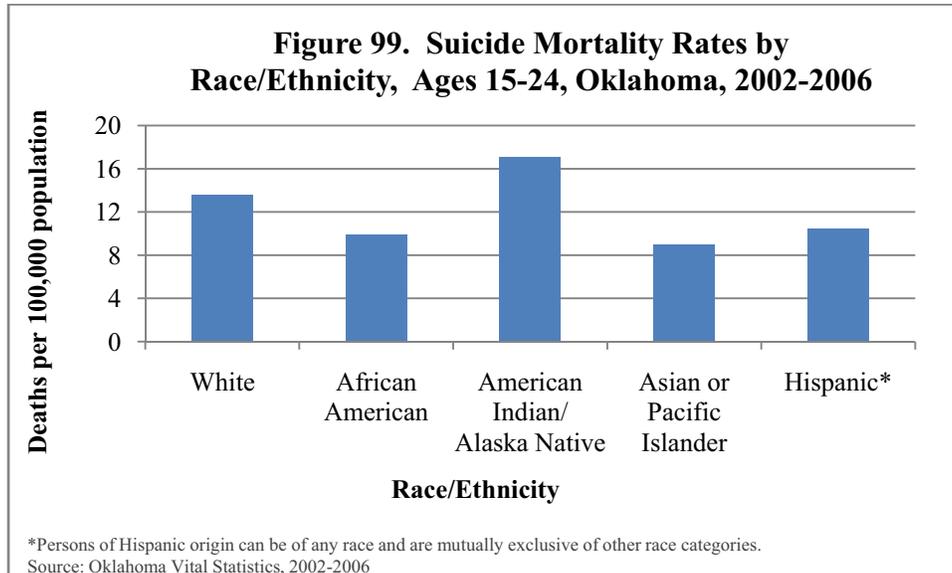


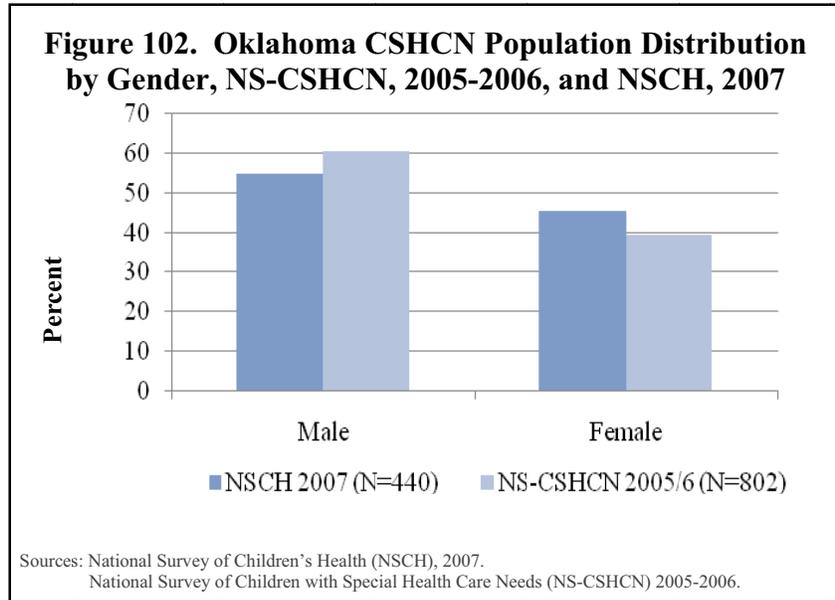
Racial/ethnic disparities exist for suicide mortality rates as the American Indian/Alaska Native rate of 17.1 deaths per 100,000 population was 25% higher than the next closest rate of 13.6 for whites. While Asian/Pacific Islanders have the lowest suicide mortality rate, this rate should be interpreted with caution as it is based on small numbers (Figure 99).



C. Children with Special Health Care Needs

In accordance with the MCHB definition of CSHCN, the OKDHS defines CSHCN as children who currently present or are more likely to present challenges due to physical, emotional, developmental, or behavioral needs.

Due to the inclusive nature of the definition of CSHCN, a wide range of children can be classified as CSHCN, making exact estimates of the numbers of CSHCN in Oklahoma difficult to attain. However, population estimates from multiple sources can help in presenting a portrait of CSHCN that best reflects reality. The 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) estimates that approximately 13.9% of children below the age of 18 in the U.S. have special health care needs. In Oklahoma, a larger percentage of children are estimated to be CSHCN, 16.5% (The Child and Adolescent Health Measurement Initiative (CAHMI), 2005-2006). Based on the state population distribution and the estimated numbers of CSHCN, Sooner SUCCESS developed the following map to illustrate the possible distribution of CSHCN within Oklahoma. Greater numbers of CSHCN are expected to reside in counties with larger populations, e.g., Oklahoma County estimated at 29,769 and Tulsa County estimated at 25,169 (Figure 100).



Regarding the race and ethnicity breakdown of CSHCN, the 2007 NSCH and the 2005-2006 NS-CSHCN both showed that white males make up the largest proportion of the CSHCN population in Oklahoma. The large proportion of white CSHCN in Oklahoma (63.4%) is not unusual as it reflects the percentage of white CSHCN (75.2%) in the U.S. population (Table 46).

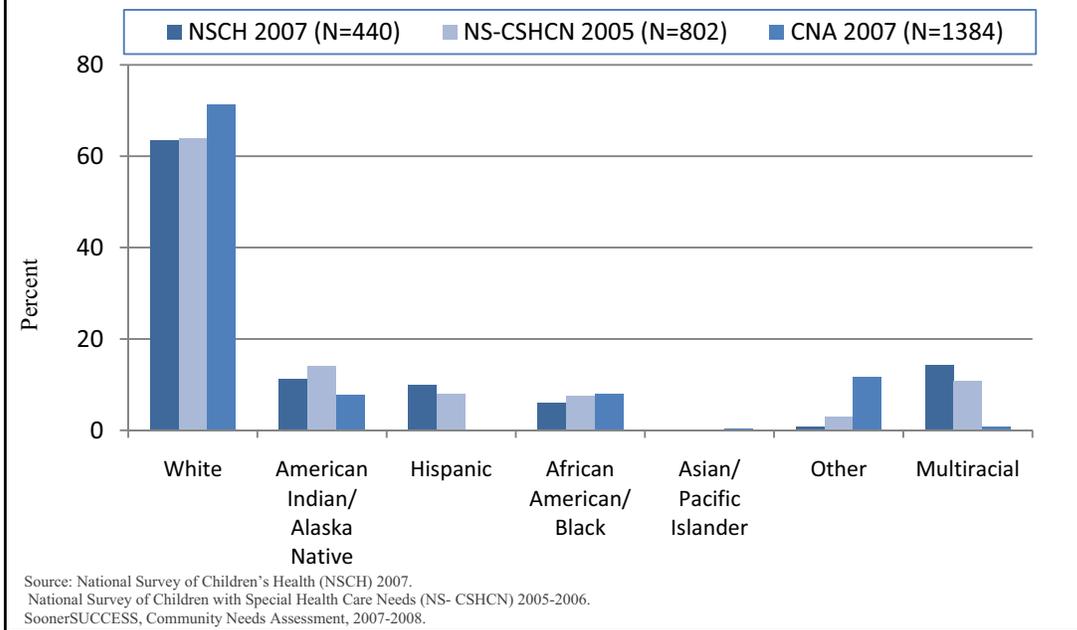
Table 46. Race/Ethnicity and Family Structure of CSHCN in Oklahoma, Compared to U.S., NSCH, 2007

	Oklahoma	U.S.
Race/Ethnicity		
Hispanic	9.8	10.0
White	63.4	75.2
African American/Black	5.9	10.8
Multiracial	14.3	6.0
Other	0.7	3.7
American Indian/Alaska Native	11.1	-
Family Structure		
Two parent biological/adopted	57.7	61.0
Two parent stepfamily	10.2	9.1
Single mother, no father present	21.1	21.0
Other	10.2	8.3

Source: National Survey of Children's Health (NSCH), 2007.

