency and effectiveness by protecting and improving the health of all Ohioans.

To clearly illustrate this point, in April 2009, a new pandemic influenza virus first emerged in the U.S. causing illness across the country and throughout the world. We faced a complicated public health crisis and slowing the spread of the H1N1 virus became a national priority. As Ohio's lead agency in the fight against the pandemic, ODH responded with remarkable effectiveness.

For example, in April 2009 Governor Strickland and I signed an authorization to request antiviral medications from the federal Strategic National Stockpile (SNS) Program. This marked the beginning of our medical materials management response strategies. By the end of 2009, ODH had overseen the receipt and transport of more than two million items of protective personal equipment and nearly 263,000 courses of antiviral medications to eight regional nodes, 88 county drop sites, and 172 hospitals throughout Ohio.

Ohio's public health system proved its value to the public both in terms of efficiency and effectiveness by protecting and improving the health of all Ohioans.





In addition, our Immunization Program, in collaboration with the Centers for Disease Control and Prevention (CDC), was instrumental in coordinating the distribution of more than four million doses of H1N1 vaccine to over 3,000 immunization providers statewide. The program used a centralized immunization registry to monitor and track vaccinations of Ohio citizens. This registry was recognized by the CDC as a standard for all other states to follow in their future pandemic planning efforts.

This combined annual report highlights many of the other significant achievements accomplished by the ODH and its partners over the past two years. It also captures some of the looming crises Ohio's public health system must be prepared to face in the future.

One such issue is the fight against obesity. There are more than one-million people affected by diabetes in Ohio and more than two-million have pre-diabetes (a pre-cursor to the development of type 2 diabetes). It is estimated that by the year 2050, one in three persons will develop this disease. Diabetes is a leading cause of heart disease, stroke, adult blindness, lower limb amputations and kidney failure. Each year, more than 250,000 Ohioans are hospitalized due to complications of diabetes. This report provides insight into what ODH is doing to combat this serious public health threat.

Included also in this publication is a detailed agency budget section which outlines the many revenue funding streams and reporting codes of ODH. The funding and reporting complexity driven by federal and state reporting requirements assures that ODH is meeting the legislative (state and federal) intent of the funding, and provides data documenting accountability and transparency for all stakeholders.

I would like to give a special thanks to ODH's executive leadership team. These dedicated leaders go above and beyond their job descriptions each day to help make Ohio a healthier state. Without their work and leadership, many of these accomplishments would not have been achieved.

I hope you find this report useful in gaining a better understanding of the role, mission and importance of public health in our society.

Sincerely,

Alvin D. Jackson, M.D.
Ohio Department of Health
Director

PREFACE

What is Public Health?



“Health care is vital to all of us some of the time, but public health is vital to all of us all of the time.”

– Former U.S. Surgeon General C. Everett Koop

Public Health is an exciting, dynamic, multi-disciplinary field of science where people work to protect and improve the health of communities and populations through education, promotion of healthy lifestyles and research for disease and injury prevention. Public health professionals analyze the effect on health of genetics, personal choice and the environment in order to develop programs that protect the health of communities.

The nation's public health system focuses on the health of entire populations while they are still healthy, rather than on individual patients after they become ill. This proactive, preventive approach is the single most important distinction between public health and clinical medicine. Public health advances in areas such as vaccinations, clean water, infectious disease control, healthier foods and safer workplaces has helped add 25 of the additional 30 years of life we now experience. Since the early 1900's, only five of those additional years are attributed to clinical medicine.

To highlight the importance of public health in the 20th century, the Centers for Disease Control and Prevention (CDC) developed the top 10 public health accomplishments. These accomplishments showcase the vast range of issues that public health addresses each and every day.

Vaccination

This achievement resulted in the eradication of smallpox; elimination of poliomyelitis in the Americas; and control of measles, rubella, tetanus, diphtheria, Haemophilus influenzae type b, and other infectious diseases in the United States and other parts of the world.

Motor-vehicle Safety

Improvements in motor vehicle safety have resulted from engineering efforts to make both vehicles and highways safer and from successful efforts to change personal behavior (e.g., increased use of safety belts, child safety seats, and motorcycle helmets and decreased drinking and driving). These efforts have contributed to large reductions in motor-vehicle-related deaths.

Safer Workplaces

Work-related health problems, such as coal workers' pneumoconiosis (black lung), and silicosis – common at the beginning of the century – have come under better control. Severe injuries and deaths related to mining, manufacturing, construction, and transportation also have decreased; since 1980, safer workplaces have resulted in a reduction of approximately 40 percent in the rate of fatal occupational injuries.

Control of Infectious Diseases

Control of infectious diseases has resulted from clean water and improved sanitation. Infections such as typhoid and cholera transmitted by contaminated water, a major cause of illness and death early in the 20th century, have been reduced dramatically by improved sanitation. In addition, the discovery of antimicrobial therapy has been critical to successful public health efforts to control infections such as tuberculosis and sexually transmitted diseases (STDs).



Public Health
Prevent. Promote. Protect.

Developed by National Association of County and City Health Officials - NACCHO, a universal public health symbol has been born to offer all local and state health departments a common symbol that prominently helps to show pride in the people and power of public health who are at work every day in every community. It is important for the health department's mission and function to be recognized and understood by all people and to differentiate public health from health care provided the medical professionals. ODH encourages all program areas to utilize this symbol in their communications to emphasize our public health mission.



The dramatic achievements of Public Health in the 20th century have improved our quality of life: an increase in life expectancy, world wide reduction in infant and child mortality, and the elimination or reduction of many communicable diseases.

Decline in Deaths from Coronary Heart Disease and Stroke

Declines in deaths from coronary heart disease and stroke have resulted from risk-factor modification, such as smoking cessation and blood pressure control coupled with improved access to early detection and better treatment. Since 1972, death rates for coronary heart disease have decreased 51 percent.

Safer and Healthier Foods

Since 1900, safer and healthier foods have resulted from decreases in microbial contamination and increases in nutritional content. Identifying essential micronutrients and establishing food-fortification programs have almost eliminated major nutritional deficiency diseases such as rickets, goiter, and pellagra in the United States.

Healthier Mothers and Babies

Healthier mothers and babies have resulted from better hygiene and nutrition, availability of antibiotics, greater access to health care, and technologic advances in maternal and neonatal medicine. Since 1900, infant mortality has decreased 90 percent, and maternal mortality has decreased 99 percent.

Family Planning

Access to family planning and contraceptive services has altered social and economic roles of women. Family planning has provided health benefits such as smaller family size and longer interval between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs.

Fluoridation of Drinking Water

Fluoridation of drinking water began in 1945 and in 1999 reaches an estimated 144 million persons in the United States. Fluoridation safely and inexpensively benefits both children and adults by effectively preventing tooth decay, regardless of socioeconomic status or access to care. Fluoridation has played an important role in the reductions in tooth decay (40-70 percent in children) and of tooth loss in adults (40-60 percent).

Recognition of Tobacco use as a Health Hazard

Recognition of tobacco use as a health hazard and subsequent public health anti-smoking campaigns have resulted in changes in social norms to prevent initiation of tobacco use, promote cessation of use, and reduce exposure to environmental tobacco smoke. Since the 1964 Surgeon

General's report on the health risks of smoking, the prevalence of smoking among adults has decreased, and millions of smoking-related deaths have been prevented.

Public health regards the entire community as its patients and serves communities and individuals within them by providing an array of essential services. Many of these services are invisible to the public and are only noticed when a problem develops (e.g., an epidemic occurs).

Public Health in the 21st Century

Public health continues to play an important role. In March 2010, President Barack Obama signed the Patient Protection & Affordability Care Act (PPACA), also known as federal healthcare reform, into law. Over the next few years, there will be a shift of the emphasis of the health care system from acute care to prevention. This will fundamentally change how health care is financed, provided, monitored and delivered.

The funding and new partnerships that will evolve from the Patient Protection & Affordability Care Act will allow public health to be more proactive on key issues, such as access, prevention and health equity. The additional emphasis on prevention will also enable public health to do more outreach and put more educational campaigns into place.

As Ohio's flagship of public health, ODH works with 128 local health departments to provide local services and statewide public health programs.

Patient Protection & Affordability Care Act (PPACA)

The law includes numerous health-related provisions to take effect over a four-year period, including prohibiting health insurers from denying coverage or refusing claims based on pre-existing conditions, expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, establishing health insurance exchanges, and support for medical research.

ODH collaborates with 128 local Ohio health departments providing local services and statewide public health programs for over 11 million Ohioans.



CHAPTER 1

About the Ohio Department of Health



MISSION

“To Protect and Improve the Health of All Ohioans by Preventing Disease, Promoting Good Health and Assuring Access to Quality Health Care”

VISION

“Optimal Health for All Ohioans”



History of ODH

Public health in Ohio has undergone many changes since 1886 when the State Board of Health – a precursor to the Ohio Department of Health (ODH)– was established. The State Board of Health was formed to help coordinate the fight against tuberculosis (TB). In 1917, ODH was created by the Ohio General Assembly and spent the first half of the 20th century working to control the spread of infectious diseases.

With the development of antibiotics and other treatments in the 1970s, a premature victory was declared against diseases such as TB, gonorrhea and other diseases caused by antibiotic-resistant bacteria. However, those diseases are re-emerging and newly recognized illnesses such as *E. coli* and Ebola continue to be a public health threat.

Through the years, ODH overcame many obstacles and took on more responsibilities as the focus of public health evolved from infectious disease control to management of chronic diseases. At the dawn of the 21st century, new roles such as first responder and response to bioterrorism events were added to the mission of public health.

Today, as Ohio’s flagship of public health, ODH works with 128 local health departments to provide local services and has some 150 programs of its own. The agency is divided into three divisions and numerous bureaus and offices all designed to provide essential public health services and supports to Ohio communities. One such office, the Office of Healthy Ohio, was established during the Strickland Administration to promote healthy habits and improve the health and wellness of Ohioans through chronic disease prevention, health equity, coordination and accountability.

ODH also works with the seven-member Public Health Council to adopt enforcement rules for laws such as home sewage systems standards and Ohio’s Smoke-Free Workplace Act, often referred to as the smoking ban.

ODH truly is a pre-birth to end-of-life service agency.

ODH provides the first vaccines for many Ohio children and offers family and early childhood intervention services. Older Ohioans can take comfort in knowing that ODH inspects nursing homes to ensure safer environments for residents.

ODH's Cabinet-level Structure

Assistant Director for Programs:

- Division of Family and Community Health Services
- Division of Prevention
- Division of Quality Assurance
- State Epidemiology Office

Assistant Director for Administration:

- Office of Public Health Preparedness
- Office of Local Health Department Support
- Office of Management Information Systems
- Office of Employee Services

Director's Office:

- Office of General Counsel
- Office of Government Affairs
- Office of Public Affairs
- Office of Financial Affairs
- Office of Performance Improvement
- Office of Healthy Ohio

ODH truly is a cradle to end-of-life service agency and not just because it issues birth and death certificates. If you go out for a meal, the restaurant you choose was likely inspected by an ODH-regulated program. ODH provides the first vaccines for many Ohio children and offers family and early childhood intervention services. Older Ohioans can take comfort in knowing that ODH inspects nursing homes to ensure safer environments for residents.

Mission, Vision & Goals

The mission of ODH is to “Protect and Improve the Health of All Ohioans by Preventing Disease, Promoting Good Health and Assuring Access to Quality Care.” The ODH public health vision is “Optimal Health for All Ohioans.”

To accomplish its mission and vision, actions are taken each day by ODH's nearly 1,300 public health professionals who are dedicated to ensuring Ohioans live longer and healthier lives.

ODH's strategic goals focus on those public health activities essential to:

- *Promoting good health to improve birth outcomes and reduce chronic disease*
- *Preventing infant mortality, chronic, genetic and infectious diseases*
- *Assuring quality and safety of health care services*
- *Assuring public health preparedness and security and*
- *Eliminating health disparities*

Structure

ODH is a cabinet-level agency, meaning the director reports to the governor and serves as a member of the Executive Branch of Ohio's government. ODH is made up of three primary divisions and a number of offices and bureaus all aligned to bring direct public health services to Ohioans in their home communities.

Assistant Director for Programs

The **Division of Family and Community Health Services** provides administrative direction, leadership, and coordination of the activities for child and family health services, children with medical handicaps, early intervention services, nutrition services, and community health services. The mission of DFCHS is to assure access to health services for Ohioans. The division's goals are to assure access to high quality interdisciplinary, culturally appropriate/competent health services.

The **Division of Prevention** promotes good health, evaluates health status, and prevents and controls injuries and diseases (chronic and infectious). The division contributes to the ODH mission by carrying out core public health functions and essential public health services. The division supports a systems approach to prevention and preparedness that is based on science and innovative technology. Collaborations and partnerships at the federal, state and local levels provide enhanced capacity to meet strategic priorities.

The **Division of Quality Assurance** protects the health and safety of Ohio citizens through activities that assure the quality of both public health and health care delivery systems. The division's primary mission is ensure the proper licensure and regulation of long-term and non long-term care facilities as well as employ professionals in the environmental fields such as lead abatement and radon mitigation.

The **State Epidemiology Office** uses epidemiology to protect and optimize the health of Ohioans. The office works closely with programs in all divisions and with the Office of Health Preparedness and the Center for Public Health Statistics and Informatics to protect and optimize the health of Ohioans.

Assistant Director for Administration

The **Office of Public Health Preparedness** operates at the executive level with a primary mission of coordinating the emergency preparedness and response activities of ODH. Included in these responsibilities are preparedness for man-made and natural disasters, technological emergencies, public health emergencies, and chemical, biological and radiological terrorism.

The **Office of Local Health Department Support** works closely with local health departments (LHDs) to carry out the mission of public health in Ohio. The office serves as the agency liaison to LHDs, administers public health improvement standards, drafts recommendations regarding approval of LHD contracts, serves on statewide committees, workgroups and task forces and provides technical assistance to LHDs.

The **Office of Management Information Systems** administers the computer-based management systems across the ODH enterprise. The office is responsible for maintaining ODH computer networks and servers and for the development and implementation of strategies that support the current and future technology needs of the agency.





Under the leadership of Dr. Jackson, ODH formed the Office of Workforce Development to offer learning opportunities for all employees that will help them, both personally and professionally, to perform at their optimal level and develop to their highest potential. Dr. Jackson's vision is that ODH will be a continuously developing, self-directed and mentor-supported learning environment.

The **Office of Employee Services** oversees the management of ODH's human resource needs through the daily operations of:

- **Human Resources** creates and maintains a competent, well-qualified workforce, in support of ODH's strategic priorities.
- **Labor Relations** provides labor-relations services and technical assistance to the employees and managers at ODH in accordance with Ohio Laws and Collective Bargaining Agreements.
- **Workforce Development** facilitates learning opportunities for all employees that will help them, both personally and professionally, to perform at their optimal level and develop to their highest potential.
- **Employee Assistance Program** helps state employees and their families resolve personal and work related problems by providing confidential counseling referrals, consultations and other services.
- **Equal Employment Opportunity Program** insures ODH remains compliant with equal employment opportunity laws through key initiatives such as employee education, training, investigations and outreach.

Director's Office

The agency functions associated with the Director's Office provide executive-level support for the Director of Health by assisting in formulating and implementing policy directives for both the administrative and programmatic operations of the agency. The office includes the agency chief of staff and its two assistant directors. These functions, along with the following offices are aligned with the agency's chief executive officer to best serve the strategic goals of ODH by facilitating a more direct line of communication and reporting.

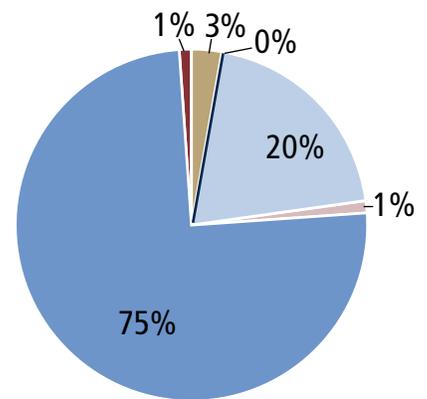
- The **Office of General Counsel** assists the Director of Health in defining agency goals and objectives by overseeing and coordinating all ODH legal activities. Its primary responsibilities include negotiating, developing and advocating the legal and legislative positions of the department. The General Counsel also oversees the activities in the Office of Government Affairs.
- The **Office of Government Affairs** directs and coordinates legislative affairs for ODH and develops policies and procedures to promote the department's legislative agenda. The office is the primary liaison for the agency in working with the Ohio legislature

and with all federal, state and local elected officials.

- **The Office of Public Affairs** is responsible for the development of all ODH internal and external communication strategies. Its primary functions include media relations, public relations and marketing and the office leverages mass and social media channels to ensure the general public has immediate access to critical public health information.
- **The Office of Financial Affairs** assists in the establishment of ODH's long and short-rang fiscal goals and objectives. The office provides the agency with the overall fiscal administration support through its various unit operations including accounting, purchasing, budgeting and grants administration. The office oversees the agency's biennial budget process, provides technical assistance to agency decision-makers and provides daily monitoring and analysis of agency spending trends.
- **The Office of Performance Improvement** helps define agency goals and objectives relative to strategic planning and performance improvement. The office coordinates the development of performance measures for local health departments and for programs within ODH through working with division chiefs and program staff. The Office oversees the Department's Data Center, Compliance and Accountability Unit and Vital Statistics office
- **The Office of Healthy Ohio** is a key component of Gov. Ted Strickland's comprehensive health care reform initiative and is located at the Ohio Department of Health. Healthy Ohio's goal is to improve the health of all Ohioans in order to create a better quality of life, assure a more productive workforce and equip students for learning, while also contributing to the more efficient and cost-effective use of medical services.

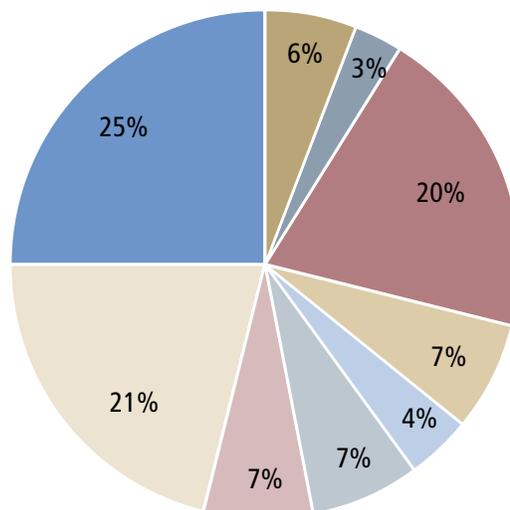
ODH Workforce Stats

Total Employee Distribution by Race



- American Indian (3)
- Asian (37)
- Black (261)
- Hispanic (15)
- White (966)
- Unknown (15)

ODH Workforce Composition by Program Area

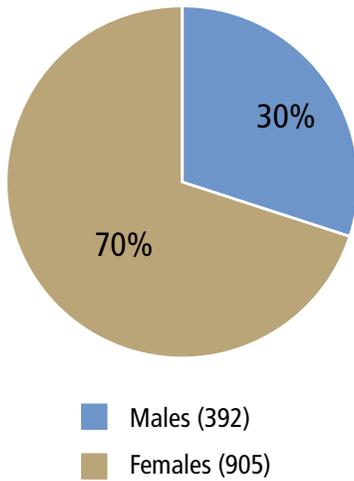


- Directors Office (73)
- Employee Services (35)
- Family (262)
- Financial Affairs (91)
- Healthy Ohio (54)
- OMIS (90)
- Performance Improvement (96)
- Prevention (269)
- Quality (327)

TOTAL = 1297

ODH Workforce Stats

Total Employee Distribution by Gender

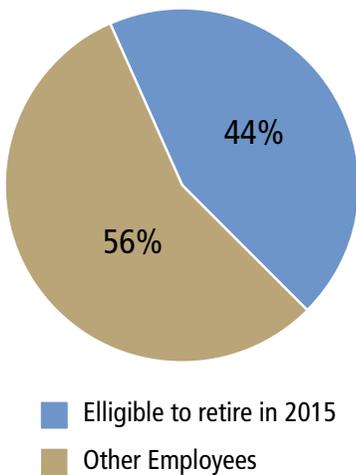


ODH is committed to fostering a culturally competent workforce that is prepared to meet the challenges and opportunities that diversity presents. ODH also works to create and maintain, consistent with the applicable law and collective bargaining agreements, a competent, well-qualified workforce, in support of the department’s strategic priorities.

ODH’s aging workforce is both a challenge and an opportunity. The challenge rests in the loss of institutional knowledge and continuity of service; the opportunity lies in Ohio’s ability to recruit and train future public health professionals.

Under the leadership of Dr. Jackson, ODH formed the Office of Workforce Development to offer learning opportunities for all employees that will help them, both personally and professionally, to perform at their optimal level and develop to their highest potential. Dr. Jackson’s vision is that ODH will be a continuously developing, self-directed and mentor-supported learning environment.

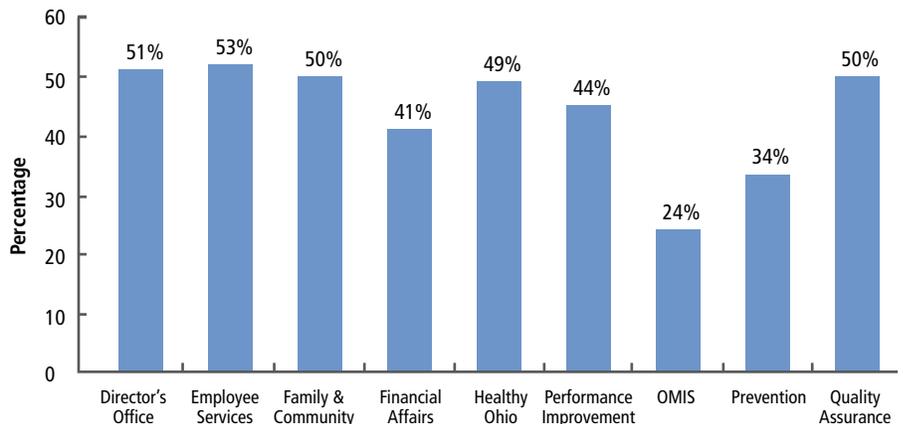
Percent of ODH Employees Eligible for Retirement in 2015



Through the Office of Workforce Development, and in collaboration with the Ohio State University College of Public Health and the University of Cincinnati, ODH executive leadership commissioned a workforce needs assessment to determine the competency-based gaps in knowledge and skill among ODH employees for the purpose of indentifying and prioritizing training initiatives and/or non-training solutions to improve both individual and agency performance.

The information gained from the assessment will assist in the development of a comprehensive strategic workforce development plan for the agency. This plan will not only assist employees in increasing their competency, it will also assist in the achievement of ODH’s mission and address requirements associated with the agency’s quest for voluntary accreditation.

Percent of ODH Staff by Division Eligible for Retirement in 2014



ODH Helps Set Standard for National Accreditation

The goal of accreditation is to improve and protect the health of every community by advancing the quality and performance of public health departments. ODH is committed to achieving accreditation as soon as it is available and is working with the Alexandria, Virginia-based Public Health Accreditation Board (PHAB) on the standards.

During this biennium, PHAB selected ODH along with seven other state health departments, 19 LHDs (including Mahoning County District Board of Health, also located in Ohio) and three tribal health departments to participate in a pilot program to establish standards which will be used in a national voluntary accreditation process.

During this pilot “beta test,” sites work through the entire accreditation process and provide valuable, on going feedback and evaluation. Based on the feedback, PHAB will refine and improve the accreditation program to ensure that it is effective, feasible and is applicable to all public health departments.

ODH submitted materials to PHAB during March 2010, including about 500 documents. The PHAB team then reviewed the information which documented processes including development of infrastructure, human resources policies, database security, Web site content, public affairs engagement and program development and implementation. Accreditation will drive public health departments to continuously improve the quality of the services they deliver to the community.

- The accreditation assessment process provides valuable, measurable feedback to health departments on their strengths and areas for improvement.
- Engaging in the accreditation process provides an opportunity for health departments to learn quality and performance improvement techniques that are applicable to multiple programs.
- Gaining accreditation status has resulted in increased credibility among elected officials, governing bodies and the public.
- The recognition of excellence brought on by meeting accreditation standards has positively impacted staff morale and enhanced the visibility of the health departments.
- Accreditation is a means of demonstrating accountability to elected officials and the community as a whole.

In the first month of SFY11, PHAB conducted its site visit at ODH. PHAB members met with ODH team members, collaborators from across the state. At the conclusion of the two-day visit, they conducted an exit conference, providing feedback on ODH’s operations (PHAB will not acknowledge whether it would have recommended accreditation in an actual situation).



Budget Picture State Fiscal Years 2008-2009-2010

State Fiscal Year (SFY) 2010 resources were allocated across seven fund groups, with the most significant amount of funding (72 percent) coming from the Federal Revenue Fund group and 13 percent from Ohio's General Revenue Fund (GRF). Approximately eight percent of funding was allocated in the State Special Revenue Fund group and five percent allocated in the General Service Fund group. These resources were identified through 56 distinct appropriation line items.

ODH funding is distributed through 40 major programs grouped in seven major programmatic areas including Disease Prevention, Family and Community Health Services, Quality Assurance and Public Health Preparedness. The funding and reporting complexity driven by federal and state reporting requirements assures that ODH is meeting the legislative (state and federal) intent of the funding and provides data documenting accountability and transparency for all stakeholders.

ODH was able to offer services consistent with previous years, with fewer resources. Due to the worst recession since the great depression, in SFY10, all cabinet level agencies in the state of Ohio were required to implement cost saving days, which meant each employee was required to take 10 non-paid days off of work.

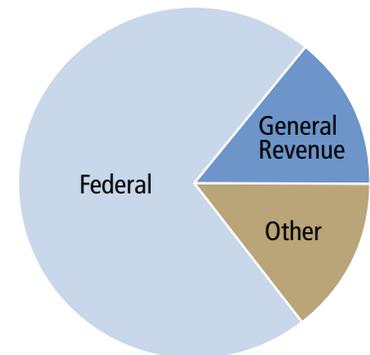
ODH funding increases in GRF in the biennium 2010/11 are attributed to increased funding for Help Me Grow (HMG), Ohio's early childhood development program. The majority of other GRF funded public health programs sustained significant GRF funding reductions. When HMG funding is excluded from comparison, the overall ODH reliance on GRF funding has declined between SFY08 and SFY10 GRF by over 19 percent.

While the overall ODH spending grew from SFY08 to SFY09 by 0.05 percent and from SFY09 to SFY10 by approximately 6 percent, the ODH payroll expenses declined between SFY09 and SFY10 by over 7.5 percent. In the same period, the ODH contract expenditures declined by over 38 percent and its grant/subsidy payments to local partners increased by over 15 percent from \$396.5 million to \$457.6 million annually, a \$61 million increase.

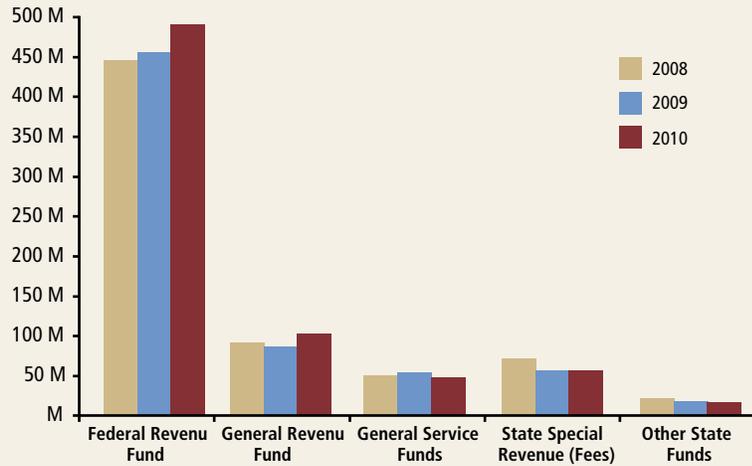
From the programmatic perspective, a significant 60 percent increase in spending for Public Health Preparedness programs between SFY09 and SFY10 needs to be noted. The ODH response to 2009 H1N1 pandemic resulted in increased spending from \$56.4 million in SFY09 to \$90.5 million in SFY10, a \$34 million increase.

