

**Maternal and Child  
Health Services Title V  
Block Grant**

**Ohio**

**FY 2019 Application/  
FY 2017 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



## OHIO DEPARTMENT OF HEALTH

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Dear Ms. Lawler:

I am pleased to submit Ohio's application for the Maternal and Child Health (MCH) Services Block Grant (BG) for Federal Fiscal Year 2019. The Title V MCH Program fully embraces the charge of improving healthcare for the populations it serves in Ohio. Included in this application are: the final MCH Priorities and 5-Year Action Plan; the Block Grant Annual Plan for FFY 2019 and the Block Grant Annual Report for FFY 2017.

The Ohio Department of Health (ODH) developed this application with input from stakeholders, providers, consumers and family members under the leadership of the Governor's Office of Health Transformation (OHT). A mechanism for public review and comment were developed and feedback is included in the application. ODH will review the recommendations and feedback received by the public, where appropriate, ODH will incorporate this information into Ohio's Title V program.

The Title V MCH priorities and BG application were drafted in alignment with the OHT State Innovation Model and the ODH State Health Improvement Plan (SHIP). Alignment of the MCH Block Grant with this major public health work will better enable ODH to address the healthcare needs of MCH populations in Ohio. As we revise the goals identified in the SHIP we will make adjustments to the MCH priorities and action plan as warranted.

If you have any questions, please contact:

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Sincerely,

A blue ink signature of Lance D. Himes, written in a cursive style.

Lance D. Himes  
Director of Health



### **I.B. Face Sheet**

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

### **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

### **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

## **II. Logic Model**

*Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.*

### III. Components of the Application/Annual Report

#### III.A. Executive Summary

##### III.A.1. Program Overview

#### **Ohio Title V Maternal and Child Health Service Block Grant Executive Summary**

The Ohio Department of Health's (ODH) mission is to protect and improve the health of all Ohioans by preventing disease, promoting good health and assuring access to quality care. ODH's strategic agenda is informed by a State Health Assessment and a State Health Improvement Plan which include maternal and child health priority focus areas.

The Title V Maternal and Child Health (MCH) program is an organized community effort to eliminate health disparities, improve birth outcomes and improve the health status of women of childbearing age, infants, children, including children with special health care needs (CSHCN), adolescents, and families in Ohio. The MCH program utilizes a life course approach in developing strategies for improving systems and factors impacting social determinants of health.

Strategies are accomplished by engaging in a focused, multidisciplinary, collaborative approach to health improvement. This is done in coordination with internal and external stakeholders that serve individuals and populations that are disproportionately affected by poor health outcomes under the MCH umbrella. Also, included in collaborative efforts are families, youth and consumers whose voice lends to vital understanding of the unique needs of the population. These systems, stakeholders and consumers work together on achieving shared policy, programmatic goals and data integration to ensure that all of Ohio's women, infants, children with and without special health care needs, youth and adolescents, and families receive the services they need to promote their health and wellness. These partnerships are critical because no single system has the resources or capacity to accomplish this goal alone.

In 2015, MCH led a collaborative and comprehensive needs assessment process with internal and external MCH experts, agency partners and consumers. These efforts resulted in the identification of Ohio's priority focus areas.

Ohio's priority needs for 2015-2020 include:

- Increase the prevalence of women receiving preconception care
- Reduce the rate of infant mortality and disparities statewide
- Increase comprehensive newborn screenings and improve Ohio's newborn screening system
- Increase access to early infant care and wellness
- Increase the prevalence of children receiving integrated physical, behavioral, mental, and developmental services
- Reduce the rate of childhood obesity
- Increase access to care via patient centered medical homes for children with special health care needs
- Reduce barriers, improve access, and increase the availability of health services for all populations
- Reduce the rate of maternal smoking and substance abuse by pregnant women

Information continues to be collected through data analysis, surveys, program evaluations and consumer engagement. A 5-Year Action Plan drives the development and implementation of strategies and activities aligning the National Performance Measures and state priorities within six population health domains: women/maternal health, perinatal/infant Health, child health, children w/special health care needs (CSHCN), adolescent health, and

cross-cutting/life-course areas. A summary of strategies and National Performance Measures (NPM) and State Performance Measures (SPM) by domain are listed described below:

### Women/Maternal Health

Strategies identified in the five-year action plan include: 1) Ensure comprehensive preconception health care services are provided; 2) Align MCH funded programs that serve reproductive age women and men to improve access, quality, and increase availability of preconception health services; 3) Increase provider utilization of evidenced based, culturally-competent, preconception care; 4) Partner with stakeholders and relevant health care providers to increase the prevalence of women receiving preconception care; 5) Utilize social media to promote preconception care and targeted health messages; 6) Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits; 7) Support efforts that impact socio-emotional health and addiction needs of reproductive age women 8) Increase the number of health care providers who have received training in trauma informed care to reduce the extent to which experience of trauma is a barrier to women receiving preconception health care; and 9) Increase the number of health care providers and community members receiving training on violence prevention and on appropriate response to victims of sexual and domestic violence and human trafficking.

In FY17, for those served by the Ohio Department of Health's Reproductive Health and Wellness Program, 65.2% of female, unduplicated clients had primary care coverage. This is a 47.6% increase since the same time in FY2012 when only 44.2% of women had primary care coverage.

NPM 1: Percent of women, ages 18 through 44, with a past year preventive visit

### Perinatal/Infant Health

Ohio has identified the following priorities to improve perinatal and infant health:

- Reduce the rate of infant mortality and disparities statewide
- Increase comprehensive newborn screens and improve Ohio's newborn screening system
- Increase access to early infant care and wellness

To address the complex issues and systems, there are several large, data-driven initiatives implementing evidence-based strategies. These include the Ohio Equity Institute whose aim is to reduce infant mortality and associated disparities in nine urban communities; the Ohio Perinatal Quality Collaborative (OPQC) that utilizes quality improvement science including: the Progesterone Project which works to reduce preterm births & improve outcomes of preterm newborns in partnership with the Ohio Department of Medicaid; Help Me Grow which is a system of supports for evidence-based home visiting aimed at empowering parents and caregivers with skills and tools to nurture the healthy growth of children and support early engagement through prenatal enrollment; and enhancements in newborn screenings focusing on system linkage to increase and improve identification and referrals.

NPM 5a - Percent of infants placed to sleep on their backs, b) percent of infants placed to sleep on a separate approved sleep surface, c) percent of infants placed to sleep without soft objects

NPM 4a - Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

SPM 1 – Black Infant Mortality Rate (per 1,000 live births)

SPM 4 – Percent of infants who are exclusively breastfed at hospital discharge

SPM 5 – Percent of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system

### Child Health

Ohio's child health domain focuses on comprehensive well child visits and childhood obesity. A diverse group of professionals are promoting strategies to increase the prevalence of children receiving integrated physical, behavioral and mental health services. A second workgroup's effort are aimed at increasing the number of at-risk children receiving interventions through health practitioners to prevent and manage obesity and increasing the number of licensed early child and school-aged child care providers that have adopted healthy eating and active living policies.

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool

SPM 2 – Percent of children 0-17 years with a preventive medical visit in the past 12 months

SPM 6 – Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day

#### Children w/Special Health Care Needs (CSHCN)

Children with special health care needs (CSHCN) are defined as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond the required by children generally.

Ohio's efforts to address CSHCN includes Ohio Revised Code 3701.023 requiring ODH to review eligibility for medically handicapped children (CMH) that are submitted to the department by city and general health districts and physician providers approved in accordance with the code.

ODH convenes a state-wide workgroup comprised of representatives from ODH, the Ohio Department of Medicaid, clinicians specializing in treatment of CSHCN, parents of CSHCN, hospitals, condition-specific advocacy groups, and members of the ODH CSHCN Parent Advisory Committee. Partnerships are leveraged with key stakeholder groups to educate families, specialists providing services to CSHCN, educators and other school personnel, and advocacy groups on the qualities and benefits of a Patient-Centered Medical Home. The ODH CSHCNs program works directly with more than 40,000 families of CSHCN annually.

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

#### Adolescent Health

Ohio's adolescent health experts are working to increase the percent of adolescents receiving a preventive well-visit and improve adolescent-centered care. ODH has partnered with the Ohio Chapter, American Academy of Pediatrics to provide trainings and implement quality improvement strategies in practices serving higher percentages of Medicaid patients. Only 43% of Ohio's Medicaid eligible adolescents received at least one well-care visit in the past year. However, 28 counties increased the number of Medicaid eligible adolescents receiving visits by 3% or more with one Appalachian county achieving a nearly 9% increase.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

#### Cross-cutting

Ohio is striving to reduce the number of women who smoke before, during and after pregnancy and to reduce exposure to second-hand smoke by increasing the adoption, reach and impact of evidence-based behavioral cessation programs. Strategies include cessation programs Baby & Me – Tobacco Free (BMTF) and Moms Quit for Two for the pregnant and post-partum population and a quality improvement collaborative to enhance 5A's implementation. These strategies have been integrated into different health care setting including the Supplemental Nutrition Program for Women, Infants, and Children (WIC), Maternal Child and Health (MCH), Help Me Grow (HMG), Ohio Infant Mortality Reduction Initiative (OIMRI, rebranded as Moms and Babies First), Reproductive Health and Wellness Program (RHWP), and Federally Qualified Health Centers (FQHCs). Ohio also works with various healthcare leaders, stakeholders, and medical professionals to implement Medication Assisted Treatment (MAT) for opioid dependent pregnant mothers eligible for or enrolled in Medicaid during and after pregnancy.

NPM 14.1 – Percent of women who smoke during pregnancy

Ohio's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program will continue the current expansion of high quality evidence-based home visiting services which target children and families who are most at-risk for poor birth or childhood outcomes. Ohio's newly launched statewide Central Intake System was developed to ensure children and families access appropriate available home visiting and identified support services. By way of the state's well-coordinated risk-based continuum of evidence-based home visiting programing, Ohio seeks to provide families with their choice of available programing. The state of Ohio has a long history of statewide early childhood collaboration to ensure that all children are born healthy and ready to succeed in school.

In summary, the description of strategies and measures represent key initiatives but does not reflect the entirety of work being implemented across the state and in collaboration with stakeholders. Significant contributing stakeholders include other state agencies, local health departments, health care and health care organizations, managed care organizations, insurance, community-based agencies, and consumers.

### **III.A.2. How Title V Funds Support State MCH Efforts**

#### **MCH Complementing Overall State Efforts**

Title V supports the implementation of evidenced-based strategies aimed to improve population health outcomes through a life-course approach and by addressing social determinants of health.

MCH strategies are aligned to the 2017-2019 State Health Improvement Plan (SHIP). Developed with input from many state and local-level stakeholders, the SHIP serves as a strategic menu of priorities, objectives and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners engaged in community health improvement planning, education, housing, employers, transportation and criminal justice. The SHIP drives more efficient and effective allocation of resources toward measurable improvements on a number of health outcomes by focusing on three priority topics: maternal and infant health, mental health and addiction and chronic disease.

Governor Kasich initiated an unprecedented package of reforms to improve overall health system performance for pregnant women and infants. Over two years, \$41 million has targeted initiatives to improve birth outcomes and reduce racial and ethnic disparities in infant mortality. These initiatives include increased home visiting in at risk neighborhoods, transportation services for pregnant mothers, and safe-sleep awareness programs and align with the SHIP priorities to reduce preterm births, reduce low birth weight, and reduce infant mortality.

### **III.A.3. MCH Success Story**

#### **Success Story**

##### Infant Vitality

New Beginnings for New Fathers (NBNF) is an initiative of the Ohio Equity Institute in Columbus, Ohio. The following true story represents the value of providing comprehensive programming to new fathers for reducing infant mortality.

While supporting a pregnant couple through the Home Visiting program, the boyfriend of the pregnant woman was referred to the NBNF program. The baby was born with heart complications that required a lengthy stay in the neonatal intensive care unit. While in the program, the new father had learned about infant safe sleep practices and the importance of breastfeeding. He said he felt more comfortable with bringing the baby home and creating a safe and healthy environment.

Admittedly, this dad had been an occasional smoker and was living in a home where smoking was taking place from time to time. But, once he learned the risk factors to his baby, he changed his environment and made it completely smoke-free. He also received a porta-crib through the NBNF program to provide a safe sleeping environment for baby, and made sure to participate in the car seat program through Columbus Public Health to learn how to properly install and fasten a child into a car seat.

The knowledge this father about healthy infant feeding practices, ABC's of Safe Sleep, and the importance of car seat safety contributed to the baby's healthy development. His baby has surpassed his first birthday and is happy, healthy, and thriving!

### III.B. Overview of the State

#### Maternal and Child Health Services Title V Block Grant – Overview

Public health in Ohio has undergone many changes since 1886 when the State Board of Health was established to help coordinate the fight against tuberculosis. In 1917, the Ohio Department of Health (ODH) was created by the Ohio General Assembly to control the spread of all infectious diseases. Today, ODH is a cabinet-level agency, and its Director reports to the Governor. The Administration's health and human services (HHS) cabinet agencies are tasked with goals to improve services to vulnerable Ohioans, reduce cost and increase efficiency. Through collaboration and innovation, the Governor's Office of Health Transformation (OHT) leads the health and human services agencies and has achieved many successes in streamlining services to vulnerable populations in Ohio.

ODH fulfills its mission through collaborative relationships, including with Ohio's 114 local health departments. The ODH mission is to protect and improve the health of all Ohioans by preventing disease, promoting good health and assuring access to quality care. ODH's strategic agenda is informed by a State Health Assessment, and a State Health Improvement Plan to address key health issues identified in the assessment. Key health issues identified include infant mortality, prevention of infectious disease, and Ohioans' access to primary care. ODH became an accredited health department by the Public Health Accreditation Board (PHAB) in 2015.

Title V provides vital funding and infrastructure to the ODH and is an asset to improving health outcomes. The Bureau of Maternal, Child and Family Health (BMCFH) houses the majority Title V programs, and works closely with other ODH Bureaus such as the Bureau of Health Services (BHS) where the WIC program, Children with Special Healthcare Needs, and Ryan White are housed. The Title V MCH Block Grant is administered by BMCFH and the Title V Director serves as the Chief of BMCFH. The BMCFH and the BHS work together to coordinate and leverage resources, funding and partnerships to provide the needed public health services at the state and local level.

The BMCFH is designed to be an organized state and local effort to improve the health status of women, infants, children and families in Ohio by identifying needs and implementing programs and services to address those identified needs. BMCFH's capacity to address the six population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders. Our primary goal is to serve as a safety net for all MCH populations including racial and ethnic groups disproportionately affected by poor health outcomes. Specific efforts are made to transition families from direct service through population-based system improvements that impact social determinants of health.

BHS, housed within the Office of Health Improvement and Wellness administers the Children with Medical Handicaps (CMH) program serving Children with Special Health Care Needs (CSHCN), including: a Diagnostic, Treatment, and Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and helping families navigate the health care system. BHS utilizes vital committee/council structures to foster open dialogue, receive input and feedback in regard to CSHCN needs across the state. The Director of Children with Special Health Care Needs serves as the Office Chief.

In 2015-2016, ODH developed a strategic plan that outlines the strategic issues, goals and objectives to move the agency forward and position it for continued success in the new healthcare environment. These strategic issues included aligning ODH's work with the state health improvement plan, state health initiatives and priorities; ensuring effective decision-making processes to support the agency's goals; developing the workforce to support ODH's public health priorities; and ensuring that ODH's data infrastructure supports data-driven decisions. ODH realigned

their organizational structure to manage the overall Department more effectively and efficiently which provides opportunity for collaboration and partnership with sister agencies, local health departments, and other organizations. A revised table of organization is included in the Supporting Documents Section.

Through this process, ODH strengthened its commitment to core public health responsibilities with a renewed focus on what it calls the “Pillars of Public Health”:

- Infectious Diseases,
- Preparedness,
- Health Improvement and Wellness,
- Health Equity and Access,
- Environmental Health and Regulatory Compliance.

To address the complex needs of the population, agency priorities and goals of Title V, ODH uses a life course framework to improve health outcomes across the lifespan. The life course perspective recognizes the linkages between early life experiences and later experiences in adulthood and looks at health as an integrated continuum:

- Today’s experiences and exposures determine tomorrow’s health.
- Health outcomes are affected during critical or sensitive periods in our lives.
- Social determinates of health, including biological, behavioral, psychological, social, and environmental factors contribute to health outcomes.
- Populations within Ohio face significant barriers to achieving the best health possible these groups include Ohio’s poorest residents, persons with disabilities and racial and ethnic minority groups.

The state health assessment (SHA), released in August 2016, described the current status of health and well-being in Ohio and highlighted the state’s many opportunities to improve health outcomes, reduce disparities and control healthcare spending. This 2017-2019 state health improvement plan (SHIP) seizes upon those opportunities by laying out specific steps to achieve measurable improvements on key priorities including, maternal and child health, behavioral health and chronic disease. Developed with input from many state and local-level stakeholders, the SHIP serves as a strategic menu of priorities, objectives and evidence-based strategies to be implemented by: State agencies; local health departments, hospitals and other community partners engaged in community health improvement planning; and sectors beyond health, including education, housing, employers/business, regional planning/transportation and criminal justice.

### **Ohio Demographic Information**



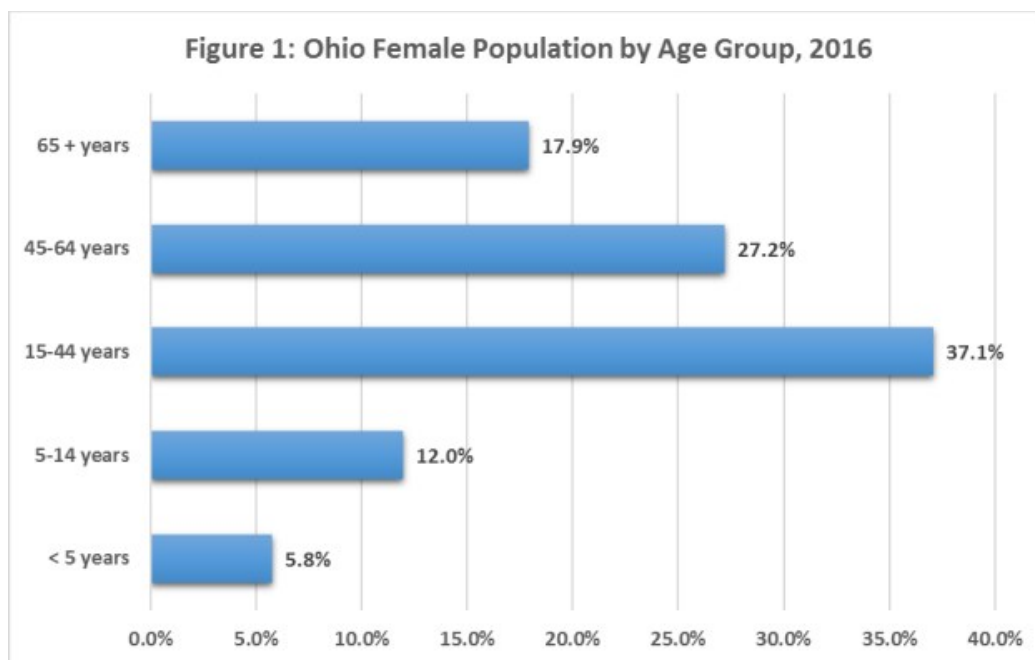


In 2017, the population of Ohio was estimated at 11,658,609, a net increase of approximately 121,880 since 2010. It is the seventh most populous state in the United States. The capital of Ohio is Columbus which is Ohio's most populous city with a population of 860,090 (2016) and is one of the fastest growing large cities in the United States. It is located in Franklin County in Central Ohio. The most densely populated area of the state is the northeast corner which encompasses Cleveland, Akron, Youngstown, and Canton. The least densely populated area of the state is the Appalachian region which follows the line of the Appalachian Mountains from Lake Erie to the Ohio River.