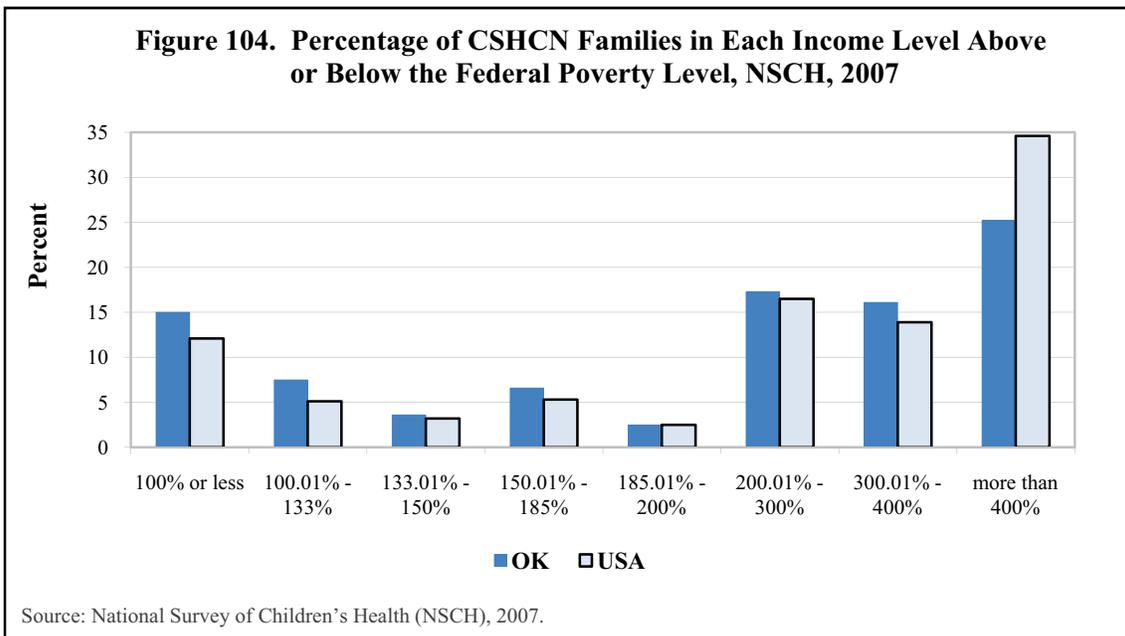
Data on American Indian/Alaska Native CSHCN were gathered in Oklahoma and other states where the population of American Indian/Alaska Native represented a large subset of the non-white population. Eleven percent of the Oklahoma CSHCN were identified as American Indian/Alaska Native (Figure 103). More than one in twenty (5.7%) of this population received services from an Indian Health Service Hospital or clinic within the past 12 months.

Figure 103. Three Survey Comparisons of CSHCN Population Distribution by Race/Ethnicity in Oklahoma, 2005-2008



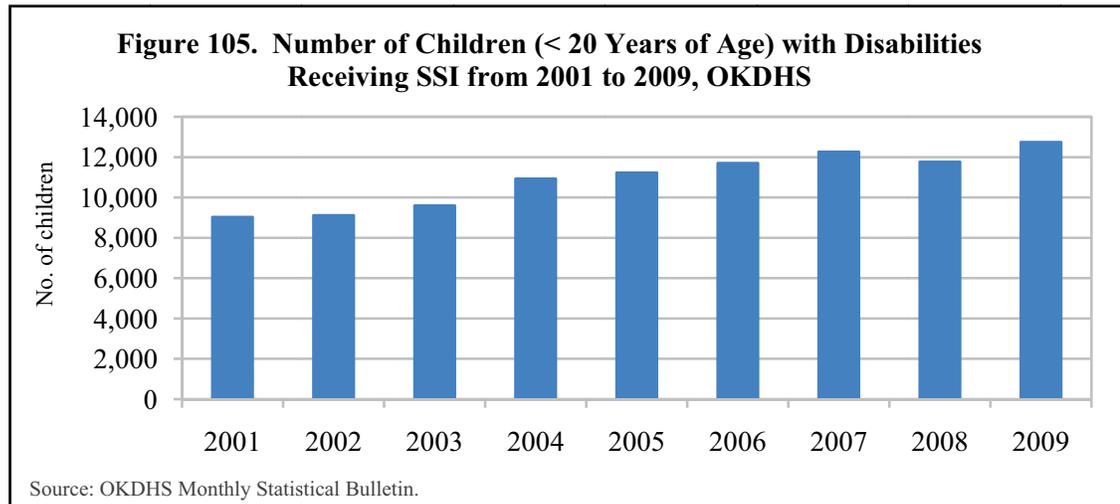
CSHCN families represent a broad range of income levels. Figure 104 shows the income distribution of CSHCN families in the NSCH 2007 survey, based on how far above or below the FPL the family income fell.

Figure 104. Percentage of CSHCN Families in Each Income Level Above or Below the Federal Poverty Level, NSCH, 2007

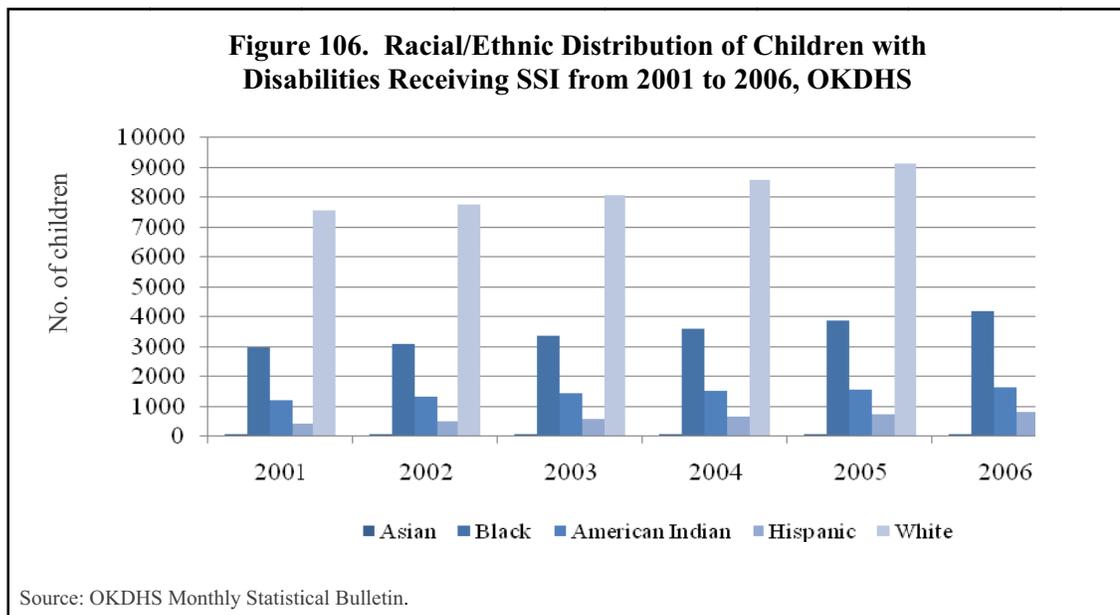


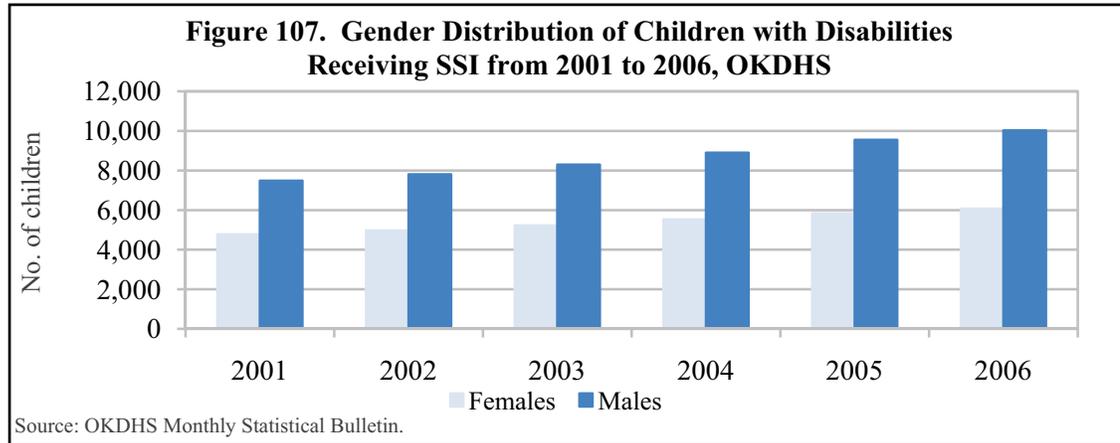
The trends in Oklahoma are generally consistent with those across the nation, whereby families of CSHCN represented a broad range of income levels. Approximately 25% of Oklahoma's families of CSHCN were above 400% of the poverty line; on the other hand, another 26% fell below 150% of the poverty level.

Data from the monthly bulletins issued by the OKDHS show that a growing number of children (less than 20 years of age), with disabilities, are receiving Supplemental Security Income [SSI, (Oklahoma Department of Human Services, 2010)]. Whether the increase in numbers also reflects an increase in numbers of children with disabilities, changes in program requirements, or changes in the numbers of children applying for SSI, is not clear (Figure 105).



The demographic profile of Oklahoma children with disabilities receiving SSI is similar to that of the CSHCN included in the national surveys (e.g., NSCH, NS-CSHCN). Children with disabilities receiving SSI were more likely to be males and white as illustrated in Figure 106 on racial identity and Figure 107 on child gender.