ODH Funding Sources

ODH Funding Composition – SFY2010

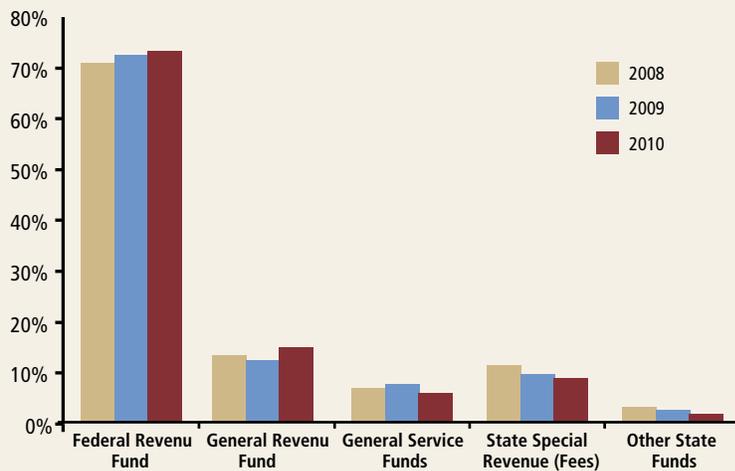


Expenditures By Fund Type	SFY08	SFY09	SFY10
Federal Revenue Fund	435,194,627	443,755,275	477,094,346
General Revenue Fund	75,098,823	74,412,147	87,787,167
General Service Funds	36,786,239	40,752,156	35,371,849
State Special Revenue (Fees)	62,216,176	53,393,099	53,925,098
Other State Funds	11,953,571	9,269,078	4,463,816
Grand Total	621,249,437	621,581,755	658,642,276

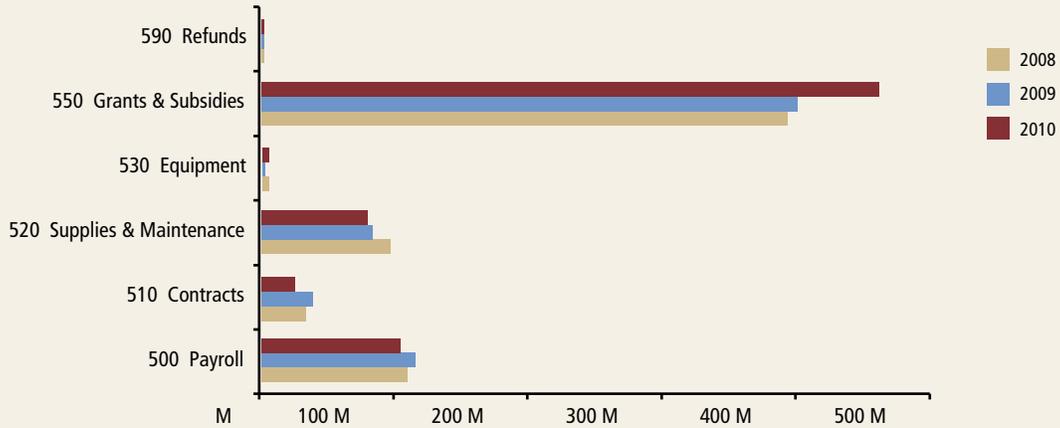


Expenditures By Fund Type By %	SFY08	SFY09	SFY10
Federal Revenue Fund	70%	71%	72%
General Revenue Fund	12%	12%	13%
General Service Funds	6%	7%	5%
State Special Revenue (Fees)	10%	9%	8%
Other State Funds	2%	1%	1%
Grand Total	100%	100%	100%

* Other State Funds Include Tobacco MSA, Holding Acocunts, State Highway Safety

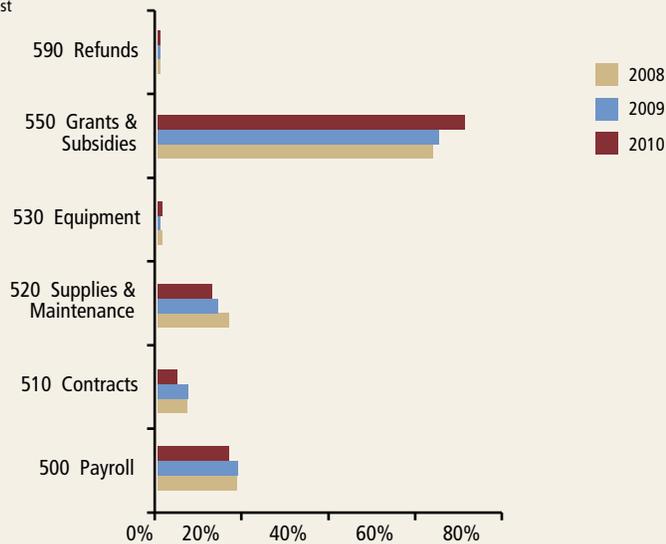


Expenditures By Spending Category	SFY08	SFY09	SFY10
500 Payroll	106,368,600	110,081,255	101,739,204
510 Contracts	29,995,548	35,212,662	21,544,356
520 Supplies & Maintenance	92,924,384	78,598,294	74,363,319
530 Equipment	2,773,633	927,296	3,016,623
550 Grants & Subsidies	388,636,828	396,549,998	457,623,206
590 Refunds	550,445	212,249	355,568
Grand Total	621,249,437	621,581,755	658,642,276

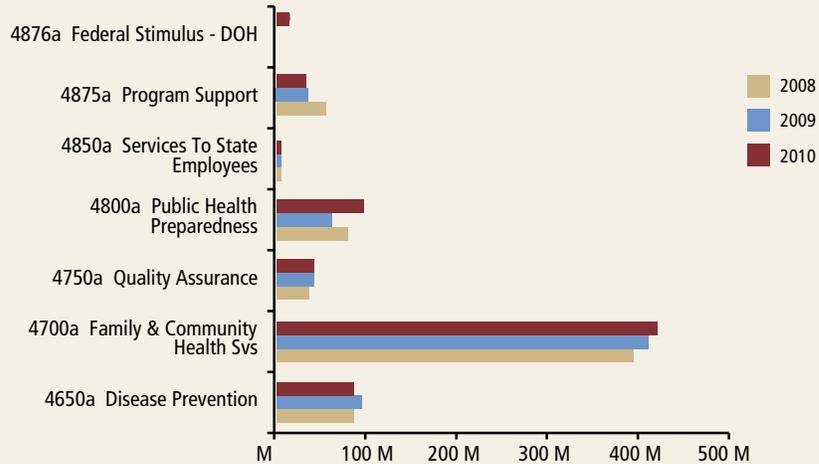


Expenditures By Spending Category By %	SFY08	SFY09	SFY10
500 Payroll	17%	18%	15%
510 Contracts	5%	6%	3%
520 Supplies & Maintenance	15%	13%	11%
530 Equipment	0%	0%	0%
550 Grants & Subsidies	63%	64%	69%
590 Refunds	0%	0%	0%
Grand Total	100%	100%	100%

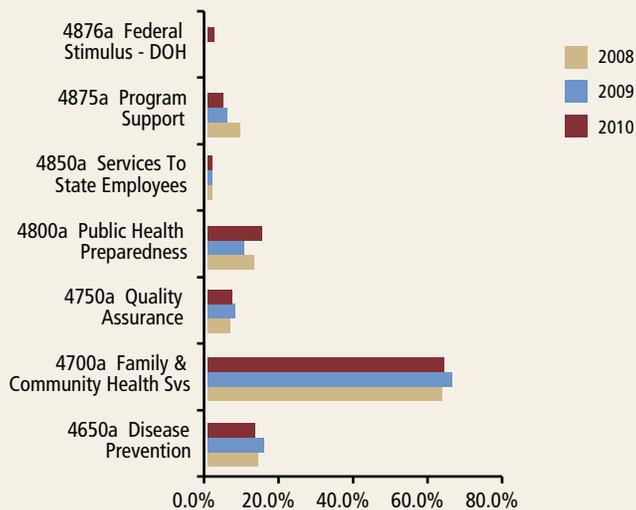
** 520 Supplies & Maintenance Includes Indirect Cost



Expenditures By Program Series-A	SFY08	SFY09	SFY10
4650a Disease Prevention	78,736,299	88,515,846	79,620,373
4700a Family & Community Health Svs	385,906,080	403,976,851	413,317,639
4750a Quality Assurance	33,334,271	40,597,205	38,646,546
4800a Public Health Preparedness	72,678,893	56,474,670	90,560,547
4850a Services To State Employees	3,040,653	2,897,109	1,716,484
4875a Program Support	47,553,240	29,120,073	27,373,886
4876a Federal Stimulus - DOH			7,406,802
Grand Total	621,249,437	621,581,755	658,642,276

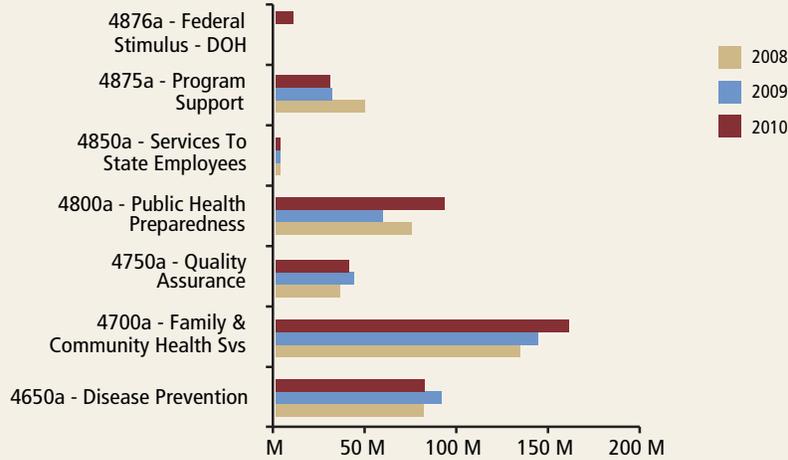


Expenditures By Program Series-A By %	SFY08	SFY09	SFY10
4650a Disease Prevention	13%	14%	12%
4700a Family & Community Health Svs	62%	65%	63%
4750a Quality Assurance	5%	7%	6%
4800a Public Health Preparedness	12%	9%	14%
4850a Services To State Employees	0%	0%	0%
4875a Program Support	8%	5%	4%
4876a Federal Stimulus - DOH			1%
Grand Total	100%	100%	100%



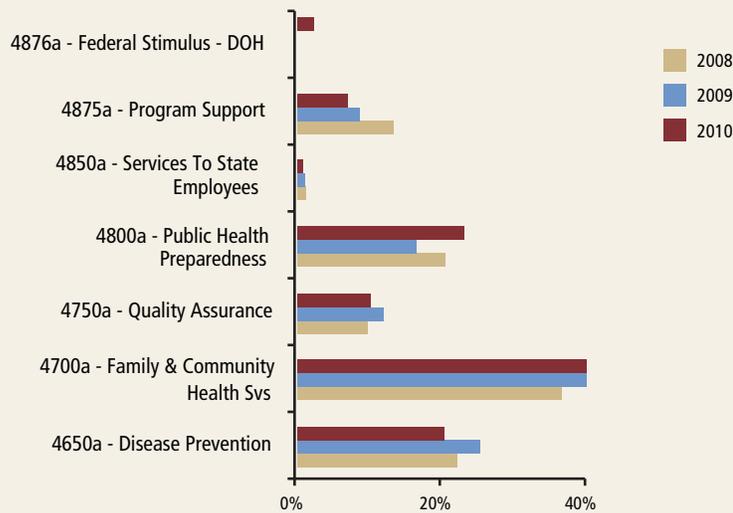
Below WIC Program Is Excluded From The Program Analysis To More Accurately Represent ODH Program Spending

Expenditures By Program Series-A	SFY08	SFY09	SFY10
4650a - Disease Prevention	78,733,131	88,515,816	79,620,373
4700a - Family & Community Health Svs	131,079,276	141,084,561	158,135,253
4750a - Quality Assurance	33,334,271	40,597,183	38,646,546
4800a - Public Health Preparedness	72,678,893	56,474,670	90,542,380
4850a - Services To State Employees	3,040,653	2,897,109	1,716,484
4875a - Program Support	46,726,737	29,115,568	27,373,886
4876a - Federal Stimulus - DOH			7,406,802
Grand Total	365,592,962	358,684,907	403,441,724



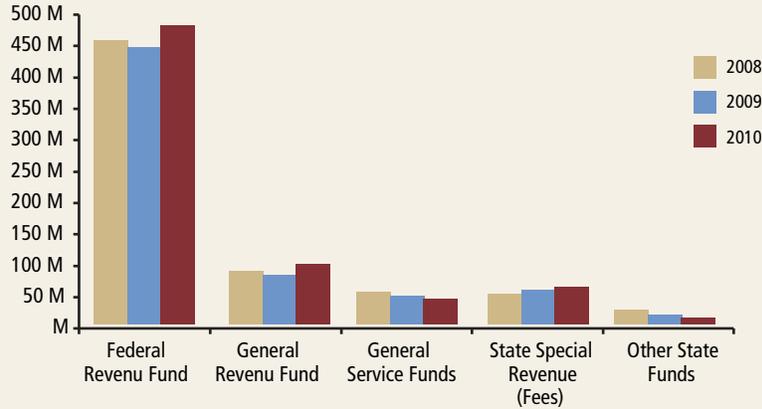
WIC Excluded

Expenditures By Program Series-A By %	SFY08	SFY09	SFY10
4650a - Disease Prevention	22%	25%	20%
4700a - Family & Community Health Svs	36%	39%	39%
4750a - Quality Assurance	9%	11%	10%
4800a - Public Health Preparedness	20%	16%	22%
4850a - Services To State Employees	1%	1%	0%
4875a - Program Support	13%	8%	7%
4876a - Federal Stimulus - DOH			2%
Grand Total	100%	100%	100%

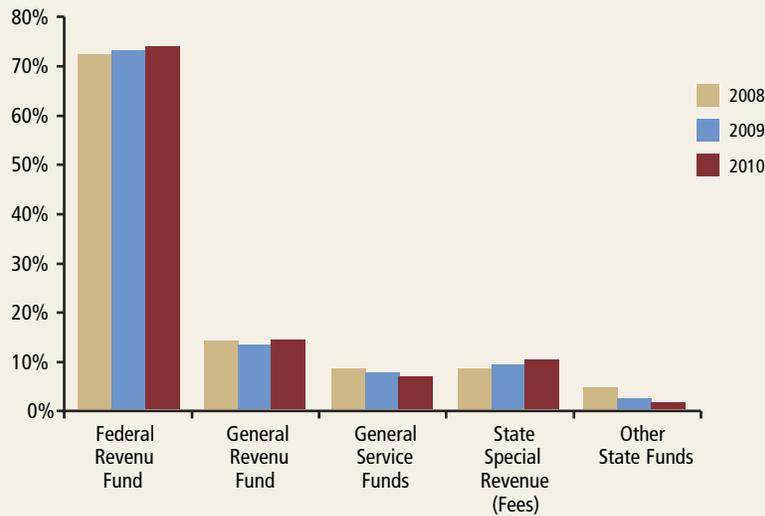


Revenue By Fund Type	SFY08	SFY09	SFY10
Federal Revenue Fund	442,562,769	437,708,682	470,978,956
General Revenue Fund	78,314,710	75,046,826	88,195,994
General Service Funds	43,232,269	40,797,677	36,821,068
State Special Revenue (Fees)	45,685,946	51,228,425	58,541,518
Other State Funds	19,191,675	7,689,216	1,156,717
Grand Total	628,987,369	612,470,826	655,694,253

* Other State Funds Include Tobacco MSA, Holding Acocunts, State Highway Safety



Revenue By Fund Type By %	SFY08	SFY09	SFY10
Federal Revenue Fund	70%	71%	72%
General Revenue Fund	12%	12%	13%
General Service Funds	7%	7%	6%
State Special Revenue (Fees)	7%	8%	9%
Other State Funds	3%	1%	0%
Grand Total	100%	100%	100%



The ODH response to 2009 H1N1 pandemic resulted in increased spending from \$56.4 million in SFY09 to \$90.5 million in SFY10, a \$34 million increase.



CHAPTER 2

Essential Public Health Partnerships



Good public health policies require dedicated champions and strong partnerships. ODH is fortunate to have both. The public health system in Ohio is comprised of ODH, local public health departments (LHDs), health care providers, public health associations, universities and others that work together to promote and protect the health of Ohioans. The role each plays is critically important to ensuring a strong public health system in our state.

The most essential ODH partners, however, are the 128 LHDs who provide local leadership, front line delivery of services, coordination, collaboration and oversight of public health services authorized under state and local statutory guidelines.



Local Health Departments in a “Home Rule” State

In Ohio, LHDs- like school districts- maintain independent governance, but often work together, along with the state and federal public health agencies. The 1912 Home Rule Amendment to Ohio’s Health Code authorized LHDs to “exercise all powers of local self-government and to adopt and enforce within their limits. Many municipalities decided to draw up charters regarding administration of the health district in order to take advantage of the home rule provisions.

Depending on the type of health district (city, county or combined) funding for LHDs comes from the support of their community through levies, city general operating funds, contracts, county government and/or what is known as “inside millage.” To help support LHDs, ODH receives funds from federal agencies, state general revenue and other sources and distributes many of these funds through contracts and grants that contribute toward local public health programs and services. ODH also provides technical support, laboratory services, an IT communication network and other critical services to aid local health department efforts.

LHDs strive to promote health and improve quality of life by preventing and controlling disease, injury and disability. As was seen during SFY10, LHDs play a vital role in responding to public health issues, like H1N1, providing significant public value in terms of dollars and lives saved. On a more day-to-day basis, depending on the size and budget of a LHD, services may include environmental health programs, immunization clinics, well-baby visits, pre-natal, health screenings, dental, health promotion activities and disease surveillance.

ODH Director Alvin D. Jackson’s LHD Visits

When Dr. Alvin D. Jackson was appointed director of the ODH by Gov. Strickland in 2007, he made a commitment to LHDs that he would visit each of the then 131 separate departments during his time as director. It was a lofty goal to be sure but no one would have faulted the new agency

As a profile of local health departments here are a few highlights:

- 58 urban health departments
- 71 rural health departments
- 22 city charters
- 61 combined health districts
- 24 counties with more than one health department
- Employs 5,574 individuals (2009)
- Total budget from federal, state and local sources combined approximately \$405,463,448.40 (2009)

Until now, no other state health director had visited all local departments during his or her tenure.

head had he fell short of his promise—particularly given that many locals had never received a visit by a sitting director of health.

Dr. Jackson began his journey by visiting Columbus Public Health on June 28, 2007. His promise to locals was fulfilled nearly three years later, when he visited the Licking County Health Department on April 29, 2010. Until now, no other state health director had visited all local departments during his or her tenure.

While this accomplishment was remarkable, it was what Dr. Jackson learned during those visits that will truly benefit Ohio’s public health system and help build a better understanding of the needs of local communities.



Dr. Jackson completed his last LHD visit in Licking County, in April, 2010.





OHIO DEPARTMENT OF HEALTH

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Alvin D. Jackson, M.D./Director of Health

December 2010

Dear Ohio Local Health Department Staff,

During my 131 visits, I learned a great deal about the importance of the work you do each day. My visits reaffirmed my belief that local public health provides essential services that are vital to the well being of a community.

In these challenging economic times, I was amazed to learn of the extent to which local health departments (LHDs) are doing more with less. Despite shrinking budgets and limited resources LHDs have been able to investigate an increased number of foodborne outbreaks and provide services to a growing number of Ohioans in need. I know as we move forward there is a vital need for continued funding conversations at the state and local level.

One commitment I made to you was to streamline the ODH grant process to help reduce the amount of administrative work required to apply for funding. To accomplish this goal, I have worked with the Office of Performance Improvement and the Ohio Department of Administrative Services to implement an improved grant process which will require 44 steps, rather than 184.

During my visits, I also was able to see Ohio's diversity first hand. Our state is made up of urban areas, Appalachian areas, small farming communities, suburban areas and everything in between. This diversity is both an asset and a challenge for Ohio's public health system. This first hand knowledge helped me to better understand that just because a program is effective in addressing health disparities in one community, does not mean that it will be effective in addressing disparities in all communities. Both ODH and LHDs must develop and support public health initiatives that address the needs of all of our citizens and this goal is one that we must continue to advance.

The visits also reinforced my understanding that we can better protect the health of our citizens by implementing new technology and improving communication. I have been working with ODH staff to improve our technologies to reduce costs and increase communication. These changes will ensure that resources are used as effectively as possible. Our first step was to provide each LHD with an Internet-based phone system, that allows increased connectivity to ODH and other LHDs without costly long distance fees.

In an additional effort to improve communication, my administration also began hosting a weekly on-line live meeting and conference call with LHDs. This has helped to keep people informed of our efforts and lead to increased partnership and coordination.

The information I learned traveling across the Buckeye state and meeting face-to-face with Ohio's health leaders has proven to be a valuable asset in the decision making process. I am proud to be the first director to visit all of the LHDs and I challenge those who serve after to me to do the same.

Sincerely,

Alvin D. Jackson M.D.

As a leader in this effort, Ohio was one of ten states that received a grant from the Robert Wood Johnson Foundation to contribute to the national discussion and position Ohio's LHDs and ODH for potential transition to a national voluntary accreditation model.

Ohio Voluntary Accreditation Team (OVAT)

Increasing demands on our public health system require continuous improvement to meet the public's health and safety needs. As a leader in this effort, Ohio was one of ten states that received a Multi-state Learning Collaborative -2 (MLC-2) grant from the Robert Wood Johnson Foundation to contribute to the national discussion and position Ohio's LHDs and ODH for potential transition to a national voluntary accreditation model.

To facilitate this grassroots effort, the Ohio Voluntary Accreditation Team (OVAT) was formed, comprised of local boards of health representatives, local health commissioners, directors of nursing, environmental health directors, academics, public health association members, and ODH. Based on input from partners across Ohio's public health system and supplemented with national research, OVAT drafted revised performance improvement standards and developed a draft of 31 new standards which were vetted extensively.

Given excellent alignment with PHAB standards, OVAT recommended among other policy changes that Ohio adopt the PHAB standards as the revised Ohio Improvement Standards. Using the new national Public Health Accreditation Standards as a model for Ohio performance standards would reduce redundancy in working with two sets of standards (Ohio standards and national accreditation standards) and would enable benchmarking with other state and LHDs across the country.



CHAPTER 3

Demographics, Socioeconomics & Health Indicators



The health of a community impacts the health of the individuals who reside in it. There are many factors impacting a community's overall well being including socioeconomic status, access to health care, age distribution and lifestyle behaviors.

Ohio is made up of 88 counties, each of which share similarities but also have unique characteristics that set them, and the communities within them, apart from each another. In Ohio, the burden of disease and injury is not equally distributed across communities. This section gives a brief overview of Ohio's population and outline the major health challenges facing the Buckeye State.

Population

Ohio was home to 11,364,401 residents in 2000. 86.4 percent of Ohio's residents are white and 13.6 percent of residents are black or other races. 1.9 percent of Ohio residents are Hispanic/Latino ethnicity.

In Ohio, 17.3 percent of the population is 60 years of age or older.

About 150,000 babies are born each year in Ohio.

Population Estimates for Ohio by Age Group, Gender and Race/Ethnicity, 2000.^{1,2}

Age Groups	Gender		Race / Ethnicity				Total Populations
	Male	Female	White	Black	Hispanic/Latino	Other	
< 19	1,642,195	1,642,195	2,666,646	493,912	89,591	52,552	3,213,110
20-39	1,554,745	1,554,745	2,667,890	389,045	75,599	70,891	3,127,826
40-59	1,496,928	1,496,928	2,700,195	312,969	39,387	43,883	3,057,047
60-79	698,145	698,145	1,417,388	140,827	12,635	12,990	1,571,205
80+	126,813	126,813	366,019	27,646	1,836	1,548	395,213
All Ages	5,518,826	5,518,826	9,818,138	1,364,399	219,048	181,864	11,364,401

¹ Vintage 2006 postcensal estimates for July 1, 2000, U.S. Census Bureau, 2007

² The Hispanic/Latino population estimates includes individual of white, blacks or other races.

In 2000, the median household income for residents of Ohio was \$40,956, which was \$1,038 less than that of the United States. On average, 7.8 percent of families had incomes below the poverty level and 7.3 percent were headed by females with children less than 18 years of age.

Socioeconomic Profile of Ohio with Comparison to the U.S.¹

Socioeconomic Measure	Ohio	U.S.
Median Household Income	\$40,956	\$41,994
Families Below Poverty Level	7.8%	9.2%
Female-headed Households with Children <18	7.3%	7.2%
Educational attainment (Ages 25+)		
No High School Diploma	17.0%	19.6%
High School Graduate (Incl. Eqiv)	36.1%	28.6%
Some College, No Degree	19.9%	21.1%
Associate Degree	5.9%	6.3%
Bachelor Degree	13.7%	15.5%
Master's Professional Degree or Higher	7.5%	8.9%

¹ Census 2000 Demographic Profiles. U.S. Census Bureau, Summary File 1 (SF1) and Summary File 3 (SF3)

Seventeen percent of the residents over the age of 25 did not graduate from high school or obtain a GED. At this same time, 21 percent of Ohioans had a bachelor's degree or higher.

Access to Health Care

In 2000, there were 28,853 physicians averaging 25.4 physicians per 10,000 people living in Ohio. There were 207 registered hospitals with 45,505 beds and 40.0 hospital beds per 10,000 Ohio residents.

In 2004, 12.5 percent of adults age 18 and older and 5.4 percent of children 17 years and younger did not have health insurance, in Ohio.

Leading Causes of Death

In Ohio, an average of 107,217 residents died each year during 2004-2006. Leading causes of death may differ in a population depending on the age, sex, race and socioeconomic status of individuals within a population. Chronic diseases, particularly heart disease, stroke, diabetes, and cancer, along with unintentional injuries such as poisonings, motor vehicle traffic crashes and falls, accounted for the majority of all the deaths in Ohio during 2004-2006.

These leading causes of death may also result in extended pain and suffering for the individuals and a decreased quality of life. The diseases on this list are the primary causes of disability and contribute heavily to the burden of health care costs for all Ohioans.

Average Annual Number of Deaths and Average Annual Age-adjusted Mortality Rates (per 100,000 Population) among Ohio Residents with Comparison to the United States, 2005.^{1, 2, 31}

Causes of Death	Ohio			U.S.		
	Rank	Number of Deaths	Age-Adjusted Rate	Rank	Number of Deaths	Age-Adjusted Rate
All Deaths	-	107,217	855.0	-	2,447,910	798.8
Diseases of the Heart	1	28,617	225.3	1	649,399	210.3
Cancer	2	24,825	198.8	2	559,300	183.8
Stroke	3	6,183	48.6	3	143,497	46.6
Chronic Lower Respiratory Diseases	4	6,170	49.2	4	130,957	43.2
Unintentional Injuries	5	4,473	37.6	5	114,876	38.1
Diabetes Mellitus	6	3,717	29.7	6	74,817	24.5
Alzheimer's Disease	7	3,321	25.6	7	71,696	22.9
Influenza and Pneumonia	8	2,191	17.2	8	62,804	20.3
Nephritis, Nephrotic Syndrome, and Nephrosis Septicemia	9	1,834	14.5	9	43,679	14.3

¹Deaths and rates from Statistical Analyses Unit, Office of Vital Statistics, Ohio Department of Health, 2008. ²U.S. Data from National Vital Statistics Reports 2005. CDC, 2008. ³Rank based on number of deaths For age-adjustment and causes of death definitions see Technical Note (1).

Physicians, Registered Hospitals and Beds, 2006, and Percent Uninsured, 2004, in Ohio.^{1, 2}

Health Care	Ohio
Physicians (MDs and DOs)	28,853
Per Population	25.4
Registered Hospitals	207
Number of Beds	45,505
Per 10,000 Population	40.0
Percent Uninsured	
Uninsured Adults (Ages 18+)	12.5%
Uninsured Children (<17)	5.4%

¹Ohio County Profiles: Office of Strategic Research, Ohio Department of Development, 2007.

²Health Insurance Coverage in Ohio 2004: The Role of Public and Private Programs in Assuring Ohio Family Health Survey, Ohio Department of Job and Family Services, March 2005.

The leading cause of death for Ohio residents was heart disease during 2004-2006, causing an average of 28,617 deaths annually.

Cancer was the second leading cause of death for Ohio residents resulting in an average of 24,825 deaths each year, while stroke was the third-leading causes of death for Ohio residents during 2004- 2006.

Individuals who have high blood pressure, high cholesterol, low fruit and vegetable intake, low levels of physical activity, use tobacco products or drink heavily are at a higher risk of developing at least one of the leading causes of death diseases including diseases of the heart, cancer, stroke and diabetes. There is evidence that people can reduce their risk of developing these diseases by increasing their fruit and vegetable consumption, eliminating the use of tobacco products and heavy drinking, and increasing their amount of physical activity. Regular doctor visits and screening procedures can also increase a person’s chance of survival by aiding in proper management of a chronic disease.

Risk Factors

Together, prevention and early detection may reduce the overall incidence and mortality of certain causes of death by increasing the prevalence of symptom awareness and screening procedures and reducing risk factor behaviors within a population.

5.3 percent of Ohio adults reported heavy drinking of alcoholic beverages. Heavy drinking is associated with cancers of the oral cavity and gastrointestinal system; heart disease and stroke; unintentional injuries, e.g. motor vehicle crashes and falls; and intentional injuries, e.g. homicide and suicide.

Estimated Prevalence (Percent) of Selected Risk Factors among Adult Residents, by Race and Gender, in Ohio, 2004-2007.¹⁻⁷

OHIO					
Chronic Disease Risk Factors	White Male	White Female	Black Male	Black Female	All Residents
Heavy Drinking	7.1%	4.0%	4.1%	3.6%	5.3%
Current Cigarette Smoking	23.4%	22.2%	29.6%	25.6%	23.4%
Current Use of Smokeless Tobacco	5.3%	0.3%	2.6%	0.2%	2.7%
Consuming <5 Fruits/Vegetables Per Day	84.2%	73.5%	75.8%	73.5%	78.3%
Lack of Physical Activity	21.0%	25.7%	26.1%	34.6%	24.4%
Overweight	43.5%	29.7%	35.8%	27.9%	36.2%
Obese	27.2%	24.0%	36.7%	43.3%	26.5%

1 2004-2007 Ohio Behavioral Risk Factor Surveillance System; Chronic Disease and Behavioral Epidemiology Bureau of Health Surveillance – Prevention, Ohio Department of Health, April 2008.

2 Heavy Drinking = Men having more than 2 drinks/day, women having more than 1 drink/day.

3 Current Cigarette Smoking = Persons who reported smoking at least 100 cigarettes in their lifetime and currently smoke every day or some days

4 Current Use of Smokeless Tobacco = Persons who reported using smokeless tobacco at least 100 times in their lifetime and currently use smokeless tobacco every day or some days.

5 Lack of Physical Activity = Persons who failed to participate in moderate physical activity for 30 or more minutes per day on five or more days per week; or vigorous physical activity for 20 or more minutes per day on three or more days per week.

6 Overweight = Body Mass Index (BMI) of 25-29.9.

7 Obese = BMI of 30.0 or greater.

For description of Ohio Behavioral Risk Factor Surveillance System data and analyses see Technical Note (2).

In Ohio, 23.4 percent of adults currently smoke cigarettes. Smoking is the leading preventable cause of disease and premature death in Ohio. Cigarette smoking is not only causally associated with lung cancer, but also nine other sites/types of cancer, heart disease, stroke, chronic lower respiratory disease, and numerous adverse reproductive outcomes including low birth weight and infant death.

Similar to Ohio as a whole, adult males are more likely to use smokeless tobacco than adult females in Ohio. Smokeless tobacco use has been causally associated with cancers of the oral pharynx.

Of the adults in Ohio, 78.3 percent reported consuming fewer than the minimum recommended five servings of fruits and vegetables daily. Increasing individual fruit and vegetable consumption to five or more servings a day could reduce the burden of heart disease, stroke and cancers of the esophagus, lung, colon and rectum.

In Ohio, 24.3 percent of adult residents are physically inactive. Physical inactivity is an important risk factor for overweight, obesity and multiple chronic diseases including heart disease, stroke, type 2 diabetes and cancers of the colon and breast.

A high body mass index (BMI) is an indicator of being overweight or obese. In Ohio, 36.2 percent of adults are overweight, while 26.5 percent of adults are obese. Being overweight or obese is associated with amplified risk for several chronic diseases, particularly if the excess body fat is deposited within the abdomen. Disease outcomes associated with excess body weight include type 2 diabetes, heart disease, stroke, osteoarthritis and cancers of the breast, colon, endometrium and kidney.

Youth Behaviors

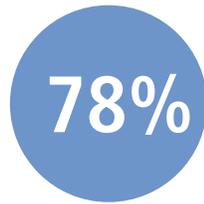
The 2007 Ohio Youth Risk Behavior Survey (YRBS) was conducted by ODH under the direction of the CDC. It focuses on 11 major categories: youth development; injury; violence; mental health; tobacco; alcohol; illegal drugs and prescription drug abuse; sexual behaviors; nutrition; physical activity; and preventive health care. The YRBS was completed by 2,527 Ohio students in 101 high schools during spring 2007.

The key findings of the 2007 YRBS were:

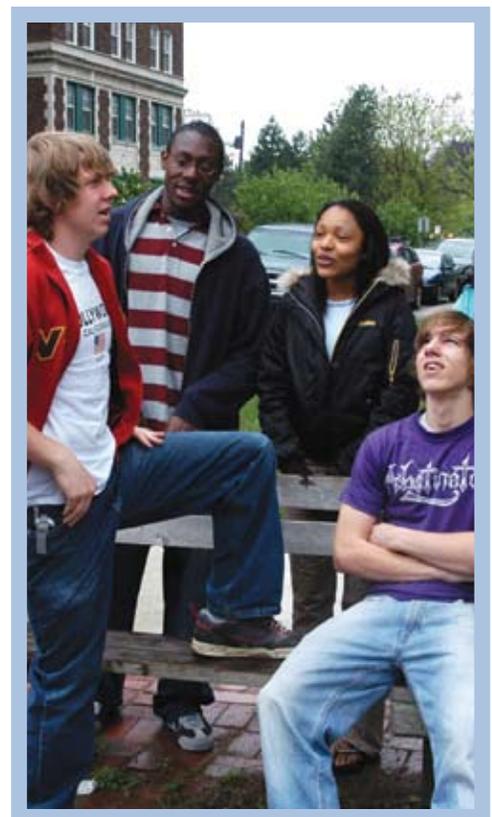
- 59 percent of Ohio teens report spending one or more hours in a month doing volunteer work.
- 84 percent of Ohio teens say they would be comfortable seeking help from an adult if they had an important issue affecting their lives.
- 90 percent of Ohio teens report wearing seat belts when driving a car.
- 90 percent of Ohio teens report that they did not drink and drive in the past month.



Of Ohio teens report that they did not drink and drive in the past month.



Of Ohio teens report they did not smoke any cigarettes in the past month.