Most Populous Counties in Ohio, 2017	
Franklin	1,291,981
Cuyahoga	1,248,514
Hamilton	813,822
Summit	541,228
Montgomery	531,542
Lucas	430,887
Butler	380,604
Stark	372,542
Lorain	307,924
Lake	230,117

## Population Distribution

Children and young adults through age 24 years accounted for 31.8 percent of the total population in 2016. Females comprise 51 percent of Ohio's population. Figure 1 below shows how the age distribution of the female population.



The foreign-born (anyone who was not a U.S. citizen at birth) share of Ohio's population rose from 3.0 percent in 2000, to 4.2 percent in 2016. The largest proportion of foreign-born residents come from Asia (42.1%) followed by Europe (22.6%) and Latin America (19.5%).

18.5% of foreign-born residents live below 100 percent of the poverty level, compared with 15.2% percent of the native-born population. Seventy-seven percent of foreign-born residents speak a language other than English. Of those, 37.7% speak English less than 'very well'. The most common languages spoken in Ohio other than English is Spanish.

Non-Hispanic Black or African Americans make up 13.3% of Ohio's population. Hispanic or Latino (of any race) is 3.7% of the population. The percentage of the population that is non-Hispanic Black is comparable to the United States (13.0%). However, the percentage Asian (non-Hispanic) and Hispanic is substantially lower than the in the US population.

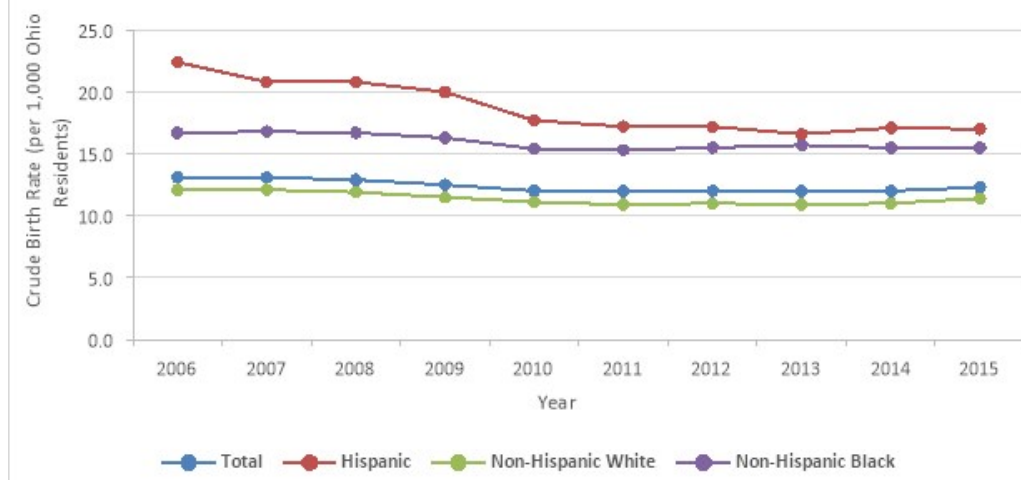
Table 2: Ohio and US Population by Ethnicity and Selected Races, 2016

Race/Ethnicity Group		Ohio (Count)	Ohio (%)	US (%)
Non-Hispanic	Total	11,189,748	96.3	82.2
	White	9,339,854	80.4	62.3
	Black or African American	1,544,892	13.3	13.0
	Asian	274,894	2.4	6.0
	American Indian or Alaska Native	30,108	< 1	< 1
Hispanic or Latino	Total	424,625	3.7	17.8
	White	357,252	3.1	15.9
	Black or African American	47,344	< 1	1.0
	Asian	7,705	< 1	< 1
	American Indian or Alaska Native	12,324	< 1	< 1

### Birth Rates

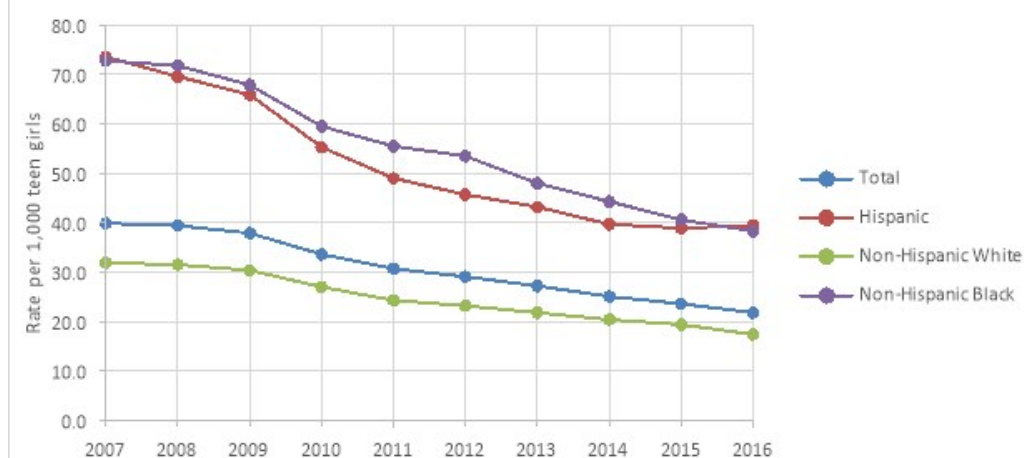
Ohio's crude birth rate has decreased in the past ten years from 12.9 to 11.9 per 1,000 persons in 2016. (Figure 2). Hispanic births declined 23.7% from 2006 to 2014 (from 22.4 to 17.1 per 1,000), but remains higher than non-Hispanic whites and non-Hispanic blacks (11.0 and 15.5 per 1,000 respectively).

**Figure 2: Crude Birth Rate by Race/Ethnicity, 2006-2015**



Ohio's teen birth rate (ages 15-19 years) decreased from a high of 39.9 per 1,000 persons in 2007 to 21.8 per 1,000 in 2016 (Figure 3). Teen births among Hispanics and non-Hispanic blacks are comparable and showed a similar decline in the past 10 years.

**Figure 3: Teen Birth Rate (15 - 19 years) by Race/Ethnicity, Ohio, 2007-2016**



### **Ohio's Disability Population**

It is estimated that 13.8% of Ohioans have a disability. This includes vision or hearing impairment, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty. Not surprisingly, people 75 years of age and older are most likely to have a disability (48.4%). About six and a half percent of children 5-17 years old have a disability.

Twenty-three percent of people 16 and over with a disability are employed compared with 66.8% of those who don't have a disability. Additionally, 22.9% of people 16+ years old with a disability are below 100 percent of the poverty level versus 11.7% of those without a disability. (Ohio Disability Status Report, 2016)

### **Ohio's Social and Economic Indicators**

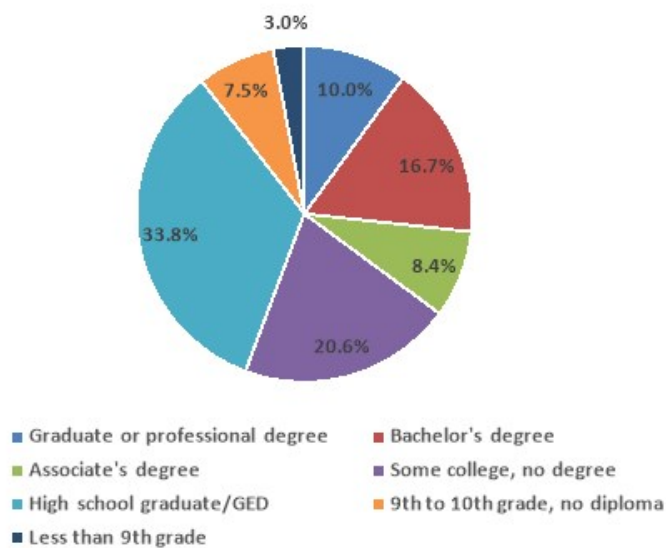
#### **Hospitals**

Ohio has six children's hospitals serving children from all 88 counties, all fifty states and many international countries. According to the Ohio Children's Hospital Association, Ohio's Medicaid costs for children are among the lowest of any state nationwide, despite having the best network of hospitals in the country: Ohio ranks 47th nationally in costs per member per month for pediatric Medicaid expenditures. Additionally, on average, Ohio's spending for the state's Covered Families and Children population is 20% below the national average.

## Education

Approximately, 11% of Ohioans aged 25 and older have less than a high school diploma, 34.1% have only a high school diploma. Please refer to Figure 4 for a breakdown of educational attainment in Ohio.

**Figure 4: Educational Attainment (25+ Years), Ohio, 2016**



The percentage of women with a bachelor's degree or higher (26.6%) is comparable to the percentage of men with a bachelor's degree or higher (26.7%). However, there is a gender gap when we look at black women (17.7%) compared to black men (14.3%).

When examining educational attainment by race and ethnicity, Asian adults were more likely to have a bachelor's degree or higher (60.8%) when compared with white, non-Hispanic (27.6%), Hispanic (17.8%) and black (16.1%) adults.

The poverty rate for persons who have less than a high school diploma is 28.4% compared with 3.9% with a bachelor's degree or higher.

According to the Ohio Department of Education, in school year 2017-2018 14.9% of students enrolled in public schools (K-12) had a disability. Almost half (48.8%) of the students were economically disadvantaged.

## Economic Overview

Ohio is the seventh largest state economy with a gross domestic product (GDP) of \$625.7 billion dollars in 2016. The manufacturing industry accounts for 17% of the GDP (see Figure 5). The two leading exports are motor vehicles and machinery.

According to the Ohio Department of Development, the unemployment rate in Ohio was 4.9 percent in December 2017 compared to 4.5% in the US. Rate of unemployment varies across the state with the highest rates ( $\geq 5.0\%$ ) in

Appalachian counties and urban centers in the Northeast including Cleveland, Akron, Youngstown, and Canton. The lowest rates ( $\leq 4.0\%$ ) are seen in central Ohio and western counties along the Indiana border. This includes the cities of Columbus and Cincinnati.

The median household income in Ohio in 2016 was \$52,334.

## Poverty

Almost 1 in 6 Ohioans live in poverty (15.4%). The map below was obtained from the Ohio Development Services Agency. It shows the distribution of poverty in Ohio during 2012-2016. Based on five years of data, 46 of Ohio's 88 counties were above the national average. The 32 counties that make up the Appalachian region had a poverty rate of 17.6 percent compared with 14.9 percent for the rest of the state. Eleven of the twelve counties with a poverty rate above 20.0 percent are in this region.

Higher rates of poverty are also seen in counties with the central or principal cities of metropolitan areas. Allen (Lima), Clark (Springfield), Cuyahoga (Cleveland-Elyria), Franklin (Columbus), Hamilton (Cincinnati), Jefferson (Steubenville), Lucas (Toledo), Mahoning (Youngstown), Montgomery (Dayton), Richland (Mansfield), and Trumbull (Warren) all had rates higher than the state average.

The counties with the lowest poverty rates are all bordering or a part of a metropolitan area: Delaware (4.9%), Warren (5.4%), Putnam (7.8%), Medina (6.6%), and Geauga (6.9%).

People at the greatest risk for poverty include children. The poverty rate for children under 11 and young adults ages 18 to 24 exceeded 21 percent in 2016. The rate for children 0 to 4 years is 23.9%. Poverty rates are also higher among families with a single female head of household compared to a household with a married couple (41.1% and 1.0% respectively).





## Poverty in Ohio by County

2012-2016 American  
Community Survey

**Statewide Poverty**  
**1,732,839**  
15.4%

Percentage  
County Population  
in Poverty

4.9% - 9.9%  
10.0% - 15.4%  
15.5% - 19.9%  
20.0% - 31.2%

Appalachian Ohio

This map shows the 2012-2016 American  
Community Survey estimates of the  
number and percentage of persons in  
poverty by county

Source:  
2012-2016 American Community Survey,  
U.S. Census Bureau

Prepared by:  
Office of Research  
Ohio Development Services Agency  
January 2018



## Public Assistance

According to the Ohio Department of Job and Family Services (ODJFS), about 1.7 million persons received benefits from the Supplemental Nutritional Assistance Program (SNAP) during state fiscal year (SFY) 2017. This is a 6.5% decrease from 2016 and an 10.1% decrease from 2015. The average monthly benefit per person was \$123.92. The total expenditure was approximately \$2.2 billion, a 7% decrease from 2016 and a 10.9% decrease from 2015.

ODJFS also administers Ohio Works First (OWF) which is the financial assistance portion of Ohio's Temporary Assistance to Needy Families (TANF) program. In SFY 2017, 103,649 individuals received OWF benefits totaling \$244 million. This is a decrease of 3.2% from 2016 and 8.0% from 2015.

Disability financial assistance has continued decreased since 2015. In SFY 2017, 6,282 individuals received disability financial assistance totaling \$9.5 million. This is a 33.8% decrease from the disability financial assistance provided in 2015.

As a result of the federal Affordable Care Act, the extension of Medicaid coverage and Ohio's efforts to increase value in healthcare and public health spending, the healthcare and public health fields are changing in Ohio. In January 2014, Ohio extended coverage to adults making less than 138 percent of the federal poverty level. The percentage of adults receiving Medicaid in Ohio in 2015 was 18.8 percent compared with 12.6 percent in 2012 (Ohio Medicaid Assessment Survey (OMAS), <http://grc.osu.edu/OMAS/>). About 2 percent of adults in Ohio received insurance coverage from the health insurance exchange (OMAS). In 2015, 7.0 percent of adults and 2.2 percent of children were uninsured (OMAS). Data updates will be available in the Fall of 2018.

According to a report developed by Georgetown University Health Policy Institute and the American Academy of Pediatrics, the following percentages of children depend on Medicaid and Healthy Start (CHIP) for health care (<http://ccf.georgetown.edu/2017/04/19/snapshot-source-2/>) :

- 81% of Children living in or near poverty
- 44% of infants, toddlers, and pre-schoolers
- 47% of children with disabilities or other special health care needs
- 100% of children in foster care
- 52% of newborns

## Health Care System

In 2011, Ohio health care system was fragmented in a way that leads to disrupted relationships, poor information flows, and misaligned incentives that combine to degrade quality and increase cost. Ohio HHS policy, spending and administration was split across multiple state and local government jurisdictions, and this inefficient structure impeded innovation and lacked a clear point of accountability. Ohioans spent more per person on health care than residents in all but 17 states, yet higher spending did not result in better health outcomes for Ohio citizens.

Ohio has significant disparities for many health outcomes by race, income and geography, and spends more on health care than most other states. To turn this around, the Kasich Administration has increasingly targeted the state's health-related resources to address the most pressing needs. The Office of Health Transformation (OHT) is incorporating population health performance measures into regulatory and payment systems, and using those measures to align population health priorities across clinical services, public health programs, and community initiatives. Ohio leads the nation in efforts to improve the health of its citizens by resetting the basic rules of health care competition to reward better care, not just more care. OHT and its state agency partners have been working with private sector health plans and providers since 2012 to pay for what works to improve and maintain health and shift from volume-based fee-for-service payments to value-based payments. One clear path to better value was to invest in comprehensive primary care (CPC). Beginning January 1, 2017, Ohio's four largest health insurance plans, along with Medicaid and Medicare changed how they pay to financially reward primary care practices that do more

to keep people well and avoid unnecessary costs, creating Ohio's Comprehensive Primary Care Program.

Ohio's State Innovation Model (SIM) focuses on increasing access to patient-centered medical homes and implementing episode-based payments. The patient-centered medical home payment structure encourages practices to organize and deliver care that broadens access while improving care coordination, leading to better outcomes and lower total cost of care. The episode-based payment is based on performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition. In the third wave, neonatal episodes are being reported with performance payments expected in 2019.

The proposed Governor's 2018-2019 Budget provides enhanced maternal care coordination through Medicaid for women living in neighborhoods most at risk for poor infant health outcomes. Ohio ranks 8th in the nation in the percent of adults who smoke. In addition, 15 percent of high school students and nearly 4 percent of middle school students were current smokers (2013). To combat these issues, the budget increased the current tax on cigarettes by 35 cents. In addition, ODH priorities include improving birth outcomes and reduce infant mortality rates by building on past initiatives. New efforts will include surging resources to high-disparity communities through the Ohio Equity Institute; expanding funding for Centering Pregnancy and Parenting; expanding safe sleep efforts; reducing Ohio's smoking rate through prevention, cessation, and smoking ban enforcement efforts.

In Spring of 2018, Ohio submitted a waiver in response to the federal government's work requirement under Medicaid expansion. The proposed waiver calls for Medicaid enrollees to work or participate in community service activities for at least 20 hours per week. Exemptions include individuals over age 55, students, those seeking substance abuse treatment or have serious physical or mental health issues. The Ohio Department of Medicaid estimates 18,000 individuals will not be able to comply and lose coverage.

### **Emerging Issues and Efforts to Improve Population Health Outcomes**

**Intensified Response to Opiate Abuse** - In response to this growing opiate epidemic, Governor Kasich created the Governor's Cabinet Opiate Action Team to attack opiate abuse on every front. Governor's Cabinet Opiate Action Team finished the development of three sets of opioid prescriber guidelines: 1) the Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OACS) 2) guidelines for the treatment of chronic pain and 3) guidelines for the management of acute pain for patients treated outside of emergency departments. Ohio is currently in the process of developing a social marketing campaign aimed at both prescribers and the general public. The objectives of the campaign are to 1) Engage and educate prescribers on appropriate prescribing practices 2) Support positive prescriber interactions with patients by raising awareness of appropriate prescribing practices among the general public. As part the campaign tools and resources for prescribers to use for support those positive patient interactions and supporting patient education will be developed and disseminated. Additions, in April of 2017 Gov. Kasich and the health regulatory boards announced new limits on prescribing opiates for acute pain which will be enacted by rule.

**Targeted Resources to Reduce Infant Mortality** - More than 1,000 Ohio babies die each year before their first birthday; it is one of the worst infant mortality rates in the country. Continuing to build upon a comprehensive range of initiatives that have addressed infant mortality, Ohio is implementing proven and new initiatives to tackle the leading causes of infant mortality, focus resources where the needs are the greatest and implement system changes that will help save babies' lives. The Ohio Department of Medicaid (ODM) counties to invest \$26.8 million in State Fiscal Years 2016-2017 to support community-driven proposals leveraging evidence-based interventions to combat poor birth outcomes and infant mortality at the local level in the nine Ohio Equity Institute (OEI) counties. Evaluation of these evidence-based interventions as well as the coordination of the OEI efforts at the local and state levels are being conducted and coordinated collaboratively with ODH and ODM. Ohio Equity Institute counties are implementing the following interventions: CenteringPregnancy®, smoking cessation, safe sleep, breastfeeding, family planning/LARC, progesterone, fatherhood, peer advocates, health education curriculum, evidence-based home visiting, Pathways Community HUB and authentic community engagement.

The Governor's Office of Health Transformation (OHT), and the Ohio Departments of Medicaid (ODM), Health (ODH) and Higher Education (ODHE) developed the Infant Mortality Research Partnership (IMRP) to identify resources and interventions needed to improve health outcomes for underserved populations and address the complicated issue of infant mortality from a systems perspective. The IMRP funds multiple research projects to: examine and identify infant mortality solutions from a systems perspective in order to address the complexity and uniqueness of Ohio's infant mortality problem, develop predictive models to identify pregnant women and babies, among Ohio Medicaid recipients and underserved populations, apply spatial methods to identify Ohio communities with the highest infant mortality experience, and conduct an evaluation of the Ohio Infant Mortality Reduction Initiative (OIMRI) to assess the effectiveness of its community health worker model and home visiting program on birth outcomes.

**Election Impact** -The election in the Fall of 2018 will bring administration changes to the state of Ohio. The state will elect a new Governor, Attorney General, Speaker of the House and other key positions. This brings many unknowns to the state and public health pending the new administration's priorities. MCH will continue to advocate for the role of Title V and needs of families, mothers, infants, youth, and children with special health care needs.