Special Health Care Needs and Conditions

The term, “Children with Special Health Care Needs,” encompasses children experiencing a wide range of physical, behavioral, emotional, and developmental conditions. It is difficult to identify exactly which conditions are most prevalent and to enumerate those affected by each condition. One challenge to enumeration lies in the differences in the numerous conditions identified as special health care needs. The severity of the condition and prevalence and impact on daily living could vary widely and result in children seeking and needing very different types of services and health care. As a result, data about the types of conditions and the numbers of children affected would not be available in one centralized location. For example, a child may be identified as a CSHCN as a result of a physical chronic condition such as asthma, while another may be identified as a CSHCN as a result of a severe developmental disability. The child with asthma may have to take medication regularly and make occasional visits to a primary care physician. Meanwhile, the child with a severe developmental disability, may have to take medication, deal with functional limitations that impact everyday life more pervasively, and have frequent visits with a specialized medical provider. An additional challenge to establishing prevalence lies in the variability in survey development. Without the use of a standard means of counting and assessing conditions, or even a consensus about which conditions to include in a survey of CSHCN, surveys pick and choose which conditions they ask about and how they ask. The lack of consistency in the types of conditions surveys inquire about make it challenging to track changes in prevalence rates.

Condition	Percentage that have ever had the condition	Percentage currently identified as having the condition
Autism, Asperger Syndrome or Autism Spectrum Disorder	6.8	4.3
Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder	25.2	21.4
Learning Disability	NA	12.7
Developmental Delay	25.7	NA
Speech problem	NA	12.0
Tourette Syndrome	0.5	0.5
Asthma	41.6	33.2
Diabetes	1.6	1.6
Epilepsy or seizure disorder	4.3	3.2

Source: National Survey of Children's Health (NSCH), 2007.

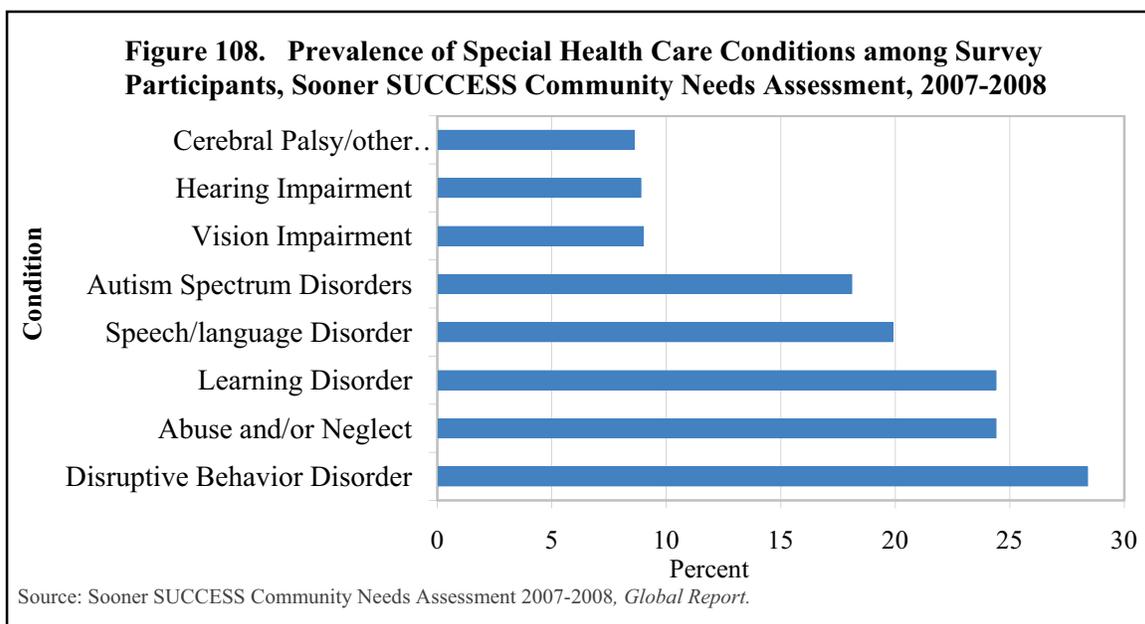
In addition to the challenges of the inclusion of numerous conditions that impact children in very different ways, and the lack of a universally accepted way of counting CSHCN, the time frame under consideration can also impact reported conditions. The NSCH 2007 provides an illustration of the difference the timing issue may make in the types of data acquired. Respondents were asked whether the children were currently identified as having a specific condition. Fewer children were identified as having the condition at the time of the survey. Whether the changes in numbers indicate that the conditions are no longer present, have been treated, or the child is no longer seeking treatment, is not clear. The results imply that surveys asking whether children have a specific condition currently or in the past year may lead to an underrepresented estimate of children that have ever had the condition (Table 47).

To address the onus of presenting a cohesive snapshot of CSHCN in Oklahoma, data from national and local surveys were examined. The primary national surveys (2003, 2007 NSCH, 2005-2006 NS-CSHCN) showed higher levels of physical special needs conditions. The 2007 NSCH found asthma to be the most prevalent condition among Oklahoma's CSHCN with 41.6% having been diagnosed with the condition in the past. Similarly, the 2005-2006 NS-CSHCN identified physical conditions as the most prevalent conditions for CSHCN with Oklahoma CSHCN survey participants presenting allergies (64.7%) and asthma (40%) respectively (Table 48).

Allergies	64.7%
Asthma	40.0%
Attention Deficit Disorder	30.7%
Emotional Problems	25.7%
Migraine/Frequent Headache	19.3%
Mental Retardation	12.3%
Autism	3.2%
Seizure Disorder	3.1%
Heart Problems	2.9%
Cerebral Palsy	2.0%
Blood Problems	1.7%
Diabetes	1.0%
Down Syndrome	1.0%
Muscular Dystrophy	0.5%
Cystic Fibrosis	0.1%

*One or more conditions reported for each child.
Source: National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006.

Contrary to the data from the national surveys, the Oklahoma-specific Sooner SUCCESS Community Needs Assessment identified a behavioral condition, disruptive behavior disorder, as the most prevalent diagnosis. Differences in the types of conditions identified as most prevalent may also be due to imprecise definitions of conditions. While physical conditions are often medical and thereby easily defined, behavioral and emotional conditions can be difficult to define. Emotional problems could be considered the same as disruptive behavior; however, emotional problems may include other conditions as well (Figure 108).



The 2003 and 2007 NSCH provide opportunities to look for changes in prevalence rates of relevant conditions. All conditions surveyed in both 2003 and 2007 showed an increase in the percentage of children affected by the condition. The prevalence of asthma in the survey sample rose approximately 5% from 2003 to 2007. The rates of Autism, Asperger Syndrome or Autism Spectrum Disorder, more than tripled in the same five years (Table 49). The rate changes may reflect actual changes in the prevalence of conditions in the population, more accurate diagnosis or assessment, or even improved reporting, either due to caregivers seeking more assistance or providers reaching out to families more frequently.

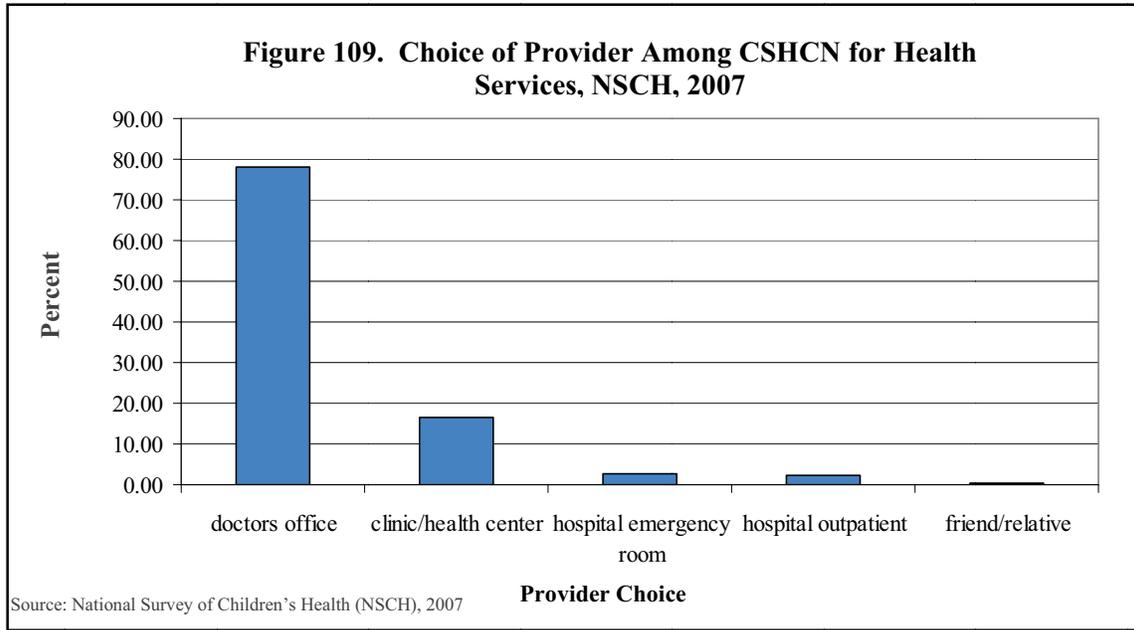
	2003	2007
Autism, Asperger Syndrome or Autism Spectrum Disorder	0.5	1.8
Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder	6.3	8.3
Asthma	13.5	17.3
Diabetes	0.4	0.6
Source: National Survey of Children’s Health (NSCH), 2003, 2007.		