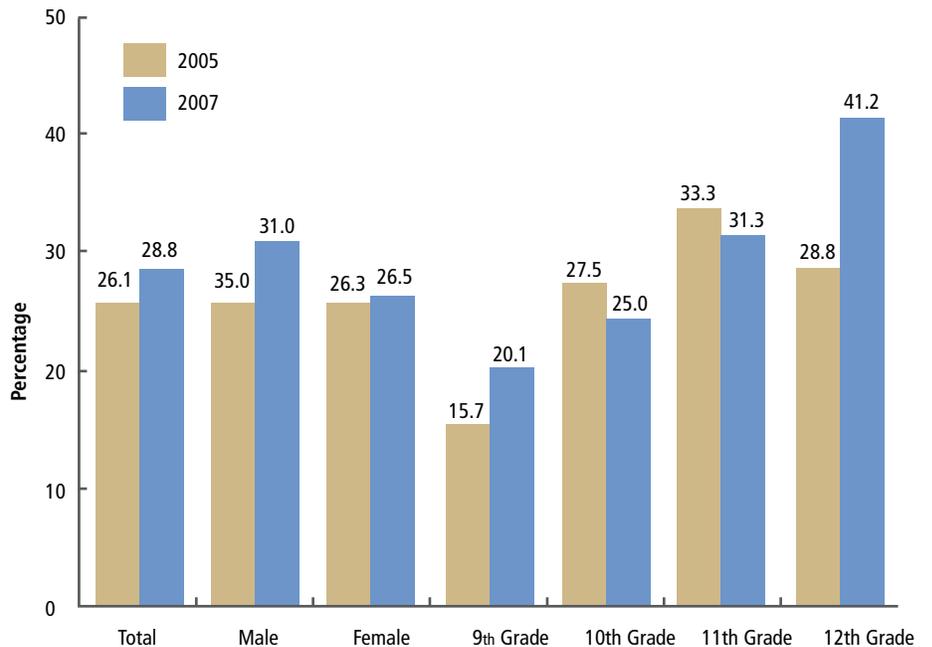
Percentage of Students who never or rarely wear a seat belt when driving a car

	2005	2007
Total	13.6%	10.0%
Male	19.3%	13.4%
Female	7.2%	6.3%
9th Grade	21.7%	11.1%
10th Grade	9.6%	7.0%
11th Grade	10.7%	8.3%
12th Grade	17.0%	13.6%

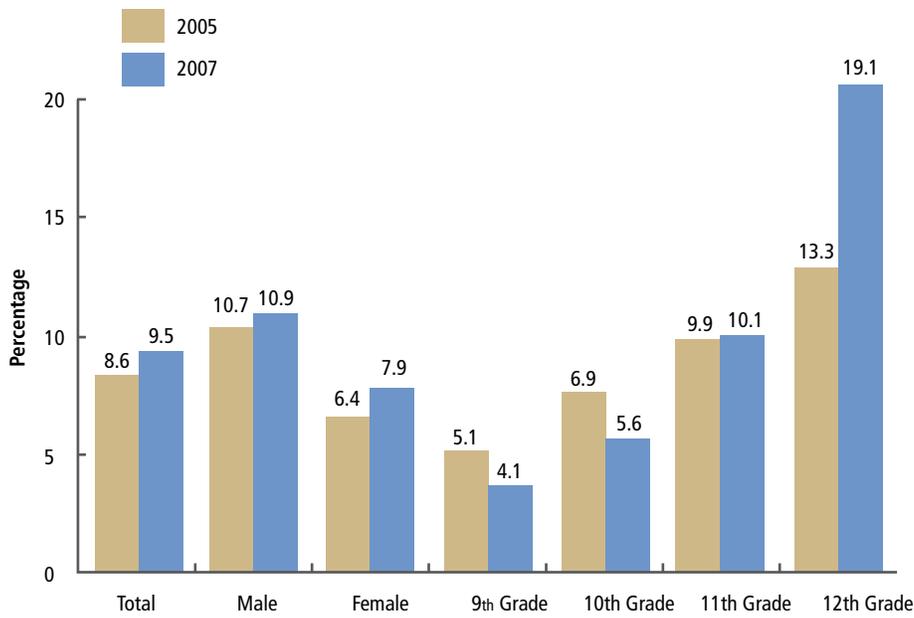
Response from the students who reported they wore seat belts sometimes, most of the time or always when they were riding in a car driven by someone else

- 77 percent of Ohio teens report that in the past month, they did not ride with someone who had been drinking.
- 28 percent of Ohio teens report being harassed or bullied by other students in the past 12 months.
- 7 percent of Ohio teens report attempting suicide.
- 55 percent of Ohio teens report they have never had sexual intercourse.
- 29 percent of Ohio teens report binge drinking.
- 34 percent of Ohio teens report using marijuana one or more times during their life.
- 78 percent of Ohio teens report they did not smoke any cigarettes in the past month.
- 68 percent of Ohio teens report seeing a doctor for a checkup in the past year.
- 73 percent of Ohio teens report seeing a dentist for oral health exams in the past year.
- 12 percent of Ohio teens report being overweight with a body mass index at or above the 95th percentile.
- 30 percent of Ohio teens report drinking soda/pop (excluding diet soda/pop) one or more times per day during the past week.
- 45 percent of Ohio teens report being physically active for a total of at least 60 minutes per day on five or more days in the past week.
- 32 percent of Ohio teens watch three or more hours of TV daily.

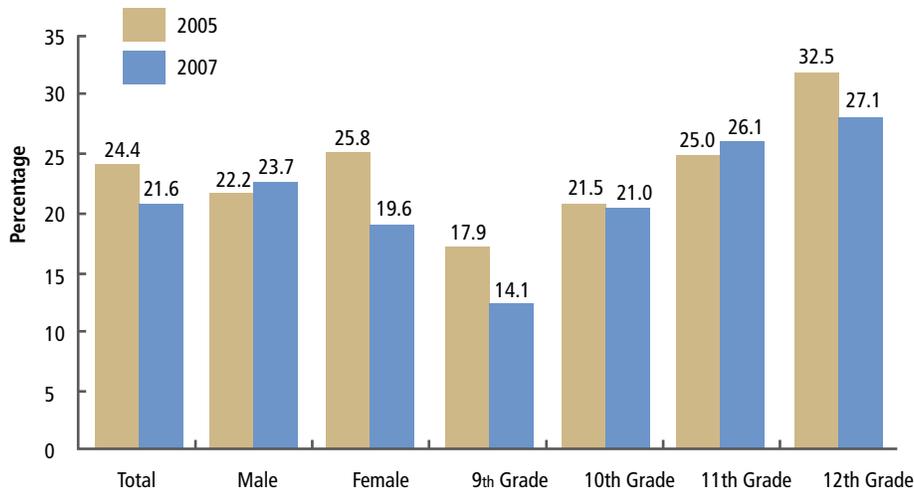
Percentage of Students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days



Percentage of Students who, during the past 30 days, drove a car or other vehicle one or more times while they had been drinking alcohol

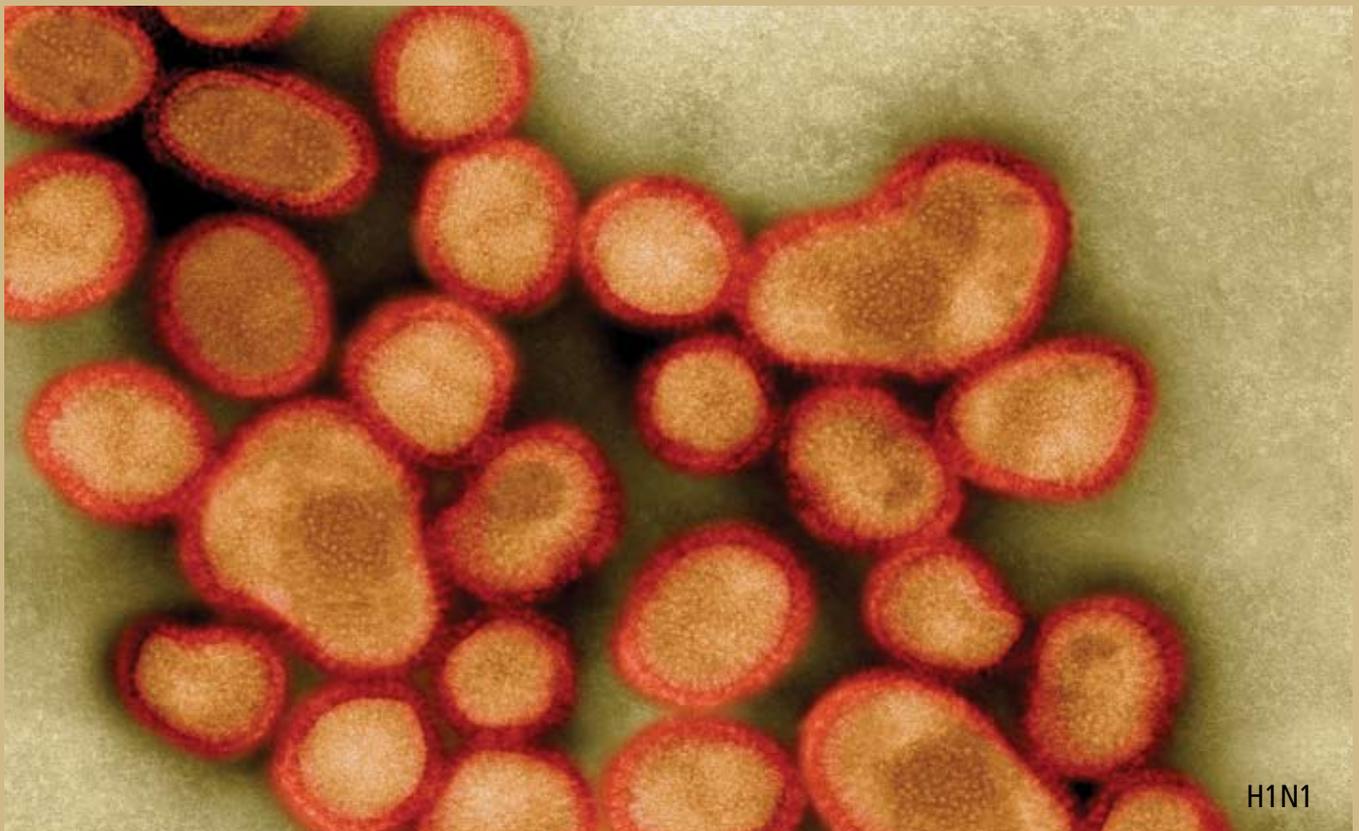


Percentage of Students who smoked cigarettes on one or more of the past 30 days



CHAPTER 4

Preventing Infectious Diseases



Infectious diseases are a continuing threat to all persons, regardless of age, sex, lifestyle, ethnic background, and socioeconomic status. They cause suffering and death and impose a financial burden on society. Although some diseases have been conquered by modern advances such as antibiotics and vaccines, new ones are constantly emerging. ODH has been actively involved in the prevention, investigation and surveillance of infectious diseases threatening the State of Ohio.



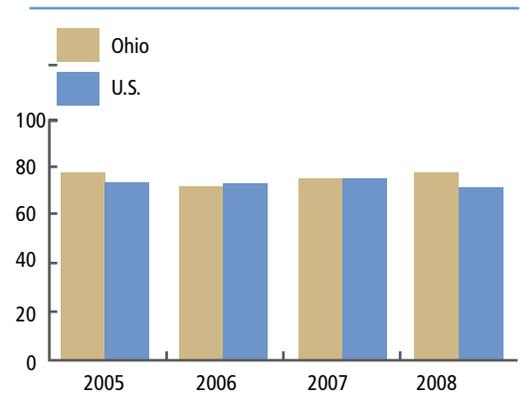
Immunizations

Immunizations are a critical tool for preventing disease. Ohio has achieved and works to maintain high infant immunization rates to ensure that the state's most vulnerable residents are protected from serious diseases. The CDC 2008 National Immunization Survey (NIS) shows the 4:3:1:3:3:1 rate (4 doses of diphtheria, tetanus, and pertussis; 3 polio; 1 measles, mumps, and rubella; 3 Haemophilus influenzae type b; 3 hepatitis B; and 1 varicella) for Ohio as 81.8 percent, representing an increase of 4.1 percent from the 2007 rates. The survey also shows that Ohio has the third highest coverage for all states.

Ohio's high immunization rates are the result of numerous initiatives and partnerships. The Immunization Program is responsible for operating the Vaccines for Children (VFC) federal entitlement program in Ohio. The program provides vaccines, free of charge, to more than 1.3 million children in Ohio each year through nearly 1,200 participating providers. Children age 18 years and under qualify for the VFC program if they are Medicaid eligible, uninsured, or American Indian or Alaskan Native. Additionally, underinsured children qualify for VFC if they receive services at a federally qualified health center or rural health center. In December 2008, LHDs gained the ability to vaccinate underinsured children through the VFC program through delegation of authority with the Tuscarawas County General Health District, a rural health center. Delegation of authority has enabled Ohio LHDs to provide all recommended vaccines to 34,000 Ohio Children.

The Immunization Program processes vaccine orders from providers for 3 million doses of vaccine annually and ship over 600 doses of hepatitis B immune globulin (HBIG) to Ohio birthing centers each year to prevent perinatal hepatitis B transmission. Research indicates that Hepatitis B vaccine administered beginning with the first dose within 24 hours of birth is 70 percent to 95 percent effective in preventing perinatal hepatitis B virus infection. Therefore, the Immunization Program provides hepatitis B vaccine to hospital birthing centers so that the birth dose may be provided universally to all Ohio newborns regardless of ability to pay. In 2009, 112,000 doses were provided to 115 Ohio hospitals.

4:3:1:3:3:1 Series Ohio rates vs the U.S. rates



Ohio has the third highest immunization coverage for all states.

The Immunization Program processes vaccine orders from providers for 3 million doses of vaccine annually.

The **Statewide Immunization Information System (ImpactSIIS)** is Ohio's immunization registry. This Web-based system was launched in 2002 and includes 43 million recorded vaccinations for 10 million Ohioans of all ages.

On June 21, 2010, ImpactSIIS 2.0 was launched, providing improved performance and functionality for over 9,000 active users from 4,397 clinics.



Through the Immunization Action Plan (IAP) grants, the Immunization Program provided nearly \$4 million in state and federal funds to local health departments to increase infant immunization rates. In 2010, grants were awarded to 38 LHDs representing 54 counties. IAP agencies partner with Women, Infant, and Children (WIC) clinics to screen and refer families for immunizations. Additionally, funding enables IAP agencies to provide targeted educational efforts in areas with low infant immunization rates.

The Ohio Revised Code requires that Ohio children have certain immunizations for enrollment in kindergarten through grade 12. In early 2010, ODH revised the immunizations requirements for school enrollment in Ohio to more closely reflect recommendations of the CDC Advisory Committee on Immunization Practices (ACIP). The major changes for the 2010-11 school year were: 1) the addition of a tetanus, diphtheria, pertussis (Tdap) booster requirement for seventh grade; 2) the addition of the second dose of varicella (a progressive requirement starting with kindergarten for 2010); and 3) a requirement that the fourth dose of polio be administered on or after the fourth birthday.

2009 H1N1 Pandemic Flu

The 2009 H1N1 virus was first detected in the United States in April 2009. This virus was a unique combination of influenza virus genes never previously identified in either animals or people

On June 11, in response to the spread of the 2009 H1N1 virus across the nation and the globe, the World Health Organization declared H1N1 a pandemic. Public health officials in Ohio prepared a response effort.

The ODH Office of Health Preparedness (OHP) coordinated five supplemental H1N1 grant processes to local public health and hospital sub grantees. These CDC funds were released in addition to the core grants for public health and healthcare preparedness.



ODH Immunization Program received Honorable Mention Award from the American Immunization Registry Association (AIRA).

The Award was received for innovative use of data in the H1N1 Web application and patient pre-registration system.



Over \$50 million was released to the local level (90 percent of the funds received by Ohio). Without these funds LHD would have been unable to mount vaccination campaigns and other H1N1 response efforts.

While the virulence of the pandemic strain of H1N1 was not meaningfully different than many seasonal flu strains, the timing and quantity of cases in conjunction with the elevated concern placed pressure on Ohio's healthcare system. ODH worked with the Ohio Hospital Association (OHA) and the regional healthcare coordinators to maintain situational awareness including an understanding of bed capacity and resource needs.

Beginning in the fall of 2009, vaccine was a key element in H1N1 response. The ODH Immunization Program was instrumental in coordinating vaccine response with the CDC and over 3,000 immunization providers in Ohio. In addition, the ODH Immunization Program accepted an Honorable Mention Award from the American Immunization Registry Association (AIRA) Center of Excellence Awards for innovative use of data in the H1N1 Web application. The AIRA committee was particularly impressed with the innovative ideas pertaining to the patient pre-registration system.

Ohio received 90 percent of the \$50 million available funding in order for local health departments to mount vaccination awareness campaigns and other H1N1 response efforts.

Flu.Ohio.gov

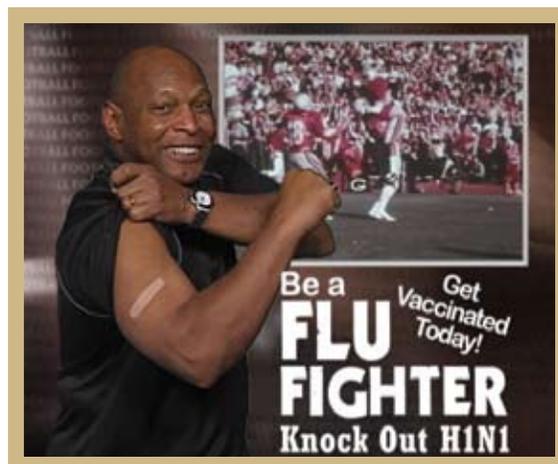


ODH also opened a call center to answer questions the general public and vaccine providers had about H1N1. The call center was open from Oct. 2009 through Jan. 2010 and received 34,219 phone calls. The popular call center topics were ordering/distribution of vaccine H1N1 vaccine recalls, vaccine availability for general public, availability of antiviral medication, vaccine priority groups, flu symptoms and seasonal flu vaccine availability.

ODH's Office of Public Affairs (OPA), in conjunction with ODH's Office of Management Information Services (OMIS), and with technical assistance from the Ohio Department of Insurance, created a comprehensive Web site for all things flu-related in Ohio: www.flu.ohio.gov. The site was created in early November 2009 with the intent of being a one-stop shop for Ohioans regarding flu information. This Web site, which received more than 7,000 visitors a day during the peak of interest in H1N1, will continue to be used during future flu seasons.

In November 2009, ODH also joined two social networking sites in its continuing efforts to protect and improve the health of all Ohioans. With its Facebook and Twitter accounts, ODH aimed to reach new audiences, disseminate important public health information and receive followers' feedback on items that matter to them. These accounts helped provide timely, accurate information about H1N1 vaccine distribution, vaccine clinics, and healthy tips.

In December 2009, ODH hosted two conference calls for multicultural leaders. One call was for African American leaders and the other was for Hispanic/Latino leaders. On the conference calls, Dr. Jackson and other ODH officials outlined the H1N1 pandemic and the unique risks associated with each community. In addition to these conference calls, ODH also reached out to multicultural communities to raise awareness about the H1N1 pandemic through outreach to religious organizations, community outreach and through a paid media campaign. ODH also worked with the Ohio State University to tape a flu PSA featuring Archie Griffin. Griffin is a two time Heisman trophy winner and is highly respected across Ohio.



Archie Griffin supports ODH's H1N1 efforts by participating in the Flu Fighter television PSA Campaign.

Illness Investigations

The Assistant State Epidemiologist is the Medical Director for the Division of Prevention and serves as subject matter expert for infectious disease issues, including illness investigations. The Assistant State Epidemiologist also directs investigation of disease outbreaks in coordination with the ODH Outbreak Response and Bioterrorism Investigation Team (ORBIT).

In the winter of 2010, an outbreak of meningococcal disease (group B) was identified among dormitory residing students at a university in Ohio. During the 2008-2009 and 2009-2010 academic years, seven students aged 18-19 became ill, one of which died. Four of these students had samples available for further testing and all four were found to be identical. Two other cases also had genetically identical isolates and had known links to the university. On March 2, 2010, a team from the CDC arrived in Ohio to assist local and state health departments with the investigation. A study of students at the university was conducted to help officials better understand the epidemiology of the cases, identify risk factors for acquiring meningococcal disease, investigate whether there was any spread of disease into the community and develop recommendations for further disease control efforts. The final CDC report from the investigation is currently pending.

In addition to reported outbreaks, ORBIT also tracks cases of individually reportable diseases in Ohio. Among the most commonly reported illnesses are enteric diseases such as campylobacteriosis and salmonellosis, each having more than 1,000 cases reported per year. Other illnesses, such as shigellosis, have periodic increases in the number of cases reported due to outbreaks commonly seen in preschool aged children.

Rabies Prevention

Rabies is a viral disease that affects animals and people and is almost always fatal. Although vaccination helps prevent rabies in our domestic animals, rabies in wildlife is still prevalent particularly in bats, skunks and raccoons. Rabies is transmitted when saliva from an infected animal comes in contact with an open wound or mucous membrane. In humans, treatment is effective only if a costly series of vaccinations are administered beginning within days of the exposure. This is the reason Ohio law requires that all animal bites be reported to the local health jurisdiction within 24 hours. Over 18,000 bite and rabies exposure reports are investigated and over 4,000 animals are tested for rabies, each year. On average, one out of every 75 animals tested is confirmed rabid. ODH's Zoonotic Disease Program (ZDP), in conjunction with United States Department of Agriculture (USDA), Animal and Plant Health Inspection Service, Wildlife Services, initiated a program to prevent

From July 1, 2008, to June 30, 2010, ODH assisted Ohio LHDS with the investigation of 455 infectious disease outbreaks. These outbreaks were detected in 71 of Ohio's 88 counties and sickened at least 6,603 Ohioans.

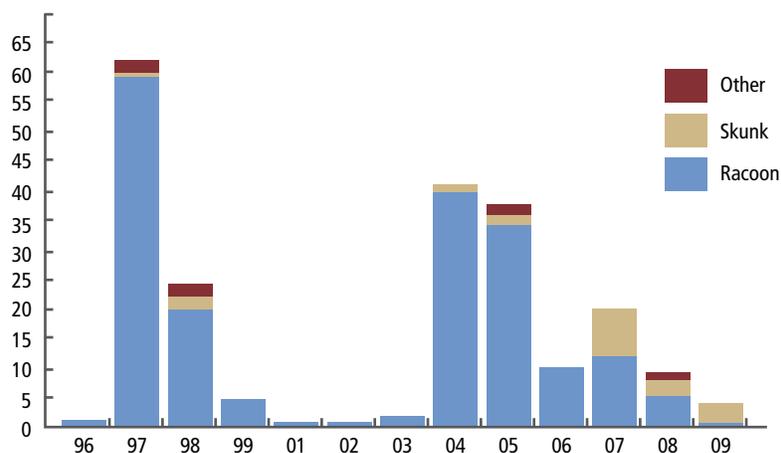




In 2008 and 2009, over 2.2 million rabies vaccine baits were delivered by aircraft, helicopters and vehicles, covering 16 Ohio counties.

further spread of raccoon rabies in northeastern Ohio. ODH is the lead agency in the program that enhances disease surveillance and distributes an oral rabies vaccine to immunize raccoons in east and northeast Ohio, creating and maintaining an immune barrier. In 2008 and 2009, over 2.2 million vaccine baits were delivered by fixed-wing aircraft, helicopters and vehicles, covering 4,000 square miles in 16 counties. This program protects not only Ohio residents and domestic animals from this deadly disease, but also those living in other Midwestern states such as Michigan, Indiana and Illinois.

Confirmed rabid animals with raccoon-strain rabies in Northeast Ohio, January 1996–July 2009



Other Zoonotic Diseases

In Ohio, infectious disease threats in the environment include those transmitted by ticks and mosquitoes. Rocky Mountain spotted fever, a bacterial disease transmitted by the American dog tick, is reported in Ohio each year. Lyme disease as well other diseases such as babesiosis and anaplasmosis can also occur because of exposure to ticks. Mosquitoes also transmit several diseases. La Crosse encephalitis a virus transmitted by the treehole mosquito tends to cause more severe illness in children and teenagers. West Nile Virus (WNV) was first discovered in Ohio in 2001 and human cases have occurred across the state since 2002. ODH and local partners follow surveillance, prevention and response plan for WNV and other mosquito-borne viruses in order to reduce mosquitoes and mosquito exposure which are key elements of a multi-agency effort to reduce human risk and disease. As of result of these efforts, human cases of WNV have decreased significantly since 2002.



Confirmed and probable human cases of tick and mosquito-borne disease in Ohio

Disease	Previous 5-yr Average	2008	2009
Rocky Mountain spotted fever (ticks)	15	31	18
Lyme disease (ticks)	49	44	60
LaCrosse encephalitis (mosquitoes)	16	9	5
West Nile virus (mosquitoes)	50	15	2

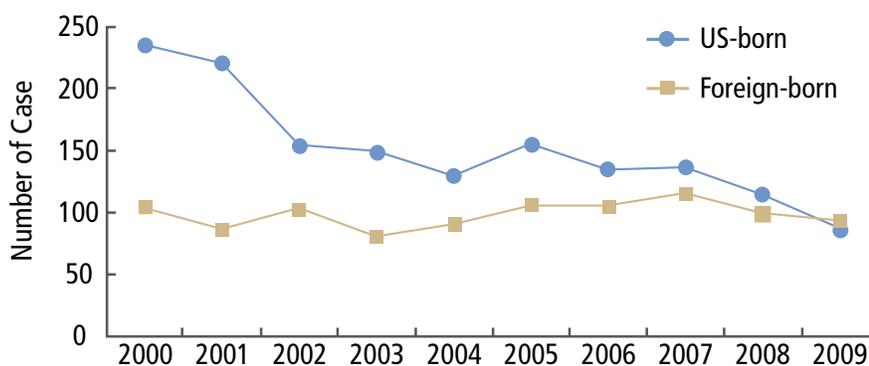
Source: Ohio Disease Reporting System 2003-2009

Ohio's response plan and implementation of that plan has resulted in a significant decrease of human West Nile virus cases since 2002.

Tuberculosis

Tuberculosis (TB) is considered the most resilient bacterial pathogen of all time. Tissue samples have identified TB in humans who died more than 5,000 years ago. While primarily a disease of the lungs, TB can occur anywhere in the body. A person with latent TB infection cannot spread their infection to others until they progress to active disease and develop symptoms. Treatment for latent TB infection can prevent a person from progressing to active disease. While in the past active TB disease was a leading cause of death, it can now be treated and cured.

Tuberculosis Cases by Country of Birth, Ohio, 2000-2009



47%

The number of TB cases reported in Ohio decreased 47 percent from 2000 to 2009.

The number of TB cases reported in Ohio decreased 47 percent from 2000 to 2009. The number of foreign-born cases remained relatively stable during this period, while the number of US-born cases decreased from nearly 250 to less than 100 cases. In fact, 2009 was the first year the number of foreign-born cases (93 cases from 35 different countries) was greater than the number of US-born cases. These data underscores the

difficulty faced by public health in treating TB cases and their contacts due to the many different cultures and languages.

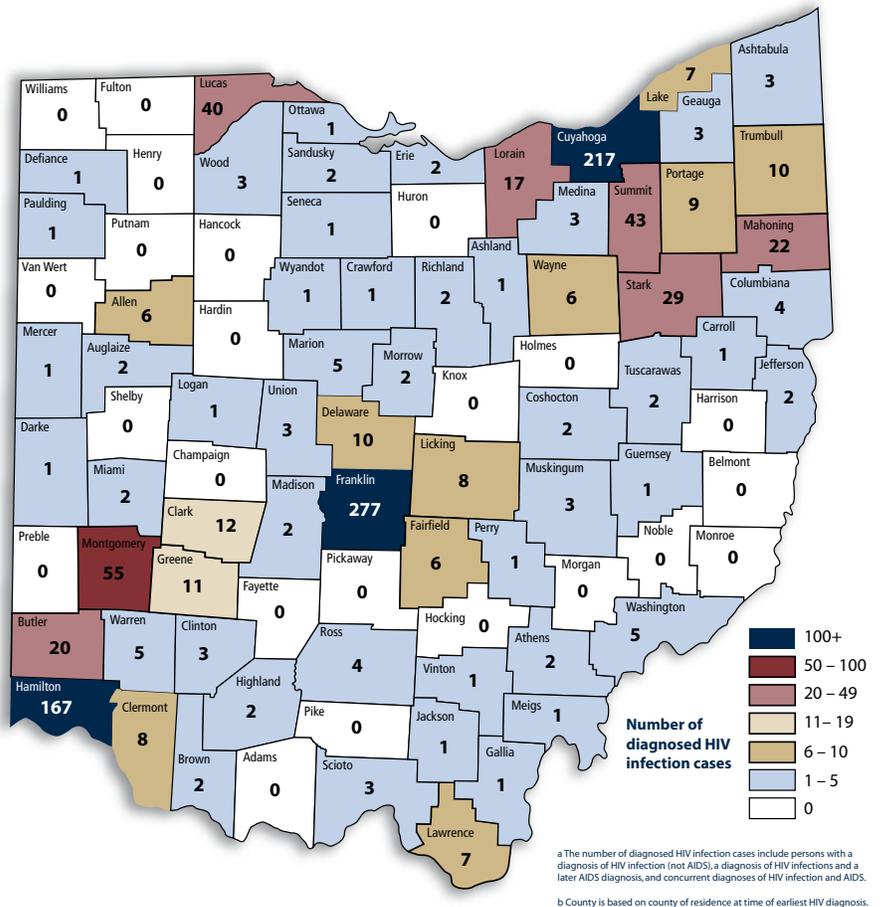
As with other infectious diseases, TB disproportionately affects minorities. While most people think of TB as a disease of the elderly, in reality less than 25 percent of the TB cases in Ohio are 65 years of age and older.

HIV/AIDS

Human Immunodeficiency Virus (HIV) is a retrovirus that causes Acquired Immune Deficiency Syndrome (AIDS). Infection with HIV is primarily through the exchange of bodily fluids such as blood, semen and breast milk, and the sharing of infected needles by those who practice unsafe injection drug use. HIV/AIDS impacts all of Ohio and the number of persons living with HIV/AIDS in Ohio continues to increase each year.



Number of AIDS cases in Ohio



New HIV Diagnoses

There were 1,154 newly reported HIV/AIDS diagnoses in Ohio as of December 31, 2009. The HIV/AIDS epidemic impacts persons regardless of sex, age and/or race/ethnicity. Ohio's 2009 risk-based estimates identify male-to-male sexual contact as the leading mode of transmission for HIV among males in Ohio, followed by heterosexual contact, and injection drug use. Among female Ohioans, heterosexual contact is the leading mode of transmission, followed by injection drug use. Recent trends suggest increases in new diagnoses of HIV infection among women, blacks and high-risk heterosexuals.

Living with HIV

Among Ohio's newly diagnosed cases in 2008: 21 percent were female, 28 percent were 35-44 years of age, 47 percent were black, 46 percent were white, and 5 percent were Hispanic.

As of December 31, 2009, 15,764 persons were known to be living with HIV/AIDS in Ohio, of whom 47 percent were living with AIDS. Black and Hispanic Ohioans are disproportionately impacted by HIV/AIDS. The rate of persons living with HIV/AIDS per 100,000 population in 2008 was nearly six times higher among blacks compared to whites (491.1 for blacks, compared to 81.6 for whites), and three times higher among Hispanics compared to whites (255.5 for Hispanics).

In 2009, ODH's Ryan White Part B program, which provides assistance to financially eligible Ohioans living with HIV/AIDS, served 9,199 clients. Of those, 8,513 received case management services and 5,787 received assistance through the Ohio HIV Drug Assistance Program (OHDAP). During SFY09 and SFY10, the OHDAP drug formulary continued to include 100 percent of all the US Public Health Service Guideline recommendations for antiretroviral medication, for the treatment of HIV.

HIV/AIDS Prevention

The HIV prevention program uses a combination of federal funds (71 percent) and state funds (29 percent) annually to provide HIV prevention support throughout the state. Federal funding is also used to support HIV and other sexually transmitted disease (STD) screening and surveillance, counseling and partner notification.

This program provides leadership that builds capacities in agencies that are dedicated to developing and mobilizing community resources to prevent the transmission of HIV. The HIV prevention program provides support to nine regional areas through nine LHDs and two statewide

Deaths among those with diagnosed with HIV/AIDS:

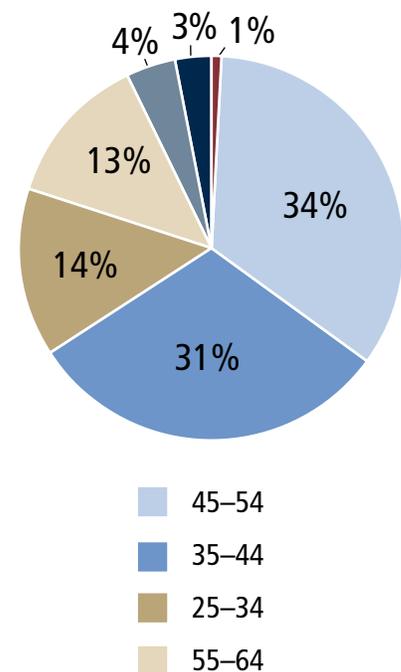
The second-leading cause of death among Hispanic females 25-44 years of age.

The sixth-leading cause of death among all persons 25-44 years of age.

The fifth-leading cause of death among:

- Black males 25-44 years of age
- Black females 25-34 years of age
- Hispanic males 35-44 years of age
- White males 35-44 years of age

Age distribution of Ohioans living with HIV/AIDS



During SFY09 and SFY10, the OHDAP drug formulary continued to include 100 percent of all the US Public Health Service Guideline recommendations for anti-retroviral medication, for the treatment of HIV.

initiatives. The LHDs distribute ODH dollars to community-based organizations for HIV prevention and education programming. This shift in how dollars reach the local community allowed for greater cooperation between LHDs and the regional advisory groups representing the affected communities.

Prevention activities target men who have sex with men, persons practicing high-risk sexual behavior, young people, women and substance users/abusers. The prevention program also supports HIV counseling and testing activities. The two statewide programs directly supported by ODH focus HIV prevention education and training efforts toward the general population.