### **Key State MCH Statutes**

- In 2016, Ohio Governor John R. Kasich signed House Bill 483 into law, which formally established Help Me Grow as the state's evidenced-based home visiting program. The legislation required the state to implement the program in a fashion similar to that of the federal home visiting program, to include the use of evidence-based models and performance measures.
- The Home Visiting Unit was established within the Bureau for Maternal, Child, and Family Health. Under this new alignment, all state and federal home visiting programs were moved to one section under singular leadership. Additionally, Ohio established the first ever statewide performance measurement benchmark plan for home visiting agencies operating in the state. During FY16, Ohio's home visiting programs served 11,586 families, completing more than 114,000 home visits. 42% of the families served were enrolled prenatally, with an overall average length of stay of 419 days. 58% of families enrolled were at or below 50% of the federal poverty guidelines.
- The final version of the Governor's budget supported enhanced care management for women in high-risk neighborhoods and engages leaders in those neighborhoods to connect women to care (ORC 5167.17); maintained current Medicaid eligibility levels for pregnant women (ORC 5163.06); covered additional services in home visitation for pregnant women and newborns, including cognitive behavioral therapy and depression screenings (ORC 5167.16); required the Health Director to identify and report on performance of programs to reduce infant mortality (ORC 3701.95); improved the administration of Progesterone for at-risk mothers (ORC 289.20); required additional disease screenings for newborns (ORC 3701.501); provided funding for evidence-based tobacco cessation programs for pregnant women in areas with high infant mortality rates (ORC 289.20, 289.33, 3794.07); and conducted safe infant and child fatality reviews (ORC 121.22, 2151.421, 3701.70).
- Ohio General Assembly passed landmark infant mortality legislation via the passage of Senate Bill 332 (SB 332) based on recommendations of the Infant Mortality Commission and public testimony. SB 332 represents the largest effort to date by the Ohio General Assembly to combat infant mortality and implements a series of initiatives to lower Ohio's infant mortality rate. Key initiatives include requirements for state agencies to publish timely data; provide training; ban the sale of crib bumper guards; requires the creation of a comprehensive tobacco plan; increases access to long-acting, reversible contraception (LARC); and creates a Home Visiting Consortium and task force to examine the impacts of the social determinants of health on

infant mortality. Effective July 1, 2018 new rules for implementing evidenced-based home visiting, the new data collection system and reporting go into effect.

- ORC 3701.67 established an infant safe sleep screening procedure for hospitals and birthing centers. Hospitals are required to screen new parents and caregivers prior to the infants discharge home to determine if the infant has a safe sleep environment at their residence. If the infant is determined not to have a safe sleep environment, the hospital may do any of the four following activities: obtain a safe crib with its own resources; collaborate with or obtain assistance from persons or government entities that are able to procure a safe crib or provide money to purchase a safe crib; refer the parent, guardian, or other person to a person or government entity described above to obtain a safe crib free of charge from that source.

\*Except where otherwise indicated, the data for this summary was obtained from the 2016 American Community Survey 5-year estimates available at [www.census.gov](http://www.census.gov).

### **III.C. Needs Assessment**

#### **FY 2019 Application/FY 2017 Annual Report Update**

#### **Ohio's Needs Assessment Update**

#### **Ongoing Needs Assessment Activities**

The Title V program uses an Action Group structure to manage its MCH Priorities and implement strategies within the 5-Year Action Plan. Each Priority Action Group is assigned two Co-Leads, an Epidemiologist, and Program Researcher to guide the work of a diverse stakeholder group. These stakeholders are made up of internal and external subject matter experts in that Priority topic as well as consumers. The Action Group Co-Leads are responsible for working with the stakeholder group to: update the 5-year Action Plan, assess performance measures outcomes, implement and monitor strategies to impact the performance and outcome measures, and create or identify an evaluation plan used to assess whether or not the interventions have been successful. In addition to the Domain Action groups, program managers utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes. External stakeholders involved in the Action Groups include sister state agencies, medical associations, providers, insurance, parent and family groups representing CSHCNs, universities, local health departments, and community agencies.

In addition to the Action Groups and stakeholder involvement, the BMCFH has created a data workgroup comprised of epidemiologists, researchers and policy analysts. This group is intended to increase awareness of the numerous data sources and program data in the BMCFH; cooperation among the staff responsible for data analysis, support, and production of data products and providing data support; and peer learning. The group has set up a system for review of data reports published by the BMCFH. Additionally, this group has produced an instruction guide for using the Ohio Public Health Data Warehouse and a 'Quick Guide to MCH Surveillance Systems' as a resource for other bureau staff.

The following are examples of continued stakeholder involvement and feedback, data collection, monitoring, and evaluation that support and enhance the work of the five-year needs assessment and action plan strategies:

The Ohio Pregnancy Assessment Survey (OPAS) was designed in a partnership with the Ohio Department of Health (ODH), ODM and the Government Resource Center at the Ohio State University (GRC) to develop a statewide, ongoing, targeted population-based survey aimed at identifying groups of women and infants at high-risk for health problems. The 2016 data was synthesized to provide information to Ohio Equity Institute counties to improve intervention selection and implementation; as well as monitor statewide progress in maternal and infant health initiatives and infant mortality risk factors.

The Infant Mortality Research Partnership (IMRP), a collaboration between the ODH, ODM, Office of Health Transformation and GRC, continued to use big data to better understand how to reduce infant mortality in Ohio. The IMRP leveraged a diverse array of data methods to answer three questions: where, should interventions be targeted, to whom, should they be targeted and how, should interventions be implemented. The second phase of this work aimed to improve upon and expand the previously developed models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. Supported by ODH and ODM, The Ohio Perinatal Quality Collaborative's (OPQC) progesterone project continues to expand to all of Ohio's Federally Qualified Health Centers. Development and launch of an OPQC data infrastructure project to record and track performance of quality improvement measures continues.

The Adolescent Health Program and the Ohio Equity Institute communities have partnered to host and facilitate

forums aimed at addressing and reducing risks for infant mortality and improved access to positive youth development activities for adolescent girls age 10-14. During the Spring of 2018, stakeholders in each of the nine OEI communities assessed local capacity, data, and identified interventions to reduce infant mortality and related inequities for adolescent girls. Communities also hosted focus groups with girls and their parents/guardians to gain perspective of need and interest in positive youth development activities. Results will be available for state and local planning in Summer 2018.

During this fiscal period, ODH overhauled the state's home visiting system of services, creating a risk-based continuum designed to offer enhanced parent choice of a full spectrum of models and services. This process began by collaborating with stakeholders to revise program rules and policy contained in Ohio Administrative Code 3701-8. These rule changes largely required providers of home visiting services to meet model fidelity standards, as well as expand eligibility by removing the first-time mother requirement. Additionally, the department enhanced relationships with the community and stakeholders by facilitating the first ever statewide home visiting summit, as well as standing up the Ohio Home Visiting Consortium as the state's first every home visiting advisory body.

In January 2017, Ohio's CSHCN who are recipients of Medicaid were transitioned from traditional fee for service coverage to managed care plans (MCPs). In December 2015, the CMH program identified thousands of CSHCN who were impacted and coordinated communication between Medicaid and families. In preparation for the transition, CMH facilitated regional, public meetings with the Ohio Department of Medicaid (ODM), MCPs, hospitals, clinicians, public health nurses, hospital-based service coordinators, and parents to inform the process. Meetings held prior to, during, and in the year following the transition provided opportunities for the MCPs to understand critical priorities for CSHCN and their families. Members of the CMH Medical Advisory Council and Parent Advisory Council were key to the process. As implementation occurred, families provided feedback on progress and challenges. While issues are now fewer in number, they continue to be addressed within the weekly CMH-ODM case conference.

ODH has implemented data management processes to improve access to publicly available data, standardize access to confidential datasets, and enable sharing of data between public health partners, state agencies, citizens, and other interested parties. The Ohio Public Health Data Warehouse is a self-service online tool where anyone can obtain the most recent public health data available about Ohio. Additionally, there is a secure site for authorized public health personnel and IRB-approved researchers to access secure data and line level data. Examples of data sets and reports include vital statistics data (birth, mortality, fetal death, and linked infant mortality files), cancer incidence, county-level youth behavior survey data, and lead blood testing data for children and Ohio lead hazardous properties. Vital statistics is updated on at least a weekly basis. Automation of the vital statistics files has facilitated epidemiological analysis for the Title V block grant making birth and death information available in a timelier and streamlined fashion. Additionally, it makes the data more accessible to our external partners and stakeholders.

<http://publicapps.odh.ohio.gov/EDW/DataCatalog>

### **Title V Program Capacity**

The Bureau of Maternal, Child and Family Health (BMCFH) houses the majority of Title V programs, and works closely with other ODH Bureaus such as the Bureau of Health Services (BHS) which includes the WIC program, Children with Special Healthcare Needs, and Ryan White programs. The Title V MCH Block Grant is administered by BMCFH and the Title V Director serves as the Chief of the Bureau of Maternal, Child and Family Health (a table of organization for the Bureau is included in the attachment section). A total of 1,113 employees work for ODH; a majority work in the central office located in Columbus, Ohio.

BMCFH also utilizes the medical expertise of two highly skilled physicians who serve as subject matter experts in



addressing issues directly impacting MCH populations. Mary Katherine Francis, MD serves as the Assistant Medical Director. Dr. Francis oversees medical issues with the goal of developing and implementing public health policies to improve the health of all Ohioans. Her work places a strong focus on efforts to decrease Ohio's infant mortality rate, improve maternal health outcomes and collaborate with health care providers. Dr. Francis began her career in the public sector as a licensed social worker and spent many years working in the areas of child welfare and mental health.

In addition, Cynthia Shellhaas, MD, MPH provides medical consultation to BMCFH programs serving reproductive age/pregnant women/children/families and guides ODH's work in fetal, child and pregnancy fatality and mortality reviews. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN.

The Children with Medical Handicaps (CMH) program serves Children with Special Health Care Needs (CSHCN) in the BHS, and administers a diagnostic, treatment, and hospital based service coordination program, supporting team based service coordination for conditions such as spina bifida and hemophilia; community based service coordination, supporting public health nurses in local health departments who assist families in linking to local resources and helping families navigate the health care system. BHS utilizes vital committee/council structures to foster open dialogue, receive input and feedback in regards to CSHCN needs across the state. One of these committees is the Medical Advisory Council (MAC), whose members are appointed by the Director of Health, and represents various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions. BHS also houses the Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise CMH. The mission of PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CSHCN.

The BMCFH is designed to be an organized state and local effort to improve the health status of women, infants, and children in Ohio by identifying needs and implementing programs and services to address those identified needs. The BMCFH capacity to address the six population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders. Our primary goal is to serve as a safety net for all MCH populations including racial and ethnic groups disproportionately affected by poor health outcomes.

Programs administered and housed within the BMCFH funded by the MCHBG include: Title X Family Planning (FP), infant mortality reduction (including a statewide Ohio Collaborative to Prevent Infant Mortality (OCPIM), Breastfeeding, Safe Sleep), prenatal tobacco cessation, Save Our Sight vision programs, Genetics Services, Sickle Cell Services, Children's Hearing and Vision, Newborn Screening for Critical Congenital Heart Disease state mandated by SB4Ohio Revised Code 3701-5010, screening for 36 metabolic, endocrine, and genetic conditions, Ohio's Birth Defects Information System state mandated by ORC 3705-30, Gestational Diabetes Collaborative, Perinatal Quality Improvement programs, Early Childhood Comprehensive Systems (ECCS) program, Ohio Equity in Birth Outcomes Institute (OEI), Ohio Infant Mortality Reduction Initiative (OIMRI), Help Me Grow (HMG) Home Visiting, Maternal Infant and Early Childhood Home Visiting (MIECHV) program, Ohio First Steps for Healthy Babies Breastfeeding Initiative, Centering Pregnancy, Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Pregnancy Associated Mortality Review (PAMR), and Sudden Infant Death (SID) Program. BMCFH also houses the School and Adolescent Health and School Nursing programs, the Universal Newborn Hearing Screening (UNHS), Infant Hearing Program, and the Domestic Violence Prevention Program.

### **Key Leadership and Notable Changes**

Lance Himes, former General Counsel, serves as the agency director. Ms. Jennifer Davis joined the senior

executive team as Chief of Staff and works with the director in assisting in defining agency goals and objectives, formulates policies, procedures and agency directives and coordinates the development of strategic plans and budget policy. Ms. Davis also maintains an ongoing relationship with the governor's staff and collaborates with other state agencies for efficiency and best practices.

Clint Koenig, MD, Medical Director, joined ODH in 2017. Dr. Koenig advises the Director of Health on clinical and medical issues as the agency fulfills its mission. He has served in several leadership roles within managed care organizations, federally qualified health centers and substance use centers.

Mary Katherine Francis, MD serves as the Assistant Medical Director. Dr. Francis oversees medical issues with the goal of developing and implementing public health policies to improve the health of all Ohioans.

Sandra Oxley is the Chief of the Bureau of Maternal, Child and Family Health and serves as the MCH Title V Director for Ohio. Ms. Oxley has 15 years of child health and public policy, government relations and management experience, with an emphasis on children's health and system approaches. She has an in-depth knowledge base of maternal and child programs and Medicaid. Ms. Oxley previously served in various capacities at Voices for Ohio's Children since 2008, ranging from Chief Advocacy Officer/State Field Director to her final position as Chief Executive Officer.

Shancie Jenkins, MBA, Chief of the Office of Health Improvement and Wellness (OHIW) and serves as the Title V Director of Special Health Care Needs. The OHIW encompasses WIC (Women, Infant, and Children), Children with Medical Handicaps, Ryan White, Chronic Disease Prevention, and Injury and Violence Prevention programs.

In February 2018, Laura Rooney, MPH was hired as the Title V Maternal Child Health Block Grant Program Services Administrator. Prior to this role, she served as the Adolescent Health Program Manager within the BMCFH.

Maurice Heriot, was hired as the BMCFH Financial Program Manager in March 2018. Prior to this position, Mr. Heriot served as fiscal liaison for MCH within the Office of Financial Affairs.

Reena Oza-Frank has extensive training and expertise as a Maternal and Child Health epidemiologist. She manages the Epidemiology and Research/Evaluation sections for the Bureau. Dr. Oza-Frank leads the State System Development Initiative (SSDI) and Ohio Pregnancy Assessment Survey (OPAS).



## Needs Assessment Summary

### Ohio's Needs Assessment Process

The ODH Bureau of Maternal, Child and Family Health (BMCFH) led a collaborative and comprehensive needs assessment process from January 2014 through March 2015. A strategic mixed-methods approach was used to uncover the gaps in services to Ohioans, which included a review of existing data sources, a stakeholder survey, a consumer survey, nine regional community forums, and one ODH staff forum. The results of these efforts helped members of the MCH leadership team in making recommendations to senior leadership regarding the most critical MCH priority focus areas in Ohio.

### Participant Engagement

Survey results revealed that across all stakeholders surveyed, the perception was that infants were the most at risk population. The mixed-methods approach used to collect the required information to determine the unmet needs in Ohio included a detailed review and analysis of census and vital statistics data, life course indicators, and health disparities data. Criteria used to identify the unmet need included: (1) if an undesirable health indicator was experienced at a higher rate than the national average, (2) was experienced by a significant number of Ohioans, or (3) if a disparity exists. The top priorities related to each population domain were also identified through an analysis of the qualitative data and information collected, and recommendations identified by individual communities across Ohio, and using the criteria outlined above as a filter.

### MCH Population Findings

Needs Assessment findings by MCH Population Domain (Ohio combined its analysis of Women and Perinatal/Infant Health during the needs assessment process). Throughout the process Ohio reached out to both MCH professional stakeholders and MCH consumers, family members and parents for feedback.

- **Women Perinatal/Infant Health** - Top priorities for women and infants were similar among professionals and community perspectives with regard to preconception health, health care education, smoking cessation, breastfeeding policies, and medical home. Professionals generally recommended a focus on preconception health care, provider and family education, and smoking cessation. Community participants referred to policy changes for preconception health, Medicaid incentives, and statewide support for health and wellness. Recommendations to address substance use and abuse issues in women, improved access to maternal and infant care, and enhanced home visiting programs were universal.
- **Child Health** - The child health recommendations were similar between professionals and community participants. First, both groups recommended age appropriate and early screening. Staff highlighted screening procedures, technology, collaboration and Medicaid coverage as specific recommendations. Community participants emphasized provider and parent education, services, and programs. Access to care was a recommendation by professional and community participants specifically related to barriers to access. Community participants focused on provider availability and Medicaid incentives. Both groups cited nutrition issues related to obesity, food insecurity/access, and education as a priority. Parent education was the other shared recommendation for both professional and community participants with regard to resources, classes and WIC programming. There were some differences in recommendations. For instance, professionals recommended access to safe and healthy homes as a priority while the community participants would like to improve coordination of services, focus on dental health and behavioral health/ mental health, expand home visiting, focus on Fetal Alcohol Syndrome, and address issues

related to poverty.

- **Children with Special Healthcare Needs** – Professional and community participants proposed similar priorities for children with special health care needs. For instance, they both recommended coordination of care. They both strongly recommended access to care as a priority. Professionals focused on access to care by acknowledging different population needs and community participants proposed an increase in availability of services, incentives, transportation, Medicaid and marketing of services. Family support was another recommendation by both participants. Professionals highlighted family support and education while community participants related family support to advocacy. Community participants highlighted financial support and insurance, addressing effects of substance abuse, communication of programs/policy issues, education, behavioral/mental health, and transition to adult care as recommended priorities.
- **Adolescent Health** - Professionals and community participants shared similar recommendations related to adolescents, including access to care. Professionals highlighted access in disparate populations with regard to dental and mental health, substance abuse, and transportation. In contrast, community participants recommended improvement in access to care related to medical and health home improvement, coordination of services, increase in providers and increase in services. Both groups highlighted education on healthy relationships as an unmet need. Professionals emphasized healthy relationships supported through evidence-based programs while community participants recommended access to physical activity, prosocial activities and physical education. Driving safety was a proposed priority for all participants. Professionals focused on reduction of injury and community participants emphasized a decrease in texting while driving. Another shared recommendation focused on healthy lifestyle through physical activity, nutrition education and healthy eating habits. The two groups differ on several priorities: professionals recommended sleep as a priority in daily life while community participants highlighted behavioral and mental health, community involvement and parent/youth education, sexual health education, and transition to adult care as recommended priorities.
- **Cross Cutting or Life Course** –All participants shared similar recommendations related to cross cutting or life course issues that have a critical impact on the health of MCH populations. Addressing the disparities issue, especially as it relates to infant mortality was recommended the most by both groups. Other recommendations focused on addressing substance abuse and use in women and adolescents, issues of financial support and insurance, access to safe and healthy homes, lack of transportation, poverty and smoking.

These findings represent the major MCH needs in Ohio, and serve as the basis for identifying the 9 critical priority areas the Title V program is address over the 5-year period.

## **Title V Program Capacity**

### **Organizational Structure**

As a result of the federal Affordable Care Act, the extension of Medicaid coverage and Ohio's efforts to increase value in healthcare and public health spending, the healthcare and public health fields are changing in Ohio. The Ohio Department of Health (ODH) is positioned structurally and strategically to continue fulfilling its mission to protect and improve the health of all Ohioans.

In 2015-2016, ODH developed a strategic plan that outlines the strategic issues, goals and objectives to move the agency forward and position it for continued success in the new healthcare environment. These strategic issues included aligning

ODH's work with the state health improvement plan, state health initiatives and priorities; ensuring effective decision-making processes to support the agency's goals; developing the workforce to support ODH's public health priorities; and ensuring that ODH's data infrastructure supports data-driven decisions. ODH realigned their organizational structure to manage the overall Department more effectively and efficiently which provides opportunity for collaboration and partnership with sister agencies, local health departments, and other organizations. A revised table of organization is included in the Supporting Documents Section.

Through this process, ODH strengthened its commitment to core public health responsibilities with a renewed focus on what it calls the "Pillars of Public Health":

- Infectious Diseases,
- Preparedness,
- Health Improvement and Wellness,
- Health Equity and Access,
- Environmental Health and Regulatory Compliance.