Access to Health Care

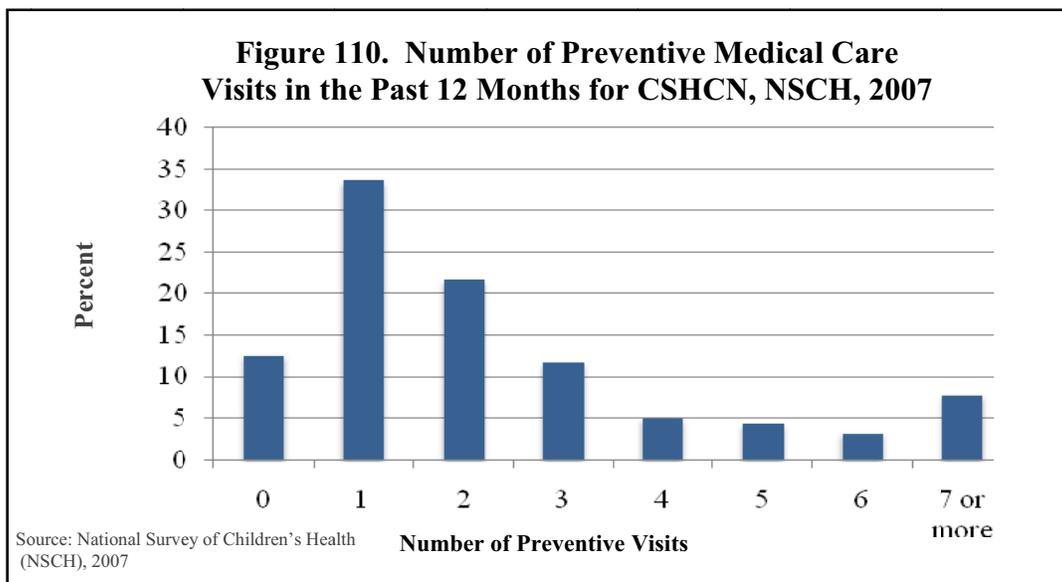
The National Initiative for Children’s Healthcare Quality indicates that 80% of health care dollars spent annually on children is spent on children with special health care needs (NICHQ). This does not necessarily equate to better access to better care for CSHCN. The AAP notes that access to care involves several different components, including physical, communicative, geographic, and financial access. For health care to be accessible, the location must be easily reached, communication of relevant information must be understandable, and health care must be affordable. In addition to those components, health care must also be appropriate, available in a timely manner, and culturally relevant for it to be of use.

- **Medical Care**

According to the 2007 NSCH, almost all CSHCN have access to medical care. More specifically, 95.2 % of Oklahoma CSHCN had one place where they usually went when sick, 2.7% had more than one option to choose from when they were sick. The majority of CSHCN received medical care at a doctor’s office (Figure 109). This implies that general medical care is available for most CSHCN in Oklahoma.



According to the same survey, the majority of Oklahoma CSHCN received a preventive medical care visit within the past 12 months (Figure 110). Approximately 12% of CSHCN did not have a preventive medical care visit. The findings are not surprising to researchers Van Cleave and Davis (2008) who found that CSHCN attend preventive medical visits at high rates, in some cases even higher rates than other children. Preventive medical care visits are important because they have been associated with unmet needs. This study indicated that CSHCN, who attended more preventive care visits, were less likely to have unmet medical needs (Van Cleave & Davis, 2008).

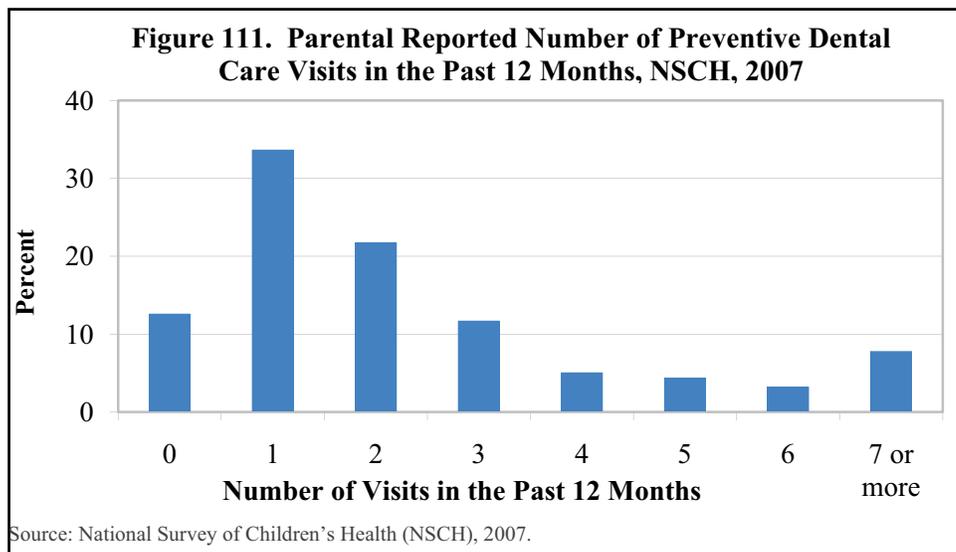


In summary, the available data on CSHCN shows that general health care services access may not be as great of a problem as access to specific services. For example preventive dental care

visits are for the most part taking place; however, CSHCN need more dental care dealing with dental problems. There is a scarcity of Oklahoma specific data on access to mental health and medical health services for all CSHCN. To speak conclusively regarding access to mental and medical services, data is needed on children who are not in foster care and who are receiving services for needs beyond preventive medical care needs.

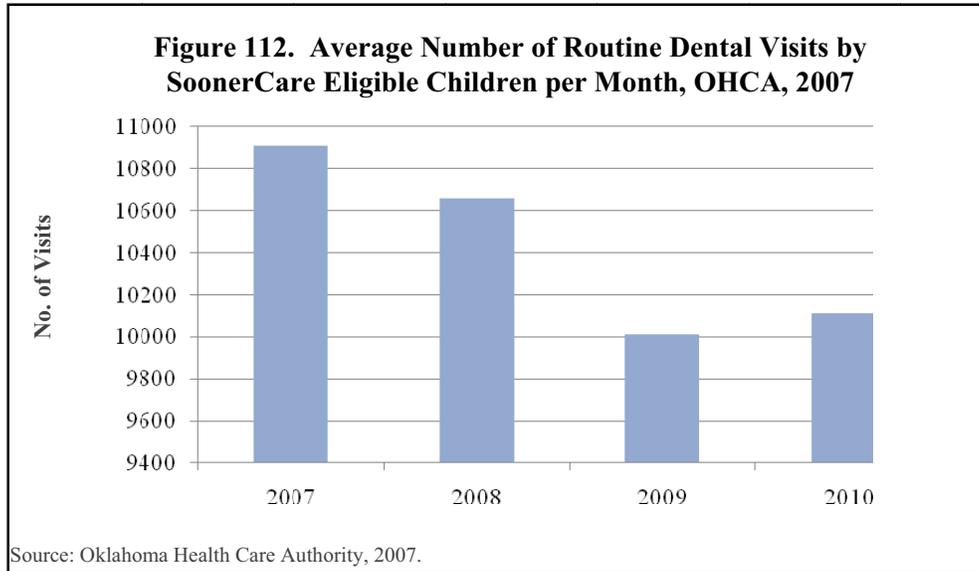
- **Oral Health**

Since the landmark publication by Newacheck and colleagues on access to health care in 2000, dental care has been routinely identified as the primary unmet need of CSHCN (Newacheck, McManus, Fox, Hung, & Halfon, 2000). A study by Lewis (2009) recently examined data from the 2005/2006 NS-CSHCN to determine whether the survey found support for the popular perspective (Lewis, 2009). Findings indicated that CSHCN reported similar amounts of unmet need for preventive/routine oral health care as non-CSHCN. The 2007 NSCH data on Oklahoma CSHCN showed similar trends.