Sexually Transmitted Diseases

The STDs that are reportable in Ohio are chancroid, chlamydia, gonorrhea, granuloma inguinale, herpes (congenital) and syphilis. Very few cases of chancroid, granuloma inguinale and congenital herpes are reported each year compared to chlamydia, gonorrhea and syphilis. In order to interrupt transmission and prevent complications, those infected with an STD and their sexual partners should be treated. If not treated, a person can develop pelvic inflammatory disease, infertility, epididymitis, and for those with syphilis, neurologic complications and even death. As with other infectious diseases, excluding HIV/AIDS, STDs are reportable to the LHD in which the patient resides, which reports the information to ODH.

The number of chlamydia cases has increased from less than 40,000 in 2001 to more than 48,000 in 2009. While cases of chlamydia increased by 15 percent from 2005 to 2009, cases of gonorrhea decreased by 20 percent. Both chlamydia and gonorrhea primarily affect teens and young adults. In 2009, 77 percent of the chlamydia cases and 66 percent of the gonorrhea cases were less than 25 years of age.

In addition, both chlamydia and gonorrhea disproportionately affect blacks/African Americans. Rates of chlamydia average ten times higher and gonorrhea rates are over three times higher than rates for white cases. Both chlamydia and gonorrhea affect more females than males. Approximately 75 percent of the chlamydia cases and 60 percent of the gonorrhea cases reported in 2009 were female.

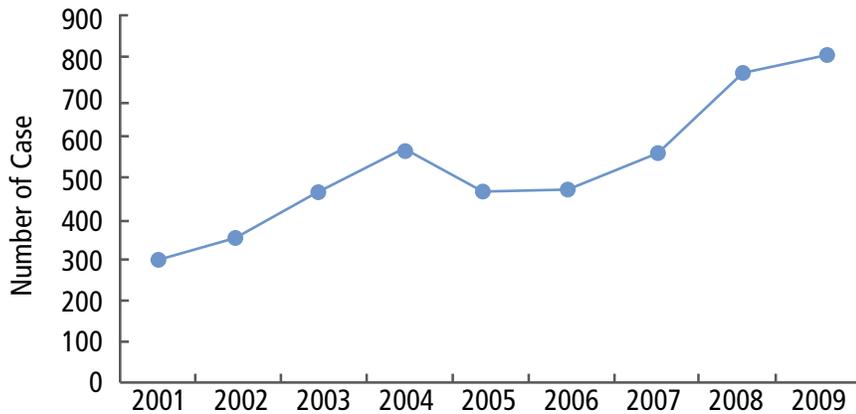
The number of syphilis cases has increased by 160 percent since 2001. While most chlamydia and gonorrhea cases occur in teens and young adults, most syphilis cases have occurred in older persons (30 years of age and older) until recently. Over the last three years, the number of



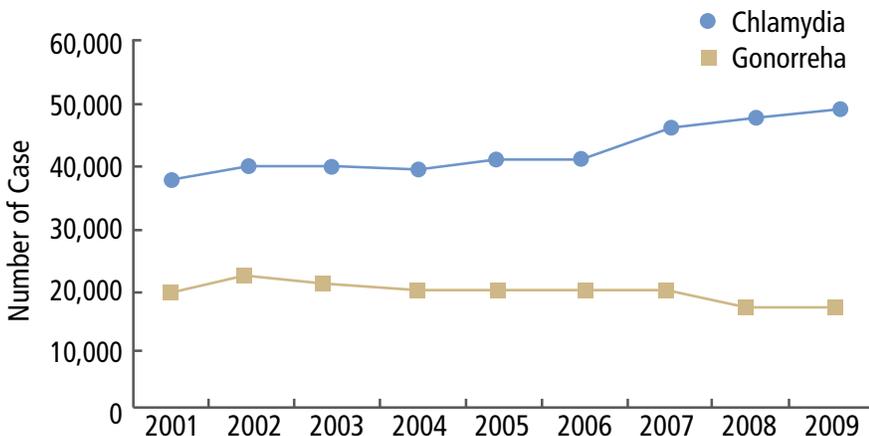
syphilis cases in those less than 30 years of age has increased until it is nearly equal to the number of cases in those 30 years of age and older.

In contrast to chlamydia and gonorrhea, syphilis primarily affects men rather than women with approximately 75 percent of the cases being male.

Number of Syphilis Cases in Ohio 2001–2009



Number of Chlamydia and Gonorrhea Cases in Ohio 2000–2009



STD/HIV Prevention

The goal of ODH’s STD Prevention Program is to prevent and control sexually transmitted diseases. The program provides syphilis, gonorrhea and chlamydia testing, treatment and partner services in public health agencies statewide who serve STD clients. Program staff collaborate and consult with a wide variety of public and private medical and service agencies on all aspects of STD prevention and control, including primary prevention, case management and intervention, surveillance and case



reports, community planning and outreach activities and professional and individual education and training projects.

The Infertility Prevention Project, in collaboration with Ohio’s Family Planning programs, has demonstrated that the largest proportion of those at risk are adolescents (15-19 years) and young adults (20-24 years). In many cases, ODH targets awareness campaigns and other prevention efforts towards these populations.

Public Health Laboratory

The Public Health Laboratory (ODH Lab) was established in 1898 to function as the State Reference Laboratory for human-related diseases. The laboratory provides reference testing, consultation, education, training and preparedness in support of public health programs and medical services.

When there are outbreaks of diseases or natural or man-made disasters, the laboratory provides critical services to identify and reference bacteria, mycobacteria, fungi, viruses, parasites, toxins and blood specimens. The lab also provides public water supply testing, assessment of selected environmental risks, screens for diseases of public health interest, laboratory proficiency surveys and education programs. The laboratory training and preparedness services reflect a new service line for the lab. This new line of service offers clinical laboratory personnel as well as first-responder (e.g., fire departments, police departments, hazardous materials teams, and the FBI) educational and training services on personal safety, communication strategies and safe handling, packaging, shipping and transport of potential select agent samples.

Programs within the Laboratory:

- Reference microbiology services
- Newborn screening services
- Radiological chemistry services
- Laboratory training and preparedness services

Test Conducted by ODH Lab

Test Area	CY 2008	CY 2009
Enteric specimens	5,762	5,360
Foodborne outbreaks	63	104
Pulsed Field Gel Electrophoresis	1,541	1,379
Preparedness program	47	53
Tuberculosis	791	645
Gonorrhea/Chlamydia	85,164	67,839
Rabies	3,847	3,651
HIV	8,935	4,986

In addition, ODH lab's Radiochemistry Program provides environmental services for nuclear power plants in Ohio, Michigan, and Pennsylvania. The testing includes milk, soil, vegetation, and air to ensure the environment surrounding the power plants is safe.

Test Area	CY 2008	CY 2009
Air samples	719	768
Milk, soil, vegetation	136	67
Water	1,685	1,152



CHAPTER 5

Preventing Chronic Diseases



The Office of Healthy Ohio (OHO) strives to improve the health of all Ohioans and create a better quality of life, assure a more productive workforce and equip students for learning, while also contributing to the more efficient and cost-effective use of medical services.

OHO's three core program areas of health promotion, disease prevention and health equity work collaboratively with public and private partners and consult with the Healthy Ohio Advisory Council to create the changes in communities, worksites, schools and health care settings that lead to better health for all Ohioans.



Office of Healthy Ohio (OHO) works to provide the information and tools Ohioans need to lead more active lives, eat a balanced diet and receive appropriate health screenings - - strategies that will, over time, help reduce the incidence and increase the early detection and long-term management of chronic disease.

OHO's Web site, www.HealthyOhioProgram.org, provides information on risk reduction and resources for developing a healthy lifestyle.

Health Disparities

Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence and mortality of certain diseases or health conditions. These are commonly referred to as health disparities. Health disparities are not limited to one disease or health condition and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors.

People in such groups also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as social determinants. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants among these groups is referred to as health inequities. As long as health inequities persist, marginalized groups will not achieve their best possible health.

ODH is working to combat these statistics. In SFY08, ODH hired a health equity coordinator who works with individuals at all levels to develop initiatives and strategies to promote health equity, target services to minority populations, measure performance and assess outcomes.

ODH provided approximately \$500 million annually during SFY09 to SFY10 through various grant and subsidy agreements for local public health activities. By focusing on key components of the grant request for

Under the direction of Dr. Jackson, the ODH social media pilot project was awarded to OHO. This has allowed the program to achieve additional public outreach through its Facebook account, posting links to resources and tips to reduce Ohioans' health risks.



www.facebook.com/HealthyOhio

Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination.

While breast cancer is diagnosed 10 percent less frequently in African-American women than white women, African-American women are 35 percent more likely to die from the disease.

African Americans have the highest mortality rate of any racial or ethnic group for all cancers combined and for most major cancers.

In Ohio, lung cancer is the second most common cancer in the African-American community and the leading cause of death. African-American males in Ohio have a higher incidence rate of lung cancer than all males in Ohio and all African American males nationally.

Sexually transmitted diseases disproportionately affect minority women. Among Ohio females in 2005, African Americans accounted for more than half (63.5 percent) of HIV/AIDS cases, although only 11.6 percent of females are African American. The chlamydia rate among African American females is nearly nine times that among white females.

proposal (RFP) template, health disparity and health equity strategies were simultaneously and efficiently incorporated into all ODH grant-funded program interventions.



The RFP language that was developed is designed to:

- Incorporate health equity and health disparities concepts throughout the lifecycle of the grants process.
- Enhance a three-dimensional understanding of the root causes of health disparities in order to develop effective interventions.
- Develop programs that respond to health disparities, health equity and the connection to social determinants of health.

Obesity Prevention

Obesity has become one of the most pressing health issues in Ohio. Compared to the rest of the nation, Ohio ranks among the least healthy states in terms of weight, daily physical activity and nutrition. As the precursor to many chronic diseases, obesity threatens the health and academic success of our children, productivity of our workers, vitality and viability of our communities, affordability of our health care system and overall quality of life for all age groups. Because reversing the obesity epidemic depends on more than changing individual behavior, Gov. Strickland issued a directive to OHO to develop a comprehensive, multi-faceted public health approach to obesity prevention.

The result was the issuance in March 2009 of **The Ohio Obesity Prevention Plan**. The plan represented a collaborative effort between state agencies, key stakeholders and obesity experts to identify best practices for obesity prevention strategies. The plan serves as a guide for agencies to advance policies and system changes to support increasing physical activity and improved nutrition and to address the needs of those most at risk. Because a great deal of work is already underway across the state, the plan also provides a framework for new statewide initiatives to

target obesity prevention in six settings: individuals and families, schools and childcare, communities and built environment, healthcare, worksites and government.

To further complement the progress happening in smaller communities, OHO is supporting obesity prevention across the state through Community Wellness and Obesity grants. These grants also support policy changes to improve health by focusing on initiatives that will increase physical activity and improve nutrition in child care, increase provider screening of Body Mass Index (BMI) in children and referral for those needing support, increase use of Ounce of Prevention is Worth a Pound nutritional education kit, and develop and create a Complete Streets policy to encourage active transportation.

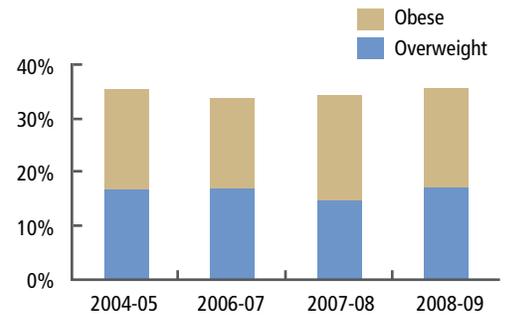
As ODH moves forward in the fight to reverse childhood obesity, alignment of focus will be crucial to accomplish the goals set forth in the Ohio Obesity Prevention Plan. Along with the Wellness and Obesity grant program, OHO will continue to support community-based initiatives targeting physical activity, nutrition and tobacco use, as well as programs that increase access to fresh fruits and vegetables to those most in need, programs that increase breastfeeding at home and in the workplace, BMI surveillance across the state, and community-wide efforts to create policies that encourage healthy lifestyles.

Diabetes Prevention

The Ohio Diabetes Prevention and Control Program (ODPCP) and OSU Extension partnered to bring the “Dining with Diabetes” program to individuals and families affected by diabetes. From July 2008 to June 2010, Dining with Diabetes classes were held in 50 counties with a total of 5,125 participants. The follow-up report shows that of the 5,125 DWD attendees, 93 percent of the participants increased their knowledge of diabetes management; 90 percent learned food safety skills with more than half reporting that they are practicing skills learned in class; and 75 percent of the participants reported eating smaller portion sizes, understanding the plate method and knowing how to count carbohydrates.

The ODPCP awarded four grants to provide diabetes self-management education, including monitoring physical activity for persons with diabetes, pre-diabetes and those at risk of developing diabetes. Initiatives funded by the grants included diabetes screenings and a 10-week diabetes self-management education program that provided information about healthy nutrition, the importance of physical activity and medication management. More than 6,000 persons were screened for diabetes and more than 1,400 persons participated in the self-management projects.

Overweight and Obesity trends among 3rd graders in Ohio, 2004-2009



ODH has been measuring height and weight on 3rd grade students throughout the state since the 2004-2005 school year.

To address growing obesity rates in Ohio, ODH developed the Ohio Obesity Prevention Plan in March 2009.

To further complement the progress, OHO is supporting the plan through state-wide Community Wellness and Obesity grants.



93 percent of the “Dining with Diabetes” participants increased their knowledge of diabetes management.



90 percent learned food safety skills with more than half reporting that they are practicing skills learned in class.

The ODPCP produced periodic newsletters covering topics such as new initiatives and programs, activities by the ODPCP, current research findings and the use of surveillance data to monitor trends. The publication is distributed to more than 1,600 diabetes care partners throughout the state. In March 2010, the ODPCP Nutritionist/Health Educator was given the **2010 Ohio Nutrition Council’s Media Excellence Award** for *Accurate and Responsible Journalism in Nutrition* for the ODPCP Newsletter.



Creating Healthy Communities Program

The Creating Healthy Communities (CHC) Program receives \$1.7 million from the Preventive Health and Health Services Block Grant through the CDC. The money is awarded to 16 counties through a competitive grants process. The CHC Program staff assists local county grants by providing extensive technical assistance, training and resources.

The CHC program uses a population-based, evidence-based approach to expand and enhance a community’s ability to develop and implement policy, systems and environmental change strategies that can prevent or manage health-risk factors for chronic conditions. The program’s specific activities are directed toward reducing tobacco use and exposure, promoting physical activity and healthy eating, improving access to quality preventive healthcare services and eliminating health disparities. Focusing on high-need populations is an important strategy to eliminate these disparities.

In 2009, the local CHC Program assisted in establishing 109 policies and made 409 environmental and/or system changes. The 24 counties impacted over 3,877,000 high- need Ohioans.

Worksite Setting:

- 303 worksite wellness committees were formed.
- 42 policies were adopted impacting 31,117 employees.
- Made healthier cafeterias and vending machine choices available.

Community Setting:

- 75 new walking trails were built with over 93,450 residents using the trails.
- 270 walking groups were formed with 2,895 walking participants.

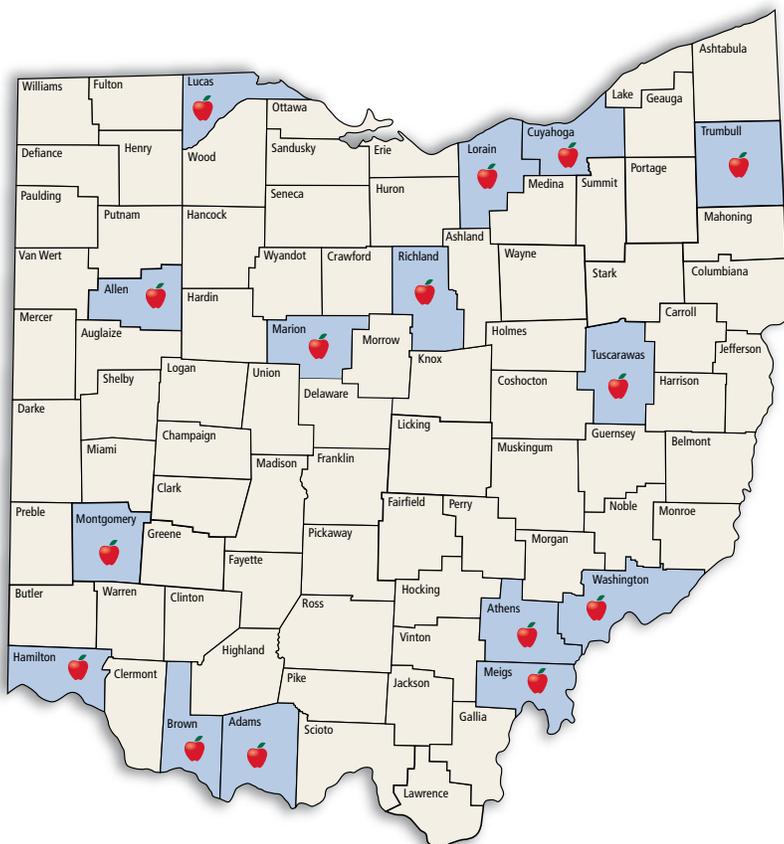
- 264 community gardens were established in high-need communities.
- 73 new Farmer’s markets were started in high-need communities.
- 32 Faith-based organizations started health committees to provide nutrition, physical activity and risk factor screenings for their congregations.
- 151 new GOLD Plate (healthy options available) restaurants impacting 178,800 customers.

In 2009, the local CHC Program assisted in establishing 109 policies and made 409 environmental and/or system changes. The 24 counties impacted over 3,877,000 high-need Ohioans.

School Setting:

- Formed more than 218 school health teams since 2003.
- 354 schools have implemented their school wellness policies.
- 165 schools have 100 percent tobacco free campus in their target communities.
- Adopted 49 policies to address nutrition and physical activity in the schools.
- Held 55 trainings for schools.

Location of Health Ohio Programs as of 2010





ODH and seven other state health departments are participating in the Coverdell Stroke Project.

To-date there are 40 Ohio hospitals now enrolled in the Registry with the mission of improving stroke care outcomes in Ohio.

Ohio Coverdell Acute Stroke Registry

In 2001, Congress charged CDC with implementing state-based registries that measure and track acute stroke care and to use data from the registries in efforts to improve the quality of that care. Congress further directed that this project be named the Paul Coverdell National Acute Stroke Registry, after the late U.S. Senator Paul Coverdell of Georgia, who suffered a fatal stroke in 2000 while serving in Congress.

There are currently seven state health departments participating in the Coverdell Stroke Project, including ODH. In 2007, Ohio received new five-year funding from CDC to improve acute stroke care in hospitals. The long-term goal of this national program is to ensure all Americans receive the highest quality acute stroke care currently available and to reduce the number of untimely deaths attributable to stroke, prevent stroke-related disability and prevent stroke patients from suffering recurrent strokes. The purpose of the registry is to:

- Measure, track and improve the quality of care for acute stroke patients;
- Decrease the rate of premature death and disability from acute stroke through secondary prevention;
- Increase public awareness of stroke treatment and prevention;
- Reduce disparities in acute stroke care by providing underserved populations with better access to such care.

ODH works closely with the Coverdell Clinical Coordinating Center based at Metro Health in Cleveland to provide training to Ohio hospitals in data abstraction and evidence-based, comprehensive stroke care. At the end of SFY10, there were 40 Ohio hospitals enrolled in the Ohio Coverdell Acute Stroke Registry with the mission of improving stroke care outcomes in Ohio.

Chronic Disease Epidemiologist

"I serve to assist the state health department in the use of health data, especially population-based data, to plan and evaluate health promotion and disease prevention efforts, set priorities, and develop sound public policy, while helping strengthen the state's chronic disease epidemiology capacity in the long term." – Rosemary Duffy, Chronic Disease Epidemiologist

One of the Deputy State Epidemiologists, in the State Epidemiology Office, serves as the Ohio Chronic Disease Epidemiologist. The current Chronic Disease Epidemiologist is from the CDC National Center for Chronic Disease Prevention and Health Promotion.

The role of the state Chronic Disease Epidemiologist is to provide Data analysis, interpretation and dissemination. This person is also responsible for outreach, maintaining partnerships, working with epidemiologists from Center for Public Health Statistics & Informatics and other ODH programs, and presenting on topics at national conferences.

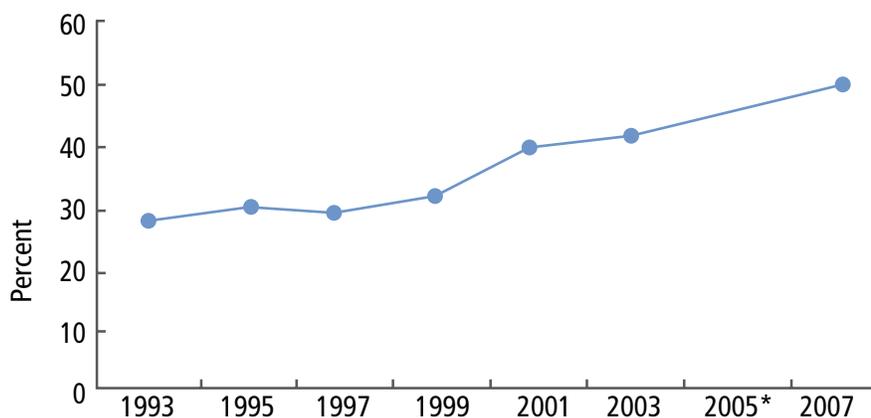
The CDC funds this position because four of every five deaths and \$325 billion in health care costs and lost worker productivity per year are related to chronic diseases. In addition, the number of epidemiologists who work on chronic diseases is less than one-third of the combined number who work on infectious disease and bioterrorism.

Cancer Prevention

ODH traditionally has addressed cancer through surveillance, primary prevention and early detection. Ohio's role expanded to include cancer prevention and control, with the receipt of federal dollars to implement Ohio's Breast and Cervical Cancer Program (BCCP) and Comprehensive Cancer Control Program (CCCP).

BCCP and CCCP worked together to create and activate the ODH Cancer Medical Advisory Team. This group of medical practitioners serves to assure quality in the operation of Ohio's cancer programs. The team meets quarterly with BCCP and CCCP staff to share information and provide feedback on key issues and initiatives.

Trend in the Prevalence of Persons 50 and Older Who Reported Having a Sigmoidoscopy/Colonoscopy om the Past Five Years in Ohio, 1993–2007^{1,2,3}



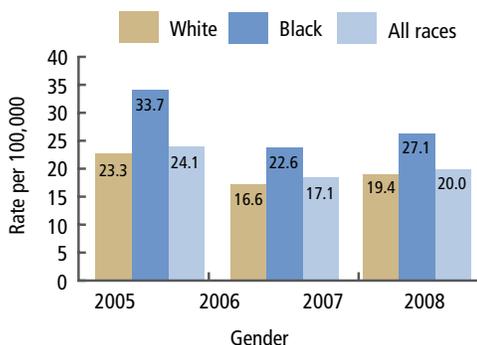
1 Source: Ohio Behavioral Risk Factor Surveillance System, Ohio Department of Health, 2008

2 The weighted percentages were adjusted to: 1) probability of selection, i.e. the number of different phone numbers that reached the household, the number of adults in each household, and the number of completed interviews in each cluster; and 2) demographic distribution, i.e. age and gender.

3 "Don't Know" and "Refused" were excluded from the denominator. This can cause an artificially high percentage.

* The Ohio Behavioral Risk Factor Surveillance Survey did not include colorectal screening questions in 2005

Average Annual Colon & Rectum Cancer Mortality Rates by Race and Gender in Ohio, 2002-2006^{1,2,3}



1 Source: Chronic Disease and Behavior Epidemiology Section and the Vital Statistics Program, Ohio Department of Health, 2009.

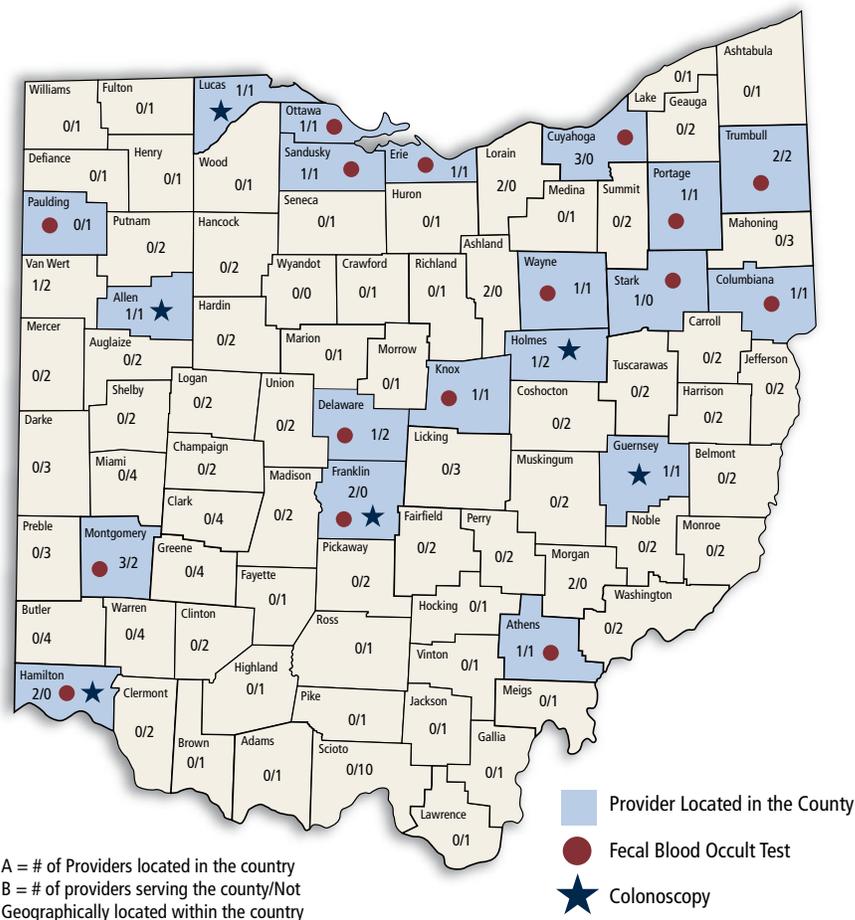
2 Average annual rate per 100,000, age-adjusted to the 2000 US standard population.

Comprehensive Cancer Control Program

The CCCP's primary focus is colorectal cancer. According to the 2008 Behavioral Risk Factor Survey, only 51 percent of Ohioans aged 50 years and older reported having had a sigmoidoscopy or colonoscopy within the past five years.

In Ohio, an average of 6,422 (3,214 men and 3,208 women) new cases of colorectal cancer were diagnosed annually between 2002 and 2006.

Free/Reduce Cost Colorectal Cancer Screening Resources in Ohio 2009* (American Cancer Society and Healthy Ohio)





and post-participation chart audit to see how many current patients were receiving appropriate colorectal cancer screening recommendations. This information was then used to improve their colorectal cancer screening recommendations.

Participants were evaluated immediately after the workshop and then again one year later. Immediately after the workshop, a survey of the participants showed that 98 percent were able to identify office-based factors that affect colorectal cancer screening rates and 96 percent planned to develop an office protocol to improve colorectal cancer screening rates.

One year after the workshop, those who completed the entire program showed that:

- The practices saw a 16 to 30 percent improvement in speaking with their patients about the importance of getting screened for colorectal cancer.
- When a fecal occult blood test card was returned with a positive result, 100 percent of the practice teams referred their patients to have a colonoscopy.
- All practices saw an increase in recommendations for colonoscopy, with one practice increasing their referral rate by 49 percent.
- Four out of five practices increased their number of results reported back from the gastroenterologist regarding their patient's referral for colonoscopy.

The practices saw a 16 to 30 percent improvement in speaking with their patients about the importance of getting screened for colorectal cancer.

All practices saw an increase in recommendations for colonoscopy, with one practice increasing their referral rate by 49 percent.

Breast and Cervical Cancer Project

Ohio's BCCP provides high quality breast and cervical cancer screening, diagnostic testing and case management services at no cost to eligible women in Ohio.

In the 16th year of operation (2008-2009), BCCP served 16,553 women with both state and federal dollars, a significant increase over the 13,398 women served in SFY07-08. In the 17th grant year 2009-2010, Ohio's BCCP served more than 13,500 Ohio women with both state and federal dollars, despite a 70 percent cut in state funds. According to the "Ohio Family Health Survey 2008," more than 168,000 women in Ohio are eligible for BCCP.

The proportion of minority women served by BCCP in Program Year 2008-2009 was:

- Black women: 22.3 percent.
- Hispanic women: 3.1 percent.
- American Indian women: 0.4 percent.
- Asian women: 0.7 percent.

Additionally, the program worked with partners to develop "Filling in the Gaps During Difficult Economic Times," a directory of free and reduced-cost breast and cervical cancer screening resources throughout the state of Ohio.

Ohio Breast and Cervical Cancer Project – March 1994-April 2010

Total Clients Served* 70,117

*Clients received at least one BCCP funded procedure between March 1994 and April 2010.

By Age:	# Clients	% Total	By Race/Ethnicity:	# Clients	% Total
<40 years	129	<1%	White	50,172	72%
40-49	29,435	42%	Black	15,595	22%
50-64 yrs	37,931	54%	Asian	1885	2%
65+	2,622	4%	Amer Indian	323	<1%
Total	70,117	100%	>1Race***	208	<1%
			Other/Unknown	189	<1%
			Total	70,117	100%

** Clients of white, black, >1 race, other, or unknown race and Hispanic ethnicity are reported only in this category.
 *** Clients reporting more than one race. Category was added in 2003

Cancer Rate Investigations

ODH receives multiple inquiries of perceived high rates of cancer from LHDs, the media and the general public. To address these concerns, a Community Cancer Assessments Workgroup consisting of representatives

from the Chronic Disease and Behavioral Epidemiology Section, CCCP, the Bureau of Environmental Health, Ohio Cancer Incidence Surveillance System (OCISS) and State Epidemiology Office convene on a bi-monthly basis to discuss these concerns and determine need for further action.

High-profile cancer assessments during SFY09 and SFY10 include Avon Lake, Clyde and Port Clinton. These assessments require extensive resources, including time, labor and funding, and often involve multiple external stakeholders such as local health departments and the Ohio Environmental Protection Agency (EPA).

Sodium Reduction

OHO signed on to the National Salt Reduction Initiative and joined a national effort to prevent heart attacks and strokes by reducing the amount of salt in packaged and restaurant foods. These foods contribute about 77 percent of dietary sodium; only 11 percent of the sodium consumed is added at home during cooking or at the table. The goal of the NSRI is to reduce Americans' salt intake by 20 percent over five years.

Current dietary guidelines recommend a maximum of 2,300 mg of sodium a day (about one teaspoon). Americans consume roughly twice that amount each day. High sodium consumption contributes to high blood pressure, a major risk factor for heart disease and stroke.



CHAPTER 6

Maternal and Child Health



In 1935, President Franklin Roosevelt signed into law Title V of the Social Security Act. Title V represented a new and unique commitment of the federal government to support states in improving the health and well being of all women and children. At the same time, it extended a path begun decades earlier to “investigate and report upon matters pertaining to the welfare of children and child life among all classes of people.” The legislation ensured that women and children will receive vital support, in both good times and bad.

This year, ODH celebrated Title V’s 75th year anniversary which is now the longest-standing public health legislation in the United States.



Over the course of its 75-year history, the Title V program has adapted to changing needs and new scientific knowledge. However, the founding principles and functions have endured, setting the stage for continued improvement in the health, safety, and well-being of mothers and children. ODH receives approximately \$23 million annually, made available through Title V, from the Health Resources and Services Administration (HRSA).

The program touches the lives of every infant, child and family in Ohio in important ways that often go unrecognized. In Ohio, every newborn is screened for heritable disorders before leaving the hospital. Infants and toddlers are vaccinated against preventable diseases. Mothers are assessed for postpartum depression and receive breastfeeding support. School children with no other access to dental care receive sealants and oral health screenings. Children with special health care needs and their families have access to high quality, specialized medical care and supportive services that allow children full integration in family and community life.

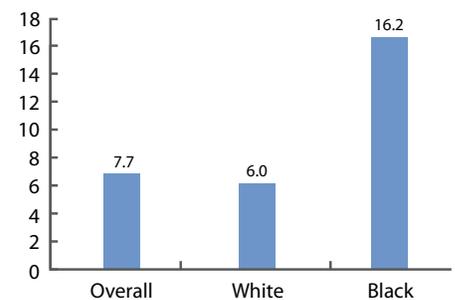
Infant Mortality

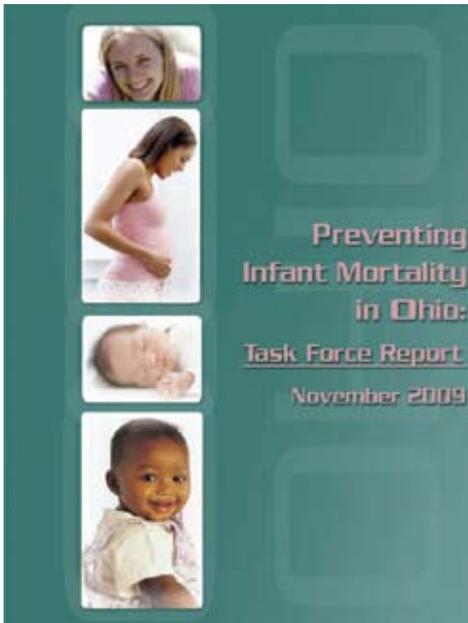
In Ohio, despite continuing statewide and local efforts, the infant mortality rate exceeds the national average of 6.75 deaths per 1,000 live births.