ODH is a cabinet level agency that reports to the Governor's Office. When Governor Kasich took office, he challenged the Administration's health and human services (HHS) cabinet agencies to improve services to vulnerable Ohioans, reduce cost and increase efficiency. Through collaboration and innovation, the Governor's Office of Health Transformation (OHT) leads the health and human services agencies and has achieved many successes in streamlining services to vulnerable populations in Ohio. As a cabinet level agency, the ODH Director Lance Himes reports to the Governor's Office, and works closely with the Director of OHT.

ODH is organized by Offices that report to the Chief of Staff. There are seven Offices, including the Office of Health Improvement and Wellness (OHIW) which houses the Bureau of Maternal, Child and Family Health. A total of 1,113 employees work for ODH; a majority work in the ODH central office located in Columbus, Ohio. Approximately 200 work in the field at district or remote locations across Ohio. ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCHBG) in Ohio. The Office of Health Improvement and Wellness (OHIW) is responsible for MCH programs at the state/local level.

### **Agency Capacity**

The Bureau of Maternal and Child Health (BMCH) houses the majority of Title V programs, and works closely with other ODH Bureaus such as the Bureau of Health Services (BHS) which includes the WIC program, Children with Special Healthcare Needs, and Ryan White programs. The Title V MCH Block Grant is administered by BMCFH and the Title V Director serves as the Chief of the Bureau of Maternal, Child and Family Health (a table of organization for the OHIW is included in the attachment section).

In addition to the full-time ODH staff, BMCFH contracts with a highly skilled physician who serves as subject matter experts in addressing issues directly impacting MCH populations. Cynthia Shellhaas, MD, MPH provides medical consultation to BMCFH programs serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN. Dr. Shellhaas is a Professor at OSU for the OB/GYN Department and is the first female physician in that department.

The Children with Medical Handicaps (CMH) program serves Children with Special Health Care Needs (CSHCN) in the BHS, and administers a diagnostic, treatment, and hospital based service coordination program, supporting team based service coordination for conditions such as spina bifida and hemophilia; community based service coordination, supporting public

health nurses in local health departments who assist families in linking to local resources and helping families navigate the health care system. BHS utilizes vital committee/council structures to foster open dialogue, receive input and feedback in regards to CSHCN needs across the state. One of these committees is the Medical Advisory Council (MAC), whose members are appointed by the Director of Health, and represents various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions. BHS also houses the Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise CMH. The mission of PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CSHCN.

The BMCFH is designed to be an organized state and local effort to improve the health status of women, infants, and children in Ohio by identifying needs and implementing programs and services to address those identified needs. The BMCFH capacity to address the six population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders. Our primary goal is to serve as a safety net for all MCH populations including racial and ethnic groups disproportionately affected by poor health outcomes.

Programs administered and housed within the BMCFH funded by the MCHBG include: Title X Family Planning (FP), infant mortality reduction (including a statewide Ohio Collaborative to Prevent Infant Mortality (OCPIM), Breastfeeding, Safe Sleep), prenatal tobacco cessation, Save Our Sight vision programs, Genetics Services, Sickle Cell Services, Children's Hearing and Vision, Newborn Screening for Critical Congenital Heart Disease state mandated by SB4Ohio Revised Code 3701-5010, screening for 36 metabolic, endocrine, and genetic conditions, Ohio's Birth Defects Information System state mandated by ORC 3705-30, Gestational Diabetes Collaborative, Perinatal Quality Improvement programs, Early Childhood Comprehensive Systems (ECCS) program, Ohio Equity in Birth Outcomes Institute (OEI), Ohio Infant Mortality Reduction Initiative (OIMRI), Help Me Grow (HMG) Home Visiting, Maternal Infant and Early Childhood Home Visiting (MIECHV) program, Ohio First Steps for Healthy Babies Breastfeeding Initiative, Centering Pregnancy, Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Pregnancy Associated Mortality Review (PAMR), and Sudden Infant Death (SID) Program. BMCH also houses the School and Adolescent Health and School Nursing programs, the Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program.

## **FY 2017 Application/FY 2015 Annual Report Update**

### **Ohio's Needs Assessment Process**

The ODH Bureau of Maternal and Child Health led a collaborative and comprehensive needs assessment process from January 2014 through March 2015. A strategic mixed-methods approach was used to uncover the gaps in services to Ohioans, which included a review of existing data sources, a stakeholder survey, a consumer survey, nine regional community forums, and one ODH staff forum. The results of these efforts helped members of the MCH leadership team in making recommendations to senior leadership regarding the most critical MCH priority focus areas in Ohio.

### **Participant Engagement**

Survey results revealed that across all stakeholders surveyed, the perception was that infants were the most at risk population. The mixed-methods approach used to collect the required information to determine the unmet needs in Ohio included a detailed review and analysis of census and vital statistics data, life course indicators, and health disparities data. Criteria used to identify the unmet need included: (1) if an undesirable health indicator was experienced at a higher rate than the national average, (2) was experienced by a significant number of Ohioans, or (3) if a disparity exists. The top priorities related to each population domain were also identified through an analysis of the qualitative data and information collected, and recommendations identified by individual communities across Ohio, and using the criteria outlined above as a filter.

### **MCH Population Findings**

Needs Assessment findings by MCH Population Domain (Ohio combined its analysis of Women and Perinatal/Infant Health during the needs assessment process). Through out the process Ohio reached out to both MCH professional stakeholders and MCH consumers, family members and parents for feedback.

- **Women Perinatal/Infant Health** - Top priorities for women and infants were similar among professionals and community perspectives with regard to preconception health, health care education, smoking cessations, breastfeeding, policies, and medical home. Professional's, generally recommended a focus on health care, provider and family education, and smoking cessation, with regard to preconception health. Community participants referred to policy changes for preconception health, Medicaid incentives, and statewide support for health and wellness. And recommendations to address substance use and abuse issues in women, improve access to maternal and infant care, and enhance home visiting programs were universal.
- **Child Health** - The child health recommendations were similar between professionals and community participants. First, both groups recommended screening with regard to age appropriate and early screening. Staff highlighted screening procedure, technology, collaboration and Medicaid as specific recommendations. Community participants emphasized provider and parent education, services, and programs. Access to care was a recommendation by professional and community participants specifically, barriers to access. Community participants focused on provider availability and Medicaid incentives. Next, both groups recommended nutrition related to obesity, food insecurity/access, and education as a priority. Parent education was the other shared recommendation for both professional and community participants with regard to resources, classes and WIC programming. There were some differences in recommendations. For instance, professionals recommended access to safe and healthy homes as a priority while the community participants would like to improve coordination of services, focus on dental health and behavioral health/ mental health, expand home visiting, focus on Fetal Alcohol Syndrome, and address issues related to poverty.
- **Children with Special Healthcare Needs** – Professional and community participants proposed similar priorities for children with special health care needs. For instance, they both recommended coordination of care. They both strongly recommended access to care as a priority. Professionals focused on access to care by acknowledging different population needs and community participants proposed an increase in availability of services, incentives, transportation, Medicaid and marketing of services. Family support was another recommendation by both participants. Professionals highlighted family support and

education while community participants related family support to advocacy. Not mentioned by professionals, community participants highlighted financial support and insurance, addressing effects of substance abuse, communication of programs/policy issues, education, behavioral/mental health, and transition to adult care as recommended priorities.

- **Adolescent Health** - Professionals and community participants shared similar recommendations related to adolescents. Access to care was a common recommendation, but with different focuses. Professionals highlighted access in disparate populations with regard to dental and mental health, substance abuse, and transportation. In contrast, community participants recommended improvement in access to care related to medical and health home improvement, coordination of services, increase in providers and increase in services. Both groups highlighted education on healthy relationships as an unmet need. Professionals emphasized healthy relationships supported through evidence-based programs while community participants recommended access to physical activity, prosocial activities and physical education. Driving safety was a proposed priority for all participants. Professionals focused on reduction of injury and community participants emphasize a decrease in texting while driving. Another shared recommendation focused on healthy lifestyle through physical activity, nutrition education and healthy eating habits. The two groups differ on several priorities: professionals recommended sleep as a priority in daily life while community participants highlighted behavioral and mental health, community involvement and parent/youth education, sexual health education, and transition to adult care as recommended priorities.
- **Cross Cutting or Life Course** –All participants shared similar recommendations related to cross cutting or life course issues that have a critical impact on the health of MCH populations. Addressing the disparities issue, especially as it relates to infant mortality was recommended the most by both groups. Other recommendations focused on addressing substance abuse and use in women and adolescents, issues of financial support and insurance, access to safe and healthy homes, lack of transportation, poverty and smoking.

These findings represent the major MCH needs in Ohio, and serve as the basis for identifying the 9 critical priority areas the Title V program will address over the 5-year period.

## **Title V Program Capacity**

### **Organizational Structure**

As a result of the federal Affordable Care Act, the extension of Medicaid coverage and Ohio's efforts to increase value in healthcare and public health spending, the healthcare and public health fields are changing in Ohio. The Ohio Department of Health (ODH) is positioning itself structurally and strategically for this change in order to continue fulfilling its mission to protect and improve the health of all Ohioans. In 2015, new senior leadership was appointed to ODH, as a result a new senior leadership model was implemented with a Director and Medical Director co-leading to strengthen agency management and ensure broader medical participation in agency decision-making.

The new leadership drafted an ODH 2015-2016 Strategic Plan that outlines the strategic issues, goals and objectives to move the agency forward and position it for continued success in the new healthcare environment. These strategic issues include aligning ODH's work with the state health improvement plan, state health initiatives and priorities; ensuring effective decision-making processes to support the agency's goals; developing the workforce to support ODH's public health priorities; and to ensuring that ODH's data infrastructure supports data-driven decisions. ODH also realigned ODH's organizational structure to make a good agency even better by promoting collaboration; operating more effectively and efficiently, and better planning for and managing change (a revised table of organization is included in the attachment section).

ODH did not change, but strengthened the commitment to its core public health responsibilities, with a renewed focus on what it calls the "Pillars of Public Health":



- Infectious Diseases,
- Preparedness,
- Health Improvement and Wellness,
- Health Equity and Access,
- Environmental Health and Regulatory Compliance.

ODH is a cabinet level agency that reports to the Governor's Office. When Governor Kasich took office in January, he challenged the Administration's health and human services (HHS) cabinet agencies to improve services to vulnerable Ohioans, reduce cost and increase efficiency. Through collaboration and innovation, the Governor's Office of Health Transformation (OHT), leads the health and human services agencies and has achieved many successes in streamlining services to vulnerable populations in Ohio. As a cabinet level agency, the ODH Director Richard Hodges MPA reports to the Governor's Office, and works closely with the Director of OHT.

ODH is organized by Offices that report to the Chief of Staff. There are seven Offices and the Office of Health Improvement and Wellness (OHIW) is one of them. A total of 1,287 employees work for ODH, and that majority work in the ODH central office located in Columbus, Ohio; approximately 200 work in the field at district or remote locations across Ohio. ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCHBG) in Ohio. The Office of Health Improvement and Wellness (OHIW) is responsible for MCH programs at the state/local level.

### **Agency Capacity**

The Bureau of Maternal and Child Health (BMCH) houses the majority of Title V programs, and works closely with other ODH Bureaus such as the Bureau of Health Services (BHS) where the WIC program, Children with Special Healthcare Needs, and Ryan White are housed. The Title V MCH Block Grant is administered by BMCH and the Title V Director serves as the Chief of the Bureau of Maternal Child Health (a table of organization for the OHIW is included in the attachment section).

In addition to the full-time ODH staff, BMCH contracts with two highly skilled physicians who serve as subject matter experts in addressing issues directly impacting MCH populations. Arthur James, MD, is leading Ohio's community efforts to eliminate infant mortality and health disparities. As a pediatrician and OB/GYN, Dr. James is a faculty member of the Ohio State University (OSU) Department of Obstetrics and Gynecology and University Medical Center leader in their effort to eliminate disparities in health care for women and infants in Central Ohio. Dr. James also serves as the Ohio Better Birth Outcomes coordinator with Nationwide Children's Hospital in Columbus, and Co-chair of the Ohio Collaborative to Prevent Infant Mortality (OCPIM). BMCH also contracts with Cynthia Shellhaas, M.D., MPH to provide medical consultation to BMCH programs serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN. Dr. Shellhaas was recently promoted to a Professor at OSU for the OB/GYN Department and is the first female physician in that department.

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The BMCH is designed to be an organized state and local effort to improve the health status of women, infant, and children in Ohio by identifying needs and implementing programs and services to address those identified needs. BMCHs capacity to address the six population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders. Our primary goal is to serve as a safety net for all MCH populations including racial and ethnic groups disproportionately affected by poor health outcomes.

Programs administered and housed within the BMCH, most but not all are funded by the block grant: Title X Family Planning (FP), infant mortality reduction (including a statewide Ohio Collaborative to Prevent Infant Mortality (OCPIM), Breastfeeding, Safe Sleep), prenatal tobacco cessation, Save Our Sight vision programs, Genetics Services, Sickle Cell Services, Children Hearing and Vision, Newborn Screening for Critical Congenital Heart Disease state mandated by [SB4Ohio Revised Code 3701-5010] and screening for 36 Metabolic, Endocrine, and Genetic Conditions, Ohio's Birth Defects Information System state mandated by [ORC 3705-30], Gestational Diabetes Collaborative, Perinatal Quality Improvement programs, Early Childhood Comprehensive Systems (ECCS) program, Ohio Equity in Birth Outcomes Institute (OEI), Ohio Infant Mortality Reduction Initiative (OIMRI), Help Me Grow (HMG) Home Visiting, Maternal Infant and Early Childhood Home Visiting (MIECHV) program, Ohio First Steps for Healthy Babies Breastfeeding Initiative, Centering Pregnancy, Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Pregnancy Associated Mortality Review (PAMR), and Sudden Infant Death (SID) Program. BMCH also houses the School and Adolescent Health and School Nursing programs, the Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program state mandated by [Statutory Authority: 3701.508 OAC 3701-40].



## **Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)**

### **II.B.1. Process**

#### **1. Ohio Overview**

The Ohio Department of Health (ODH) is the designated state agency responsible for Title V Maternal and Child Health (MCH) Programs. Within ODH, the Office of Health Improvement and Wellness (OHIW) administers Title V programs, funded by the Block Grant, to address preventive and primary care needs, which are family-centered, community-based and culturally appropriate for MCH populations. The overarching goal of the MCH Block Grant is to support and promote the development and coordination of systems of care for women of childbearing age, infants, and children, including children with special health care needs (CSHCN), adolescent and families in Ohio.

In compliance with Title V legislation, every five years ODH is required to assess the needs of the MCH population, identify gaps in services, and ensure the state's capacity to meet these needs. In alignment with state and national health objectives, the MCH needs assessment process serves as the driver in determining state Title V program priority needs and developing a five-year Action Plan to address them. Ohio's needs assessment findings help inform the selection of the state's nine highest priority needs for its MCH and CSHCN populations. Based on the highest priority needs, Ohio has selected eight of the 15 national performance measures to track our progress in improving health outcomes for the MCH population. This Executive Summary of findings from the five-year needs assessment process is being submitted as part of the Federal Fiscal Year 2016 Block Grant Application and Federal Fiscal Year 2014 Block Grant Annual Report due on July 15, 2015.

The results of Ohio's needs assessment serve as the cornerstone in the identification of the nine priority focus areas, and the development of the five-year Action Plan. The results of the needs assessment process were aligned with the ODH State Health Improvement Plan (SHIP), and the Office of Health Transformation (OHT) State Innovation Model (SIM) priorities. Both the SIM and SHIP are major initiatives leading the state's healthcare reform and improvement efforts. This work is further described in this Executive Summary and in the Block Grant Application.

#### **2. Needs Assessment Methods**

##### **Process**

The ODH Bureau of Maternal and Child Health led a collaborative and comprehensive needs assessment process from January 2014 through March 2015. The intention of this needs assessment was to uncover the unmet needs of women, infants, and families across the state of Ohio. This process identified the need for:

- Preventive and primary care services for pregnant women, mothers, and infants up to age one;
- Preventive and primary care services for children and adolescent; and
- Services for children with special health care needs.

A strategic mixed-method approach was used to uncover the gaps in services to Ohioans, which included a review of existing data sources, a stakeholder survey, a consumer survey, nine regional community forums, and one ODH staff forum. The results of these efforts helped members of the MCH leadership team in making recommendations to senior leadership regarding the most critical MCH priority focus areas in Ohio.

##### **Participant Engagement**

A goal of Ohio's maternal and child health needs assessment was to be representative and reflective of stakeholders across the state and to represent the voices of consumers at every level. The process included feedback from consumers of maternal and child health services, providers of maternal and child health services, insurance providers, local and state-level public health professionals, epidemiologists and researchers studying maternal and child health. Stakeholders were given a variety of opportunities to contribute their perspectives and expertise. These opportunities included stakeholder and consumer surveys in both electronic and paper format, as well as nine regional community forums[1] and one staff forum.

##### **Stakeholder Survey**

An electronic survey was sent to 2,700 individuals listed as a stakeholder from various programs at ODH, and stakeholders were asked to identify the unmet needs for women, infants, children, and adolescents across Ohio. A convenience sampling methodology was used as stakeholders were asked to complete the survey as well as forward it to others who may want to provide feedback. A total of 695 respondents completed the survey.

Participant zip codes were used to assign responses to one of ten regions across the state (see map in Figure 1). These regions correspond with the regions that were also used for the Needs Assessment Community Forum invitations.

Survey results revealed that stakeholders perceived infants to be the most at risk population. In many cases, there were consistent themes across all population groups. For example, health-related issues that were identified as needs not being met for virtually all populations included:

- Substance abuse services (including tobacco, alcohol, prescription, and illegal drugs)
- Family planning (birth control, knowledge/education regarding sexual health)
- Access to health care (including insurance and quality health care providers)
- Obesity and nutrition (including health education and obesity-related health conditions)
- Safe environment (including free from violence/crime, as well as physical safety concerns including proper car seats, safe sleeping practices, and quality childcare)

### **Consumer Survey**

The Maternal and Child Health Needs Assessment Consumer Survey was an electronic survey sent to consumers who received services funded by ODH Bureau of Maternal and Child Health (MCH) (formally the ODH Division of Family and Community Health Services). A total of 616 respondents completed the survey. Of these respondents 88 percent were White and 12 percent were Black/African American. All ten regions of the state were represented in this survey. Given that the response rate for minority populations in Ohio was so low, BMCH staff reached out to community programs that specifically target minority populations and asked for their assistance in distributing the survey. Unfortunately, this did not increase the minority response rate this is an issue Title V seeks to address over the next five-year period.

The Consumer Survey results revealed that, overall participants were satisfied with the maternal and child health services in Ohio. Although satisfaction scores were generally favorable, satisfaction scores decreased as a child ages and/or the health issues become more complicated. Parents with adolescents and children with special health care needs were much more likely to report unmet needs compared to other parents. Across all population groups surveyed, parents reported that mental health treatment and health insurance were unmet needs. More specific findings from the Consumer Survey are contained throughout this Needs Assessment summary.

### **Regional Community Forums**

Two hundred and seventy-seven (277) Ohioans participated in nine Maternal and Child health region forums. Forum participation ranged from 20 to 50 individuals per forum, and contained a mix of ODH staff other state agency staff community MCH related professionals, and parents. The same meeting format and prioritization process was used in each of the forums. In addition to formal presentations, participants had access to a MCH Demographic data book, MCH population based fact sheets and the results of both survey reports.

After the formal presentation, participants were asked to divide themselves into one of four groups representing the four populations of women and infants; early childhood; school-age children and adolescents; and children with special health care needs. The goal of the small groups was to begin a prioritization process in order to identify three to five key **“needs not currently being met”** and rank their importance per each MCH population group.

Each group first brainstormed unmet needs related to the population group they initially self-selected. Using the criteria below, each group then prioritized the unmet needs that were identified in the previous step. The groups were asked to make their priorities specific, provide recommendations where applicable, and if possible, link priorities to measureable outcomes.

Once each group had agreed upon three to five priorities, they recorded their recommendations on a flip chart in rank order, highest priority to lowest priority. Each group was also asked to prepare a short 10 minute presentation of their top priorities, and to include specific details along with any recommendations and evidence-based practices to address the unmet needs.