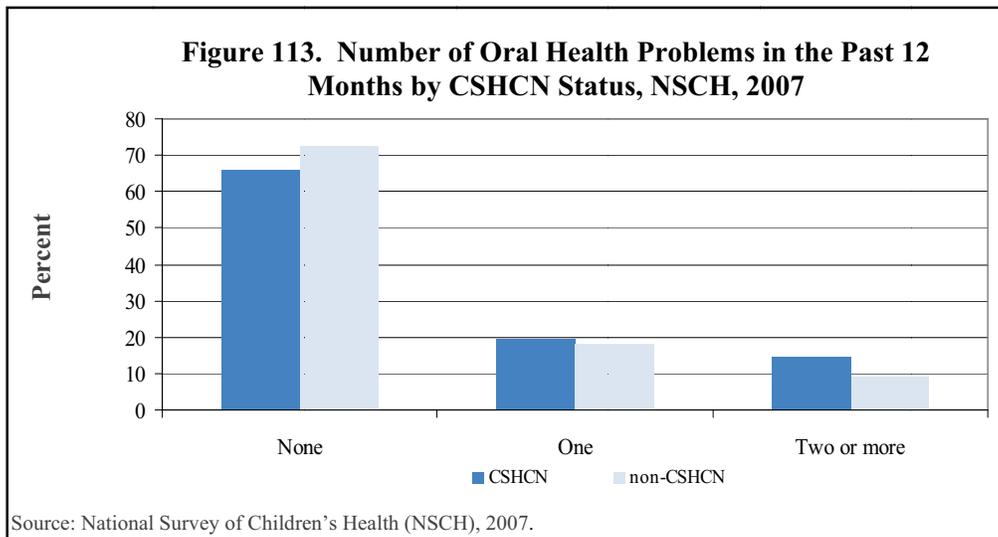


Approximately 85%, of Oklahoma CSHCN saw a dentist for one or more preventive dental care visits in the past year (Figure 111). In addition, the 2005-2006 NS-CSHCN showed that 91.3% of Oklahoma CSHCN received all the preventive dental care they needed, 3.9% received only some of the needed care, and 4.8% received none of the preventive dental care needed, indicating that generally Oklahoma CSHCN received necessary preventive dental care.

Data from the OHCA provided a glimpse of the actual numbers of children with special needs attaining preventive dental care (Figure 112). In 2007, OHCA collected the first set of data on the number of routine dental encounters per month from SoonerCare eligible children who are classified as disabled or in the custody of the state.

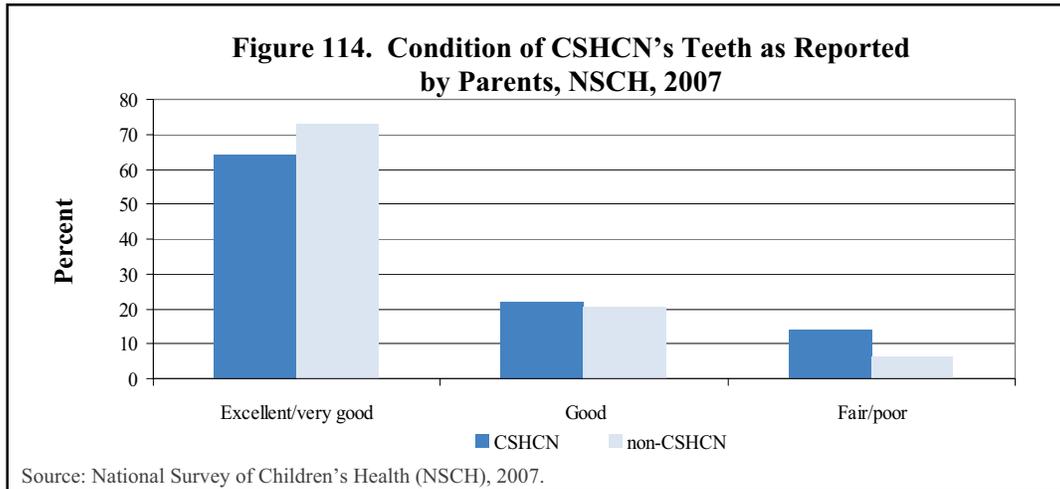


An average of 10,908 encounters per month was recorded in 2007. The following year the number decreased to an average of 10,660 routine dental encounters per month. The decrease was explained as a result of improved counting and the removal of duplicate counts. In 2009, the average number of monthly routine dental encounters decreased by approximately 649 encounters a month. The decrease was attributed to a 44% decrease in the number of children in foster care receiving dental services. In 2010, an average of 10,112 encounters per month was recorded, which indicated a stabilization of numbers.



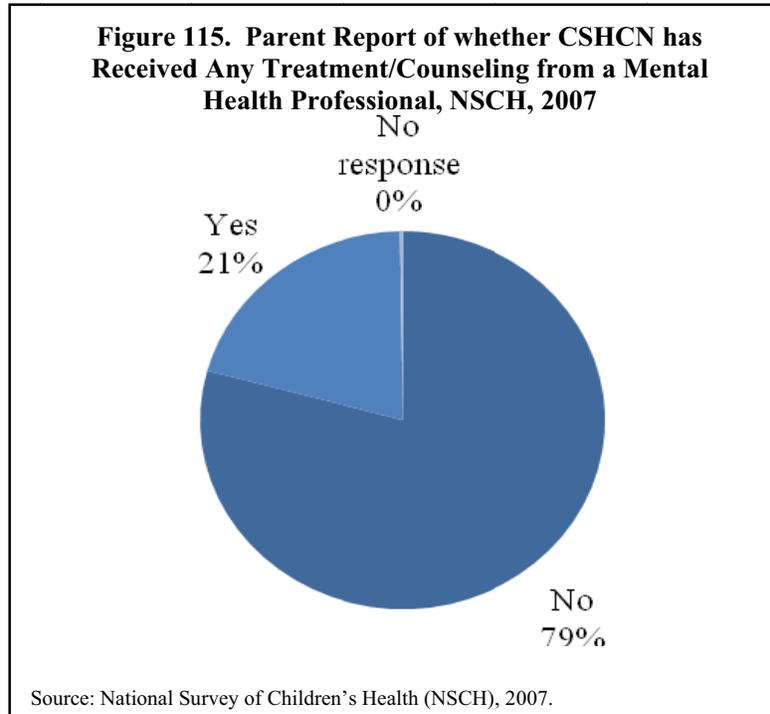
Overall, the national surveys and OHCA data show that CSHCN are generally able to access the necessary routine dental care they need. However, there is some indication that CSHCN experience a significant unmet need for non-preventive dental care. According to NSCH 2007, Oklahoma CSHCN had more oral health problems than non-CSHCN in Oklahoma, based on parent reports (Figure 113).

According to 2007 NSCH data, the disparities in the condition of oral health among the CSHCN population compared to the non-CSHCN population as reported by parents suggests that the need is great to ensure that appropriate oral health services are attained by the CSHCN population (Figure 114). Approximately 14% of CSHCN in Oklahoma have parents who reported the condition of their children’s teeth to be fair or poor compared to 6.1% of children without special health care needs.



- **Mental/Behavioral Care**

Access to mental/behavioral care presented variable findings, depending on the source. According to the 2007 NSCH, approximately 20% of CSHCN received treatment or counseling from a mental health professional (Figure 115). Of those that needed mental health services, 33% received the necessary services, while 67% did not. The 2005-2006 NS-CSHCN found that the majority (76.6%) of Oklahoma CSHCN received all of the mental health care or counseling they needed, 14.4% got some of the care they needed, and 9.0% did not get any of the care needed.