Recognizing this problem, Gov. Strickland asked ODH to establish a task force to take a fresh look at infant mortality and disparities and develop recommendations and strategies to address these challenges. The Ohio Infant Mortality Task Force, which was chaired by Dr. Jackson, was established in 2009 and published its final report in Nov. 2009. The report, which is available online by searching “Ohio Infant Mortality Task Force,” contains detailed information about infant mortality and disparities in Ohio as well as a description of efforts underway to address these challenges.

The report recognizes that a new science-based and coordinated approach to reducing infant mortality will create a better quality of life, assure healthier women and children, strengthen families and contribute to a more efficient and cost-effective use of medical services.

Ohio Infant Mortality Rate per 1,000 Live Births – 2008





Central to the report are these ten recommendations:

1. Provide comprehensive reproductive health services and service coordination for all women and children before, during and after pregnancy.
2. Eliminate health disparities and promote health equity to reduce infant mortality.
3. Prioritize and align program investments based on documented outcome and cost effectiveness.
4. Implement health promotion and education to reduce pre-term birth.
5. Improve data collection and analysis to inform program and policy decisions.
6. Expand quality improvement initiatives to make measurable improvements in maternal and child health outcomes.
7. Address the effects of racism and the impact of racism on infant mortality.
8. Increase public awareness on the effect of preconception health on birth outcomes.
9. Develop, recruit and train a diverse network of culturally competent health professionals statewide.
10. Establish a consortium to implement and monitor the recommendations of the Ohio Infant Mortality Task Force.

To follow up on the tenth recommendation, the group created the Ohio Collaborative to Prevent Infant Mortality, in 2010. The collaborative is a broad-based, statewide consortium that will implement the task force's recommendations, develop a strategic plan, influence policy, raise awareness and provide an annual progress report to the governor.

In 2010, the collaborative formed workgroups to study the following:

- Coordinated health care throughout a woman's life
- Disparities and their underlying causes, including racism
- Data, metrics and quality improvement
- Education and outreach
- Public policy

Oral Health



Dental care remains the number one unmet health care need among Ohio's children, according to the 2008 Ohio Family Health Survey. In 2008, ODH convened a task force of key stakeholders from throughout the state to make recommendations for improving the oral health of Ohioans and their access to dental care. With input from local providers of health care, patients, families and advocates, the task force considered the compelling issues that Ohioans face in improving their oral health. The task force developed recommendations and implementation plans to address identified issues. One of the results of the task force process was the establishment of the Children's Oral Health Action Team (COHAT), composed of more than 20 member organizations committed to changing children's oral health policy in Ohio.

One of the recommendations of the task force, which is also a priority of COHAT, is to increase the number of children who benefit from School-Based Sealant Programs (S-BSPs). These programs, established at ODH in 1987 and funded through the federal Maternal and Child Health Block Grant, provide one of the most effective ways to prevent tooth decay among children. Dental sealants are thin, plastic coatings that are painted on the biting surfaces of the back teeth. Sealants block food and decay-causing bacteria from entering the narrow grooves of teeth where cavities are most likely to occur.

ODH funds sub-grants to local agencies and organizations to provide dental sealants to children at school. Schools are targeted where 40 percent or more of the students are considered low-income (i.e., eligible for the Free and Reduced Price Meal Program). Most of the programs operate in highly urbanized or very rural areas of Ohio, where many children don't have regular dental care and are at higher risk for tooth decay.

A. Normal tooth with pits and fissures **B. Tooth with dental sealants**



A.

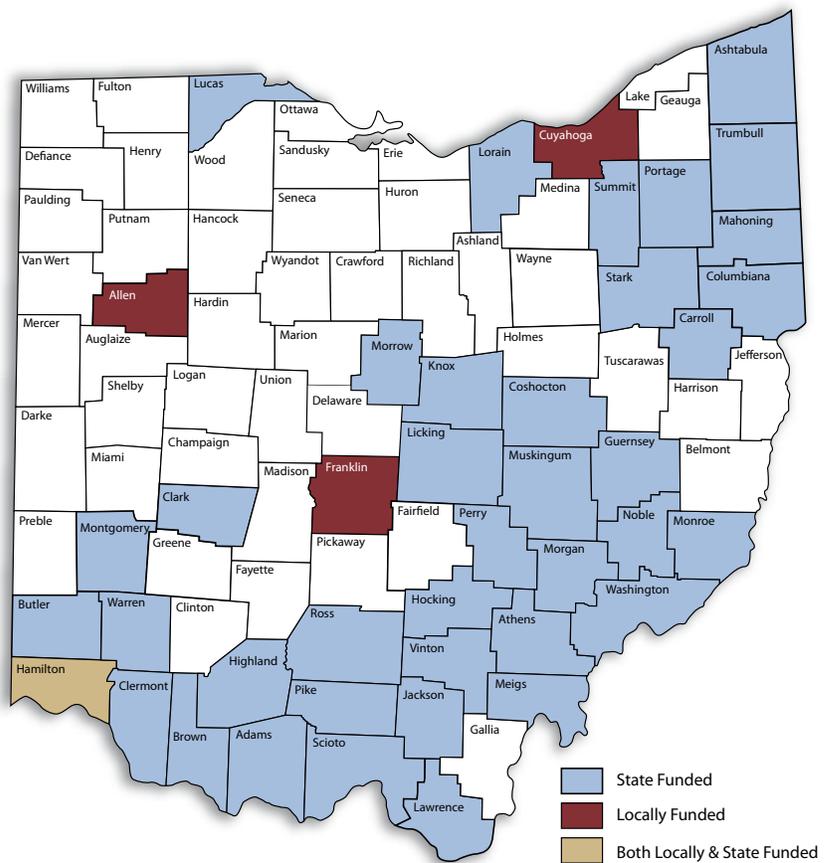
B.

ODH’s School-Based Sealant Program has been nationally recognized by the CDC. In addition, the PEW Center for the States report called it a “national model” due to results tracking and measuring program effectiveness.

With parental consent, students in grades two and six are examined by a licensed dentist to determine which teeth need sealants. These grades are targeted because students are most likely to have newly-erupted permanent molars. Using portable dental equipment, teams of dental hygienists and dental assistants place the sealants. The teeth are checked the following school year to make sure the sealants are still in place and to seal any other newly-erupted molars. Parents are notified if their children are found to need other dental care.

During SFY09 and SFY10, 15 S-BSP sub-grants provided sealants to 39,368 children in 39 counties. The following map shows the counties (shaded in blue) served by ODH-funded S-BSPs during this period.

School-based Sealant Programs in Ohio, SFY09–SFY10



ODH’s S-BSP has been nationally recognized by the CDC for efforts to effectively target its sealant program to low-income children. It was also highlighted in the Pew Center for the States February 2010 report, “The Cost of Delay: State Dental Policies Fail One in Five Children.” In the report, Ohio’s S-BSP is lauded as a “national model, thanks in part to rigorous monitoring and evaluation of program effectiveness.” In early SFY11, ODH received notification from HRSA that it had been selected to receive additional funding to significantly expand its program.

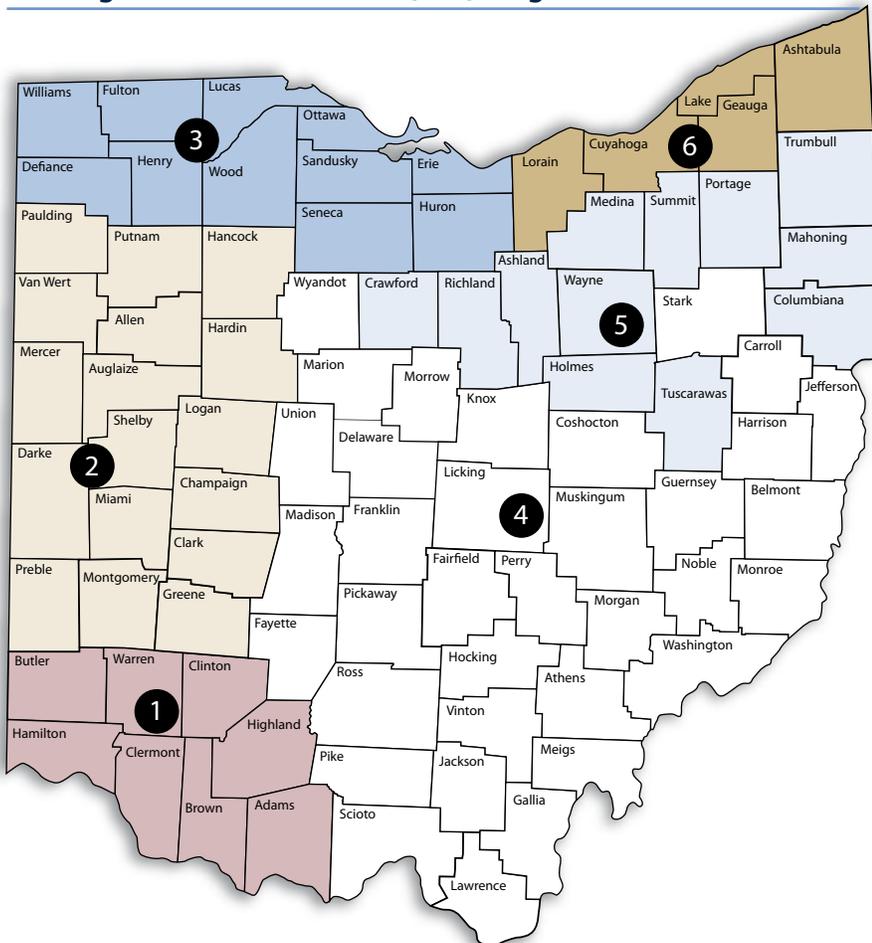
Perinatal Care

The Regional Perinatal Center (RPC) Program promotes access to evidence-based and risk-appropriate perinatal care to women and their infants through regional activities with the overall goal of reducing perinatal mortality and morbidity.

The program divides Ohio into six regions and used an \$80,000 block grant to fund six agencies to support regional perinatal system development, including coordination of resources for prenatal, delivery/birth, post-partum and newborn care. All grantees are located in a Level III birthing or Level III pediatric hospital with staff specialists assigned to perinatal system and perinatal data activities.

During a 19-month period beginning in SFY09, more than 8,000 babies who would have been delivered at the preterm 36 to 38 week mark were delivered after 38 weeks.

The Regional Perinatal Center (RPC) Program



The Ohio Perinatal Quality Collaborative (OPQC), in which ODH plays a key role, successfully helped hospitals reduce late preterm births performed through non-medically-indicated Caesarians.

ODH’s Office of Vital Statistics (VS) worked with partners in the collaborative to analyze more than two years of birth certificates to determine statewide birth patterns. ODH’s Data Center partnered with VS to deliver 350 different fields of “real-time” birth data to all the hospitals participating in the project. Meanwhile, the RPC Program assisted in the identification of key perinatal and neonatal contacts and leaders at maternity and pediatric hospitals, which lead to the involvement of perinatal teams all across the state.

All of this meant that, during a 19-month period starting in September, 2008, more than 8,000 babies who usually would have been delivered at the 36 to 38 week mark were delivered after the 38-week mark.

Newborn Screening

The Ohio Newborn Screening Program (NBS), located in the ODH Lab, screens every baby born in Ohio for 35 metabolic, endocrine and genetic disorders. The purpose of the program is to identify babies within the first few days of birth for treatable disorders. The results provide valuable information to the medical community and improve the quality of life for at-risk infants. Since the screening was started in 1961, more than seven million newborns have been screened and more than 3,000 newborns have received life saving treatment, as a result of the screening program.

The NBS receives over 3,000 specimens each week. These samples are tested and the results are released within 48 hours of receipt. Results with alert values are called to the physician of record and the hospital newborn screening coordinators. Parents are notified by their physician or the birth hospital. Families are referred to state-funded regional genetic sickle cell or cystic fibrosis centers for specialized counseling, diagnosis and treatment. The ODH Lab follows up with the medical providers to ensure that the babies receive the appropriate diagnostic work-up and care.

NBS	2008	2009
Specimens received	151,583	147,769
Unsatisfactory specimens	159	194
Unique Infants	149,301	145,723
Presumed positives	2901	3592
Newborns confirmed w/disorder	248	220

The program also provides the special metabolic formula to support the babies identified with some of these metabolic disorders. ODH's Metabolic Formula Program provides formula to approximately 400 individuals in Ohio, at a cost of approximately \$600,000 per year.

ODH's Metabolic Formula Program provides formula to approximately 400 individuals in Ohio.

Disorders Detected by Newborn Screening SFY 2009 and 2010

Disorder	Cases in 2008	Cases in 2009
Argininemia	0	0
Argininosuccinic Acidemia	1	1
Biotinidase Deficiency	4	2
Carnitine Palmitoyl Transferase Deficiency (Types I and II)	0	0
Carnitine/Acylcarnitine Translocase Deficiency	0	0
Carnitine Uptake Defect	0	2
Citrullinemia	0	2
Congenital Adrenal Hyperplasia	9	1
Congenital Hypothyroidism	59	70
Cystic Fibrosis	48	31
Galactosemia	6	3
Glutaric Acidemia Type I	0	2
Glutaric Acidemia Type II	1	1
Homocystinuria	0	0
3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency	0	0
Hyperphenylalaninemia	18	7
Hypermethioninemia	0	0
Isobutyryl-CoA Dehydrogenase Deficiency	0	0
Isovaleric Acidemia	0	1
3-Ketothiolase Deficiency	0	0
Long Chain Hydroxyacyl-CoA Dehydrogenase Deficiency	0	0
Maple Syrup Urine Disease	0	1
Medium Chain Acyl-CoA Dehydrogenase Deficiency	8	9
2-Methylbutyryl-CoA Dehydrogenase Deficiency	0	0
3-Methylcrotonyl-CoA Carboxylase Deficiency	1	2
Methylmalonic Acidemia	3	0
Multiple CoA Carboxylase Deficiency	0	0
Phenylketonuria	9	11
Propionic Acidemia	3	2
Short Chain Acyl-CoA Dehydrogenase Deficiency	0	2
Sickle – C disease	22	17
Sickle cell anemia	47	35
Other Hemoglobinopathies	11	11
Trifunctional Protein Deficiency	0	0
Tyrosinemia (Type I)	0	1
Tyrosinemia (Types II and III)	0	0
Very Long Chain Acyl-CoA Dehydrogenase Deficiency	3	1



Help Me Grow

Help Me Grow (HMG) allocates federal and state money to every Family and Children First Council in each of Ohio's 88 counties to provide service coordination, developmental screenings, parenting education and home visits to children prenatal to age three and their families.

HMG teaches parents about the health of their child and the importance of well-child visits and immunizations. The information HMG provides to parents about what infants and toddlers should be eating has an impact on children's nutrition and weight management starting in infancy. HMG also educates parents and caregivers about oral health, brain development and early literacy. With its focus on child development, HMG is able to inform families of appropriate ways to play with their child and is there whenever a concern arises. HMG also screens children for developmental delays and connects families with services in their communities when



Risk Success Story: SFY09

HMG Engages New and Expectant Parents who are at Risk for Poor Health and Social Outcomes

A HMG service coordinator began working with a mom, "April"*, who had a history of not being home for scheduled visits and not calling beforehand to reschedule.

The service coordinator helped April with planning and encouraged her to use the calendar hanging in her kitchen to write down home visit dates and times for her HMG, WIC and pediatrician appointments. By using this system, April was ready to meet during the majority of home visits and was better-prepared for the visits.

* Names have been changed

Through regular home visits, the service coordinator observed April becoming more affectionate with her 2 ½ year old, "Tony."* She was able to successfully potty train her child and was proud of herself for being able to stay consistent with him during such a difficult and frustrating task. Overall, April became more self-sufficient, began involving her children in HMG and received support by connecting with other parents. Tony also made progress in his articulation and his knowledge of numbers and letters. By the end of the family's participation in HMG, Tony was able to have a smooth transition to a child care center.

delays or disabilities are present.

In SFY10, HMG underwent extensive changes to make the formerly titled "At Risk" program current with evidence-based practices and program standards. ODH met with many stakeholders and after receiving much public comment, revised both the program policies and rules to start the new "Help Me Grow Home Visiting" program. During this year of much change, HMG programs in all 88 counties served 27,107 children in its At Risk program and another 26,523 children in Part C of The Individuals with Disabilities Education Act (IDEA).

In SFY10, HMG underwent extensive changes to make the formerly titled “At Risk” program current with evidence-based practices and program standards.



Risk Success Story: SFY10

HMG Connects Families with Services in their Communities

A family with four children, one grandchild and another grandchild due in December were told to move from the house they lived in. Three children were under two years of age. They lived with the grandmother, who had failed to pay the rent. The family who was already receiving HMG services, came to the HMG office to call potential landlords and agencies to find a new residence. The HMG service coordinator contacted agencies asking for assistance for the deposit, first month’s rent and utility hook ups. They wanted a new place and did not want resort to a homeless shelter as that would separate the father from the rest of the family.

Three days after being served an eviction notice a new apartment was found. HMG helped find assistance through the council of community affairs to pay the rent deposit and the board of developmental disabilities made a donation for the first month’s rent, allowing the family to move immediately. Local agencies and churches provided money to get the utilities turned on and furnishings for the apartment. The HMG service coordinator continues to work with the family once or twice a month. Together they work on budgeting and planning for unexpected incidents. The family was very appreciative of the assistance offered by HMG.

In SFY09, HMG served 35,081 children in its At Risk program and another 27,107 children in its Part C of IDEA program.



Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a fundamental part of Ohio's public health system. The program is intended to reach income-eligible pregnant, postpartum and breastfeeding women, infants and children up to five years of age with a health or nutrition risk. Ohio's WIC is the 7th-largest program in the country, serving a monthly average of 303,680 participants including 69,717 women, 78,395 infants (more than half of all infants born in the state) and 155,568 children.

Since its inception, WIC services have addressed the most important goal: prevention of nutrition-related health problems. WIC helps to improve overall health during the most critical growth and developmental years in a child's life (conception to age 5) by providing nutrition information, breastfeeding education and support; supplemental foods supplying key ingredients; and referrals to prenatal and pediatric health care and human service programs.

In 2009, WIC implemented a new food package, which includes fruits and vegetables and whole grains. The new package represents the most significant change to the food package in 30 years.

Through services like the food package, WIC not only prevents health problems early in life but also helps save health care dollars later. For every dollar spent on WIC, \$1.77 to \$4.21 is saved in Medicaid costs.

Save Our Sight

Save Our Sight (SOS) works to preserve good vision in children through early detection of vision problems and a reduction in the occurrence of childhood eye injuries. Through sub-grantee agencies, SOS collaborates with physicians, nurses, child care facilities, schools, sports and recreational leagues, children's hospitals and others to reach tens of thousands of children in Ohio.

SOS has also registered 1,936 children for the Ohio Amblyopia Registry, which is a statewide program designed to serve the needs of Ohio's children with amblyopia, commonly known as lazy eye. The registry also benefits families and eye doctors of children with amblyopia.

SOS has also literally saved a life. A screener trained through the SOS program identified a child with retinoblastoma. The child was immediately referred for care, had an eye removed within the week and is now a cancer survivor.

Ohio data trends indicate that WIC participation contributes to positive birth outcomes as evidenced by decreases in:

- Rates of pregnancy weight gain less than/greater than ideal
- Rate of anemia in the 3rd trimester
- Rate of no care
- Rates of smoking during the last three months of pregnancy and smoking in the household, both prenatally and postpartum
- Rates of low birth weight, full term low birth weight and high birth weight

WIC implemented a new food package, which includes fruits and vegetables and whole grains. The new package represents the most significant change to the food package in 30 years.

Save Our Sight's Numbers Served for SFY 2009 and 2010

	2009-2010
Vision screeners trained	934
Schools received educational modules.	547
Students participated in educational programs	138,866
Protective eyewear given to 24 vocational schools	5,158
Protective eyewear helmets distributed children's sport leagues	7,500
Non-prescription protective eyewear to children's sport leagues	1,000
Prescription protective eyewear to children in sports from families below 300% poverty level	203



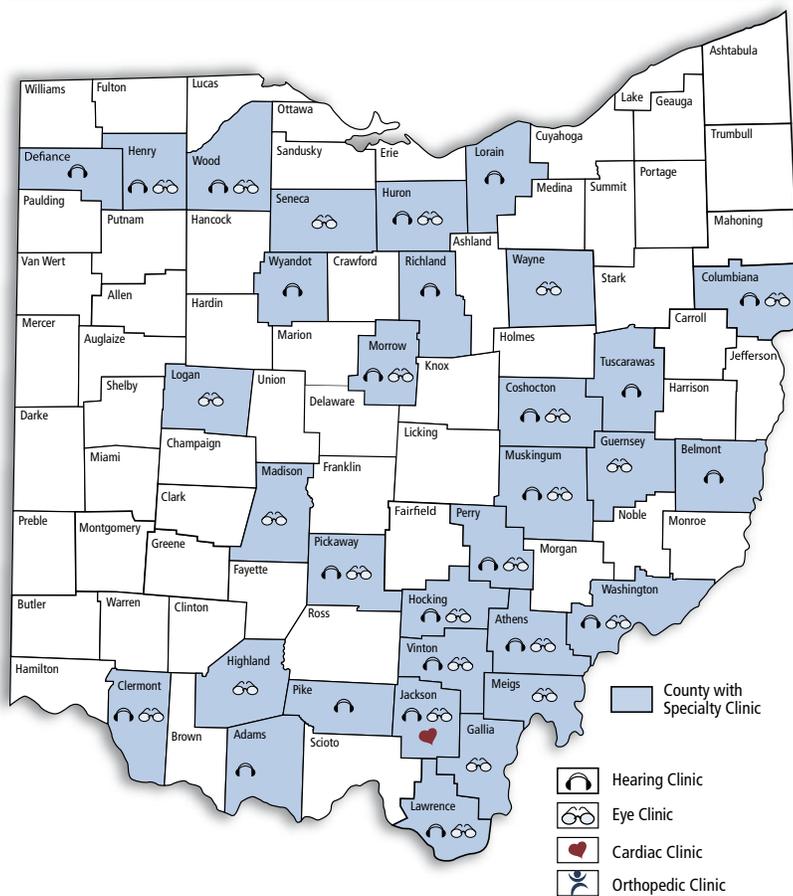
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Hearing and Vision Screening

The Medical Specialty Clinic Program is a screening, diagnostic and treatment program that provides access to pediatric specialists for thousands of low-income children in medically underserved areas of Ohio.

Areas of specialties include, cardiac, hearing, neurology, orthopedic and vision. Clinics are typically held in LHDs as well as in speech and hearing centers, rehabilitation centers and hospitals. The local public health nurses assist families in applying for Medicaid, with assistance

Ohio Location of Specialty Clinics



There were almost 4,000 visits to specialty clinics in SFY09. The clinics are located in 32 counties throughout Ohio in mostly rural and Appalachian areas.



As of Oct. 2009, it became the law in Ohio that every child younger than 8, or less than 4 feet 9 inches, must use a booster seat.

The new law – combined with existing law requiring children younger than 4 years and less than 40 pounds to use a child safety seat; and children 8 to 15 to use a safety seat or seat belt – is designed to make traveling safer for Ohio’s children.

At least 34 Ohio children between the ages of 4 and 7 died in motor vehicle traffic crashes between 1999 and 2006. Traffic accidents are the leading cause of death for this age group. 2007, only 18 percent of Ohio children ages 4 to 8 used a booster seat.

The Ohio Buckles Buckeyes (OBB) program provides child safety seats to eligible low-income Ohioans and has distributed more than 20,000 child safety and booster seats in the past five years.

through the ODH Bureau for Children with Medical Handicaps (BCMh) and help families make follow-up appointments for other testing or surgery.

The Medical Specialty Clinic Program has saved money by successfully transitioning out of services that are being covered by private providers while continuing to fill gaps, as needed. One example of this is the successful public/private partnership for the provision of pediatric cardiology services in Jackson and surrounding counties.

Child Injury Prevention

Injury remains the leading cause of death for children and youth. On average each year in Ohio, 260 children under the age of 14 die from injury and violence. For adolescents aged 15-19, unintentional injury, suicide and homicide are the three leading causes of death respectively. Through the umbrella of the Ohio Injury Prevention Partnership, the Violence Injury Prevention Program (VIPP) established and is growing the Child Injury Action Group. This group is a statewide coalition devoted to the prevention of child and youth injury.

The group is working to:

- Increase statewide collaboration around child injury prevention efforts.
- Plan a 2010 statewide symposium focusing on traumatic brain injury prevention among Ohio youth.
- Build state and local capacity for child injury prevention efforts.
- Research and assess the feasibility of implementing evidence-based IP policies and programs at the local and state level.
- Promote evidence-based child and youth injury prevention programs throughout Ohio.
- Develop a state-level child injury policy plan and recommendations for Ohio.

Child Fatality Review

Approximately 1,800 Ohio children die each year. Ohio law mandates that local boards in each county review the deaths from all causes for all children under 18 years of age. The goal of Child Fatality Review (CFR) is to prevent further child deaths through the careful study of the factors

and circumstances of each and every child death in Ohio. The review seeks to learn how best to respond to a death and how best to prevent future deaths.

For all reviewed deaths in 2008:

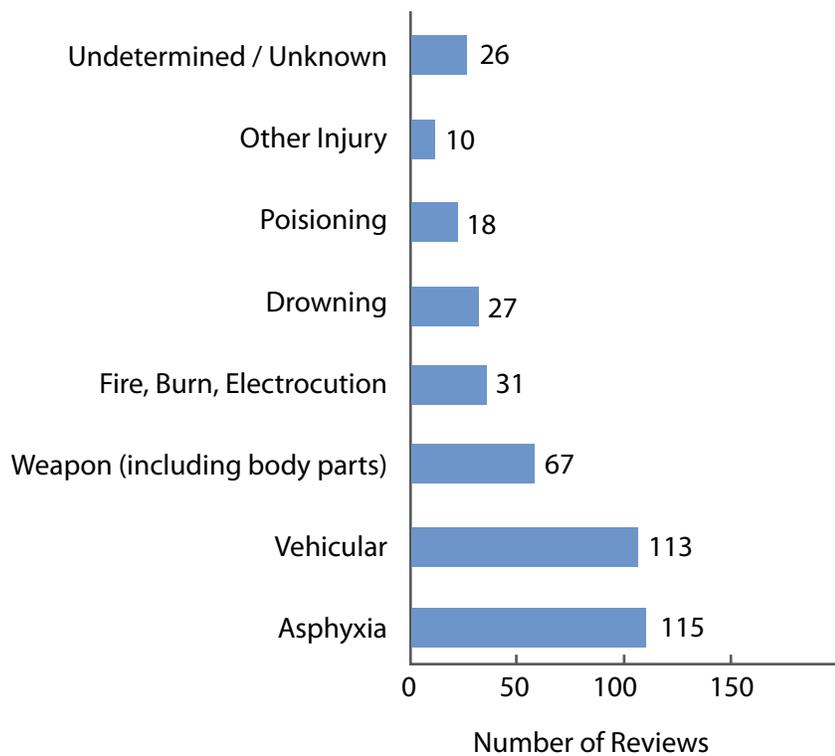
CFR boards determined that 23 percent of the deaths were probably preventable.

Black children and boys died at disproportionately higher rates than white children and girls for most causes of death. Sixty-seven percent of the deaths reviewed were to infants less than 1 year of age.

The Ohio CFR program participates in a national web based data system, and has been recognized across the country as a leader in child death review.

The Ohio CFR program participates in a national Web based data system, and has been recognized across the country as a leader in child death review.

Reviews of Deaths from External Causes by Cause of Death

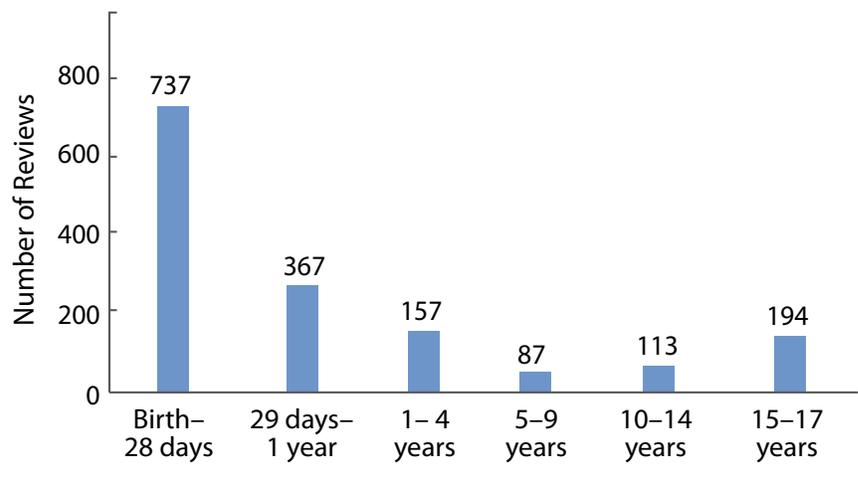


Here are some additional facts that the CFR program discovered about child deaths in 2008:

This is the first year that the number of reviews for asphyxia deaths surpassed the number of reviews for vehicular deaths. Asphyxia accounted for seven percent of all deaths reviewed. Sixty-nine percent of these were children less than 1 year old. Of the 40 asphyxia deaths to children 10-17 years old, 88 percent were suicides.

In 2008, more than half of the 88 counties shared information about local prevention initiatives and activities that have resulted from the CFR process

Reviews of 2008 Death By Age



Vehicular deaths accounted for seven percent of all deaths reviewed. Fifty-three percent of these children were 15-17 year olds and 88 percent were white. Sixty-seven percent of the children killed were boys.

CFR boards identified child abuse and neglect as a cause or contributing factor in 34 deaths. Twenty-seven resulted from physical abuse.

There were 56 suicide deaths reviewed. This represents three percent of all reviews and 18 percent of all the reviews for children 10-17 years old. Seventy-nine percent were white children; 63 percent were boys.

Also, in 2008, more than half of the 88 counties shared information about local prevention initiatives and activities that have resulted from the CFR process. In addition, many local CFR boards were active in the grassroots efforts to support Ohio’s new Booster Seat law and also the Graduated Driver License law, which allows young drivers to improve their skills and driving habits by giving them driving privileges in stages.

Bureau for Children with Medical Handicaps

The Bureau for Children with Medical Handicaps (BCMh) links families of children with special health care needs to a network of quality providers and helps families obtain payment for the services their children need. BCMh’s mission is to assure, through the development and support of high quality, coordinated systems, that children with special health care needs and their families obtain comprehensive care and services that are family centered, community based and culturally sensitive.

In SFY10, BCMh provided payment for medical services to more than 27,000 clients through its treatment program. Overall, BCMh provided services to more than 40,000 clients through a variety of programs, including Treatment, Diagnostic, Service Coordination, Adult Cystic Fibrosis, Adult Hemophilia Insurance Premium Payment and Public Health Nurses Consultative Services.

Birth defects or congenital anomalies are one of the leading causes of infant death and account for approximately 19 percent of infant deaths in Ohio. BCMH also runs the Ohio Connections for Children with Special Health Care Needs birth defects information system. This system was successful in being awarded improvement and enhancement funding from CDC for an additional five years. All hospitals in the state have been required to report birth defects cases to ODH since 2008.

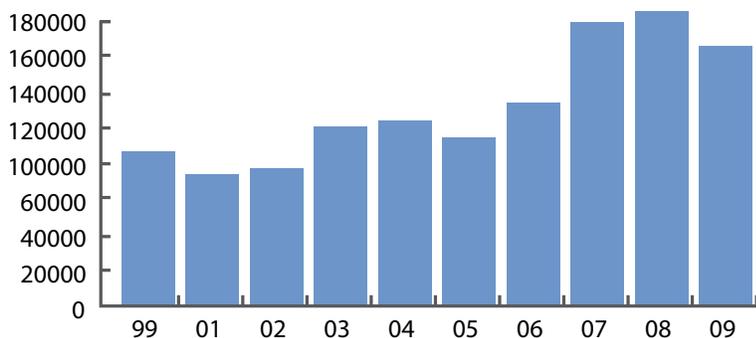
Currently, the development of prevalence rates for spina bifida, oral facial clefts and trisomies is underway and will be completed in 2011. This data will help health care providers, as well as the general public; understand the prevalence of specific birth defects in Ohio residents. It will also ensure that children with birth defects are referred to public health programs such as BCMH, HMG and WIC to improve their outcomes. In addition it will help educate health care providers and women of childbearing age regarding how birth defects occur and how women can reduce their risk of having a baby born with a birth defect.