The results from the community forums were aggregated and analyzed using a qualitative data analysis process. The priorities and their rank orders are listed in the Needs Assessment findings section for each population group.

### **ODH Staff Forum**

In addition to the nine community forums, a separate forum was conducted with ODH staff to engage in the same prioritization and recommendation exercises that were asked of the community members. Fifty-four staff, representing all areas of ODH and a variety of programs, participated in the forum. Results from the staff forum were aggregated and compared to the community forum results. The community forum and staff forum results were presented in the Comprehensive Community Forum Report; they are also highlighted in this Needs Assessment Summary.

### **Data Collection**

A mixed-method approach was used to collect the required information to determine the unmet needs in Ohio related to maternal and child health; qualitative and quantitative data were collected and analyzed in this needs assessment. Quantitative data collected included a detailed review of known census and vital statistics data, life course indicators, and health data sources. In addition, qualitative data were gathered through the community forums and open-ended survey questions.

### **Analysis of Ohio Department of Health and Other Secondary Data**

ODH epidemiologists and Researchers were formed into a Needs Assessment Data Committee and worked together to identify relevant data sources and indicators to uncover the unmet needs in Ohio. When possible, Ohio data was compared to previous state figures as well as national data. Data sources included:

- American Community Survey (ACS)

- Annual CDC Breastfeeding Report Card
- Behavioral Risk Factor Surveillance System (BRFSS)
- Bureau of Justice Statistics, National Prisoner Statistics Program
- CMS – Annual Medicaid EPSDT Participation Report
- Current Population Survey (CPS)
- Council of State and Territorial Epidemiologists (CSTE) \
- Data Quality Campaign (DQC) (Table 12)
- Guttermacher Institute
- IDEA 618 Child Count
- Kaiser State Health Facts
- Medicaid Analytical extract (MAX) files
- National Assessment of Education Progress (NAEP)
- National Center for Education Statistics
- National Center for Juvenile Justice, Office of Juvenile Justice and Delinquency
- National Child Abuse and Neglect Data System (NCANDS)
- National Immunization Survey (NIS)
- National Sexual Transmitted Disease Surveillance (NSTD)
- National Survey of Children with Special Needs
- National Survey of Children's Health (NSCH)
- National Survey on Drug Use and Health (NSDUH), SAMHSA
- National Vital Statistics System (NVSS) Records
- Ohio Department of Health Vital Statistics
- Ohio Make Your Smile Count Oral Health Screening Survey (BSS)
- Ohio Medicaid Assessment Survey
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- School-Based Health Alliance
- State Reportable Conditions Assessment (SRCA)
- Title V Information System (TVIS) (Table 12)
- U.S. Department of Housing and Urban Development Annual Assessment Report to Congress
- USDA Economic Research Survey
- Water Fluoridation Reporting System
- WIC Program data
- Youth Risk Behavior Surveillance System (YRBSS)

Data tables and fact sheets for specific populations were created based on the results of this existing data review. These documents were used to create the presentation given by MCH and CSHCN leadership during the community forums and as supplemental handouts for forum participants to use when discussing the most pressing unmet needs in their communities.

#### **Data Analysis**

After the data collection period had concluded, ODH epidemiologists and subject matter experts reviewed the data sources to identify several unmet needs regarding each of the six populations identified. Criteria of an unmet need included: (1) if an undesirable health indicator was experienced at a higher rate than the national average, (2) was experienced by a significant number of Ohioans, or (3) if a disparity exists.

[1] Originally ten community forums were scheduled. Due to low attendance in region 7, only 9 forums were held.

### **II.B.2. Findings**

Community Forum participants/ODH staff provided feedback regarding priorities. ODH leadership considered these top priorities and recommendations as part of their prioritization process for determining the top ten priorities.

#### **II.B.2.a. MCH Population Needs**

##### **3. Needs Assessment Findings**

The findings from the data collection activities related to maternal and child health unmet needs were identified for six separate population groups (Women/Maternal Health, Infant Health, Children Health, Children with Special Health Care Needs, Adolescent and Young Adult Health and Cross-Cutting Life Course). These groups align with the Title V Maternal and Child Health Bureau (MCHB) population health domains. In addition, priorities that were identified in the community forums and needs assessment surveys that cut across all life course areas were separated out and are included in the Cross-Cutting Life Course Category.

##### **3a. Women/Maternal Health**

The data collection and analysis surrounding pregnant women and women with infants focused on preconception and prenatal care, as well as postpartum health.

Overall, pregnant women and women with infants who completed the survey were satisfied with most aspects of the MCH health services they have received which relates directly to their personal health. The two areas that received the lowest satisfaction ratings were postpartum mental health services and genetic counseling. Additional data analysis identified several unmet needs impacting this population. This analysis, combined with recommendations from community forum participants provided information regarding how ODH can better meet the identified needs for pregnant women and women with infants.

##### **Substance Use Including Tobacco Use**

Addressing substance use and abuse in prenatal and pregnant women was a highly identified theme across Ohio. Almost one in three women who had a live birth in Ohio in 2010 smoked in the three months before becoming pregnant. Of those women, 47 percent quit during pregnancy, with 16.3 percent of all women still smoking in the last trimester of pregnancy. Some women who quit returned to smoking after their baby was born, with 21.8 percent of Ohio women smoking 2-6 months after delivery.[1]

Specifically, forum participants recommend addressing issues with regard to drug and tobacco usage. Desired outcomes include a reduction in maternal smoking, reduction in substance abuse by pregnant women, and a reduction of drug-addicted babies. Forum participants recommended this be achieved by developing education campaigns, enhancing resources for substance use and abuse treatment, and advocating for hospital policy changes. They suggested providing funding for parent education and programs that supply mental health resources in conjunction with Children's Services.

##### **Prenatal Care/ Family Planning**

Access to prenatal care was another top priority identified by community forum participants and the review of data sources. Results from the stakeholder survey uncovered that nearly half (42.5 percent) of the respondents reported that family planning is one of the unmet needs for reproductive age women. Access to health care was the second most unmet need (14.2 percent) mentioned for this population by the stakeholder survey. Forum participants recommended increasing access to a variety of coordinated services, location of services, and transportation services.

- a. Education initiatives about pregnancy and infant care** were identified as a method for meeting the needs of pregnant women and mothers with infants
- b. Policy change related to preconception and interconception health.** It was recommended that ODH provide additional funding to support initiatives focused on provider incentives, Medicaid improvement, media campaigns, and funding to implement resources in the community.

- c. **Emphasis on life course reproductive health** for adolescents before pregnancy for both men and women, as well as preconception and interconception care by anyone who comes into contact with women of childbearing age.

#### **Physical Health (maintaining a healthy weight, diabetes)**

Obese women are at higher risk for having babies born with serious birth defects such as neural tube defects (spina bifida) and heart problems. According to 2011 Pregnancy Risk Assessment Monitoring System (PRAMS) data, 49 percent of Ohio women were classified as overweight or obese based on BMI at the time they became pregnant.

- a. **Improve Coordination of Care through Use of Medical Homes.** Forum participants recommended patient-centered medical homes and suggested ODH identify and implement different models of care. They also proposed collaboration with community resources.

#### **Safe and Healthy Environments (stress and physical violence)**

For all races, a safe and healthy environment is important for maternal and child health outcomes. Poor nutrition; stress; abuse; lack of access to health care; and exposure to toxins can have a devastating effect on infants and mothers. In Ohio, half of mothers experience two or more stressors during pregnancy, which is 4 percent greater than the U.S. average[2]. Five percent of women reported experiencing abuse by their partners within the 12 months prior to pregnancy[3].

#### **Family Support**

Another priority for forum participants was addressing the lack of family support through identification of programs other than Help Me Grow and WIC, as well as initiatives that focus on the role of family relationships and fathers. Participants suggested additional resources for family support and the need for family education

#### **Issues Associated with Breastfeeding – initiation, continuation, education, etc.**

Increasing the breastfeeding initiation rates is key to reducing the risk of obesity, lower respiratory infections, Type 2 diabetes, Asthma, and SIDS (sudden infant death syndrome) in babies. For the mother, breastfeeding reduces the risk of breast cancer, ovarian cancer, Type 2 diabetes, and postpartum depression.

Breastfeeding rates have increased over the past five years, with 75 percent of Ohio women reporting ever breastfeeding in 2010. However, breastfeeding rates remain below the Healthy People 2020 goals of 81 percent initiating breastfeeding and 60 percent exclusively breastfeeding for six months[4]. Women who were less educated, Black, or who received Medicaid services had lower rates of breastfeeding in Ohio. Even when women initiate breastfeeding, few continue exclusively breastfeeding for longer than eight weeks.

Forum participants recommended education in hospital settings, additional support from ODH for breastfeeding-friendly hospitals, and a full-time breastfeeding education coordinator with appropriate funding, credentials, and authority.

Participants suggested an increase in funding from ODH to local health departments for breastfeeding promotion and extending peer counseling at the hospital level.

#### **3b. Infant Health**

The data reviewed revealed that some of the greatest unmet needs impacting infants are infant mortality and health disparities in infant mortality and low-birth weight babies.

Overall satisfaction ratings for issues related to infant health received slightly less positive ratings compared to the issues related to women's health. Parents were highly satisfied (approximately 90 percent of respondents) with the prenatal and well-baby care that they have experienced. Approximately, one in three respondents were only a little happy or not happy with the lead testing (32 percent), vision health (30 percent), speech development (32 percent), and hearing health (30 percent) services for their baby.

**Infant Mortality.** Infant death is one of the main indicators of a community's overall health. Infant death accounts for 66 percent of all childhood deaths in Ohio. Ohio's infant mortality rate was 7.87 infant deaths per 1,000 live births in 2011 compared to the national rate of 6.05. In 2010, Ohio was ranked as the worst out of 50 states for infant mortality[5]. Community forum participants made the following recommendations with regard to improving infant mortality rates:

- a. **Home Visiting Programs.** Forum participants recommended newborn health visits and increased insurance reimbursement for them. They also suggested increasing education and community outreach programs (Mom First).
- b. **Safe Sleep Education and Resources.** Public messaging for safe sleep and increased availability of Pack 'n Plays.
- c. **Data Collection.** Expand and improve data collection by using Centers of Disease Control (CDC) death scene investigation protocol and feeding method identification at the time of baby death.

**Health Disparities for Infants.** In 2011, the black infant mortality rate was 15.8, more than twice the white rate of 6.3. Black babies are more likely to die within the first year of life even when controlling for social and economic factors. In 2010,



the last year for which national statistics are available, Ohio's infant mortality rate again ranked low among states for white infant mortality, and among the worst for black infant mortality. In addition, metropolitan and Appalachian counties have higher rates of infant mortality compared to the state as a whole.

### 3c. Child Health

Overall, parents of children between the ages of 2 and 17 have varied attitudes about the health services and information they have received as it relates to their children. The Consumer Survey revealed that Ohioans would like to see improvement in areas that can lead to unhealthy outcomes later in a child's life.

**Safe and healthy environments.** According to the National Survey of Children's Health, 10 percent of Ohio's children live in a household where smoking occurs inside home, which is nearly double the U.S. rate of 4.9 percent. Children living in low-income households are much more likely to be exposed to tobacco smoke at home than are children living in higher-income households. In addition, Ohio's children are slightly more likely to have adverse childhood experiences (25.8 percent) compared to the U.S. average (22.6 percent).

- a. **Focus on Fetal Alcohol Syndrome.** Address fetal alcohol syndrome through increased awareness and early treatment. One measurable outcome would be a reduction in fetal alcohol syndrome cases.
- b. **Address Issues Related to Poverty.** Forum participants suggested sustainable programs where individuals do not lose access to programs and income once they obtain employment. Health related costs increase for individuals who are employed because they lose government funded benefits.
- c. **Provider and Parent Education.** Community forum participants proposed an increase in education related to the impact of children's future health and prevention. It was also recommended that caregiver education is increased regarding disease prevention best practices.

**Nutrition and healthy lifestyles.** Community forum participants were also concerned about obesity prevention and food insecurity identification. Overweight and obese children and adolescents suffer devastating effects on quality of life, including social and psychological well-being. Ohio has a higher percentage of children who are overweight or obese with 17 percent compared to the U.S. average at 15.9 percent.[6]

- a. **Family education.** Educate families on how to identify, prevent and address obesity. Offer free community classes on topics such as healthy meal preparation and life skills.
- b. **Access.** Increase food security through identifying "food desert" locations and improve access to healthy food. These additions would address food insecurity, obesity, and malnutrition.

**Early screening and intervention services.** Early childhood health screenings and early interventions are important for identifying and then treating health-related issues that could impact a child's health and development. Less than one in three children between the ages of 0 to 4 years old in Ohio (with public or private insurance) received a vision screening. In Ohio, 0 to 4 year old children with public insurance in Ohio were more likely (34.5 percent) to receive a vision screening than 0 to 4 year old children with private insurance (30.2 percent).[7]

Community forum participants proposed an increase in the number of in-depth vision, lead, hearing, dental, social emotional, development, Autism, and BMI screenings. It was also recommended that efforts were taken to make sure services are inclusive to all people.

**Access to Care.** Improving access to primary care and healthcare is the next recommended priority by community forum participants.

- d. **Provider Availability.** Increase access to medical doctors and specialists, as well as services and treatment facilities. Use Telehealth (the delivery of health-related services and information via telecommunications technologies) in cases where there is a lack of strategic help for children with specialized needs.
- e. **Medicaid and incentives.** Improve the process for how reimbursement to Medicaid providers is reviewed. Offer grants or incentives to entice service providers and tuition reimbursement for practitioners that stay in Ohio to work with practices serving children and families.
- f. **Expand Home Visiting.** Expand newborn and medical home visits through programs and community worker involvement.
- g. **Improved Coordination of Services.** Community forum participants recommended support services for parents and agency collaboration/coordination, with a focus on the development of relationships between families, services, and agencies to ensure quality of care.

**Dental Health.** Oral health continues to be one of the unmet health care needs for children. According to the ODH's statewide oral health survey of Ohio's 3rd graders (1998, 2003, 2008), 50 percent of children in third grade have experienced tooth decay. This rate has not changed significantly since the survey was conducted in 1993. In Ohio, less than 8 percent of children under the age of three years who were enrolled in Medicaid in 2012 had a dental claim.

- a. **Dental identification.** Improve dental problem identification, access to dental care treatment/screening, and

support for follow-up appointments.

- b. **Mobile Health.** Use existing mobile clinics at elementary schools and screening at early childhood education programs.

**Behavioral Health/ Mental Health.** Community forum participants suggested addressing child mental and behavioral health through education programs such as Help Me Grow and utilizing Telehealth.

- a. **Programs and childcare.** Co-locate behavioral health professionals in Head Start, child care, or preschool programs in order to improve/create communication systems between educational settings and mental health providers.
- b. **Telehealth.** Place Telehealth/Telemedicine in preschool, primary school or Head Start settings for urgent needs.

### 3d. Children with Special Health Care Needs

Children with special health care needs are defined as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Data reveal that some of the greatest unmet needs impacting children with special health care needs are access and affordability of services and transition services.

Parents of children with special health care needs are “moderately” to “not very satisfied” with the health services they have received for their children with special health care needs.

The highest ranked health-related issue for this population was information and care related to safe and stable environments. Three out of four parents indicated a high level of satisfaction. Early intervention for young children with special health care needs, early identification, and condition specific health-related information also received relatively high satisfaction scores.

The most negatively rated issues by parents of children with special health care needs were related to support for family and children with special health care needs, where only one out of four parents provided positive ratings towards the quality of the services and information. Parents also reported less than positive attitudes towards financial planning, mental health treatment and screening, homecare services, and an organized system of care.

**Access to Care and Affordability of Services.** CSHCN face challenges accessing health care coverage that is universal and continuous, adequate and affordable. Although 97 percent of CSHCN have health care coverage, 73 percent of parents report having adequate insurance[8].

In addition to affordability, CSHCN often need to coordinate a variety of medical services and providers. In Ohio, less CSHCN (43.6%) receive coordinated, ongoing, and comprehensive care within a medical home compared to non-CSHCN (61.1%).

More than half (53.5%) of the respondents reported access and coordination of care as an unmet need related to CSHCN. Community forum participants suggested addressing these unmet needs through increasing the availability of services, incentives, transportation, Medicaid, and marketing of services.

**Care Coordination/ Collaboration across Providers.** Community forum participants suggested determining a family's needs through a formal assessment process.

- a. **Database.** Create a central database that communicates between providers, stores electronic records, minimizes repetitive paperwork, and saves money.
- b. **Collaboration and coordination.** Establish a common definition and model for a “medical home” to improve agency referral and ensure efficacy.
- c. **Education.** Educate physicians to refer patients to care coordination and work with families.
- d. **Specialized services.** Increase specialized services and staff that know about the specific special health care requirements of children with special needs.

**Financial Support/ Insurance.** Community forum participants called attention to the need for financial support with regard to resources and Medicaid reimbursement.

**Family Support.** Community forum participants highlighted increased family support and advocacy for CSHCN. The need for support across lifespan with regard to respite and long-term care was identified as a need.

- a. **Advocacy and Education.** Train families to advocate for their cause, and develop a centralized vehicle for information and resources.
- b. **Support.** Increase activities, parent advocates, and support groups that allow parents to share information and focus on the need to connect with similar families and staff with expertise.



- c. **Funding.** Increase funding for skilled childcare and the development of economical career paths for professions in childcare.

**Addressing Effects of Substance Abuse.** Addressing the effects of substance abuse was another recommended priority by community forum participants through agency support and education for all families, providers, and teachers about substance abuse.

**Communication of Programs/ Policy Issues.** The next recommended priority by community forum participants was to address communication and feedback in order to prioritize funds and CMH program improvement.

- a. **Communication.** Revise quality improvement (QI), the feedback loop to state and federal programs. Use self-assessments and current data to target needs and funding sources.
- b. **CMH improvements.** Enhance marketing of CMH programs through reader and parent-friendly letters. Improve the process for obtaining help (program sign-up) and reassessing/broadening eligibility for CMH was another recommendation.
- c. **Funding.** Address the lack of long-term sustainable and stable funding, as well as silos between agencies.

**Behavioral and Mental Health.** Community forum participants recommended improving behavioral and mental health services with regard to autism, insurance coverage, and increasing access to behavioral health as distinct from developmental disabilities.

**Transition Services.** Ohio CSHCN are less likely to receive the services necessary to make transitions to all aspects of adult life, including health care, work, and independence compared to the U.S. average (35.6% vs. 40.0%).<sup>[9]</sup> Community forum participants recommended addressing transitions into adult care through increased availability of providers and education.

### 3e. Adolescent Health

Findings from secondary data demonstrate health issues that are experienced by adolescents in Ohio. The data revealed that some of the greatest unmet needs impacting adolescents are healthy lifestyles and sexual health. Sexual health (18.4%) and healthy lifestyles (15%) were the most reported unmet needs for adolescents ages 13-18. Ohioans also identified increased access to behavioral, mental, and physical health along with improved nutrition and healthy lifestyles as the top priorities for adolescent health.

**Healthy Lifestyles.** Ohio's teens generally practice healthy behaviors, however there is still need for improvement with regard to nutrition and physical activity. Only 19 percent eat the recommended daily allowance for fruits and vegetables and less than 50 percent are physically active. These behaviors contribute to the obesity epidemic in Ohio: 29 percent of Ohio teens are overweight and obese with a BMI rate at or above 85 percent.<sup>[10]</sup> Lastly, a new behavior Ohio is tracking is related to distracted driving. Automobile accidents are the number one cause of teen death. A majority (66%) of 12<sup>th</sup> graders reported texting or emailing while driving during the past month<sup>[11]</sup>.

- a. **Teen Obesity.** Community forum participants recommended a reduction in teen obesity through increased physical activity, and other secondary health conditions caused by issues including food insecurity, lack of resources, chronic disease, and screen time in at-risk and low income neighborhoods.