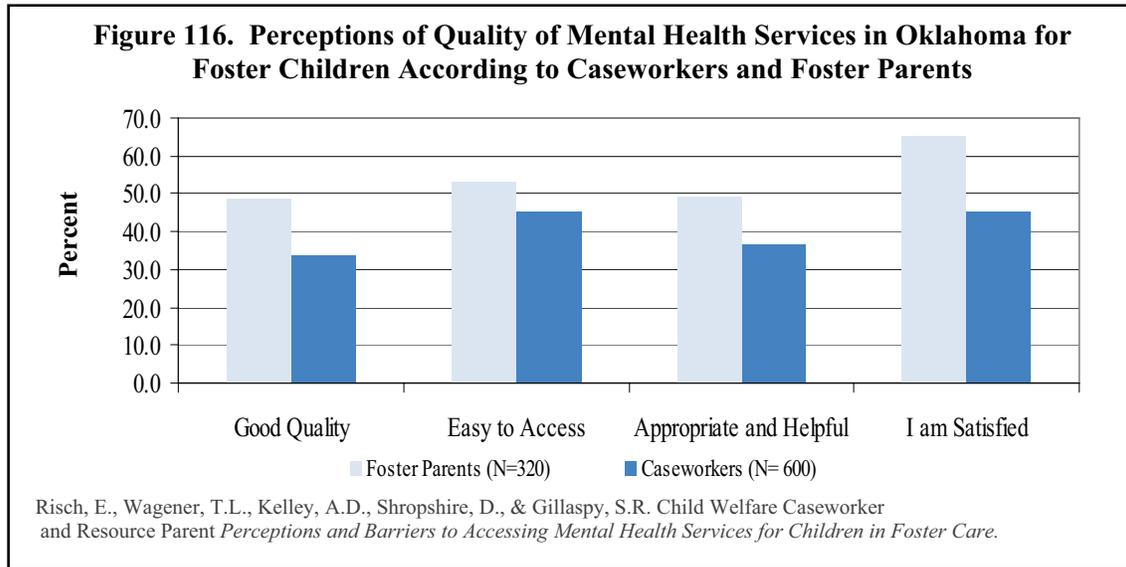


An estimated 12,000 Oklahoma children enter foster care each year, with approximately 60% identified as having emotional or behavior problems (Shropshire & Gillasp, 2009). A study on access to services for foster children in Oklahoma was carried out by Shropshire and colleagues. The study gathered data from 320 foster parents and 600 caseworkers (Risch, Wagener, Kelley, Shropshire, & Gillasp, 2009). The study found that perceptions of access and quality of mental health services for foster children differed among foster parents and caseworkers. Foster parents appeared to have a more positive perception of both quality and accessibility. For example, nearly a quarter of caseworkers stated that psychological medication management was not available in/near their county. Only 10% of foster parents and 9% of caseworkers reported that mental health therapy was not available (Table 50).

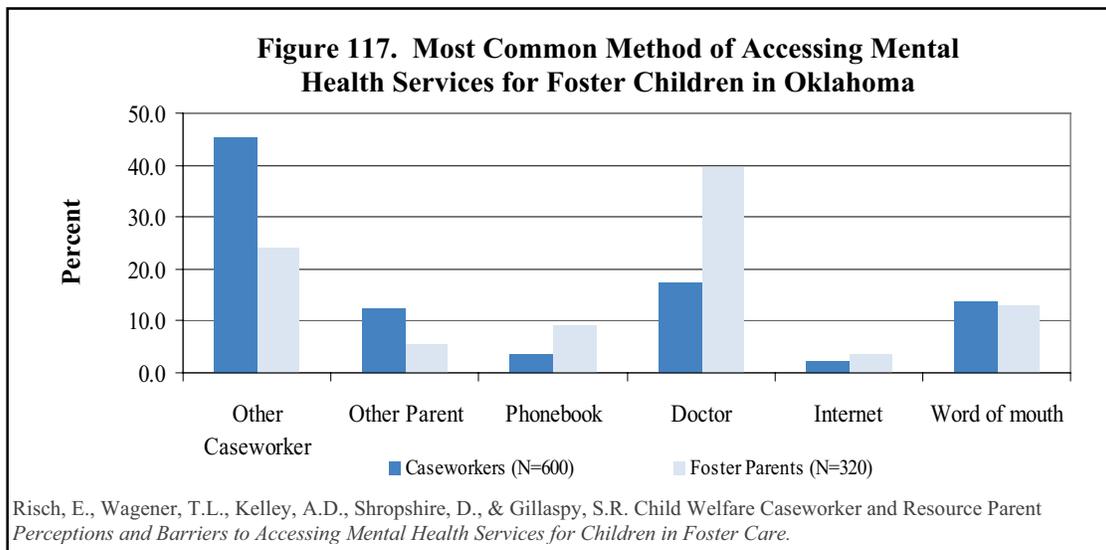
	Caseworker	Foster
Psychological testing is NOT available in/near my county.	20	14
Psychological Medication Management is NOT available in/near my county.	24	21
Mental Health Therapy is NOT available in/near my county.	9	10

Source: Risch, E., Wagener, T.L., Kelley, A.D., Shropshire, D., & Gillasp, S.R. *Perceptions and Barriers to Accessing Mental Health Services for Children in Foster Care*

Overall, foster parents were more satisfied than caseworkers, regarding the quality of mental health services available to foster children. It is important to note that 50% or fewer foster parents perceived mental health services as appropriate, helpful, easy to access, or good quality (Figure 116).

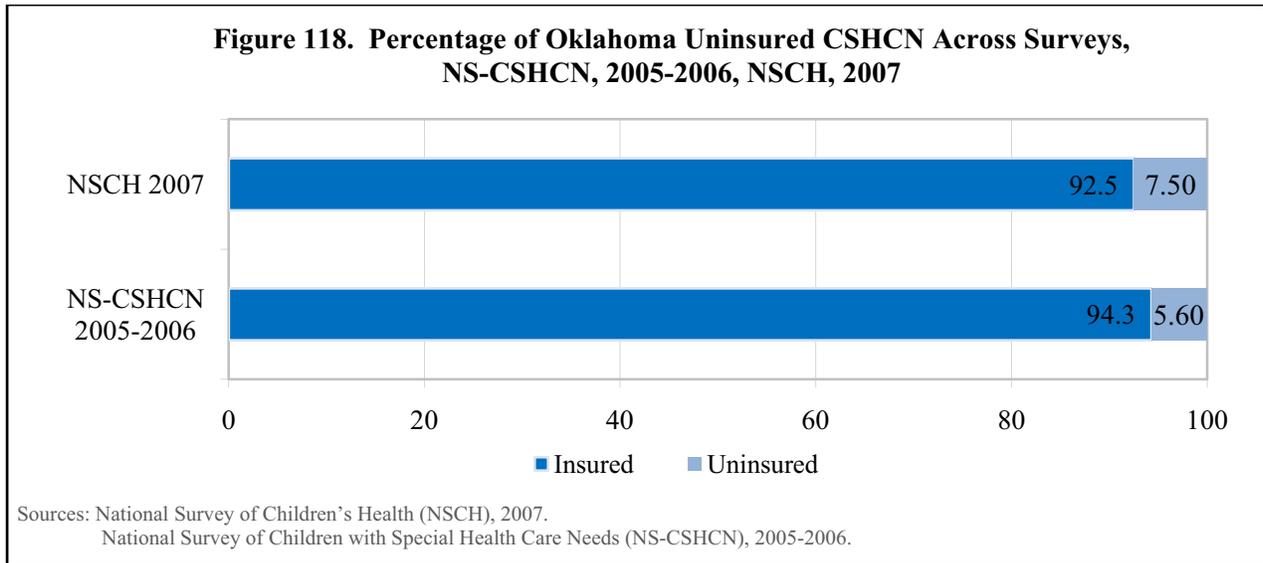


The most common methods utilized for accessing mental health for foster children are displayed in Figure 117. Foster parents considered a doctor to be their primary source for mental health care services while caseworkers considered other caseworkers as the primary source of mental health services.



- **Insurance**

Nationally, CSHCN are known to have high levels of health insurance coverage. According to the NSCH 2007, 95.1% of CSHCN in the U.S. have health care coverage. In Oklahoma according to 2007 NSCH data, the percentage of CSHCN with coverage is around 92%; the 2005-2006 NS-CSHCN reports 94% with coverage (Figure 118).



While the rates of uninsured CSHCN in Oklahoma are fairly similar to those in the rest of the nation, Oklahoma presents a larger percentage of CSHCN receiving Medicaid or coverage through the SCHIP. Nationally, 28.9% of CSHCN with insurance receive coverage from either Medicaid or SCHIP. In Oklahoma, 38.4% of CSHCN with insurance receive coverage from either Medicaid or SCHIP.

- **Medical Home**

One of the challenges of providing CSHCN access to care is the broad definition of CSHCN and the different conditions that require care. The AAP developed the medical home concept as a means of consolidating all of the components of an effective, comprehensive health care delivery system to meet the needs of all CSHCN. According to the AAP a medical home would provide care that is “...accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective...” The care would be available at the community level and would involve collaboration between the care provider, service providers, and the families. The care would not be interrupted as the child grows and would promote overall healthy development for the individual child. While the concept of a medical home has been embraced widely, there have been some challenges associated with putting it into practice.