Lead Poisoning Prevention

Lead poisoning is one of the most common and preventable childhood environmental health problems in the U.S. and Ohio is no exception. Low-income children, especially those living in the inner city, are at an increased risk for lead poisoning. The Ohio Healthy Homes and Lead Poisoning Prevention Program (OHHLPPP) is a comprehensive childhood lead poisoning prevention program offering everything from surveillance and testing, to environmental investigations, education and primary prevention to the residents of Ohio. The OHHLPPP also provides lead poisoning prevention education to medical and public health providers through its Pediatric Lead Assessment Network Education Training program.



Number of Children Less than 72 Months of Age Tested for Lead in Ohio, 1999-2009



Since 1999, ODH efforts have created a gradual decline in lead poisoning rates of children. In turn there has been a successful increase in the number of at-risk children receiving blood lead tests each year.

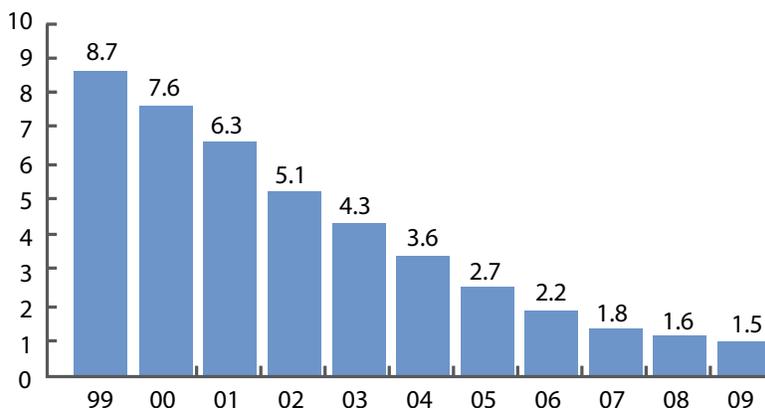


CDC recognizes OHHLPPP as one of the trailblazing lead poisoning prevention programs in the nation and awarded it the nation's largest grant award for lead poisoning prevention activities.

Since 1999, Ohio has seen a gradual decline in lead poisoning rates of children due in no small part to state and local efforts to prevent lead poisoning. During the same time period, Ohio continued to see an increase in the number of at-risk children receiving blood lead tests each year.

In 2009, 159,192 lead tests were conducted on 147,977 unique children less than 72 months of age in Ohio. Of those, 2,237 children were found to have at least one elevated blood level.

Percent of Tested Children Less than 72 Months of Age with a Confirmed Elevated Blood Lead (EBLL), 1999-2009



The OHHLPPP is also responsible for supporting the infrastructure of healthy homes programs in regional areas and in LHDs across the state. The program also provides funding for these regions, as well as primary

prevention and educational efforts to professionals throughout the state. A healthy home can support wellness, while preventing disease and injury. An unhealthy one can contribute to numerous adverse health outcomes and limit quality of life. There are many aspects of a home that make it healthy.

The seven elements of a healthy home include:

Keep it Dry: Prevent water damage and mold growth by checking plumbing, roof, and draining systems for leaks.

Keep it Clean: Keep all areas free of clutter and contaminants.

Keep it Safe: Install smoke/carbon monoxide detectors and fire extinguishers, while taking other safety measures to prevent injuries.

Keep it Well-Ventilated: Supply fresh air and eliminate the concentrations of radon, carbon monoxide and tobacco smoke.

Keep it Contaminant-free: Remove or reduce the exposure of lead and other contaminants.

Keep it Well-Maintained: Inspect, clean, and repair homes routinely.

Keep it Pest-free: Seal cracks and openings to prevent insects and rodents from entering. For all of its achievements, CDC recognized OHHLPPP as one of the trailblazing lead poisoning prevention programs in the nation and awarded it the nation’s largest grant award for lead poisoning prevention activities.

Maternal Child Health Epidemiologist

One of the Deputy State Epidemiologists, in the state epidemiology office, serves as the Maternal Child Health Epidemiologist. The current Maternal Child Health Epidemiologist is from the CDC.

The role of the state Maternal Child Health Epidemiologist is to Chair the ODH-wide MCH epidemiology coordinating committee, facilitate work with DFCHS and Title V programs and develop an ODH-wide MCH epidemiology agenda.

The CDC funds this position in order to promote and improve the health and well-being of women, children and families by building MCH epidemiology and data capacity at the state, local, and tribal levels to effectively use information for public health action.



CHAPTER 7

Alcohol, Tobacco and Other Drugs



Any healthy community must be built on a tobacco-free foundation. Significant progress has been made in the 45 years since the surgeon general first linked cigarette smoking to lung cancer, but there is still far to go. One in every five or 20.1 percent – of Ohio adults are smokers and ODH has many programs and tools to help remove tobacco from the lives of Ohioans.

In addition to helping Ohioans who are addicted to tobacco quit, ODH is working to help stop Ohioans from becoming addicted to other dangerous drugs. Prescription drug abuse is a rising public health problem on the national level and has reached an epidemic level in Ohio. Ohio's death rate due to unintentional drug poisoning has increased more than 350 percent from 1999 to 2008, and is now the leading cause of injury death in Ohio.



Ohio's Prescription Drug Abuse Epidemic

In 2007, unintentional drug poisoning became the leading cause of injury death in Ohio, surpassing motor vehicle crashes and suicide for the first time on record. This trend continued in 2008. In Ohio, there were 327 fatal unintentional drug overdoses in 1999 growing to 1,473 annual deaths in 2008.

On average, from 2006 to 2008, approximately four people died each day in Ohio due to drug-related poisoning. Prescription opioids (pain medication) are the drug type associated with the largest percentage (37 percent in 2008 compared with heroin at 17 percent) of the deaths. In 33 percent of the deaths no specific drug was identified. ODH staff anticipate that the real contribution of opioids is even higher than 37 percent.

In addition, mixing medications and multiple drug use are playing a major role in the epidemic. In at least three out of four of the deaths, more than one substance was found to be involved in the death. Because of the rapid and alarming increase in drug overdose deaths ODH's Violence and Injury Prevention Program (VIIPP) has created a subgroup, the Poison Action Group, (PAG) of the Ohio Injury Prevention Partnership (OIPP) to focus specifically on this epidemic of drug deaths. The PAG has also partnered with the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and their New and Emerging Drug Trends Workgroup in this effort.

The purpose of the Ohio PAG is to address deaths and injuries resulting from the use, misuse and abuse of prescription drugs. The PAG conducted a state symposium: Epidemic of Prescription Drug Overdoses: A Call to Action on July 29, 2009. The purpose was to raise awareness of the problem and provide data, identify contributing factors, highlight programs and promising practices, present strategies for policy and program initiatives and discuss possible action steps.

The PAG also conducted regional forums in high risk areas to present data and discuss solutions. Forums were conducted or are being planned in Scioto, Montgomery, Fairfield, Butler and Ross counties among others.

The VIIPP is also conducting pilot prevention programs in two high risk areas, Montgomery and Scioto County. The pilot programs are on task to accomplish the following goals by 2013:

- Establish Poison Death Review committees
- Develop coalitions
- Conduct education and training of health care providers about the issue
- Increase the use of the state's prescription monitoring program among prescribers
- Conduct a feasibility study of a local naloxone distribution and education program
- Develop state and local policy recommendations
- Implement a media campaign to raise awareness of the issue

The recommendations from the VIPP’s Ohio Action Group were released in April 2010 and were used as the foundation for the work of the Ohio Prescription Drug Abuse Task Force.

These efforts have been extremely successful in stimulating grassroots advocacy that has provided impetus for encouraging state policy makers to address the problem.

The PAG/NEDTW developed recommendations for consumers, prescribers and decision makers/policymakers. The recommendations were presented to the Directors of ODH and ODADAS in April 2010 and were used as the foundation for the work of the statewide Ohio Prescription Drug Abuse Task Force (OPDATF).

The OPDATF, which was formed by Gov. Strickland in April 2010, drafted initial recommendations in May of 2010 that included working with the PAG/NEDTW to address the problem. The OPDATF was chaired by an Assistant Director at the Ohio Department of Public Safety (ODPS) and was vice-chaired by Dr. Jackson. The Task Force submitted its final recommendations to Gov. Strickland and the general assembly in Oct. 2010. A copy of the final report can be found at www.odh.ohio.gov/drugoverdose.

At the end of SFY10, ODH began working on a campaign to raise awareness of this issue in the media and among the public. The campaign themed Prescription for Prevention: Stop the Epidemic is targeted in five high risk areas of Ohio and will run through SFY11.

Tobacco Cessation

Smoking causes more premature deaths than any other health-risk behavior in the United States and in Ohio. One in every five deaths in Ohio are caused by tobacco use which means that more than 18,000 Ohioans die each year from diseases related to tobacco use.

ODH’s Tobacco Use Prevention and Cessation Program (TUPCP) is dedicated to reducing the prevalence of tobacco use in Ohio and the associated health effects. The core program goals include prevention of youth tobacco-use initiation, cessation of tobacco use, the elimination of secondhand smoke exposure for all Ohioans and the elimination of disparities associated with tobacco use.

Many Ohio counties have local tobacco control and wellness coalitions that are addressing tobacco issues in their area.

To prevent youth initiation, the TUPCP provides local grants to conduct evidence-based prevention programs within Ohio’s middle and high schools. TUPCP also supports policy change efforts to assist school districts in the adoption and enforcement of 100 percent tobacco-free school campus policies. Beyond schools, TUPCP works in partnership with ODADAS and ODPS to reduce sales of tobacco products to minors.

Approximately 2 million (20.3 percent) of Ohio adults 18 and older currently smoke – 21.2 percent of men and 19.5 percent of women.

The smoking rate among Ohio African-Americans is 22.0 percent, and among whites the rate is 20.1 percent.

11.6 percent of Ohio middle school students and 28.7 percent of Ohio high school students are current users of at least one form of tobacco product.

The Ohio Tobacco Quit Line, 1-800-QUIT-NOW is funded by the TUPCP and is free and available to all Ohioans. The Quit Line provides free counseling and two weeks of free nicotine replacement therapy to callers who want to quit. The TUPCP also sustains local grants to non-profit agencies, hospitals and health departments to offer cessation services within local communities.

In SFY10, the TUPCP applied for and was awarded \$1 million in American Recovery and Reinvestment Act (ARRA) funds for a media campaign and an online cessation tool to raise awareness and assist tobacco users in the critical effort to stop tobacco use. The media campaign, titled *Dear Me: Nobody Can Make Me Quit But Me* shares the thoughts and struggles of real smokers and reminds Ohioans that when they are ready to quit, help is available.



Alcohol Testing

The Alcohol and Drug Testing Program, located in the ODH Lab, has oversight of law enforcement breath alcohol testing programs and laboratory programs for the evidentiary testing of samples for alcohol and/or drugs.

There are approximately 10,000 breath alcohol permit holders at 1,000 law enforcement agencies across the state, almost 600 of which have breath testing instruments on the premises. There are over 200 laboratory permit holders for evidentiary testing of alcohol and/or drugs in blood or urine samples at twenty laboratories. The programs five inspectors conduct renewal tests for the alcohol testing program, classes for new applicants, and site inspections and records checks at facilities that have breath testing instruments.

The program's forensic toxicologist conducts site inspections of laboratories and reviews applications for laboratory permits. Since mid 2009, the program has been involved with the installation of new breath testing instruments and conversion training of permitted applicants.



ODH applied for and was awarded \$1 million in funds for a media campaign and an online cessation tool to raise awareness and assist tobacco users in the critical effort to stop tobacco use.



CHAPTER 8

Violence and Injury Prevention



Violent death is a pressing public health concern in Ohio and the United States. In fact, some 50,000 Americans die violently each year, according to CDC, and Ohio reported 2,007 violent deaths in 2007, the most recent year for which data are available.

The vast majority of violent deaths in Ohio were either suicides (63 percent) or homicides (32 percent); other categories accounted for about five percent of violent deaths.



Ohio Violent Death Reporting System

In an effort to better understand – and ultimately prevent – violent deaths, CDC in 2002 established the National Violent Death Reporting System (NVDRS). And now, thanks to a four-year grant from CDC, Ohio is the NVDRS' 18th participant, joining Alaska, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin in this important partnership

ODH will receive about \$274,000 from CDC annually to develop, administer and implement the Ohio Violent Death Reporting System (OVDRS). ODH has convened an OVDRS advisory board comprised of stakeholders and data owners to help with this process.

OVDRS, like NVDRS, will consider violent deaths to be homicides, legal interventions, suicides, unintentional firearms deaths, terrorism-related deaths and deaths of undetermined intent. While ODH and some of its sister agencies collect violent death and/or crime data, none of them maintain a single repository of all variables of interest. With the help of these federal funds, ODH will be able to capture data from multiple sources and analyze extenuating circumstances surrounding violent deaths in Ohio.

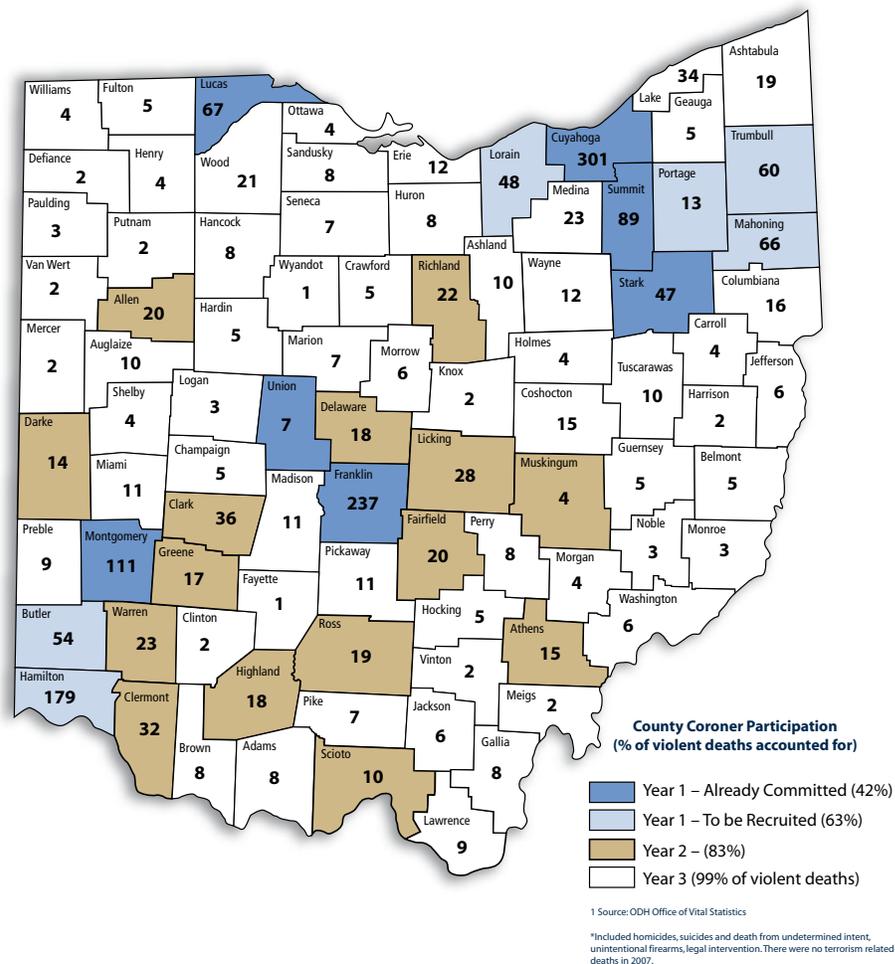
To streamline these data and make it more useful to partners, ODH will collect and link information from the following sources:

- Death certificates.
- The Bureau of Criminal Identification and Investigation Crime Laboratory.
- The Office of Criminal Justice Services' Ohio Incident-based Reporting System (law enforcement crime reports).
- Ohio's 88 county coroners.
- ODH's Child Fatality Review of violent deaths to Ohioans younger than 18.
- Local law enforcement (when needed).

Thanks to a four-year grant from CDC, Ohio is the National Violent Death Reporting System's 18th participant.

These data will eventually allow local and state partners to develop and evaluate violence-prevention strategies and increase the public's awareness of violence as a major public health problem. Counties with the highest numbers of violent deaths will be phased in first, with the goal of all 88 Ohio counties participating by the end of this four-year project.

Violent* Deaths by County Ohio 2007 – Data Phase-In¹

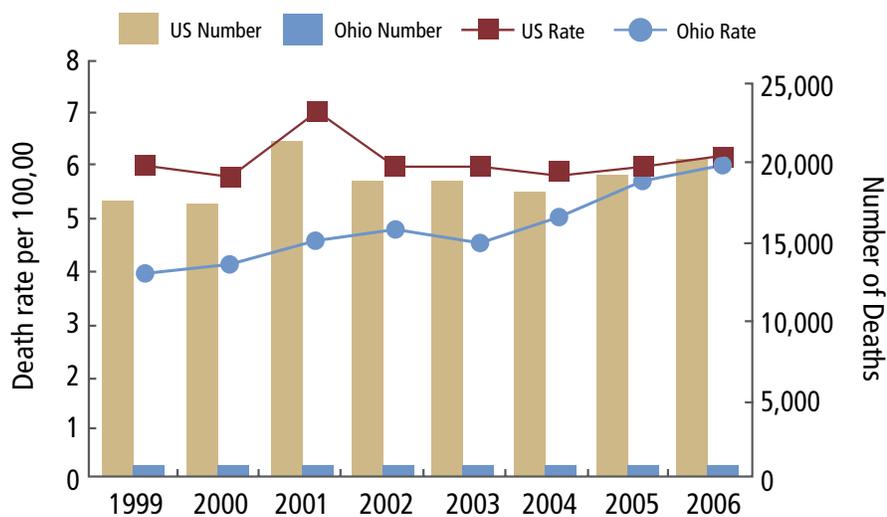


Homicide

In 2006, there were 18,573 homicides in the U.S. including the 651 in Ohio. That amounts to about 50 homicides each day on average across the U.S. and nearly two each day in Ohio.

The homicide rate across the U.S has been relatively stable from year to year over the past decade and Ohio's homicide rate has been increasing and gradually catching up to the national rate. In 2006, Ohio's homicide rate was 5.9 while the U.S. rate was 6.2 homicides per 100,000 population.

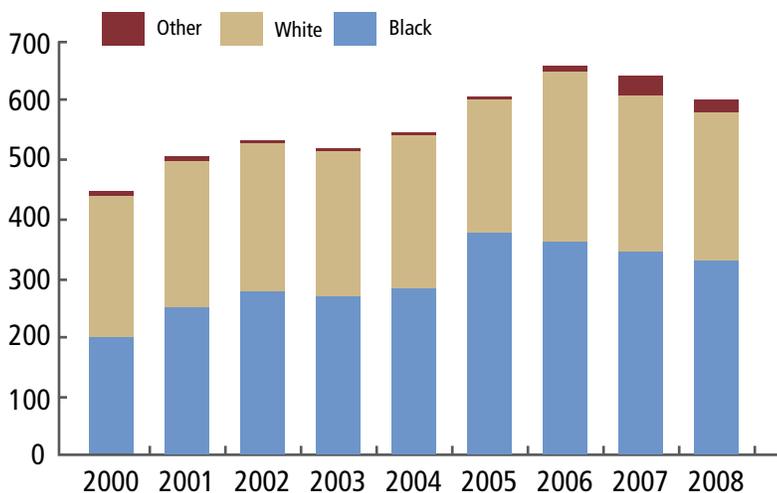
US Compared to Ohio – Violent Death Rates



There are disparities between black and white homicide rates both in Ohio and across the U.S. However, greater disparities exist in Ohio than throughout the country, on average.

In Ohio, the black total homicide rate was 8.8 times that of the white rate, while the black firearm-related homicide rate was 13 times greater than the white homicide rate.

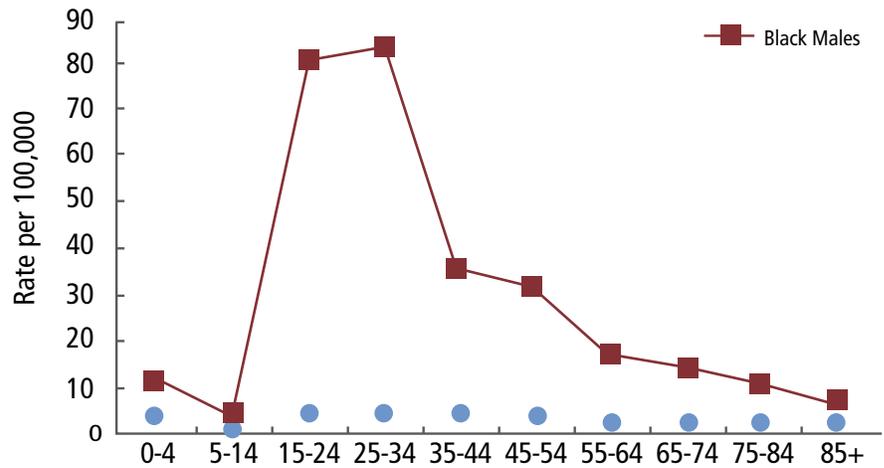
Violent Death Disparities



Death rates for black males aged 15-34 are approximately 20 times greater than anyone else in the age group. Homicide is the overall leading cause of death among young black males, ages 10-34, and the second leading cause for ages 1 to 9 in Ohio.

In SFY11 and beyond, ODH will be using data and information collected from OVDRS to develop and evaluate violence-prevention strategies and increase the public's awareness of violence as a major public health problem.

Violent Death Disparities



Overall, the number of homicides in Ohio increased 34 percent from 2000 (447) to 2008 (597). Approximately two out of three homicides in Ohio involved firearms in 2008 whereas just over half (54 percent) involved firearms in 2000. After firearms, stabbing (or cutting) and suffocation are the two leading means of homicide death.

The proportion of black homicides that are firearm-related increased by 21 percent from 2000 (68 percent) to 2008 (83 percent). This increase can largely be attributed to increasing firearm violence among young males. Homicide rates among black Ohioans are greater than national rates; while white rates are lower in Ohio. Ohio's three largest urban areas are generally driving the increase in homicides; though Mahoning County has the highest overall rate.

In SFY11 and beyond, ODH will be using these data and information collected from the OVDRS to develop and evaluate violence-prevention strategies and increase the public's awareness of violence as a major public health problem.

Sexual Assault and Domestic Violence in Ohio

Official statistics rank Ohio as 16th nationally in prevalence of forcible rape of adult women.

In 2006, 4,548 rapes were reported to law enforcement in Ohio. Research suggests that only one in six rapes is reported to the police, so the actual number of rapes in Ohio is likely higher than those reported. An estimated 166,000 Ohioans were physically or sexually assaulted by an intimate partner in 2006.

A report released in 2003 by the CDC National Violence against Women Research Center estimated that about one in seven adult women in Ohio, nearly 635,000, has been a victim of forcible rape sometime in her lifetime.

A study completed by the Health Policy Institute of Ohio (HPIO) estimated that each year, family violence costs Ohio more than 1.1 billion dollars in health care and social services. This figure does not include the costs and impacts of intimate partner violence on workplaces and on individuals in terms of adverse health outcomes.

ODH was tasked by CDC to write a state sexual violence prevention plan and the Ohio Domestic Violence Network (ODVN) was tasked to write a state intimate partner violence prevention plan; the group's created an agreement to work together to create one combined state plan. Over 60 people representing a wide range of organizations assisted in the writing of the plan and many more are now involved in its implementation. This CDC funded effort recognizes the prevalence of sexual and intimate partner violence as a public health issue and supports prevention strategies at the state and local levels.

College Campus Safety

ODH worked with the Ohio Board of Regents and the Governor's Office for Women's Initiatives and Outreach, to convene representatives of campuses from across the state and representing diverse fields to develop recommendations to improve campus safety programs.

The recommendations were released in the fall of 2010 and work to address four campus safety issues related to sexual and domestic assault.

The issues are:

- **Preparedness** – to assist campus administrators in assessment, development, and delivery of consistent and appropriate plans and protocols to prepare for the possibility that sexual violence, intimate partner violence, and stalking will occur among students, faculty, and staff on their campuses.
- **Prevention** – an opportunity for Ohio colleges and universities to bring about a critical paradigm shift – go beyond addressing violence after it happens to stopping violence before it starts.
- **Response** – assist campus administrators in assessment, development and delivery of consistent and appropriate responses to actions of sexual and intimate partner violence and stalking
- **Recovery** – support survivors of sexual and intimate partner violence and stalking in ways that will enable them to lead successful and healthy academic and social lives on campus in the aftermath of their experience.

ODH was tasked by CDC to write a state sexual violence prevention plan and the Ohio Domestic Violence Network (ODVN) to write a state intimate partner violence prevention plan; the group's created an agreement to work together to create one combined state plan.

ODH worked with the Ohio Board of Regents and the Governor's Office for Women's Initiatives and Outreach and, to convene representatives of campuses from across the state and representing diverse fields to develop recommendations to improve campus safety.

Injury Prevention

Unintentional injuries are the leading cause of death and disability for Ohioans ages 1 through 44 and the fifth-leading cause of death for all Ohioans.

The VIPP is working toward the development of a comprehensive state-level injury prevention program to help every Ohioan live his or her life to its fullest potential by reducing death and disability associated with intentional and unintentional injury.

Suicide and homicide are the 2nd- and 3rd- leading causes of death respectively for ages 1 - 34 in Ohio.

Because injury affects Ohioans across the entire lifespan, including the very young and those in the prime of their lives, injuries account for more years of potential life lost (YPLL) than any other singular cause, including cancer, heart disease and stroke. In 2006, unintentional injuries alone accounted for 85,697 (18.5 percent) YPLL in Ohio, while suicide and homicide resulted in an additional 28,213 (6.1 percent) and 21,944 (4.7 percent) YPLL respectively.

Age Group	1st Leading Cause	2nd Leading Cause
< 1 year	Suffocation	Homicide
1 to 4	Homicide	Motor vehicle traffic
5 to 24	Motor vehicle traffic	Homicide
25 to 34	Motor vehicle traffic	Poisoning
35 to 54	Poisoning	Suicide
55 to 64	Suicide	Poisoning
65 and older	Falls	Motor vehicle traffic
All ages	Poisoning	Motor vehicle traffic

Senior Injury Prevention

Falls among older adults in Ohio have reached epidemic proportions and account for a disproportionate share of fall-related injuries. In 2007, older Ohioans (age 65+) accounted for 21 percent of all fall-related emergency room visits, 70 percent of fall-related inpatient hospitalizations and 83 percent of deaths due to falls, despite representing only 13 percent of the state's overall population.

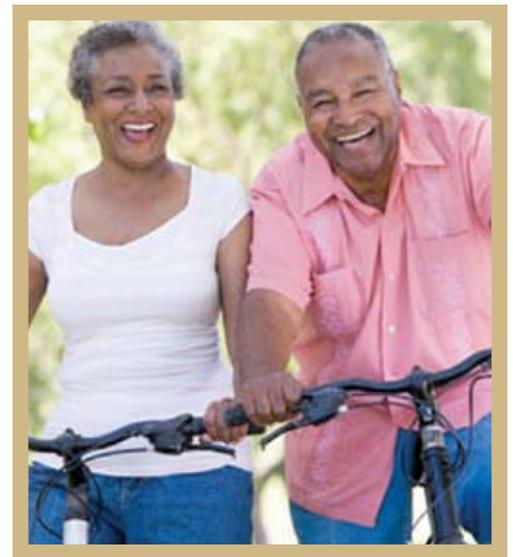
The VIPP is working to implement community strategies that will help to address these statistics by working with the Ohio Department of Aging on the Ohio Older Adult Falls Prevention Coalition. The coalition is comprised of professionals from health, aging and public safety agencies throughout the state. The coalition identifies statewide priorities for reducing the incidence of falls among older Ohioans and helps communities address the issue at a local level.

The coalition promotes education and awareness, aids with fall prevention infrastructure building, helps shape policy, develops interventions and risk assessments, and monitors trends. The coalition's goal is to raise awareness about falls with seniors and to educate baby boomers about how to prevent falls as they age.

The group encourages seniors to:

- **Increase physical activity.** Simple exercise, like walking or swimming at least 15 minutes a day can help build muscle strength and improve balance, which can prevent falls. Exercise programs like Tai Chi that increase strength and improve balance are especially good.
- **See an eye doctor once each year.** Age-related eye diseases, such as cataracts, macular degeneration and diabetic retinopathy, can increase the risk of falling. Early detection is key to minimizing the effects of these conditions.
- **Review medications.** Talk to your doctor or pharmacist about the medicines you are taking and whether they may cause drowsiness or dizziness. Discuss things you can do to ensure you are taking your medicines safely.
- **Remove environmental hazards.** Look around the house for anything that could increase the risk of falls, including poor lighting, loose rugs, slippery floors and unsteady furniture. Remove or modify these hazards.
- **Think, plan and slow down.** Many falls are caused by hurrying. Slow down and think through the task you are performing. Be mindful of possible falls risks and act accordingly.

The VIPP is working to implement community strategies that will help to address these statistics by working with the Ohio Department of Aging on the Ohio Older Adult Falls Prevention Coalition.

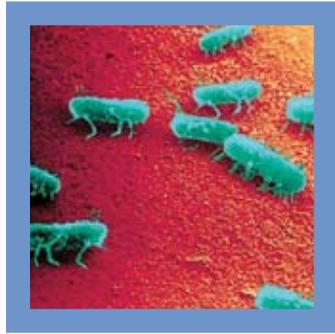


CHAPTER 9

Environmental Health



The Bureau of Environmental Health (BEH) and other sections of ODH endeavor to prevent disease and protect the environmental public health of Ohio residents and tourists by ensuring the implementation of environmental health standards established in the Ohio Revised and Administrative Codes. Different from other health prevention and protection programs, many environmental public health programs have the benefit of law and rule that help ensure prevention measures are followed.



Foodborne Illness Investigations and Food Safety

Foodborne illnesses accounted for nearly one-third of outbreaks reported in Ohio, during this time period. ORBIT assisted in the investigation of 141 potential foodborne disease outbreaks, of which, 53 were confirmed as such. Causative agents included: *Campylobacter* spp; *Clostridium botulinum*; *Clostridium perfringens*; *E. coli* O145; *E. coli* O157; norovirus; *Salmonella* serotypes Enteritidis, Poona and Typhimurium; and *Shigella sonnei*. Foodborne botulism is required to be reported immediately to ODH (Class A reportable condition) due to the severity of the illness and its potential use as a bioterrorism agent. In September 2008, four cases of foodborne botulism were reported in Ohio; the outbreak was traced to home canned green beans.

Recently, large multi-state foodborne outbreaks have been detected with increasing frequency, primarily due to the reporting of genetically identical bacterial isolates by public health laboratories. The ODH Laboratory provides DNA “fingerprints” to outbreak investigators who are able to look for common exposures among cases with the same genetic identity. Exposure histories are shared with other state health departments and the CDC to try to identify the likely food vehicle. Ohio was linked to two multistate outbreaks during this period. There were 103 cases of *Salmonella* serotype Typhimurium linked to a peanut butter product recall which occurred between November 2008 – April 2009 and 11 cases of *E. coli* O147 linked to a shredded romaine lettuce recall, which occurred in April 2010.

ODH and the Ohio Department of Agriculture both adopted the Ohio Uniform Food Safety Code and established joint oversight of the Food Safety Program. ODH has oversight of the Food Service Operations statewide. Responsibilities of food safety staff include: rule development and interpretation, consultation and technical assistance to industry and LHDs, training, evaluation of local programs, oversight of the food service manager certification program, food recall information and development of forms. During SFY09 and SFY10, ODH staff conducted 30 surveys of LHD Food Safety Programs.

Ohio was linked to two multistate foodborne outbreaks.

103



There were 103 cases of *Salmonella* Serotype Typhimurium linked to a peanut butter product recall occurring between November 2008 – April 2009.

11



11 cases of *E. coli* O147 linked to a shredded romaine lettuce recall occurring in April 2010.



ODH organized a workgroup to assess the growing bed bug problem, identify how it is currently being handled across the state to determine the best possible approaches to assist Ohio's citizens and communities in prevention and control efforts.