**Sexual Health.** Forty-two percent of Ohio high school students reported having sexual intercourse in 2013. Females are more likely to report having intercourse (47%) comparing to males (39%). Adolescent birth rates have consistently fallen among 15-19 year olds in Ohio from 41.0 in 2008 to a historic low 33.5 per 1,000 females<sup>[12]</sup>.

- a. **Sexual Health Education.** Community forum participants recommended sexual health education to reduce teen pregnancy and sexually transmitted diseases, which would allow youth to focus on life plans as a priority. They highlighted education and programming as specific ways to address sexual health education.

**Behavioral and Mental Health.** Community forum participants proposed a focus on mental health because it functions as an umbrella for other issues related to adolescent health.

- a. **Stigmas.** Break stigmas surrounding mental and behavioral health in order to increase use of these services and produce long-term effects.
- b. **Holistic approach.** Increase use of holistic approaches, which include involving all of a child's health care providers and partnerships with schools to ensure care coordination, as well as more trauma-informed care to help identify the root of the adolescents' issues.

**Access to Care.** Another recommended top priority by the community forum participants was an improvement in access to care with regard to services and providers. Specifically, participants focused on medical and health home improvement, coordination of services, increase in providers, and increase in availability of services.

**Community Involvement and Parent/Youth Education.** Community involvement and education with regard to addressing urban, suburban, and rural community needs were identified as an unmet need by forum participants.

- a. **Health education.** Increase health education for everyone regarding the needs for adolescents like healthy habits and avoiding risky behaviors such as safe sex and drug prevention.
- b. **Youth engagement.** Promote positive activities of youth in the community, and establish mentorship opportunities. Consider community center models for local areas.

**Substance Abuse.** Forum participants recommended reducing substance experimentation and abuse through increased after-school and alternative programming to prevent substance abuse and education about addiction.

**Transition to Adult Care.** Community forum participants highlighted a plan for appropriate care and transition from pediatric to adult health or mental health care as their next priority. They recommended an increase in support of teen-specific programs to help them transition into adulthood.

**Safe Driving.** Forum participants recommended decreasing texting while driving and focusing on texting/driving safety through teen-appropriate messaging.

#### 3f. Cross-Cutting Life Course

Stakeholders agreed that poverty is an issue related to Ohio's health outcomes. Poverty was the primary category of mention that participants identified as a barrier to health of Ohio's MCH populations. Although forum participants did not specifically focus on cross-cutting life course issues, nutrition and health living and poverty and social determinates of health were identified as priorities for women and these cut across all life courses.

**Nutrition and Healthy Living.** Forum participants recommended education for healthy food preparation, nutrition and life skills. Initiatives should highlight food access and physical activity.

**Poverty/Social Determinants of Health.** Community forum participants recommended building resilient communities and improving the social determinants of health as a priority. The forum participants proposed doing this by addressing the infrastructure of support in Ohio for issues such as: housing, child care, sustainable employment, poverty, transportation, education, and coordination of care. These issues came up at each forum regardless of the location (rural, urban, metropolitan, etc). Forum participants strongly suggested that until the State devotes efforts to addressing these issues, health outcomes in Ohio will not improve.

[1] "PRAMS Data by State." Center for Disease Control and Prevention. 2009-2011. Web. 2015. .

[2] "PRAMS Data by State." Center for Disease Control and Prevention. 2009-2011. Web. 2015. .

[3] "PRAMS Data by State." Center for Disease Control and Prevention. 2009-2011. Web. 2015. .

[4] "Maternal, Infant, and Child Health Goals." Healthypeople.gov. 2014. Web. 2015. .

[5] Ohio Department of Health. (2013) Ohio's Commitment to Prevent Infant Mortality.  
<https://www.odh.ohio.gov/~media/Images/Ohio%20Commitment%202013h%202%20FNL%2012172013.ashx>

[6] "Child Health Measures." National Survey of Children's Health. 2011-2012. Web. 2015. .

[7] "Ohio Medicaid Assessment Survey." Ohio Colleges of Medicine Government Resource Center. 2012. Web. 2015. .

[8] "Ohio Medicaid Assessment Survey." Ohio Colleges of Medicine Government Resource Center. 2012. Web. 2015. .

[9] "Ohio Medicaid Assessment Survey." Ohio Colleges of Medicine Government Resource Center. 2012. Web. 2015. .

[10] "Ohio Medicaid Assessment Survey." Ohio Colleges of Medicine Government Resource Center. 2012. Web. 2015. .

[11] Ohio 2013 Youth Behavior Risk Survey

[12] Ohio Department of Health. (2013) Vital Statistics

#### II.B.2.b Title V Program Capacity

ODH is the designated state agency for implementation of the Title V Maternal & Child Health Block Grant (MCH BG). The Office of Health Improvement and Wellness (OHIW) is responsible for the provision of MCH programs at the state/local level. Program capacity resides within Bureaus who are responsible for administering the MCH related programs and coordination with non-MCH BG programs. OHIW ensures ODH's capacity to promote and protect the health of mothers and children including CSHCN, and address the priority health issues through the administration of preventive and primary health care services. The MCH priorities were selected because they address the important health care needs and issues that were

identified via the Needs Assessment process. All 9 priorities are reflected through the programs in the OHIW. These programs are on-going and a broader description of each can be found by visiting the ODH website at [www.odh.ohio.gov](http://www.odh.ohio.gov).

## **II.B.2.b.i. Organizational Structure**

### **4a. Organizational Structure**

ODH is a cabinet level agency that reports to the Governor's Office. When Governor Kasich took office in January, he challenged the Administration's health and human services (HHS) cabinet agencies to improve services to vulnerable Ohioans, reduce cost and increase efficiency. Through collaboration and innovation, the Governor's Office of Health Transformation (OHT), the Departments of Health (ODH), Medicaid (ODM), Developmental Disabilities (DODD), Aging (ODA), Mental Health and Addiction Services (MHAS) and Job and Family Services (ODJFS) have achieved many successes in streamlining services to vulnerable populations in Ohio. As a cabinet level agency, the ODH Director--Richard Hodges MPA--reports to the Governor's Office, and works closely with the Director of OHT. The ODH Medical Directors Office and the ODH General Counsel are direct reports to the ODH Director.

Governor Kasich created House Bill 487, which is legislative language that requires ODH to refocus its efforts at the local level and to interact with local health departments to further strengthen our relationship. One of the key tools ODH uses to work more closely with the community on public health issues is through the State of Ohio Network of Care Public Health Web site housed at ODH. Network of Care is designed to provide local health departments, payers, providers, public-health professionals, universities, individuals and other organizations a platform to display and track public-health assessment and planning data. Network of Care is an innovative, local-delivery public-health dashboard to enhance health decision-making and display public-health data and resources in an easy-to-read format.

This gives Ohio a dynamic and integrated platform to track key public-health indicators, model practices and collaboration tools from around the nation. The site integrates statistics from national, state and other sources into a collection of more health and quality-of-life indicators specific for each health jurisdiction and the State of Ohio. Indicators also include Healthy People 2020 targets, historical data by county and evidence-based intervention. This platform gives Ohio the ability to align, track and integrate state and local public-health efforts.

## **II.B.2.b.ii. Agency Capacity**

### **4b. Agency Capacity**

ODH is organized by Offices that report to the Chief of Staff. There are seven Offices and the Office of Health Improvement and Wellness (OHIW) is one of them. All of the Title V and MCH Programs sit within the Office of Health Improvement and Wellness. The Bureau of Maternal and Child Health (BMCH) houses the majority of Title V programs, however the Bureaus of Health Promotion (BHP) and Health Services (BHS) work closely with BMCH to serve our target population. The Title V MCH Block Grant is administered by BMCH and the current Title V or MCH Director is also housed in this Bureau. A table of organization for ODH and OHIW are included for review. A total of 1,060 employees work for ODH, and the majority work in the ODH central office located in Columbus, Ohio; approximately 200 work in the field at district or remote locations across Ohio.

The BMCH is designed as an organized community effort to improve the health status of women, infant, and children in Ohio by identifying needs and implementing programs and services to address identified needs. BMCH goals are accomplished by engaging in a focused, multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders that serve racial and ethnic groups disproportionately affected by poor health outcomes. These partners include but are not limited to: local public health agencies, community health centers, community-based organizations, faith-based organizations, Regional Perinatal Centers, private sector organizations, Medicaid, and other public health providers.

The programs and initiatives housed within BMCH that directly contribute to addressing the health outcomes for MCH populations include (but may not be all inclusive): Title X Family Planning (FP), infant mortality reduction (including a statewide Ohio Collaborative to Prevent Infant Mortality (OCPIM) charged with addressing infant mortality and disparities), prenatal tobacco cessation, Save Our Sight vision programs, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Genetics Services, Sickle Cell Services, Children Hearing and Vision, Newborn Screening for Critical Congenital Heart Disease state mandated by [SB4Ohio Revised Code 3701-5010] and screening for 36 Metabolic, Endocrine, and Genetic Conditions, Ohio's Birth Defects Information System state mandated by [ORC 3705-30], Gestational Diabetes Collaborative, Perinatal Quality Improvement programs, Early Childhood Comprehensive Systems (ECCS) program, Ohio Equity in Birth Outcomes Institute (OEI), Ohio Infant Mortality Reduction Initiative (OIMRI), Help Me Grow (HMG) Home Visiting, Maternal Infant and Early Childhood Home Visiting (MIECHV) program, Ohio First Steps for Healthy Babies Breastfeeding Initiative, Centering Pregnancy, Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Pregnancy Associated Mortality

Review (PAMR), and Sudden Infant Death (SID) Program. BMCH also houses the Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program state mandated by [Statutory Authority: 3701.508 OAC 3701-40].

In addition ODH contracts with two highly skilled physicians who serve as subject matter experts in addressing issues directly impacting MCH populations. Arthur James, MD, is leading Ohio's community efforts to eliminate infant mortality and health disparities. As a pediatrician and OB/GYN, Dr. James is a faculty member of the Ohio State University (OSU) Department of Obstetrics and Gynecology and University Medical Center leader in their effort to eliminate disparities in health care for women and infants in Central Ohio. Dr. James also serves as the Ohio Better Birth Outcomes coordinator with Nationwide Children's Hospital in Columbus, and Co-chair of the Ohio Collaborative to Prevent Infant Mortality (OCPIM and Co-lead for Ohio's COIIN efforts.

ODH also contracts with Cynthia Shellhaas, M.D., MPH to provide medical consultation to BMCH programs serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN. Dr. Shellhaas was recently promoted to a Professor at OSU for the OB/GYN Department and is the first female physician in that department.

The Title V program works to ensure that we not only have adequate programs, and clinical expertise, but that we have the voice of those we serve included in our efforts. Within the BMCH is a Parent Consultant who is the mother of a young woman, who has special health care needs. The Parent Consultant has numerous years of experience working with families and children. Previously she was a Family Support Specialist for Franklin County Help Me Grow and also served as the Early Childhood Resource Network Family Support and equipment loan manager.

The Parent Consultant is a member of the Parent Advisory Committee and has served as the AMCHP Ohio Title V Family Delegate. She has also served on numerous statewide/CMH workgroups and committees, worked on various medical home initiatives and has started and facilitated numerous parent support groups.

ODH leadership continues to stress the importance of programs using data to make informed decisions about programs, funding and location of services we provide. BMCH uses epidemiology to protect and optimize the health of MCH populations by guiding epidemiologic priorities and activities; coordinating and collaborating with local, state and federal partners; building epidemiologic capacity; and assisting with the translation and reporting of epidemiologic findings and the application of those findings to MCH programs and policies. The Bureau has a team of MCH epidemiologists, as well as a MCH Epidemiologist CDC Assignee. Both areas report to the Title V/MCH Director.

The Bureau of Health Promotion (BHP) is responsible for the administration of School and Adolescent Health services. The School and Adolescent Health (SAH) section promotes the health and safety of the school-aged and adolescent populations in Ohio through data collection, resource development, technical assistance, and training of approximately 1200 school nurses through regional continuing education and professional development opportunities throughout Ohio. The Title V program coordinates with BHP to implement MCH BG strategies related to immunization, deaths due to motor vehicle crashes, and women's health issues, including domestic violence, and other issues related to primary/secondary prevention of chronic diseases (e.g., asthma, diabetes, heart disease) in school settings. BHP works collaboratively on prevention efforts such as childhood obesity, smoking, and diabetes, and oral health.

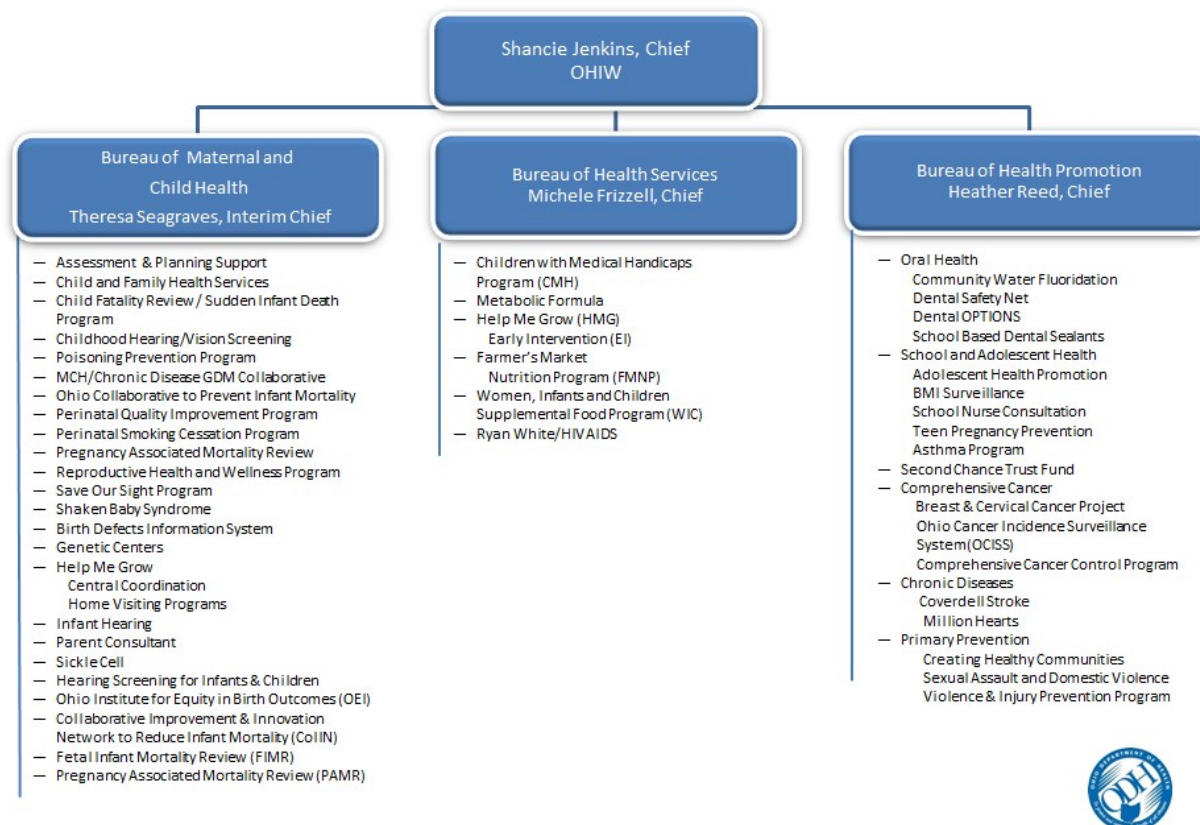
The Bureau of Health Services (BHS) is where the Children with Medical Handicaps (CMH) program is administered serving Children with Special Health Care Needs (CSHCN), including: a Diagnostic, Treatment, and Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and helping families navigate the health care system.

BHS utilizes vital committee/council structures to foster open dialogue, receive input and feedback in regards to CSHCN needs across the state. One of these committees is the Medical Advisory Council (MAC), whose members is appointed by the Director of Health, and represent various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions. The Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise CMH. The mission of PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CSHCN.

Ohio WIC continues use of the ODH immunization registry, ImpactSIIS, in local clinics; ImpactSIIS provides local staff with an accurate, efficient tool to determine if children are up-to-date on their immunizations. All local WIC clinics currently enter data into the system and have entered over 300,000 doses. And finally, Ohio's breastfeeding peer helper program was expanded statewide in 2011 to include all local WIC projects, employing a total of 195 breastfeeding peer helpers. Although the number of peer helpers has declined due to funding restrictions; Ohio continues to see results, as our "ever breastfed" rates continue to improve, breastfeeding duration is increasing and our exclusively breastfed rates at 3 and 6 months are significantly higher than the national rates. Although not Block Grant funded, these maternal and child health initiatives tremendously support our MCH efforts.



## Office of Health Improvement and Wellness (OHIW)



### II.B.2.b.iii. MCH Workforce Development and Capacity

#### 4c. MCH Workforce Development and Capacity

Ohio's Title V program is committed to using data to drive its decision making, however it faces some challenges in its ability to do this. The overall epidemiology capacity in Ohio is lacking and has been identified as a statewide issue. Among the workforce, it was found that more than 30% of entry and mid-level epidemiologists reported that they had not yet achieved competency in a number of areas and expressed a need for additional training. Moderate turnover indicates the projected need for recruiting efforts and the need to examine retention strategies. This is the case at both the state and local level in Ohio.

Having employees that are culturally and linguistically competent is a major component in achieving good health which promotes strong communities and a prosperous nation. Though life expectancy and overall health has increased over the years thanks to preventative health services and advances in medical technology, not all Americans have experienced equal benefits. Women, racial and ethnic minorities, and low-income individuals often experience extreme health disparities, attributed to inequalities among economic status and access to appropriate care. Cultural and linguistic competence is a key strategy for closing health disparities.

The need for targeted, appropriate services in Ohio is growing. According to the Ohio Department of Development, the minority population in Ohio increased by 20 percent between 2000 and 2010, and population surveys show that 27 percent of adult Ohioans and 18 percent of children report having a disability. To build capacity in Ohio's Title V Programs, ODH enlisted the support of a consulting group[1] to develop a comprehensive cultural and linguistic competency approach that includes strategic planning, training and resource development, and sustainability planning. BMCH wanted to assist Title V staff and sub grantees in progressing through the cultural competence continuum, ensuring effective and appropriate care for women and children in Ohio. The result is to develop a comprehensive plan that articulates goals, strategies, and action items to develop the tools and processes for ODH to infuse cultural and linguistic competency practices throughout the agency.

[1] RAMA Consulting Group, Inc.

## **II.B.2.c. Partnerships, Collaboration, and Coordination**

### **4d. Partnerships, Collaboration, and Coordination**

The Governor's Office of Health Transformation (OHT) takes a leadership role in assuring that all the Health and Human Service State agencies are working in collaboration across the enterprise. OHT ensures that programs are coordinating efforts in an efficient and effective manner. Strong relationships exist between Ohio's Title V program, Medicaid, local health departments, other safety net providers, public and private businesses, professional associations (Ohio AAP, Ohio Hospital Association, March of Dimes, etc.), academic programs and professional associations to improve health outcomes for the MCH and CSHCN population.

The Title V program continually looks for opportunities to build, sustain and expand partnerships in its commitment to address the needs of the MCH population. Our goal is to always collaborate and generate more efficient processes through the coordination of efforts. In addition, the Title V program has specifically targeted initiatives that will enable us to engage family and consumer partners and address disparities where they exist. The following paragraphs will highlight some of the critical efforts being made in Ohio to expand the capacity to serve MCH populations through collaboration and partnerships.

The Title V program contracted with an organization called Everyday Democracy<sup>[1]</sup> to assist in our health equity initiative. The role of Everyday Democracy will be to work with ODH, the Ohio Equity Institute (OEI) team members, and local community-based partners to co-design and build capacity for a dialogue-to-change initiative. The initiative will engage young people, parents, the health service community, students, service providers and other community members across backgrounds and ethnicities in authentic conversations about racism and its effects on Ohio's infant mortality rates, especially in the nine targeted OEI sites.

Further efforts to engage consumers and family members can be found in the CMH program as outlined in section 4b. In 2015 the Title V program plans to establish a Maternal and Child Health Advisory Committee in order to incorporate the voice of consumer in all MCH programs.