Oklahoma has made some progress in implementing the medical home concept within CSHCN service delivery systems. Oklahoma was one of ten states to participate in a “National Initiative on Children’s Healthcare Quality’s Medical Home Learning Collaborative.” The 2003 Collaborative supported Sooner SUCCESS, a partnership between the University of Oklahoma Child Study Center and the State’s Title V CSHCN Program, to develop a network of

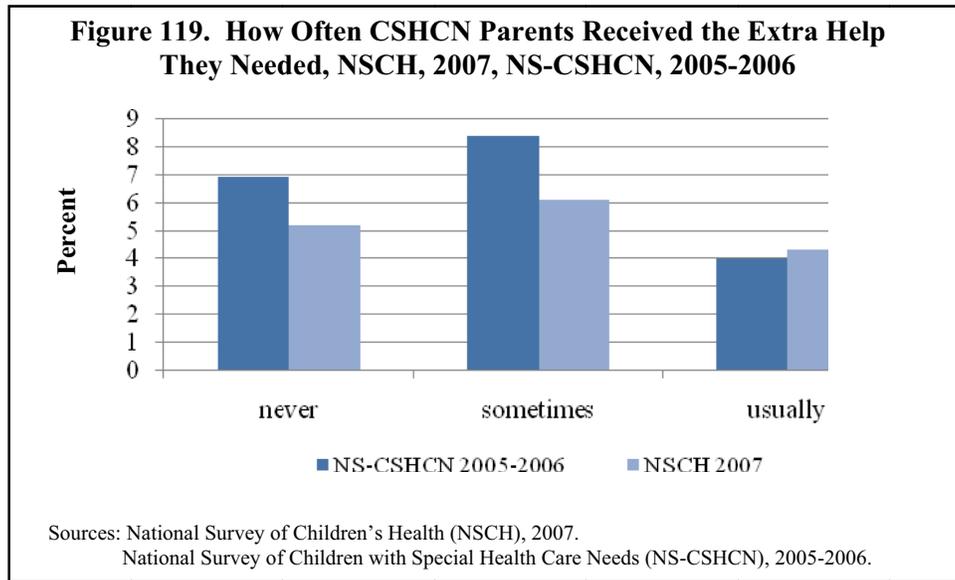
interagency providers and promote collaborative service provision for CSHCN. In 2005 a “State Implementation Grant for Integrated Community Systems of Services for CSHCN” was received. The grant supported the implementation of the Sooner SUCCESS model in an urban region further promoting the medical home concept in Oklahoma. Sooner SUCCESS continues to provide leadership in the support of a comprehensive service delivery system for CSHCN in Oklahoma, with an emphasis on building community capacity, family, and provider partnerships. Sooner SUCCESS has received funding from other sources, including the OHCA which has also developed initiatives to promote the medical home concept among Medicaid providers.

The OHCA’s medical home initiative began in 2007 with the formation of a Medical Advisory Task Force (MAT). The primary goals of the task force were to impact payment structure, credentialing, and access to medical homes. The initiative has resulted in the OHCA developing a medical home tier system. Providers have to meet and maintain certain requirements for each tier level. The system is specifically developed to target providers for SoonerCare. According to OHCA’s April 2010 provider fast facts report, there are 488 Tier 1 Patient-Centered Medical Homes (PCMH), 234 Tier 2 PCMH’s and 46 Tier 3 PCMH’s. While the OHCA’s numbers show that some medical homes are available, it is important to note that OHCA works primarily with providers targeting state insured children. In Oklahoma approximately 30% of the insured utilize state programs for insurance, so the majority would probably seek care outside of the OHCA targeted health care providers. In addition, OHCA does not identify which PCMH’s are providing for CSHCN. Therefore, other ways to measure or assess CSHCN medical home providers need to be found.

The 2007 NSCH data provides some ideas about the extent to which some of the components of a medical home are being addressed for CSHCN. Specifically, survey items regarding the amount of help caregivers need are useful in understanding the extent to which caregivers feel the care received addressed needs in a comprehensive and effective way. Table 51 indicates that the percentage of parents of CSHCN needing help was slightly higher among Oklahoma parents than in the nation.

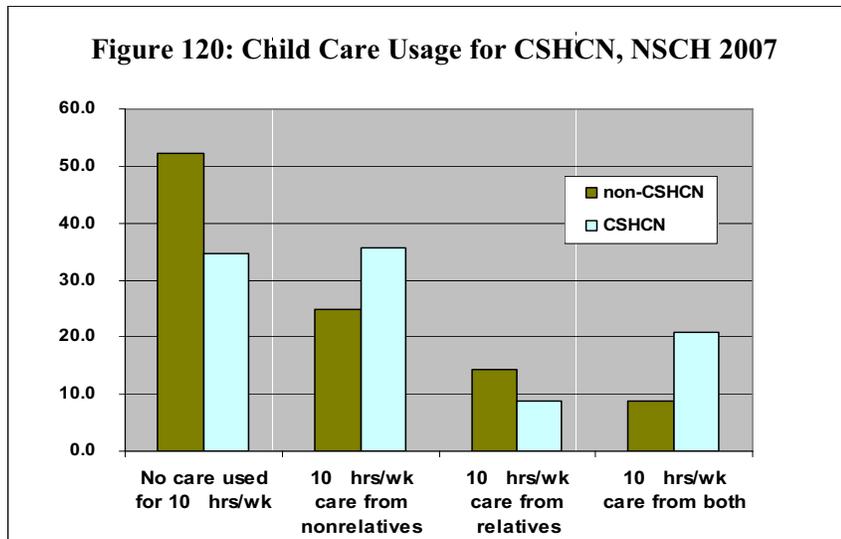
Table 51. Percentage of Parents of CSHCN Who Needed or Received Help Arranging or Coordinating Care Concerning CSHCN, NSCH, 2007		
	Oklahoma Percentage	National Percentage
Parents who received help arranging or coordinating care for CSHCN	24.3	22.9
Parents who needed extra help arranging or coordinating care during the past 12 months	15.7	14.3
Source: National Survey of Children’s Health (NSCH), 2007.		

Among those who needed extra help arranging or coordinating care during the past 12 months, 7% never received the necessary help, only 4% felt that they usually received help, while more than 8% felt they received help sometimes (Figure 119).



Child Care

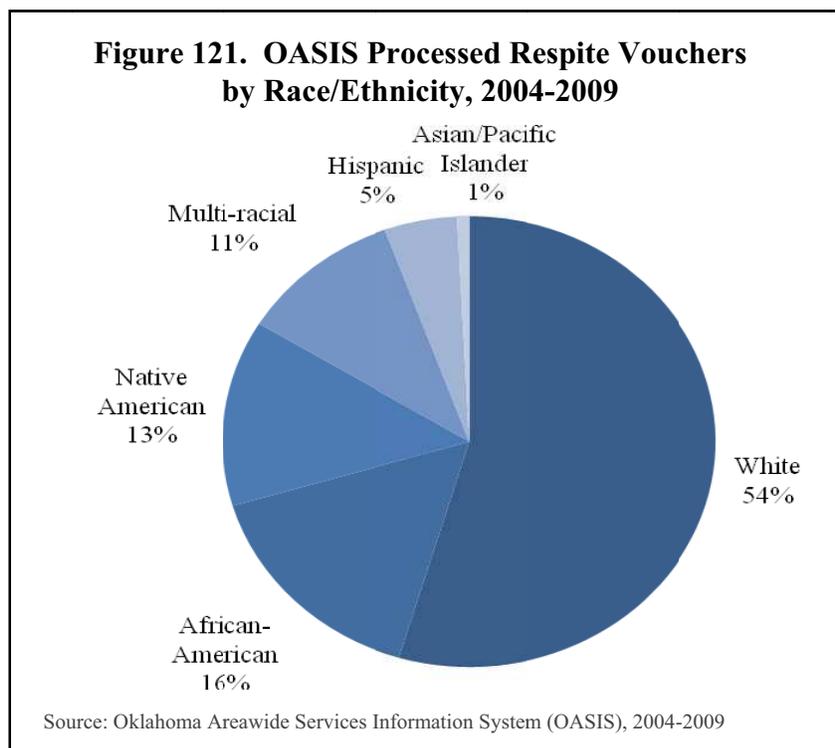
According to 2007 NSCH data, families of CSHCN use child care from non-relatives more often than non-CSHCN families, at 10 or more hours per week. CSHCN are also more likely to receive child care from both relative and non-relative providers compared to non-CSHCN (Figure 120).



Therefore, it is not surprising that one of the needs from the CNA was also child care for CSHCN. During this past year, the Sooner SUCCESS State Interagency Coordinating Council focused on this topic at some of their meetings. The challenging issues from the child care provider’s perspective were not having enough trained staff to provide for the children’s needs and disruption to the activities of the other children. Families agreed that lack of trained staff is the major issue.

Respite

The Oklahoma Areawide Services Information System (OASIS) is a resource center that provides information and referrals to persons in Oklahoma who have disabilities and/or special health care needs. The OASIS is available statewide and has a database of thousands of service providers across the state, as well as state and local support groups. The OASIS also serves as the home of the Oklahoma Respite Resource Network (ORRN) and is the primary point of contact for individuals applying for the Respite Voucher Program. Between January 2004 and December 2009, the OASIS received 1,433 respite voucher applications for caregivers providing care to youth aged 21 or below. The majority of care recipients were males, (880) with 553 female care recipients. The racial/ethnic identities of the 1,369 (95%) who chose to indicate their race/ethnicity are presented in Figure 121. Similar to the general race/ethnicity group trends the majority identified as white (54%). Sixty-two percent (884) identified their specific condition/disability as a developmental disability. Thirty nine percent (558) identified with the chronic or special health care needs option. Almost one-fourth (323) of the care recipients were being raised by a grandparent (McCullom, 2009).