Bed Bugs

Bed bugs are blood-sucking insects and have been significant pests to humans for thousands of years. However, this insect all but disappeared in the U.S. and other developed countries in the mid 1950s, likely the result of the development and use of broad-spectrum residual pesticides. Unfortunately, today's bed bugs have become resistant to most of the pesticides currently available to pest management professionals (PMP). This pesticide resistance along with international travel and commerce are thought to be major contributing factors to the return and spread of bed bugs in the U.S. and other countries.

During the past decade in Ohio, bed bug complaints have continued to increase and cities such as Cincinnati, Dayton and Columbus have experienced major bed bug infestations. Bed bugs are now migrating to suburban areas and becoming a significant problem statewide. While bed bugs have been most widely reported as a problem in homes, apartments, hotels, nursing homes, and senior centers, there have also been more recent reports that movie theaters, schools, office buildings and universities are experiencing problems. Contributing to this problem is the insect's ability to hide in small places and to hitchhike in furniture, luggage and other items.

The impact of these infestations has been greatest felt in low income areas where the cost of treatment and lack of information puts safe and effective control out of reach for many residents. At the local level, the response to bed bug complaints is determined by local ordinances and resource availability. While a few LHDs provide extensive bed bug response programs, many other health departments are unable to provide the attention required to prevent infestations from growing and spreading to other areas due to a lack of resources

Although bed bugs are not known to transmit disease, the insects pose a significant health threat for which ODH's Zoonotic Disease Program is working to develop solutions. In December 2009, ODH organized a meeting with other state agency legislative liaisons and the Governor's office to discuss Ohio's growing problem. After thoroughly discussing the issue in this capacity, it was decided that ODH would organize a workgroup to assess the growing bed bug problem, identify how it is currently being handled across the state to determine the best possible approaches to assist Ohio's citizens and communities in prevention and control efforts.

The Ohio Bed Bug Workgroup, made up of approximately 40 members and stakeholders was assembled to provide broad representation and expertise. The workgroup, which is chaired by the ODH director, has met several times since Feb. 2010 to share information, bring all members

up to date on the scope of the problem, and identify critical issues and priorities for action planning and to make recommendations to the governor and General Assembly. The workgroups final report will be released in the coming months.

Private Water and Home Septic Systems

New sewage rules were adopted by ODH in Jan. 2007 to update the 30 year old sewage regulations. Due to concerns over cost and readiness of LHDs and contractors to implement the rules, Amended Substitute House Bill 119, which passed on July 1, 2007, rescinded the newly adopted sewage treatment system rules and suspended the law.

When the rules were rescinded, the original 1977 state minimum sewage treatment system rules were temporarily re-established. LHDs were authorized to adopt local rules which can be more stringent or detailed than the state minimum rules during this interim period. Since July 2007, several more bills have continued to suspend several sections of the Ohio Revised Code Chapter 3718, the sewage law, while legislators met with interested parties to decide how the law should be changed.

During SFY09 and SFY10, the ODH Private Water and Home Sewage Program and the ODH Office of Government Affairs worked closely with State Senator Tom Niehaus, interested stakeholders and interested legislators to pass Senate Bill (S.B.) 110, updated home sewage treatment system regulation standards for Ohio.

ODH staff made significant efforts to engage parties, even those on the opposite side of the issue, and build consensus on very technical and complex issues of debate which facilitated the final passage of S.B. 110 in the Ohio General Assembly.

ODH through a newly formed technical advisory committee will be approving sewage treatment products and systems for use in Ohio. ODH will also work during SFY11 to engage stakeholders to begin the rule development process. The rules will be effective in calendar year (CY) 2012.

An estimated 25 percent of existing home sewage systems in Ohio are reported as failing and during difficult economic times funding to replace these systems has not been readily available. Understanding the immense importance of replacing these systems, The ODH Private Water and Sewage Program and Ohio EPA were able to develop a program, using \$3.4 million in ARRA funding, to repair or replace these failing systems.

During SFY10, funding was awarded to LHDs, which worked with local residents, to finance 75 percent of the cost to repair a failing home septic system. The funds helped to save homes, in communities across the state,

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S.B. 110 requires that new statewide rules be adopted no sooner than January 1, 2012 and that these rules require the following:

- Require a site evaluation (review of soils, topography, lot size, etc.) for a proposed installation of a sewage treatment system.
- Allow for the progressive alteration or repair of a failing system.
- Include specifications for vertical separation distances (VSD) or the thickness of soil required at a site beneath the soil absorption component (leaching trench, mound, drip tubing, chamber, etc.) to treat the sewage effluent.
- Include the ability to reduce the required VSD using soil depth credits and the use of different types of engineered, subsurface drains.
- Allow LHDs to petition ODH to approve an increase in the VSD.
- Establish requirements for the reasonable maintenance of systems.
- Require statewide bonding for installers, service providers, and septage haulers as a condition of registration, and requires a cost methodology in rules to set the bond and local registration fee amounts.
- Require standards for the inspection of septage hauling tanks.
- Ensure that all types of septic and related tanks are structurally sound and watertight.
- Require local boards of health to give notice and opportunity for a hearing regarding board of health actions.

which would likely have been vacated because of deteriorating public health conditions. In fact, at the conclusion of this project more than 460 new septic systems will have been installed, ensuring that drinking water in many Ohio communities is safe for years to come.

This innovative use of ARRA funds has been recognized by federal officials. During a Feb. 2010 visit to Ohio, U.S. EPA administrator Lisa Jackson said, “There is something here in what Ohio has done today that U.S. EPA can try to spread to other communities, to parts of rural America.”

Indoor Environments

The Indoor Environments section is responsible for administering the statewide Smoke Free Workplace Law, also known as the indoor smoking ban. Compliance rates for the Smokefree Workplace Law have been encouraging. Ohioans can now go to most of their favorite public places – and to work – without being exposed to unwanted secondhand smoke. The section conducts enforcement in 40 health jurisdictions, while LHDs conduct enforcement in the others. ODH conducted 869 of the total 5,437 investigations for smoking enforcement, during SFY09 and SFY10.

The law is complaint based. This means that in order for an investigation to take place, a complaint must be called in to the smoke free hotline. Penalties range from a warning letter for a first offense to \$2,500 for fifth and subsequent violations. LHDs also have the option of doubling penalties for intentional violations or to assess daily fines for ongoing violations.

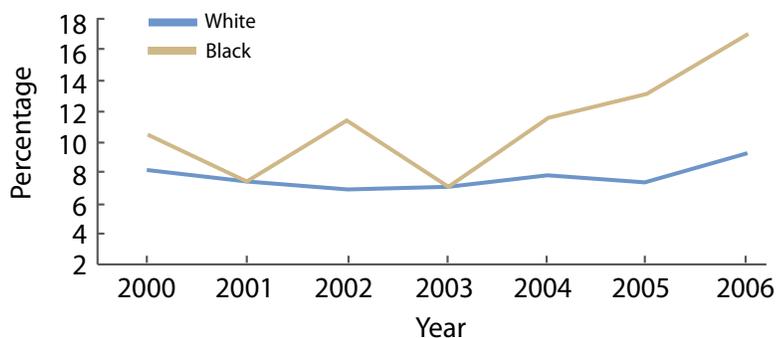
What are the main responsibilities of employers and proprietors of public places under the Smoke Free Workplace Law?

1. Prohibit smoking in all public places and places of employment.
2. Remove all ash trays and other receptacles used for disposing of smoking materials from any area where smoking is prohibited.
3. Post conspicuous signs in every public place and place of employment where smoking is prohibited, including at each entrance. The law requires these signs to say “No Smoking” or have the international “No Smoking” symbol. The signs must be clearly legible and contain the toll free number for reporting violations, 866-559-OHIO (6446). This is the only number permitted on the sign.
4. Prohibit smoking in areas immediately adjacent to building entrances and exits.
5. Ensure that tobacco smoke does not enter any area in which smoking is prohibited through entrances, windows, ventilation systems, or other means.

The section also provides guidance on school environmental health to local health jurisdictions, school personnel and the general public. The staff from the Indoor Environments Section provide telephone consultation and training to the general public and LHDs on indoor environmental issues, including indoor air quality and mold.

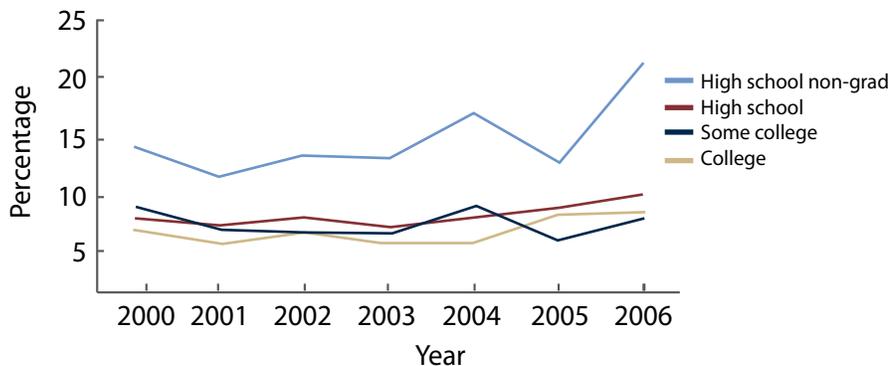
The Asthma Program is also located in this section. The program works with other organizations to improve the systems of care for asthma in Ohio and to assist other organizations in improving asthma care. It does this by gathering and analyzing asthma data through the Ohio Surveillance System for Asthma and by working with the Ohio Asthma Coalition and other local asthma coalitions throughout the state.

Estimated Adult Current Asthmas Prevalence, by Education, 2000-06



Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, Years 2000-2006

Estimated Adult Current Asthmas Prevalence, by Race, 2000-06



Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, Years 2000-2006

Recommendations issued by ODH for posting advisory signs at beach areas are based upon the *E. coli* bacteria content of water samples collected at each beach.

Evaluation of water sample results is based on the single sample maximum standard adopted by the United States Environmental Protection Agency in 2004 for the evaluation of fresh water beaches. The single sample maximum standard allows beach managers to react more quickly to short-term changes in water quality, thus providing a greater level of protection for the bathing public.

The single sample maximum for *E. coli* bacteria content is 235 colony forming units (cfu) per 100mL of water tested.

During SFY09 and SFY10, the program collected and analyzed 575 Lake Erie beach water samples for unsafe *E. coli* levels.

Recreation Programs

The recreation programs include: Public Swimming Pool/Spa/Special Use Pool, Recreational Vehicle Park/Camp, Marinas, Resident Day Camps, Manufactured Home Parks, Bathing Beach Monitoring, Tattoo & Body Piercing and Agricultural Labor Camps.

The Bathing Beach Monitoring Program is a cooperative effort between ODH, the Ohio Department of Natural Resources (ODNR) and LHDs with public beaches within their jurisdictions and private and public organizations along the Lake Erie border and throughout Ohio. The goal of the program is to assure a safe and healthy aquatic recreational environment by protecting the bathing public from risks of contracting waterborne diseases from exposure to contaminated waters. During SFY09 and SFY10 the program collected and analyzed 575 Lake Erie beach water samples for unsafe *E. coli* levels.

Marinas in Ohio are regulated by ODH with rules addressing the location, development, operation, and maintenance of marinas to assure that such marinas provide adequate sanitary facilities and do not cause a nuisance or health hazard. The program conducted eight surveys of LHD marina programs

Recreational vehicle (RV) parks and campgrounds, as well as manufactured home parks, are regulated in Ohio and are subject to rules for construction, layout, drainage, sanitation, safety and operation. During SFY09 and SFY10, ODH staff conducted 35 surveys of campground programs and 37 surveys of manufactured home park programs.

Health Assessment Section

Today's complex environmental public health problems require a coordinated response from multiple agencies, organizations and a variety of health professionals. The Health Assessment Section (HAS) works closely with the Agency for Toxic Substances and Disease Registry (ATSDR), the U.S. EPA, Ohio EPA, CDC, LHDs and concerned communities to investigate and eliminate the public health threat posed by toxic substances in the environment.

The HAS staff is diverse with backgrounds in Geology – Hydrogeology, Environmental Chemistry, Environmental Sampling (water, air, soil), Health Risk Assessment, Community Involvement, Health Education, Epidemiology and Toxicology. The HAS team evaluates and endeavors to prevent exposure and adverse human health effects associated with exposure to hazardous substances from waste sites, unplanned releases and other sources of pollution. The services provided to communities include: Public Health Assessments, Health Consultations, Exposure

Investigations, Community Involvement and Health Education. During SFY09 and SFY10, HAS completed three Public Health Assessments, six Public Health Consultations and provided technical assistance on six hazardous waste related sites.

During this time period, HAS staff also completed the Wind Turbine Report. This report assessed the potential public health impacts associated with wind turbines. The study found that when compared to the operation of a typical coal-burning power plant in Ohio, the proposed development and operation of wind turbine farms represents a minimal public health threat with minimal environmental impacts.

Environmental Engineering Unit

The recreation programs require that engineered drawings be submitted for review and approval for any newly created facilities and for alterations or extensions of existing facilities. The Engineering Unit is responsible for the review and approval of engineered plans submitted pursuant to the requirements of the recreation programs.

During SFY09 and SFY10, the Environmental Engineering Unit:
Conducted

- 160 swimming pool construction inspections.
- 10 campground construction inspections.
- 10 manufactured home park construction inspections.

Lead Contractor Certification

On April 22, 2008, the U.S. EPA issued a rule requiring the use of lead-safe practices and other actions aimed at preventing lead poisoning. Under the rule, beginning in April 2010, contractors performing renovation, repair and painting projects that disturb lead-based paint in homes, child care facilities, and schools built before 1978 must be certified and must follow specific work practices to prevent lead contamination.

ODH informed the U.S. EPA of the intent to develop an Ohio program pursuant to the EPA's Lead-based paint Renovation, Repair, and Painting program. Once authorized by the U.S. EPA, these programs would be administered by Ohio in lieu of the federal program. ODH assisted in drafting changes to Chapter 3742 of the Ohio Revised Code which were introduced during May 2010. The changes will enable rules to be written which will lead to authorization from the U.S. EPA to administer and enforce the program.

The HAS Wind Turbine Report found that when compared to the operation of a typical coal-burning power plant in Ohio, the proposed development and operation of wind turbine farms represents a minimal public health threat with minimal environmental impacts.

The BRP licenses 843 facilities in Ohio that use radioactive material. The licensed uses of radioactive material vary greatly and include:

- **Medical use** – diagnostic and therapeutic.
- **Research** – academic and commercial gauges that measure properties of material or control manufacturing processes.
- **Commercial** – irradiators, industrial radiography, service providers.
- **Manufacturing and Distribution** – manufacturing and distribution of devices that contain radioactive material. Examples include gauging devices and smoke detectors.

ODH was reviewed by the NRC in 2001, 2004 and 2008 and received the highest possible grade in all categories in each review.

Radiation Protection

ODH’s Bureau of Radiation Protection (BRP) aims to control the possession, use, handling, storage and disposal of radiation sources in order to maintain the radiation dose as low as reasonably achievable. The BRP also responds to emergencies in order to protect public health and the safety of all Ohioans.

On August 31, 1999, Ohio entered into an agreement with the United States Nuclear Regulatory Commission (NRC). This agreement transferred the regulatory oversight of most radioactive material users in Ohio from the NRC to ODH. Ohio is one of 37 states that have assumed regulatory authority from the NRC.

The NRC routinely reviews state programs to ensure that they are compatible with the federal requirements. ODH was reviewed by the NRC in 2001, 2004 and 2008 and received the highest possible grade in all categories in each review.

Indoor radon public outreach and education

The BRP licenses radon testers in Ohio to ensure that radon testing is performed properly and that the results are accurate. The BRP also licenses radon mitigation specialists to ensure that systems installed to reduce the amount of indoor radon in a building are designed and installed properly. The BRP oversees a public outreach program, through a grant from the U.S. EPA, to inform the public of the dangers of indoor radon and to promote testing and mitigation.

	FY 2009	FY 2010
Total Radon Calls Received by ODH	4516	1002
Calls Related to Real Estate Transactions	342	75
Calls Related to Schools	206	17
Emails Received	423	424
ODH Ohio Radon Information System Website Hits	14,964	4,484
Radon Outreach Off-Site Activities Conducted	226	254
Free Radon Test Kits Distributed	5579	3002
Total Number of Ohioans Receiving Radon Information	1.8 M	1.5 M
Total Staff Hours on Radon Outreach Efforts	1822	1022

Nuclear Material Safety

The Nuclear Material Safety Program is tasked to function as the licensing and inspection group for radioactive materials. Program Health Physicists perform both licensing and inspection of radioactive materials, as well as respond to radiological incidents. The group addresses issues that include radon and decommissioning of facilities where radioactive material was used. The program also tracks low-level radioactive waste disposal issues and develops long-term storage and disposal requirements for low-level radioactive waste.

The program's web-based computer application has been enhanced to enable the licensees to process electronic payments and other licensing transactions which previously were only possible by U.S. mail.

Technical Support

The Technical Support Program provides necessary functions for the operation of the bureau. Dosimetry, instrumentation, equipment, quality assurance, and training needs are taken care of by this program. In addition the program coordinates nuclear power plant and U.S. Department of Energy facility oversight and maintains a technical library.

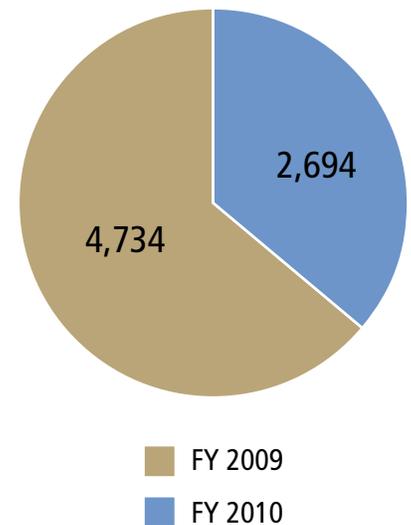
The Technical Support Program includes radiation safety officer functions that involve dosimetry and exposure record-keeping for staff, quality assurance activities including audits and research activities. Technical Support includes involvement in activities related to commercial nuclear power plants which includes environmental surveillance and monitoring federal sites undergoing radioactive material clean-up or decommissioning. Technical Support includes the Radiation Generating Equipment Registration program that maintains and processes over 10,000 X-ray registrants in Ohio. X-ray staff processed 900 new and 9,756 renewal registrations.

The BRP bureau responded to 110 radiation incidents during FY 2009 and FY 2010.

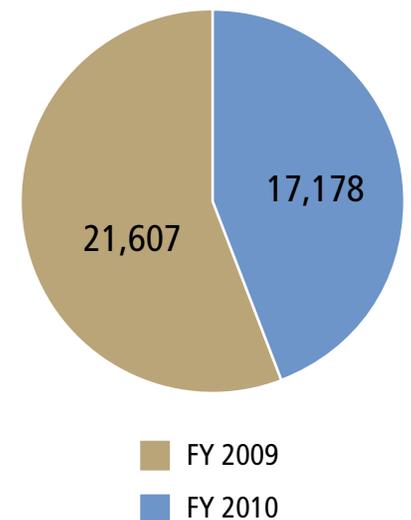
Nuclear Power Plants

Ohio's obligations under Ohio Revised Code 4937 for the safe operation of nuclear power plants in and near Ohio are accomplished through the Utility Radiological Safety Review Board. The purpose of the Utility Radiological Safety Board (URSB) is to develop a comprehensive policy for the state regarding commercial nuclear power. The URSB's member agencies include: Ohio EPA, Ohio Department of Agriculture, ODH, Public Utilities Commission of Ohio, Ohio Emergency Management

Homes Mitigated for Indoor Radon



Homes Tested for Indoor Radon



The Radiologic Technology Program of the Bureau of Radiation Protection registers approximately 33,000 radiation-generating units at 10,000 facilities. The Section also licenses approximately 15,700 operators of radiation-generating equipment and 1,648 nuclear medicine technologists.

Agency (EMA) and Ohio Department of Commerce. The Ohio EMA chairs and ODH co-chairs the URSB.

Midwestern Radioactive Material Transportation Committee

The committee, consisting of 12 gubernatorial and 12 legislative representatives from each of the Midwestern states, serves as a forum for addressing transportation safety issues associated with the shipment of radioactive material by the U.S. Department of Energy through the region. The bureau chief serves as the gubernatorial representative for Ohio and Senator Steve Buehrer is the legislative representative. The committee has met twice each year and has a number of key accomplishments, principally the establishment of a new National Transportation Stakeholders Forum, development of a better rail inspection procedure for these shipments, assessment of the adequacy of transportation planning for major shipping campaigns, routing of shipments through the Midwest, and publication of transportation fees charged by states.

Radiologic Technology

The Radiologic Technology Program regulates the safe operation and use of radiation-generating equipment such as diagnostic x-ray machines, linear accelerators and various industrial units in the state of Ohio. This regulation is accomplished through certifying radiation experts, licensing operators of radiation-generating equipment and using a registration tracking system and on-site inspection process for facilities possessing these units.

The Radiologic Technology Program of the Bureau of Radiation Protection registers approximately 33,000 radiation-generating units at 10,000 facilities. The Section also licenses approximately 15,700 operators of radiation-generating equipment and 1,648 nuclear medicine technologists.

In an effort to reduce radiation exposure to patients having Computed Tomography (CT) procedures, Ohio revised its CT regulations to include dose limits and requirements that facilities have written plans for delivering the appropriate radiation dose by using principles of as low as reasonably achievable. In other words, use the least amount of radiation to obtain the diagnostic image. Inspections are conducted to assure facilities implement and follow this process.

Below are the FY 2009 and FY 2010 inspection efforts to assure compliance with the regulations and licensing requirements:

Computed Tomography (CT) Facility Compliance Inspection

Facility Type	FY 2009		FY 2010	
	Facilities Inspected	Tubes Inspected	Facilities Inspected	Tubes Inspected
Chiropractic Office	319	325	335	342
Dental Office	1,067	3,504	1,140	4,156
Physician Office	317	411	331	440
Podiatry Office	150	153	183	191
Veterinary Office	272	351	374	512
Mobile Health Care	20	79	18	91
Registered Hospital	91	N/A	98	N/A
Non-Registered Hospital	7	23	15	23
Educational Institution	62	262	39	254
Clinic	199	515	247	603
Government Agency	47	98	45	74
Assembler/Maintainer	88	N/A	35	N/A
Corporate Office	7	9	9	9
Manufacturer	100	280	113	254
Laboratory/Testing/R&D	62	141	65	155
Correctional Facility	19	41	18	47
Public Utility	3	3	3	6
Engineer / Contractor	4	4	4	5
Transportation Company	1	2	1	1
Other	15	18	21	24
Total	2,850	6,219	3,094	7,187



CHAPTER 10

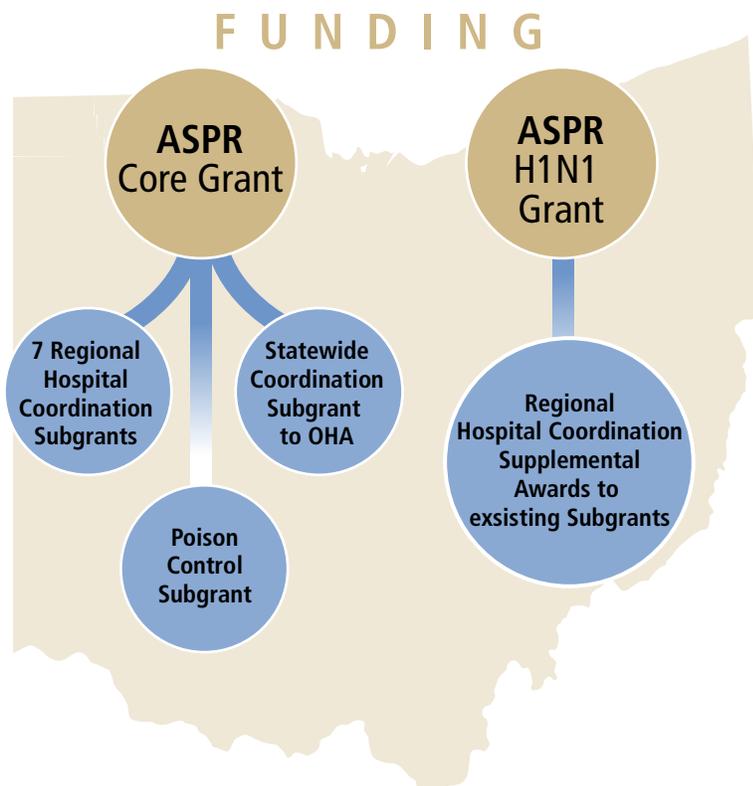
Public Health Preparedness



The Office of Health Preparedness (OHP) was created in December of 2008 from the reorganization of the Bureau of Public Health Preparedness. It was elevated to report directly to the Assistant Director for Administration, recognizing the cross agency role of preparedness and response. The OHP is responsible for assuring the agency is prepared to effectively respond to a disaster. It does this through planning and managing the personnel resources that would respond in a disaster. The OHP is also integral in any large-scale response providing communication, medical material management, incident command system and other response capabilities.



The Office of Health Preparedness (OHP) provides management of the federal Bioterrorism grants from the CDC and the HHS Assistant Secretary for Preparedness and Response (ASPR). The two grants represent all but \$60,000 of the office funding. Much of this grant money is provided to LHDs and hospitals (\$23.6 million) but some is used to fund programs across the agency (e.g. laboratory, epidemiology, and the wide area network). The OHP provides management, technical advice and oversight of the sub grants to LHDs, hospitals and Poison Control Centers.



OHP conducts emergency planning, coordinates training and exercises conducted by ODH and oversees sub grantee activities at the LHD's. The emergency communications systems, MARCS and OPHCS, are managed by the OHP. The Multi-Agency Radio Communication System (MARCS) is an 800 MHz radio and data network that provides statewide, secure, reliable public service wireless communication for ODH, LHDs, hospitals, public safety and first responders. The Ohio Public Health

Communication System (OPHCS) is a secure web based information and communications system available on a 24/7/365 basis for distribution of health alerts, dissemination of prevention guidelines, coordination of disease investigation efforts and preparedness planning.

A final critical mission of OHP is the Strategic National Stockpile (SNS) Program. During a man-made or natural disaster, OHP coordinates the receipt and distribution of pharmaceuticals and medical supplies from the federal stockpile. The SNS is prepared to receive an array of critical pharmaceuticals that can be deployed in as little as 48 hours for an event such as an Anthrax attack. The OHP also assures planning by LHD's and healthcare facilities to administer the stockpile material to the public in an emergency.

The office is organized and administered using the Incident Command System (ICS) and measurable objectives. All objectives for the coming week are identified by staff and hours required are assigned. Each Friday morning at 8:00AM, all staff meet to brief on the status of that week's objectives and identify the next week's objectives. The objectives are tied to the strategic plan for the office and the process creates accountability.

H1N1 Preparedness Response

From 2009 to 2010, OHP coordinated five supplemental H1N1 grants, three through Public Health Emergency Readiness (PHER) and one from ASPR Pandemic Influenza Healthcare Preparedness Improvements for States, to LHD's and hospital sub grantees.

These funds were released in addition to the core grants for public health and healthcare preparedness. More than \$51 million were released at the local level, with 90 percent of the funds being redistributed in Ohio, which allowed LHDs to mount effective influenza vaccination campaigns and other H1N1 response efforts. On April 26, 2009, ODH opened its Department Operations Center (DOC) to support response to the H1N1 pandemic. On that day, with the authority of the governor and the director of health, the SNS Program requested antiviral medications from the federal stockpile. This was to be the first of three requests for resources from the SNS. By the end of 2009, OHP had overseen the receipt of antiviral medication and personal protective equipment (PPE) for H1N1 response. This led to the implementation of all of the SNS plans and the development of new plans for more efficient and cost effective transportation for ongoing H1N1 response requirements.

The SNS program transported 2,066,424 items of PPE and 262,684 courses of antiviral medications to 8 regional nodes, 88 county drop sites, and 172 hospitals throughout Ohio. Significant additional caches of



2,272,620 items of PPE and 1,492,181 courses of antiviral medications continue to be held by OHP in the ODH warehouses. OHP was able to monitor antiviral medication usage and need through the Ohio Public Health Analysis Network (OPHAN).

Emergency Communications

OPHCS is Ohio's primary mechanism for statewide notification and distribution of federal and state Health Alert Network (HAN) messages. These HAN messages are received by the ODH HAN coordinator and ODH OPHCS coordinators from CDC, or are created and designated for distribution specifically within Ohio by ODH OPHCS coordinators. OPHCS provides 24/7/365 notification of incidents which may impact the health and well being of the public in Ohio to all essential state and local public health officials, hospitals and other external agency partners. OPHCS also provides timely and content-specific information on emerging and/or ongoing threats to the health of Ohioans. In order to protect sensitive health information, OPHCS restricts access to sensitive materials or information using a secure license-based system.

OHP completed and implemented the ODH Emergency Communication Plan during the H1N1 response. The plan described how the agency uses the MARCS radio system, OPHCS and other means of partner communication. OHP ran the communication unit of the H1N1 ICS and implemented the plan to provide effective communication for response partners, primarily local public health districts and hospitals. The Office also staffed and managed the message center in the DOC. The message center was the single point of contact for response questions. All messages in and out of the DOC were tracked and the DOC assured that a response occurred.



CHAPTER 11

Healthcare Quality



As the Patient Protection and Affordable Care Act prepares to insure 94 percent of Americans, 1.4 million Ohioans will soon be seeking health care services from medical providers already in short supply. The existing shortage of primary care physicians includes family practitioners, internists, pediatricians, obstetricians/gynecologists and psychiatrists. In addition, mid-level providers such as nurse practitioners, nurse midwives, and physician assistants will be in great demand. Dental hygienists and mental health professionals will also be necessary to meet the oral and behavioral health needs of Ohio's children and adults.

Primary care and Rural Health

The Patient Protection and Affordable Care Act (PPACA), also known as Federal Healthcare Reform, will insure 94 percent of Americans. This means that an additional 1.4 million Ohioans will soon be seeking health care services from medical providers already in short supply. There is an existing shortage of primary care physicians including family practitioners, internists, pediatricians, obstetricians/gynecologists and psychiatrists. In addition, mid-level providers such as nurse practitioners, nurse midwives, and physician assistants will be in great demand.

The existing shortage of healthcare providers is most evident in the urban and rural areas of the state designated as Health Professional Shortage Areas (HPSA). Ohio's HPSAs indicate a need for over 300 healthcare professionals to serve as safety net providers in Federally Qualified Health Centers (FQHC) and other community-based practice sites.

ODH's Primary Care and Rural Health Program promotes increased access to quality health care for rural and underserved Ohioans. Primary Care and Rural Health staff administer a variety of grant programs and activities designed to help develop, maintain and strengthen quality health care and to reduce health disparities. The section coordinates federal, state and local efforts focusing on access to health care in rural and underserved areas and assists with recruitment and retention of health care professionals in medically underserved areas.

The primary care and rural health staff operate the Student/Resident Experiences and Rotations in Community Health (SEARCH) Program. The SEARCH Program provides health profession students and residents with community-oriented rotations in HPSAs.

ODH applied for and received ARRA funding to help grow this vital program, for three years (2010, 2011, 2012).

The SEARCH Program engages students and residents in clinical and community experiences of 4–12 weeks at 40 hours per week or a minimum of 160 hours spread across a semester or quarter. SEARCH participants receive a stipend of \$300 per week not to exceed \$1,800. SEARCH participants engage in clinical experiences with a preceptor as well as complete a community project to learn first hand community-based approaches to care. Projects are developed in conjunction with the site and based on the needs of the community. The projects may be oriented toward patient education, community outreach, assessment, health promotion or disease prevention.

ODH has a seven-year track record of operating the SEARCH Program in Ohio during which time 300 students and residents participated in clinical and community experiences in underserved areas.



ODH applied for and received ARRA funding to help grow the Student/Resident Experiences and Rotations in Community Health (SEARCH) Program.

The plan being developed will lead to a 10-25 percent increase in the state's primary care workforce by 2020.

Another program that helps those that serve in underserved communities is the Ohio Physician Loan repayment Program (OPLRP). OPLRP was created to assist communities in underserved areas that are seeking clinicians to provide primary care, dental and/or mental health services. In addition, the program aids primary care clinicians and other health providers who are dedicated to working with the medically underserved in HPSAs. Eligible clinicians may apply for loan repayment if they choose employment at an eligible site in one of the qualified areas.