### **4e. Other collaborative partnerships include:**

#### **Maternal, Infant, and Early Childhood Home Visiting (MIECHV)**

The federal Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program provides Ohio with the means to expand home visiting services to additional families and children. Prior to MIECHV, Ohio had an existing statewide system of home visiting. With the existing system as a foundation, administrators used MIECHV funds to expand evidence-based models and provide services to at-risk communities that would otherwise not have access without supplemental funding. Additionally, MIECHV funds support systems-building initiatives, quality improvement processes, partnership development, targeted outreach, and public education across Ohio. MIECHV funds provided Ohio with the opportunity to bring together the home visiting community, the Ohio Domestic Violence Network, and the Department of Mental Health and Addiction Services to provide joint professional development training and identify potential occasions for collaboration.

#### **Early Childhood Comprehensive Services (ECCS)**

Building Health through Integration is a three year HRSA grant beginning August 1, 2013. The purpose of this grant program is to improve the health, physical, social, and emotional development during infancy and early childhood (birth to three years of age); to eliminate disparities; and to increase access to needed early childhood services by engaging in systems development, integration activities and utilizing a collective impact approach to strengthen communities for families and young children and to improve the quality and availability of early childhood services at both the state and local levels.

ODH chose to implement strategy 1: Mitigation of toxic stress and trauma in infancy and early childhood. ODH, with the advice of the Early Childhood Advisory Council (ECAC), is implementing a range of strategies designed to mitigate toxic stress and trauma in infancy and early childhood that support the goals of HRSA's Maternal and Child Health Bureau. To goal is to improve the health physical, social, and emotional development among infants and young children.

In all its programmatic efforts ODH engages systems such as: Ohio Department of Medicaid, Ohio Dept. of Job & Family Services, Ohio Dept. of Mental Health and Addiction Services, Ohio Board of Regents, Ohio Dept. of Education, Ohio Dental Association, Ohio Head Start, Health Policy Institute of Ohio, Ohio Public Health Association, Local Health Departments, Ohio Colleges and Universities, Ohio Association of Children's Hospitals, Ohio American Academy of Pediatrics, Federally Qualified Health Centers, Ohio Dept. of Developmental Disabilities, and many others.

[1] <http://www.everyday-democracy.org/>



### III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$21,112,200	\$22,103,900	\$22,103,900	\$22,430,547
<b>State Funds</b>	\$29,253,109	\$30,537,961	\$31,189,345	\$29,360,376
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$54,844,117	\$43,143,110	\$47,432,900	\$45,280,899
<b>Program Funds</b>	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$105,209,426	\$104,804,474	\$100,726,145	\$99,831,099
<b>Other Federal Funds</b>	\$219,092,735	\$402,054,693	\$251,801,699	\$246,286,853
<b>Total</b>	\$324,302,161	\$506,859,167	\$352,527,844	\$346,117,952

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$22,103,900	\$20,956,572	\$21,639,111	
<b>State Funds</b>	\$30,537,961	\$50,653,681	\$34,129,391	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$43,143,110	\$0	\$44,956,530	
<b>Program Funds</b>	\$0	\$0	\$0	
<b>SubTotal</b>	\$95,784,971	\$71,610,253	\$100,725,032	
<b>Other Federal Funds</b>	\$177,844,914	\$214,292,432	\$168,349,749	
<b>Total</b>	\$273,629,885	\$285,902,685	\$269,074,781	

	2019	
	Budgeted	Expended
Federal Allocation	\$21,289,200	
State Funds	\$57,518,051	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$78,807,251	
Other Federal Funds	\$171,656,028	
Total	\$250,463,279	

### III.D.1. Expenditures

#### Title V. Expenditures Narrative

##### A. Expenditures

###### Form 2

Title V FY17 expenditures totaled \$20,956,572. FY17 expenditures for the Preventive and Primary Care for Children totaled \$9,631,750 or 45.9% of total Title V expenditures for which is \$619,297 less than the FY 17 budget amount for Preventive and Primary Care for Children at \$10,251,047. This difference of \$619,297 is due to ODH shifting payment structure to a deliverable-based model. Time was needed for sub-grantees to adjust to the new payment structure.

FY17 expenditures for Children with Special Health Care Needs totaled \$7,415,446 or 35.3% of total Title V FY17 expenditures. FY17 expenditures for Title V Administrative cost totaled \$346,948 or 1.7% of total Title V expenditures which is \$138,722 above the FY17 budgeted amount for Title V Administrative. In FY17, the Office of Health and Improvement and Wellness and the Bureau of Maternal and Child Health administrative staff were in the process of re-organization and the budget for FY17 was delayed during the re-organization process of the two areas.

The state expenditures for FY17 totaled \$50,653,681 which is \$23,027,390 less than FY17 budget of \$73,681,071 because the FY17 budget included state funds that were used to meet Maintenance of Effort for Home Visiting program. Therefore, these expenditures related to Home Visiting were not included in the state expenditures for FY17. Historically, ODH has categorized state funds that were not used as match to the Title V in "Other Funds" and these funds are authorized by the Ohio Budget Bill. The expenditures related to Other Funds for FY17 is now included in the State MCH Fund expenditure for FY17.

Total expenditures for Federal-State Title V Block Grant Partnership is \$71,610,253.

###### Form 3A

Title V FY17 expenditures totaled \$20,609,624 excluding FY17 Administrative budget cost. FY17 expenditures for Pregnant Women totaled \$2,956,815 and Infants under the age of one totaled \$605,613. These expenditures for the pregnant women and Infant > 1 includes MCH services such as Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, and other Maternal and Child Health services that is dedicated to serving pregnant women and infants under the age of one. FY17 expenditures for the Preventive and Primary Care for Children totaled \$9,631,750. These expenditures for Primary Care for Children includes MCH services such as School and Adolescent Health, Oral Health, Lead, and other Maternal and Child Health services that is dedicated to serving children from 1-21 years of age. FY17 expenditures for Children with Special Health Care Needs totaled \$7,415,446.

State Funds FY17 expenditures totaled \$50,653,680. FY17 State Funds expenditures for Pregnant Women totaled \$7,027,802 and Infants < 1 totaled \$1,414,560. FY17 State Funds expenditures for the Preventive and Primary Care for Children totaled \$15,088,645 FY17 State Funds expenditures for Children with Special Health Care Needs totaled \$27,077,673.

Total expenditures for Federal-State Title V Block Grant Partnership is \$71,263,304 excluding FY17 Title V

Administrative cost.

### **Form 3B**

Title V FY17 expenditures totals \$20,956,572 for MCH Services. Title V Direct Service FY17 expenditures totaled \$3,823,323 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at \$2,361,414. Preventive and Primary Care Services for Children at \$854,036 and Children with Special Health Care Needs at \$607,873. These expenditures are direct services related to Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, Oral Health, and services for children with special health care needs. Title V FY17 expenditures for Enabling Services is at \$8,149,911 and Public Health and Systems at \$8,983,338. Historically, ODH MCH expenditures related to Direct Service included Case Management cost which ODH has now move Case Management costs to Enabling Services along with Oral Health, Infant Hearing, MCH Genetics and Vision program.

State expenditures for FY17 totals \$51,238,837 for MCH Services. State Direct Service expenditures totaled \$30,220,210 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at \$1,174,233 Preventive and Primary Care Services for Children at \$3,174,777 and Children with Special Health Care Needs at \$25,871,200. Title V FY17 budget for Enabling Services is at \$3,864,201 and Public Health and Systems at \$17,154,426.

### **III.D.2. Budget**

#### **Title V. Budget Narrative**

##### **A. Budget**

###### **Form 2**

Title V FY19 budget totals \$21,289,200. FY19 budget for Services for Pregnant Women, Mothers and Infants up to age one year is budgeted at \$6,062,733. FY19 budget for Preventive and Primary Care for Children is budgeted at \$6,896,193 or 32.3% of FY19 Title V budget. FY19 budget for Children with Special Health Care Needs is budgeted at \$7,240,033 or 34% of FY19 Title V budget. FY19 Title V Administrative costs is budgeted at 902,743 or 4.3% of the FY 19 Title V budget. Historically, ODH MCH budget has been highly focused on Children 1-22 years of age. Moving forward, the FY19 MCH budget is more well-rounded focusing on all MCH components which aligns with the MCH/CSHCN priorities.

The State MCH Funds budget for FY19 is \$57,518,051. Historically, ODH categorized state funds that were not used as match to the Title V in "Other Funds" and these funds are authorize by the Ohio Budget Bill. The state funds related to Other Funds for FY17 are now included in the State MCH Fund expenditure for FY19.

Total budget for Federal-State Title V Block Grant Partnership is \$78,807,251.

###### **Form 3A**

Title V FY19 budget totals \$20,386,466 excluding FY19 Administrative budget cost. Title V FY19 budget for Pregnant Women totals \$2,970,739 and Infants under the age of one totals \$3,091,994. The FY19 budget for Pregnant Women and Infants under the age of one consist of MCH services such as Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, and other Maternal and Child Health services that are dedicated to serving pregnant women and infants under the age of one. Title V FY19 budget for Children 1 through 21 years of age is budgeted at \$6,896,193 which includes budget costs for programs such as School and Adolescent Health, Oral Health, Lead, and other Maternal and Child Health services that is dedicated to serving children from 1-21 years of age. Title V FY19 budget for Children with Special Health Care Needs is budget at \$7,240,033. Title V budget for All Others is budgeted at \$187,507.

State FY19 budget totals \$57,518,052. Title V FY19 budget for Pregnant Women totals \$3,281,085 and Infant under the age of one totals \$3,415,007. Title V FY19 budget for Children 1 through 21 years of age is budget at \$27,589,528. Title V FY19 budget for Children with Special Health Care Needs is budget at \$23,025,336. Title V budget for All Others is budgeted at \$207,096.

Total FY19 Budget for Federal State MCH Block Grant Partnership is \$77,904,518

###### **Form 3B**

Title V FY19 budget totals \$21,289,200 for MCH Services. Title V Direct Service budget \$4,935,424 which contains Preventive and Primary Care Services for Pregnant Women and Infants under the age of one at \$3,760,940, Preventive and Primary Care Services for Children at \$674,484 and Children with Special Health Care Needs at \$500,000. The FY19 budget for direct services are related to Reproductive Health and Wellness, Ohio Infant

Mortality Reduction Initiative, Oral Health, and services for children with special health care needs. Title V FY19 budget for Enabling Services is at \$7,989,820 and consist of services related to Case Management, Oral Health, Infant Hearing, MCH Genetics and Vision program. The FY19 budget for Public Health and Systems is at \$8,363,956 which consist of MCH services related to Public Health Systems and Policy.

State budget for FY19 totals \$57,518,051 for MCH Services. Title V Direct Service expenditures totaled \$36,609,600 which contains Preventive and Primary Care Services for Pregnant Women and Infants under the age of one at \$2,294,830 Preventive and Primary Care Services for Children at \$2,294,830 and Children with Special Health Care Needs at \$32,019,940. Title V FY19 budget for Enabling Services is at \$2,804,792 and Public Health and Systems at \$18,103,659.

## **B. Summary and Budget Justification**

### Summary Budget Description for FY2019

- Component A: Services for Pregnant Women, Mothers and Infants up to age one year
- Component B: Preventive and Primary Care Services for Children and Adolescents
- Component C: Children with Special Health Care Needs and their families.

Component A:	\$ 6,062,733
Component B:	\$ 6,896,193
Component C:	\$ 7,240,033
Other:	\$ 187,507
Subtotal:	\$ 20,386,466

Administrative Costs: \$902,734

GRANT TOTAL: \$ 21,289,200

### Budget Justification

#### Maintenance of State Effort

In 1989, Ohio's MCH Block Grant award was \$19,369,474 and the state provided \$23,812,983 in support of the MCH activities. The fiscal year 2019 federal MCH award is expected to be \$ 21,289,200 and the state will provide \$57,518,051 to meet the maintenance of effort and state match requirements. State support is provided by appropriations from several state line items and one source of county funds which the Department is authorized to spend on behalf of children with special health care needs.

To determine the total amount of state match and funding of MCH programs, the Office of Health Wellness and Improvement (OHWI) totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations.

## Administrative Costs

The administrative costs of Ohio's 2019 MCH Block Grant request are based on the budget and expenditures related to the Office Chief's section of the Office of Health Wellness and Improvement and the MCH Bureau Chief Office.

## FY18 Carry Over Funds

The amount of carryover funds is based on the projected total amount of funds to be available in FY18 minus the projected expenditures through September 30, 2018. As of March 2018, an estimated total of \$21,639,111 in MCH Block Grant funds was available to the State of Ohio. According to the State's accounting reports, which reflect activity through June 13, 2018 the projected FY18 MCH expenditures will total \$12,732,301. When the total available funds are reduced by total projected expenditures the unencumbered balance will be \$8,906,810.

The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 4 months worth of expenditures in FY19.



### **III.E. Five-Year State Action Plan**

#### **III.E.1. Five-Year State Action Plan Table**

**State: Ohio**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

### III.E.2. State Action Plan Narrative Overview

#### III.E.2.a. State Title V Program Purpose and Design

##### State Title V Program Purpose and Design

The Ohio Department of Health (ODH) is the designated state agency responsible for Title V Maternal and Child Health (MCH) Programs. Within ODH, the Bureau of Maternal, Child and Family Health administers Title V programs address preventive and primary care needs, which are family-centered, community-based and culturally appropriate for MCH populations. The overarching goal of the MCH Block Grant is to support and promote the development and coordination of systems of care for women of childbearing age, infants, children, including children with special health care needs (CSHCN), adolescents, and families in Ohio.

The goals of the Title V Maternal and Child Health Programs are accomplished by engaging in a focused, multidisciplinary, collaborative approach to health improvement. This is done in coordination with internal and external stakeholders that serve individuals and populations that are disproportionately affected by poor health outcomes under the MCH umbrella. Also, included in collaborative efforts are families, youth and consumers whose voice lends to vital understanding of the unique needs of the population.

The MCH program utilizes a life course approach in developing strategies for improving systems and factors impacting social determinants of health. Each life stage impacts the next, and experiences of one generation may affect the health of subsequent generations. Throughout the lifespan, protective factors improve health and contribute to healthy development, while risk factors diminish health and make it more difficult to reach full developmental potential. Risk and protective factors are not limited to individual behavioral patterns or absence of medical care and social services, but also include factors related to family, neighborhood, community, and social policy. Some examples of protective factors include: a nurturing family, a safe neighborhood, strong and positive relationships, economic security, access to quality primary care and other health services. Some examples of risk factors include, among others: food insecurity, homelessness, living in poverty, unsafe neighborhoods, domestic violence, environmental pollution, racial discrimination, being born low birth weight, and lack of access to quality health services, being born preterm or too small.

Using the life course framework, MCH developed a 5-Year Action Plan with evidence-based and evidence-informed approaches to address population health domains through direct and enabling services to improve the health status of the MCH population. The Action Plan and yearly activities are designed using the core functions of public health: assessment, policy development, and assurance and applied using the following concepts:

- Assessing mortality and morbidity within MCH populations
- Approaching development through life course
- Impacting social determinants of health
- Improving health system transformation and access
- Implementing population-based interventions

### III.E.2.b. Supportive Administrative Systems and Processes

#### III.E.2.b.i. MCH Workforce Development

##### **MCH Workforce Development**

The Ohio Department of Health (ODH) supports staff development and planning by focusing on efforts that align with the core competencies of public health:

- Analytical/Assessment Skills
- Policy Development/Program Planning Skills
- Communication Skills
- Cultural Competency Skills
- Community Dimensions of Practice Skills
- Public Health Sciences Skills
- Financial Planning and Management Skills
- Leadership and Systems Thinking Skills

These competencies are reinforced for the MCH population by translating these concepts into evidenced-based and informed practices by:

- Assessing mortality and morbidity within MCH populations
- Approaching development through life course
- Impacting social determinants of health
- Improving health system transformation and access
- Implementing population-based interventions

The Bureau of Maternal, Child and Family Health (BMCFH) has 83 staff members with various backgrounds including: medicine, public health, social work, epidemiology, social work, public policy, nutrition, health care administration, education, finance, and marketing. The diversity of education and qualification creates a workforce that is knowledgeable and skilled to meet the needs of the MCH population.

The following are examples of trainings and workforce development opportunities available to ODH staff and stakeholders:

##### ODH Public Health Trainings

ODH is committed to offering learning opportunities for employees, local health departments, volunteers and contractors. As an introduction to public health, ODH offers a series of seven short modules that introduce participants to the concept and core functions of public health. In addition, ODH partners with The Ohio State University's Center for Public Health Practice to increase capacity and expertise in population health, workforce development, strategic planning, public health accreditation, and evaluation. These trainings are available to ODH staff, local health departments, agency staff and stakeholders.

##### Strengthening Parent-Professional Partnerships Conference – Promoting Partnerships and Family Centered Care in Healthcare Settings

Sponsored by the Ohio Family2Family (F2F) whose vision is for all families of children with special health care needs to receive best practice quality health care and community services.

F2F, in collaboration with ODH and multiple partners, hosted a free professional development opportunity for those who serve children and youth with special health care needs including parents, caregivers, and health care professionals. Topics included:

- Chronic Care Model
- Access to Care, Support for Care Coordination
- Shared Plan of Care
- Family engagement in health care
- Coordinated care

##### Continuous Quality Improvement/LeanOhio

The mission of LeanOhio is to make government services in Ohio simpler, faster, better, and less costly. Using the improvement methods of Lean and Six Sigma, Ohio's state agencies are cutting red tape, removing inefficiencies, improving customer service, and achieving measurable results. The LeanOhio Network includes state employee unions and members who promote Lean, improve processes, and partner with the state to teach Lean tools and strategies. Each state agency has a Lean Liaison who support the identification of improvement opportunities,

engage agency staff in improvement efforts, and ensure that changes are implemented and sustained. LeanOhio within the Ohio Department of Administrative Services. Members of the BMCFH staff have participated and completed a project for LeanOhio to improve efficiency in structure and programming.

#### Infant Mortality CollIN: Social Determinants of Health (SDOH)

The Infant Mortality CollIN set out to produce measurable improvements, increase synergy, lead and collaborative with others and improve health equity using the WHO Framework for tackling the social determinants of health. The learning collaborative setting is providing access to unique and respected subject matter experts and resources in the field of monitoring and addressing the social determinants of health related to maternal, infant and family health. With the support of the CollIN, ODH staff are working to build state and local capacity, with emphasis on innovation and spreading key strategies to reduce infant mortality and disparities in birth outcomes. The Ohio SDOH team is practicing the strategy innovation through systems change.

#### Ohio State University Summer Program in Population Health

Each year, the OSU Summer Program brings leading experts in public health to Columbus, Ohio. The unique design of the program provides an opportunity for public health professionals to learn in an atmosphere of intense scholarship and collaboration. Courses attend by ODH staff this year included: A Systems Science Approach to Addressing Infant Mortality in Ohio, Applied Qualitative Health Research, SAS for Data Analysis in Public Health, Place Matters: Building Health Communities and Population Health and Quality Measurement. Skills learned in each of these courses will be applied in infant vitality program development and implementation, as well as shared among Bureau staff for peer learning.

#### Training Course in MCH Epidemiology

Andrea Arendt, Epidemiology Investigator III, attended the Training Course in MCH Epidemiology in June, 2017. The Health Resources and Services Administration (HRSA), The Centers for Disease Control and Prevention (CDC), and CityMatCH offered the training course as part of their ongoing effort to enhance the analytic capacity of state and local health agencies. The training course is an intensive program, combining lectures, discussion, hands-on exercises, and opportunities for individualized technical assistance. Topics covered included Needs Assessment; Perinatal Periods of Risk; Relative, Absolute, and Impact Measures; Multivariable Regression Analysis; Analytic Approaches for Performance Measurement; Social Determinants of Health and Effective Data Presentation and Translation. Ms. Arendt is a leader within the MCH epidemiology section, providing support to each of the Title V Action Groups.