Transition

Transition is of great importance among CSHCN, their parents and providers. Educators often consider transition issues as they relate to Individualized Education Plans (IEP's), graduation rates, and preparing children to either attend higher education or take on a post-graduation job. Parents and some service providers are quick to acknowledge that the issue of transition involves more than academic planning. Transition planning is also necessary for preparing children to live more independent lives and receive the appropriate medical services they need as they age.

The OSDE, Special Education Services (SES), gathers information on education transition in their annual performance reports and state performance plans. Table 52 provides a brief overview of the education transition rates.

Table 52. Indicators in the Oklahoma State Department of Education, Oklahoma State Performance Plans, 2005-2007			
Percentage			
	2005	2006	2007
Graduation rates			
<ul style="list-style-type: none"> percent of students with disabilities in Grade 12 who graduated 	88.26	82.89	84.22
Drop-out rates			
<ul style="list-style-type: none"> percent of students with disabilities in Grades 9-12 who dropped out 	4.65	4.65	7.25
Secondary transition			
<ul style="list-style-type: none"> percent of youth (16 and older) with an IEP that includes coordinated, measurable, annual IEP goals and transition services that will reasonably enable student to meet post-secondary goals 	97.53	99.67	98.81
Post-school outcomes			
<ul style="list-style-type: none"> percent of youth with IEP's, who are no longer in secondary school, and who have been competitively employed, enrolled in some type of post-secondary school, or both, within one year of leaving high school 	Data not available	87.00	78.00

Source: Oklahoma State Department of Education, Oklahoma State Performance Plans, 2005-2007.

While supporting academic transition is important, of particular interest to the CSHCN Program is promoting transition planning associated with independent living and having access to adult health care services. The only available source of data on how well Oklahoma is doing with providing transition services to CSHCN is found in the 2005-2006 NS-CSHCN. The survey found that 43.7% of CSHCN, ages 12-17, successfully received the services needed to transition to adult health care, work, and independence. The remaining 56.3% did not receive the necessary services for transitioning. It is difficult to make any conclusions regarding transition as a result of the minimal data.

Gaps and Needs

- Measurement and Assessment Issues**

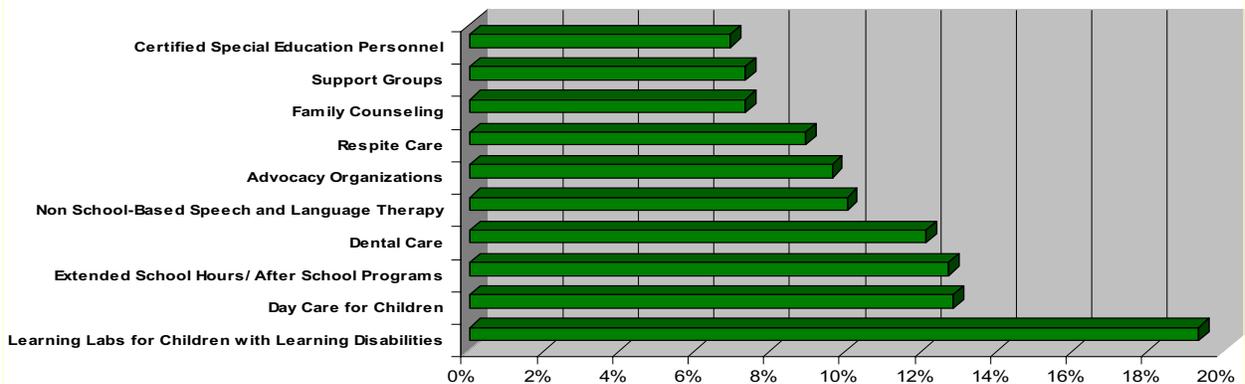
The greatest challenge to documenting the needs of CSHCN lies in the measurement and assessment issues. As discussed earlier in this needs assessment it is difficult to identify exactly who Oklahoma's CSHCN are, due to the broad definition of CSHCN and also the differences in the types of conditions providers and researchers are interested in. It is important that national surveys such as the NSCH and the NS-CSHCN continue to ask about the same conditions in upcoming surveys. This would greatly facilitate the enumeration process and the ability for states to track changes in conditions of the CSHCN population.

Another challenge to assessing needs, gaps, and being able to see how well Oklahoma serves CSHCN lies with medical, dental, and mental health services data shortages. Up until now, most of the focus on access to services has had to do with how many preventive care visits a child has. There needs to be a move toward recognizing that access involves more than having one preventive care visit, especially among CSHCN who have traditionally high levels of insurance and tend to access preventive care. It would be valuable to be able to measure whether or not, or to what extent medical or dental problems were addressed. Advancements in the medical home concept may allow for a better assessment of access to services. Overall, Oklahoma appears to be making progress; however, more consistent and rigorous measurement would increase access to more precise data of CSHCN in Oklahoma.

- **Perspective of Caregivers and Providers**

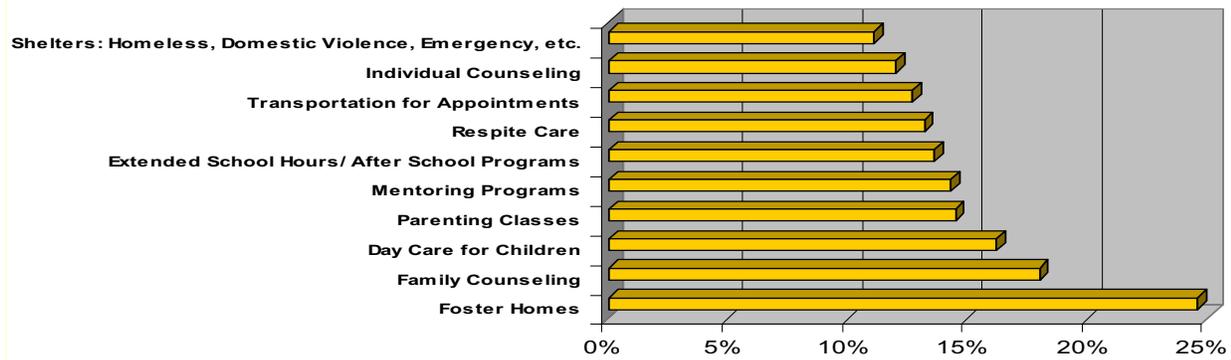
Results of the CNA showed that caregivers and providers agree that there is still a need for more respite care (Figures 122, 123). They also agree that qualified child care providers are needed for CSHCN, as well as extended school/after school programs and family counseling programs. Families reported that learning labs, after school programs, dental care, advocacy organizations, support groups, and certified special education personnel were what they needed. Providers also reported that their perceptions of what was most needed were foster homes, parenting classes, mentoring programs, and transportation for appointments.

Figure 122. Most Frequently Identified Needs, Family Perspective, CNA, 2007-2008



Source: Sooner SUCCESS Community Needs Assessment, 2007-2008.

Figure 123. Most Frequently Identified Needs, Provider Perspective, CNA, 2007-2008



Source: Sooner SUCCESS Community Needs Assessment, 2007-2008.

IV. MCH Program Capacity by Pyramid Levels

A. Direct Health Care Services

One of the foremost health needs in Oklahoma is access to comprehensive health services for the MCH population. Providers and services for high-risk children and children with special health care needs are always limited, and access for many of the specialty services is available only in Oklahoma's major metropolitan areas, Oklahoma City and Tulsa. While some regional services are available, they are inadequate for the children in need of publicly supported health care. Lack of access to health services creates barriers, including travel time and transportation costs, for families residing outside the metropolitan centers. Moreover, workplace leave policies often prevent parents and families from gaining access to special services in a manner that is timely, convenient, and productive.

Recent statewide budget shortfalls have been acutely felt by social services and health programs, challenging the capacity of Oklahoma to meet population health needs. State funds to support SoonerCare program enrollment and participation have declined as state dollars for these activities have been curtailed.

In April 2010, a targeted Voluntary Out Benefits Offer (VOBO) was extended to eligible staff in the OSDH Child Guidance Program. The VOBO option was offered as a mechanism to reduce agency expenses vis-a-vis the budget shortfall and to enable employees wishing to separate voluntarily from the OSDH to do so. The VOBO option/opportunity will terminate on June 30, 2010. As of May 28, 2010, a total of 40 employees have been approved to receive the VOBO. As a result, a Reduction in Force (RIF) will not be implemented to achieve the reduced staffing pattern outlined in the Child Guidance Business Plan for reorganization. Currently, there are 24 open positions, covering 14 counties, in the Child Guidance Program. These vacancies cover disciplines of Psychological Clinicians, Child Development Specialists, and Speech Language Pathologists.