OPLRP applicants must either be in current practice or in the final year of training at the time of application. In addition, the physician must work full time, defined as 40 hours per week, at an approved practice site. Program participants may receive up to \$25,000 per year for an initial two-year contract. Those retaining eligibility and wishing to continue with the program may receive up to \$35,000 in years three and four.

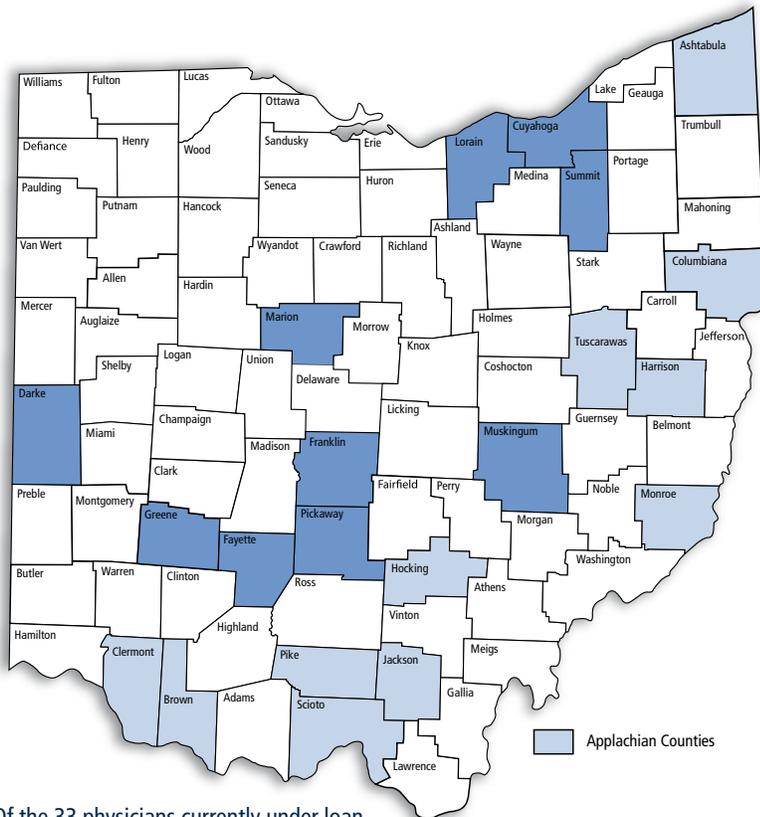
ODH has taken a leadership role in collaborative processes for developing a statewide, comprehensive and sustainable health care workforce plan which will prepare Ohio for the increased demand in the health care workforce caused by changes in population demographics and in the implementation of health care reform. The plan being developed will lead to a 10-25 percent increase in the state's primary care workforce by 2020.

To address many of the gaps Ohio residents experience with regards to the health care system, the Governor created the Ohio Health Care Workforce Planning Partnership (OHCWP), staffed by the ODH and the Governor's Workforce Policy Advisory Board. This Partnership will be a standing advisory council representing key state agencies, organizations and interest groups concerned with the health workforce.

The OHCWP will provide the Workforce Policy Advisory Board with a strategic plan to address Ohio's ongoing health care workforce needs, with an emphasis on primary care. The strategic plan will assess Ohio's health care workforce supply and demand, and the development of uniform and consistent data sets on the health care workforce in order to identify and address key health professions issues and develop informed workforce policies.

The work of the partnership will be shared with additional stakeholders at a Statewide Health Care Workforce Summit. Upon completion of the strategic plan, the planning partnership will continue to work collaboratively to promote understanding of common issues, facilitate the development of cooperative data collection programs, and help coordinate statewide and regional data collection and analysis.

Ohio Counties with at Least One Practicing Physician in the Ohio Physician Loan Repayment Program



Of the 33 physicians currently under loan repayment contracts, 17 are practicing at Federally Qualified Health Centers.

ODH is developing a plan to increase healthcare workforce 10-25 percent by 2020.

Governor Strickland created the **Ohio Health Care Workforce Planning Partnership (OHCWP)**, staffed by the ODH and the **Governor’s Workforce Policy Advisory Board** to address many of the gaps in Ohio’s health care system.

Ohio Hospital Compare Web Site

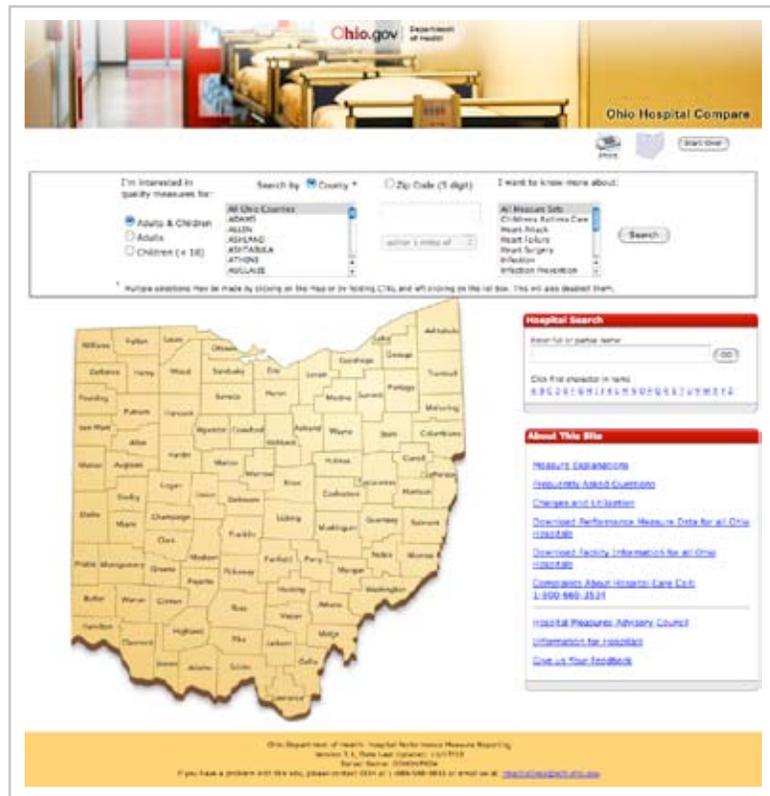
Signed into law Aug. 9, 2006, House Bill 197 of the 126th General Assembly created the Hospital Measures Advisory Council (HMAC). The goal of HMAC was to select appropriate hospital performance measures for use by the public while minimizing reporting burden on hospitals.

The legislation mandated that ODH collect and make publicly available the hospital performance measures selected by HMAC. On January 1, 2010 in compliance with the law, ODH launched the **Ohio Hospital Compare** Web site. The site was created in order to help Ohioans make more informed health care decisions. The Web site is a comprehensive, user-friendly system that gives patients deciding where to go for certain medical procedures access to important quality outcomes among Ohio’s hospitals.

www.ohiohospitalcompare.ohio.gov



On January 1, 2010 in compliance with the law, ODH launched the **Ohio Hospital Compare** web site in order to help Ohioans make more informed health care decisions.



Ohio Hospital Compare, available from the home page of ODH’s Web site, is an interactive site that allows consumers to make a side-by-side comparison of hospitals on more than 100 different performance measures in the following categories:

- Heart attack care
- Heart failure care
- Heart surgery
- Stroke care
- Pneumonia care
- Surgical care
- Hospital acquired infections
- Infection prevention (hand hygiene and infection control staffing)
- Patient safety
- Patient satisfaction
- Children’s asthma care
- Pregnancy/delivery

The site contains both process measures which reflect what is considered optimal for patient care and outcome measures which reflect negative outcomes that occur during care. The majority of the measures are based on national standards. This site also gives Ohio’s hospitals and other provider’s data to help improve quality of care.

This information, in addition to discussions with doctors, will assist consumers in selecting a hospital. ODH also encourages consumers to talk to hospitals, where they are thinking about having a procedure, about what they are doing to improve care.

ODH and HMAC are continuing to work to update the measures. In the future, more performance data will be added to the Web site.

Division of Quality Assurance

The Division of Quality Assurance (DQA) assures the quality of life, care and service of public health, environmental health and health care delivery systems. DQA regulates and inspects nursing homes, residential care facilities, intermediate care facilities for the mentally retarded, maternity units, certain hospital-based services, adult care facilities, maternity units, certain freestanding health care facilities and clinical laboratory improvement amendment laboratories.

DQA registers hospitals and nurse aides, conducts investigations into allegations of abuse/neglect/misappropriation against nursing home residents, certifies/licenses lead and asbestos abatement/mitigation/testing entities, and reviews certificates of need. DQA serves as the designated State Survey Agency of Ohio for the Centers for Medicare and Medicaid Services (CMS). By meeting contractual obligations relating to health care surveys, federal funding is secured for Ohio residents who receive direct care from facilities that participate in the Medicare and Medicaid programs.

Over the last two years, DQA's Bureau of Long Term Care Quality began work on a collaborative pilot project with the Advancing Excellence in America's Nursing Homes Campaign to improve nursing home care in the Cleveland metropolitan statistical area (MSA). The Cleveland, Chicago, Atlanta and Miami MSAs were identified as having increased numbers of nursing homes with varying degrees of poor performance, minority residents and/or residents with poor socio-economic status. One goal of the project is to identify small samples of nursing homes in these areas and develop a model of support through each of the Local Area Networks for Excellence to stop the cycle of poor performance which could lead to closure or relocation.

Cost savings

DQA has expanded the use of Web and video conference technology for surveyor distance training which has resulted in an initial savings of \$42,423. Surveyors receive orientation to the certification and licensure survey process via distance learning. Distance learning instructional modalities include video-conferencing, webcasts, and the use of "Webinar" technology which allows real-time desktop sharing with phone

Measures added to Hospital Compare January 2012 include:

- Catheter associated bloodstream infection for ICU patients.
- Surgical site infection event (cardiac, neurologic, orthopedic).
- Prophylactic antibiotic received within one hour prior to surgical incision.
- Incidence of episiotomy.
- Elective delivery prior to 39 completed weeks gestation.

conferencing. Additionally, distance learning has been used to provide on-going training sessions to surveyors, providers, and stakeholders on CMS revised interpretative guidelines.

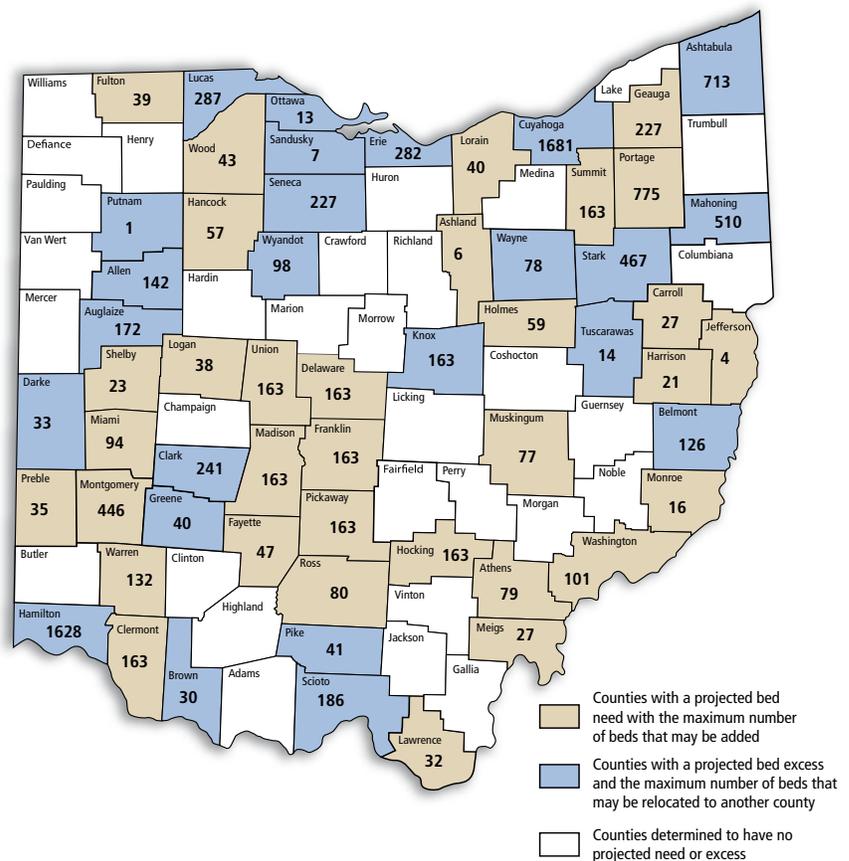
Planning for the future

In 1993, the Ohio General Assembly instituted a moratorium on creating new nursing home beds. Since then, there has not been a reason to lift the ban. Currently, Ohio has 960 nursing homes with 97,000 long-term care beds and the statewide occupancy rate is 87 percent.

During SFY10, DQA worked to identify counties that are projected to experience an increase in the population of individuals aged 65 and older in the coming years which is disproportionate to the number of available long term care beds.

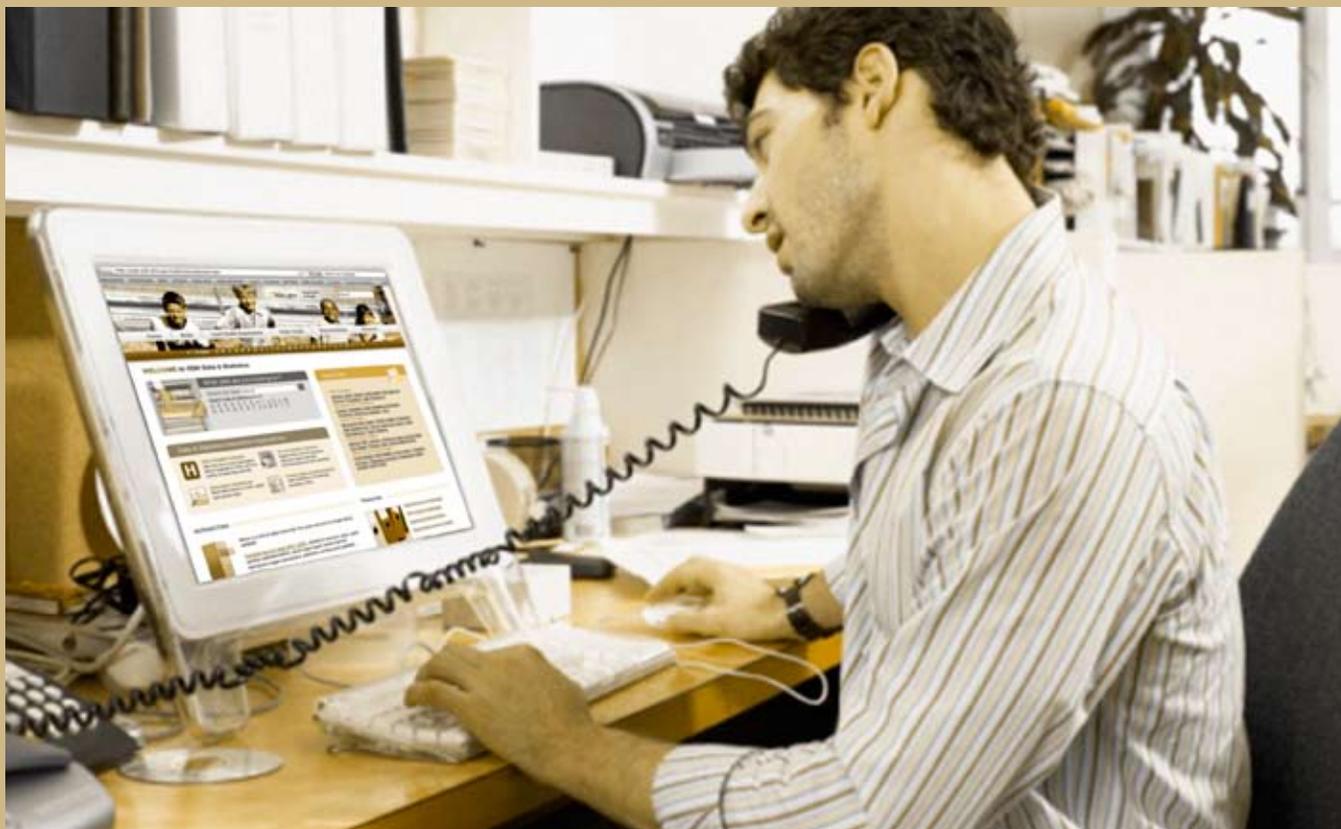
The map below identifies the counties with projected needs and or excess. DQA studies indicate that baby boomers who are becoming seniors would rather spend their time in a home or community-based setting, rather than a long term care facility. The generation is less inclined to want to go into an institution-based setting in addition community-based settings can cost less.

Inter-County Relocation of Long Term Care Beds – 2010

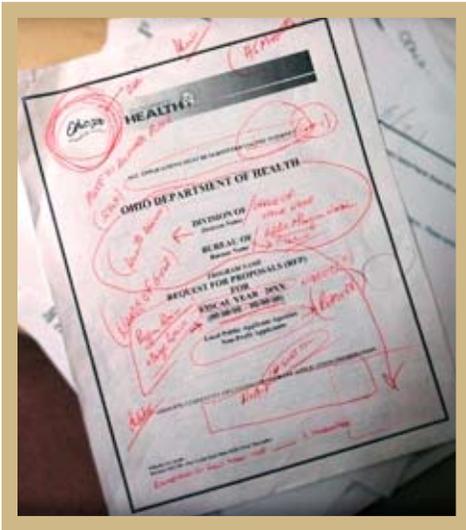


CHAPTER 12

Data Driven Decisions



Health data are a valuable resource critical to meeting ODH strategic and programmatic needs. ODH requires a centralized area responsible for overseeing the collection, analysis, dissemination and use of health data to support the mission of protecting and improving the health of Ohioans. Furthermore, as funds are reduced, it is critical to efficiently collect and manage health information, including through electronic health information exchange, which is essential to reduce health system costs both private and public. In addition to streamlining health data, ODH is implanting new technologies and strategies to make information available quicker and at a lower cost.



44

The Kaizen Grant Team streamlined and cut the grant process from 184 steps to just 44.

Streamlining the grant process

The process of applying for, implementing and subsequently claiming grants can be time consuming and tedious. In many cases sub grantees that have the greatest need, have the least resources to apply for those grants.

In SFY10, ODH employees joined with trainers from the Ohio Department of Administrative Services for a Kaizen Grant Process Event. Kaizen is a Japanese strategy for streamlining business. It calls for never-ending efforts for improvement involving everyone in the organization – managers and workers alike.

In SFY11, the grant cycle with ODH will address some of the needs identified during the Kaizen session. Most notably, there will be a significant decrease in the time between the release of the request for proposal (RFP) and the notice of award (NOA). The Kaizen Grant Team realized a grant cycle included 184 steps-- and cut that down to just 44 in the new process.

ODH staff will take on more of a team approach which will result in fewer handoffs and only eight decision points (previously 32). Sub grantees will notice more support and earlier involvement from ODH. The streamlined process also means fewer reports that need to be submitted by subgrantees. However, those reports will be more focused on compliance, quality and accountability.

Data Center

The Office of Performance Improvement (OPI) focuses on ODH's ability to meet its goals and achieve its mission by measuring the efficiency and effectiveness of its operations and workforce development. A key component is the Center for Public Health Statistics and Informatics (Data Center). The Data Center enables ODH to link currently available data sources; manage and analyze data; and use state-of-the-art technology to interpret and disseminate health-related information. Information collected and analyzed in the Data Center supports programs, identifies, health trends and quantifies the impact of health-related issues.

The community profiles project was developed to address the need for comprehensive, timely and readily accessible health data at the community level for community assessment, program planning and evaluation. Current community profiles at ODH are program-specific, manually produced and resource intensive. The current project will include a comprehensive list of key health indices from across the department and will be created in an electronic format to increase accessibility and allow for timely updates. A community profiles workgroup was developed to identify content (health indices, data sources, comparison populations, etc.) and discuss format (e.g., tabular

presentation, canned text). The target release date for the first series of profiles is Dec. 31, 2010, pending available resources.

The Data Center also continues work on automating disease reporting, including electronic laboratory reporting, which both improves the quality and timeliness of disease reporting, as well as reducing costs. From January through September 2010, over 55,000 electronic reports were received, compared to 38,000 in 2009.

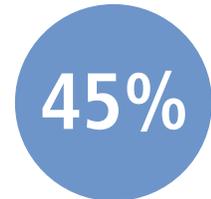
Another important project for ODH coordinated by the Data Center was the Ohio Situational Awareness Portal (OSAP). Real-time situation awareness is critical to successfully manage Ohio's response efforts to public health emergencies, such as H1N1 influenza. The system enables situational awareness for all public health response partners through the creation of a common operating picture, information management, clarity of presentation, decision support and synthesis/integration of data. Furthermore, the system consolidates the number of applications, information sources, and communication channels needed to effectively coordinate response efforts, including ICS, while providing a regular flow of disease intelligence to the director of ODH, subordinate elements of ODH, supporting state and local authorities and health care providers to enable informed decision making and implementation of appropriate actions in the event a pandemic.

Vital Statistics

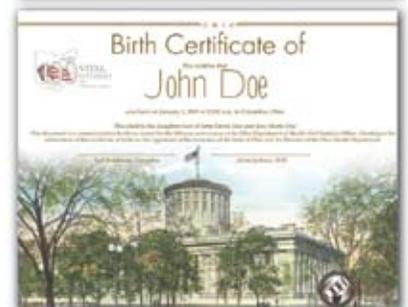
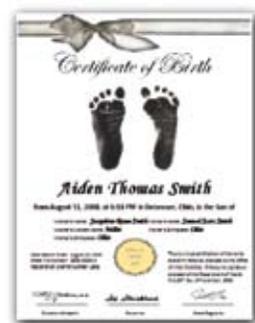
The legal records collected in the ODH Office of Vital Statistics (VS) are the data source for many important statistical measures used in public health. These indicators track Ohio's health and are used locally for planning and community analysis. In addition, members of the public are able to obtain copies of birth certificates, Ohio death records, Ohio marriage licenses and Ohio divorce decrees. There are five ways in which to obtain a birth or death record in Ohio: by visiting the LHD where the event occurred, a walk-in visit to the ODH VS office, mail, online ordering through VS or online ordering through VitalChek, a private vendor.

During the summer of 2010, VS made several heirloom birth certificates available for purchase. The three new designs were created as a response to public demand for more ornate certificates to commemorate a recent birth, celebrate a special birthday or be passed along through generations as a family keepsake. The proceeds from the sale of heirloom birth certificates benefit the Ohio Family and Children First initiative.

System applications have been upgraded to allow local registrars access to all filed birth records in the electronic birth registration system. Once an office is certified as completing all training and competencies to receive the upgrade, (target date, January, 2011), the local registrar office will be able to issue any Ohio birth record, in the form of a birth abstract, at their office from the upgraded system.



ODH increased automating disease reporting with over 55,000 electronic reports received in 2010, compared to 38,000 in 2009.





ODH reduced phone costs from \$800,000 per SFY to \$225,000. The new technology has also greatly increased the communication between ODH and LHDs.

Switch to Voice over IP

During SFY09 and SFY10, the Office of Management Information Systems (OMIS) implemented a new system that increased connectivity across public health systems in Ohio and reduced costs. OMIS implemented a shift from a traditional phone system to a Voice over IP (VoIP) system. The new system has reduced phone costs from \$800,000 per SFY to \$225,000. This new technology has also greatly increased the communication between ODH and LHDs because long distance charges are now eliminated.

The new phones also enable users to conference in up to 10 additional lines. This means that ODH staff can now often perform conference calls on demand without a need for scheduling. At the end of SFY10, 85 percent of the phones in use were VoIP phones. There are plans to fully implement VoIP technology in SFY11.

Compliance and Accountability Unit:

ODH's Compliance & Accountability Unit (CAU) has also been very busy. Making sure ODH does things well by collecting the information the agency needs in the most appropriate fashion to monitor the success of the programs. This is one of ODH's top priorities. To that end, CAU provided training to ODH staff on understanding and interpreting federal circulars, the top ten audit findings and how to watch out for them, and how to effectively engage in time and effort reporting. The CAU team also provided 31 training sessions to sub grantees so that they could better understand how to use our sub grantee performance evaluation system.

CAU received the USDA Regional Director of Financial Management's Award of Excellence in Aug. 2008. This recognition highlights the work ODH has done regarding the oversight of the WIC program through management of the single audit process.



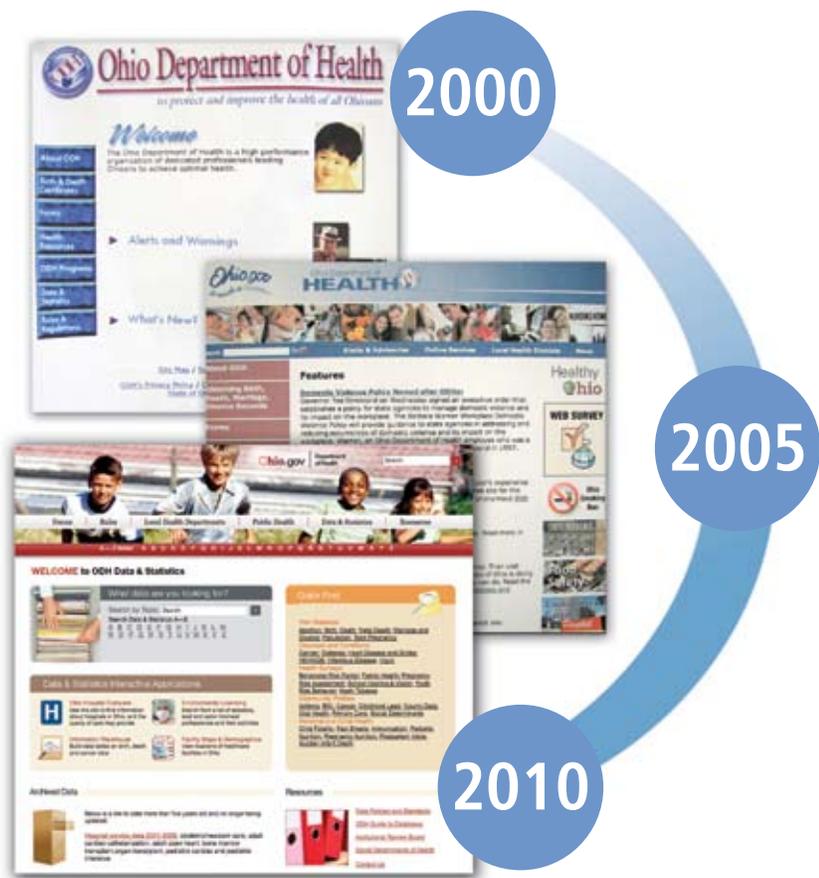
AWARD OF EXCELLENCE

Web site Upgrades

Since 2000, ODH has hosted a Web site, www.ODH.ohio.gov, for the general public as well as stakeholders. The Web site was initially very cumbersome and difficult to update.

In 2008, with the addition of a webmaster, ODH was able to update the look and capabilities of this Web site to provide a more comprehensive and user-friendly look. ODH programs are able to continually update their landing page content to reflect the latest information and health trends.

With this change came extensive graphics and menus, numerous links, tabbed boxes, animated features, an events calendar, section icons and a Google search. All of these changes have made the ODH Web site the one stop place for public health information in Ohio. With Web technology constantly improving, ODH is planning to stay an online leader. During SFY10, OPA and OMIS purchased a new content management system that will further reduce the time associated with Web updates, increase search functions and connect visitors with new technology. The change to the new content management system will be completed during SFY11.



Evolution of the ODH Web site has increased user interaction as well as brought relevant topics of public interest to the forefront. A searchable data base allows access to thousands of publications and information.

Glossary of Acronyms

AIDS	Acquired Immune Deficiency Syndrome	IAP	Immunizations Action Plan
AIRA	American Immunization Registry Association	ICS	Incident Command System
ALARA	As Low As Reasonably Achievable	IDEA	The Individuals with Disabilities Education Act
ARRA	American Recovery and Reinvestment Act	LHD	Local Health Department
ASPR	Assistant Secretary for Preparedness and Response (Federal)	MARCS	Multi-Agency Radio Communication System
ATSDR	Agency for Toxic Substances and Disease Registry	MSA	Metropolitan Statistical Area
BCCP	Breast and Cervical Cancer Program	NBS	Newborn Screening Program
BCMh	Bureau for Children with Medical Handicaps	NIS	National Immunization Survey
BEH	Bureau Of Environmental Health	NRC	Nuclear Regulatory Commission
BMI	Body Mass Index	NSRI	National Salt Reduction Initiative
BRP	Bureau of Radiation Protection	NVDRS	National Violent Death Reporting System
CAU	Compliance and Accountability Unit	OCISS	Ohio Cancer Incidence Surveillance System
CCCCP	Comprehensive Cancer Control Program	ODADAS	Ohio Department of Alcohol and Drug Addiction Services
CDC	Centers for Disease Control and Prevention	ODH	Ohio Department of Health
CFR	Child Fatality Review	ODH Lab	Ohio Public Health Laboratory
CHC	Creating Healthy Communities Program	ODNR	Ohio Department of Natural Resources
CMS	Centers for Medicare and Medicaid Services	ODPCP	Ohio Diabetes Prevention and Control Program
COHAT	Children's Oral Health Action Team	ODPS	Ohio Department of Public Safety
CPHSI	Center for Public Health Statistics and Informatics	ODVN	Ohio Domestic Violence Network
CT	Computed Tomography	OFA	Office of Financial Affairs
CY	Calendar Year	OHA	Ohio Hospital Association
DFCHS	Division of Family and Community Health Services	OHCWP	Ohio Healthcare Workforce Planning Partnership
DOC	Department Operations Center	OHDAP	Ohio HIV Drug Assistance Program
DQA	Division of Quality Assurance	OHHLPPP	Ohio Healthy Homes and Lead Poisoning Prevention Program
EMA	Emergency Management Agency	OHO	Office of Healthy Ohio
EPA	Environmental Protection Agency	OHP	Office of Health Preparedness
FQHC	Federally Qualified Health Center	OIPP	Ohio Injury Prevention Partnership
GRF	General Revenue Funds	OMIS	Office of Management Information Systems
H.B.	House Bill	OPA	Office of Public Affairs
HAN	Health Alert Network	OPDATF	Ohio Prescription Drug Abuse Task Force
HAS	Health Assessment Section	OPHAN	Ohio Public Health Analysis Network
HIV	Human Immunodeficiency Virus	OPHCS	Ohio Public Health Communications System
HMAC	Hospital Measures Advisory Council	OPI	Office of Performance Improvement
HMG	Help Me Grow	OPQC	Ohio Perinatal Quality Collaborative
HPIO	Health Policy Institute of Ohio	ORBIT	Outbreak Response and Bioterrorism Investigation Team
HPSA	Health Professional Shortage Area		
HRSA	Health Resources Service Administration		

ORC	Ohio Revised Code	VoIP	Voice Over Internet Protocol
OSAP	Ohio Situational Awareness Portal	VS	Office of Vital Statistics
OSU	The Ohio State University	WHO	World Health Organization
OVAT	Ohio Voluntary Accreditation Team	WIC	Women, Infants and Children Program
OVDRS	Ohio Violent Death Reporting System	WNV	West Nile Virus
PAG	Poison Action Group	YRBS	Youth Risk Behavior Survey
PHAB	Public Health Accreditation Board	YPLL	Years of Productive Life Lost
PHEP	Public Health Emergency Preparedness	ZDP	Zoonotic Disease Program
PHER	Public Health Emergency Readiness		
PMP	Pest Management Professionals		
PPACA	Patient Protection and Affordability Care Act		
PPE	Personal Protective Equipment		
PSA	Public Service Announcement		
RFP	Grant Request for Proposal		
RFP	Request for Proposal		
RPC	Regional Perinatal Center Program		
RV	Recreational Vehicle		
S.B.	Senate Bill		
S-BSPs	School-Based Sealant Programs		
SEARCH	Student/resident Experiences and Rotations in Community Health Program		
SFY08	State Fiscal Year 2008: July 1, 2007-June 30, 2008		
SFY09	State Fiscal Year 2009: July 1, 2008-June 30, 2009		
SFY10	State Fiscal Year 2010: July 1, 2009-June 30, 2010		
SFY11	State Fiscal Year 2010: July 1, 2010-June 30, 2011		
SNS	Strategic National Stockpile		
SOS	Save Our Sight Program		
STD	Sexually Transmitted Disease		
TB	Tuberculosis		
Tdap	Tetanus, Diphtheria and Pertussis vaccine		
TUPCP	Tobacco Use Prevention and Control Program		
USDA	United State Department of Agriculture		
USRB	Utility Radiological Safety Board		
VFC	Vaccines for Children Program		
VIPP	Violence and Injury Prevention Program		



OHIO DEPARTMENT *of* HEALTH
Living Healthier, Living Better

Combined Annual Report
State Fiscal Years 2009 –2010

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