#### Tableau Fundamentals

In the BMCFH, Tableau is used to present interactive dashboards, allowing staff to easily access program and vital statistics data. Tableau Fundamentals provided staff with skills needed to synthesize, manipulate, and visualize data in Tableau dashboards and stories. Staff learned to implement advanced geographic mapping techniques, use custom images and geocoding to build spatial visualizations of non-geographic data, and improve existing dashboards using techniques for guided analytics, interactive dashboard design, and visual best practices.

#### ODH-U

ODH-U is a supervisory preparatory education program conducted by ODH Human resources. The goal of the program is to provide a roadmap for employees who are lacking supervisory experience to gain the essential knowledge, skills, and abilities in order to meet the minimum qualifications as related to supervisory experience. Several staff members from the BMCFH participated in the inaugural class of ODH-U. Staff completed various lead work projects along with a year-long leadership development curriculum. Participation in this program builds long term internal leadership capacity in the BMCFH and throughout ODH.

#### Cultural Competency and Health Equity

The ODH has developed cultural competency training for all ODH employees that is designed to enable staff to learn and practice cross-cultural communication skills. Strategies of the Office of Health Policy for inclusion of cultural competence in policy and finance include:

- Rule-making and Health Equity in all Policies – legislative review and policy development processes will incorporate a health equity lens, and all new proposed rules must undergo a health equity review.
- Strategic use of Financial Resources – infuse health equity concepts into all Requests for Proposals to local sub-grantee agencies.

### III.E.2.b.ii. Family Partnership

#### Family and Consumer Partnerships, Title V Collaboration and Collaboration

The Ohio Title V Program has strong collaborative relationships with other state agencies, local health departments, local public health agencies, academic programs, and professional associations to improve the health of MCH and CSHCN populations. The program also utilizes vital committee and council structures to foster open dialogue, receive input and feedback in regards to implementing effective public health interventions to support and improve outcomes for the MCH population and needs across the state. These structures support the implementation of the Title V 5-Year Strategic Plan, ODH's Strategic Plan and State Health Improvement Plan.

Executive Level State Collaboration starts with the Governors Executive Sponsors Office of Health Transformation (OHT), Department of Administrative Services (DAS), and Office of Budget Management (OBM) working with the Governor's Health and Human Services Cabinet Departments of: Job and Family Services (ODJFS), Rehabilitation Services Commission (RSC), Aging (ODA), Mental Health and Addiction Services (MHAS), Developmental Disabilities (DODD), Health (ODH), and Medicaid (ODM) with connections to the Departments of: Education (ODE), Rehabilitation and Corrections (ODRC), Youth Services (ODYS), Veterans Services (DVS), Insurance (ODI), and Taxation (ODT) working together to streamline health and human service operations, governance and coordinate priorities across agency boundaries.

Within Title V programs collaborative efforts by Ohio's state, local and community based service systems for individuals and families is vitally important. These systems work together on achieving shared policy and programmatic goals to ensure that all Ohio's women, infants, children with and without special health care needs, youth and adolescent and families receive the services they need to promote their health and wellness. These partnerships are critical because no single system has the resources or capacity to meet this goal alone. Where applicable, the Title V program has established inter-agency agreements between ODH and its sister agencies to establish administrative and financial accountability for shared programs. In addition, there are data sharing and research project agreements between ODH and agencies with a mutual interest. These agreements foster the exchange of information for making data driven decisions regarding MCH policies and practice. Where appropriate and when possible, Title V programs include families of CSHCN and consumers of MCH services on its committees and councils.

A few examples of Ohio's Title V Programs collaborative efforts include:

- ODH and ODM works together on the coordination of services by the Ohio Medicaid Managed Care Programs.
- At a state, regional and local level, the Ohio Medicaid Assessment Survey (OMAS) delivers health and healthcare data and gives insight into the health status of Ohio's Medicaid, Medicaid-eligible, and non-Medicaid populations. OMAS provides necessary data to measure the impact of healthcare reform over time, especially issues relevant to the efficient administration of the Ohio Medicaid program.
- Children in the Vanguard with ODM, ODE, DODD, advocates and consumers focus on continuing progress on children's coverage as health care reform is implemented.
- DODD and ODH have an interagency agreement regarding the implementation of the Help Me Grow Early Intervention and Central Coordination services.
- Ohio Association of Children's Hospitals (OACH): The Title V Director is a member of their advisory committee. CMH program collaborates closely with OACH as they are a key partner/advocate for health care issues for all children, especially CSHCN. OACH is a key member of the MAC Advisory Council, and the Birth Defects Advisory Council. The Ohio Chapter of American Academy of Pediatrics (OH-AAP) co-chairs

the Children with Disabilities Subcommittee with the CMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. OH-AAP also participates in many of the Title V Action Groups supporting the implementation of the 5-Year Strategic Plan.

- MHAS, ODE, ODJFS, ODYS, DODD and ODH participate in an Interagency Council for Youth to support the unique needs of youth and young adults with co-occurring disorders. Policy and system improvements are made to the Deputy Directors of the Governor's Cabinet, when appropriate.
- The Title V Director represents ODH on the advisory committee for School Based Health Care. ODE and ODM are also active members.

ODH works with a number of entities to address unique challenges faced by the MCH population, including CSHCN and their families. Program policy is informed by on-going interactions with a broad representation of stakeholders and consumers.

### **Medical Advisory Council (MAC)**

The Children with Medical Handicaps Program (CMH) Medical Advisory Council (MAC), established in state statute, consists of 21 members appointed by the director of Health. Members represent various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions. MAC advises CMH on issues such as medical practice, medical eligibility, program rules, and standards of care. In addition, MAC may be consulted regarding eligibility of provider applicants, scope of provider practice/services, authorization of out-of-state provider care, medical eligibility of particular conditions, eligibility of specific services for the diagnostic and treatment programs, the development of medical policies, other medical issues and the establishment of standards of practice.

### **Parent Advisory Committee (PAC)**

The [Parent Advisory Committee \(PAC\)](#) is composed of parents from around the state who meet regularly to advise CMH regarding care for children with special health care needs. The PAC mission is to assure family-centered care is an essential component in the development and delivery of programs and services for CSHCN.

### **Ohio Developmental Disabilities Council (Ohio DD Council)**

The mission of the Ohio DD Council is to create change that improves independence, productivity and inclusion for people with developmental disabilities and their families in community life. The Ohio DD Council is one of a [national network of state councils](#), committed to self-determination and community inclusion for people with developmental disabilities. The Ohio DD Council:

- **Advocates** for people with developmental disabilities and their families.
- **Initiates** programs that enrich their lives.
- **Demonstrates** a consistent commitment to our mission.
- **Educates** about disability rights and the importance of self-determination.

The Ohio DD Council has over 30 members. Sixty percent represent people with developmental disabilities, and parents and guardians of people with developmental disabilities. Remaining members include representatives from state agencies, non-profit organizations and agencies providing services to people with developmental disabilities. Ohio DD Council members are appointed by the Governor.

### **Ohio's Interagency Workgroup on Autism (IWGA)**

Ohio has a rich and long-standing history of addressing autism spectrum disorders (ASD), driven by a strong network of individuals, families and advocates. Informed by individuals, families and stakeholders, IWGA meets monthly to review state policies, learn from current research and data, share learning and identify opportunities to



better communicate and coordinate autism policy. A hallmark of the IWGA's efforts is the creation of an innovative, free, online video training series, ASD Strategies in Action, now being used by more than 10,000 people across Ohio, giving them practical ways to care for and support loved ones with ASD, from early childhood through young adulthood.

### **Governor's Early Childhood Advisory Council (ECAC)**

The Early Childhood Advisory Council provides input and guidance to the Governor's Office on early childhood programs. ECAC membership includes a diverse array of stakeholders from early childhood programs, schools, health, social services, unions, philanthropy and other groups. Ohio's governance and administrative structures have the authority and responsibility to oversee, implement and coordinate state-funded or state-administered early childhood programs and services for children and their families. The Title V Director represents ODH on the Leadership Team.

### **Early Intervention Advisory Council (EIAC)**

EIAC is made up of governor-appointed members from other state agencies, providers, and parents of children with disabilities. The council plays an important role in advising DODD in implementing Ohio's Early Intervention (EI) program. EI is a statewide system that provides coordinated early intervention services to parents of eligible children under the age of three with developmental delays or disabilities. All meetings are open to the public.

### **CMH Collaboration to Serve Ohio's Children with Special Health Care Needs**

The CMH program works with the aforementioned entities to address unique challenges faced by CSHCN and their families. Program policy is informed by on-going interactions with a broad representation of stakeholders, representing the many conditions that CSHCN face.

The CMH program facilitates quarterly regional meetings with community-based dietitians and with public health nurses from Local Public Health Departments, as well as the MAC and PAC, to provide updates and receive feedback regarding CMH and Medicaid policy, and to review emerging trends effecting CSHCN, families, and providers.

A weekly case conference is conducted between clinical and policy teams from the CMH program and the ODM to ensure coordination of benefits, across payer systems, for CSHCN enrolled in the CMH program. These case conferences are key to ensuring quality care, providing information to Medicaid managed care plans regarding unique needs for children with multi-disciplinary and complex medical needs, and for informing policy.

In January 2017, Ohio's CSHCN who are recipients of Medicaid were transitioned from traditional fee for service coverage to managed care plans (MCPs). In December 2015, the CMH program identified thousands of CSHCN who were impacted and coordinated communication between Medicaid and families. In preparation for the transition, CMH facilitated regional, public meetings with ODM, MCPs, hospitals, clinicians, public health nurses, hospital-based service coordinators, and parents to inform the process. Meetings held prior to, during, and in the year following the transition provided opportunities for the MCPs to understand critical priorities for CSHCN and their families. Members of the CMH MAC and PAC were key to the process. As implementation occurred, families provided feedback on progress and challenges. While issues are now fewer in number, they continue to be addressed within the weekly CMH-ODM case conference.

### **Family-to-Family Health Information Centers (F2F HICs)**

F2F HICs are family-staffed organizations that assist families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. F2F HICs provide support, information, resources, and training



around health issues. F2F HICs are uniquely able to help families because they are staffed by family members who have first-hand experience navigating the maze of health care services and programs for CYSHCN. This intimate understanding of the issues that families face makes F2F staff exceptionally qualified to help families navigate health systems and make informed decisions.

Ohio F2F is based within the University of Cincinnati, University Center for Excellence in Developmental Disabilities (UC UCEDD). UC UCEDD believes that people with disabilities should and can be active, included and fully participating members of their communities. UC UCEDD has four core functions: Community Services, Information Dissemination, Interdisciplinary Training, and Research. ODH Title V program is an active member of the Ohio F2F.

### **Ohio Adolescent Health Partnership (OAHP)**

OAHP is a diverse group of agencies, organizations and individuals with expertise in adolescent health and wellness, and with common goals of supporting optimal health and development for all adolescents. Youth voice is highly encouraged through adolescent and young adult involvement.

### **Ohio Collaborative to Prevent Infant Mortality (OCPIM)**

OCPIM is comprised of wide range of clinical and public health providers, business, government, associations, faith-based organizations and advocacy groups from across the state that bring knowledge and expertise together to inform the state's infant mortality crisis. The group has developed 10 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 preterm birth.
5. Improve data collection and analysis to inform program and policy decisions.
6. Expand quality improvement initiatives to make measurable improvements in MCH 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.
10. Establish a consortium to implement and monitor the recommendations of the Ohio Infant Mortality Task Force.

### III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

#### State Systems Development Initiative and Other MCH Data Capacity Efforts

The purpose of the Ohio State Systems Development Initiative (SSDI) is to expand and enhance current state and jurisdictional MCH data capacity and to develop new more timely data systems and infrastructure that will support MCH program objectives in alignment with the Title V Block Grant. Both grants are held by the BMCFH. The BMCFH Epidemiology, Research and Evaluation section, which manages SSDI, analyze population and programmatic data, disseminate information, and strengthen the evidence base in Maternal and Child Health. These efforts inform policy makers, state and local partners, and the general public. Additionally, they assist in program evaluation which aids in quality improvement and ensures that the bureau's resources are being used wisely. As part of the Title V Block Grant workgroup process, epidemiologists and researchers focus on analysis and interpretation of indicators required for Title V annual reporting as well as assisting in setting and revising (as needed) annual objectives.

During previous SSDI project periods, ODH used SSDI funds to make final annual and current preliminary birth, mortality, fetal mortality, and linked birth/mortality raw data files available for download from the secure Ohio Public Health Data Warehouse (OPHDW). Additionally, available for anyone to use and accessible from the ODH website (<http://publicapps.odh.ohio.gov/EDW/DataCatalog>), the Ohio Public Health Data Warehouse (OPHDW) allows individuals to make charts, create reports, and track trends about births and deaths among Ohio residents. In most cases, preliminary data is available a few days after death. Development work was also completed on an infant mortality module that includes a linked birth-death file to allow for users to explore demographic information as reported on the death certificate and birth certificate. The secure infant mortality module is already available for ODH staff and Institutional Review Board (IRB)-approved researchers to access line-level data. Improvements are currently being made and the public module will be rolled out when those are complete. Automation of the vital statistics files has facilitated epidemiological analysis for the block grant making birth and death information available in a more timely and streamlined fashion. Additionally, it makes the data more accessible to our external partners and stakeholders.

In April 2017, the Ohio General Assembly passed Senate Bill (SB) 332 based on recommendations of the Infant Mortality Commission and public testimony. One of the key initiatives includes requirements for state agencies to publish timely data. Although payer status (including Medicaid) is something that is captured on the birth certificate, the data is not reliable. Calculating infant mortality rates and other indicators (e.g., low birth weight, smoking status, etc.) by Medicaid status is very important for designing and tracking the success of interventions aimed at reducing infant mortality in the Medicaid population. SSDI funds are currently being used to add fields (confirmed Medicaid paid birth and managed care plan name) to the existing birth, infant mortality and fetal death files in the OPHDW.

As the lead agency for evidence-based home visiting in the state of Ohio, ODH has worked with the Ohio Home Visiting Consortium, the Governor's Early Childhood Advisory Council (ECAC), and other stakeholders to develop a shared vision and definitions for home visiting in the state. Effective July 1, 2018 Ohio administrative Code 3701-8-01 provides key definitions for key aspects of home visiting services in the state of Ohio. Additionally, work continues in the ECAC to streamline and use a standardized set of screening tools to monitor cross-agency maternal and child health outcomes and indicators.

In an effort to examine and improve birth outcomes, the state created a novel data driven project structure, utilizing blended team structure of data scientists and state program and policy experts. The first 6 months focused on linking 31 state data sets to form a 360-degree view of at risk moms in the state, and build predictive models with the joined dataset that assess risk of infant mortality and preterm birth with a high degree of accuracy, focusing on those indicators which are knowable by the state even in the absence of clinical data or a prenatal visit and prioritizing implementation.

The next phase of the project zeroes in on enabling those analytical tools to those on the front line, and targeted high

intensity pilots of evidence based interventions to reverse the causal factors identified by the analytics, starting in the highest propensity geographies and partnering with both providers and payers to boost outcomes in the State and improve the infant mortality rate and birth weights statewide. Accenture, a global management consulting and professional services firm that provides strategy, consulting, digital, technology and operations service is facilitating this process.

### III.E.2.b.iv. Health Care Delivery System

#### Health Care Delivery System

##### Ohio Medicaid

Medicaid is Ohio's largest health payer. Over 90,000 hospitals, nursing homes and other providers deliver services for over 3 million individuals insured by Medicaid. Over 2.4 million Medicaid enrollees are served by the five statewide managed care plans (MCPs). In January 2017, enrollment was 3,054,806 of which 89% were covered by a managed care plan. As of January 1, 2017, there are 714,997 covered in the expansion category, enrolled in private managed care plans. Approximately 88,000 were served by HCBS waivers; 56,000 living in long-term care facilities. Most Medicaid beneficiaries now receive Medicaid health care benefits through one of five private managed care plans. Ohio Medicaid pays the health plans monthly, per person, using capitation rates. In 2017, Ohio extended managed care enrollment to additional populations that had previously been excluded from care coordination, including children in Ohio's foster care and children in custody system and individuals enrolled in the Ohio Department of Health Bureau for Children with Medical Handicaps and Breast and Cervical Cancer Program. The state also offered optional managed care for individuals with developmental disabilities enrolled on a HCBS Waiver administered by the Ohio Department of Developmental Disabilities.

In the 2018-19 fiscal year budget, Ohio implemented a rule that the state should seek federal approval for a work requirement that would apply to the Medicaid expansion population. Of the more than 700,000 people enrolled in Medicaid expansion, it is estimated that 36,000 will need to start working or enroll in job training, education, or certain volunteer activities, for at least 20 hours per week, in order to avoid being disenrolled. The rest of the Medicaid expansion population is either already working or would be exempt from the work requirement.

This requirement would not apply to enrollees age 50 or older, children, pregnant women, caretakers caring for minor children or a disabled person, people receiving unemployment or Supplemental Security Income, people in drug or alcohol treatment programs, or anyone deemed physically or mentally unable to work.

##### Partnership

During the past two years, the Ohio Department of Health (ODH) and the Ohio Department of Medicaid (ODM) have transformed their relationship towards joint decision-making and trusted advisors for both agencies. In strategic planning to improve health outcomes for Ohio's most vulnerable populations, the agencies have developed and defined common metrics, created dual data reports, and developed processes for bi-directional data exchange. To stay abreast of needs and relationship development, the agencies meet bi-weekly to support and advise policy implementation and planning processes.

Examples of joint initiatives include:

In FY 2018, ODM required managed care agencies to provide enhanced prenatal and maternal care. ODH served as an advisory on policy efforts. In determining strategy for ODM's infant vitality funding, ODH was an equal partner in identifying evidence-based strategies, scoring and common metrics.

The Ohio Medicaid Technical Assistance and Policy Program (MEDTAPP) enables the use of federal Medicaid administrative funds to identify barriers and improvements in accessing healthcare services and improving health care workforce in high need areas. The following agencies serve on the advisory committee: ODM, ODH, Ohio Department of Department of Developmental Disabilities (DODD), Ohio Department of Mental Health and Addiction Services (OMHAS), and the Ohio Department of Higher Education (ODHE). Specific projects include:

- Workforce Development
  - MEDTAPP Healthcare Access Initiative
  - MEDTAPP Health Professions Data Warehouse
- Maternal and Infant Health
  - Care Models Directed at Reducing Ohio's Infant Mortality Rate
  - MEDTAPP Maternal and Child Health Outcomes
  - Best Evidence for Advancing Child Health in Ohio NOW! (BEACON)
- Health Services Research and Data
  - Ohio Medicaid Assessment Survey (OMAS)
- Integrated Physical & Behavioral Health

The MEDTAPP MCH projects include Smoke Free Families quality improvement projects with the Ohio Chapter of the American Academy of Pediatrics and the Ohio Perinatal Quality Collaborative; the Ohio Progesterone Promotion Project that engages maternity care providers to increase screening and utilization of progesterone as needed, and the Ohio Type 2 Diabetes Learning Collaborative which improves health outcomes for women of child-bearing age at high risk for developing type 2 diabetes and those with a history of gestational diabetes mellitus.

The Infant Mortality Research Partnership (IMRP), a collaboration between state agencies, researchers, and subject matter experts, uses big data to gain a better understanding of how to lower infant mortality in Ohio. The IMRP team includes the ODH, ODM, ODHE, and university researchers across multiple disciplines such as biostatistics, pediatrics, and geography.

Phase I of the IMRP, leveraged a diverse array of data and methods, sought to answer three overarching questions: 1) Where should interventions be targeted to reduce infant mortality? 2) To whom should those interventions be targeted (i.e., which women are at highest risk)? and 3) How should those interventions be implemented, and what will be the likely future impact of these interventions?

Phase II will improve upon and expand previous models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. The Government Resource Center at The Ohio State University will maintain and update the IMRP Interactive Data Display which will ultimately provide state policymakers with timely, reliable, and usable results to better plan, budget, and implement quality healthcare services for Ohio's Medicaid women and children.

### **III.E.2.c State Action Plan Narrative by Domain**

#### **Women/Maternal Health**

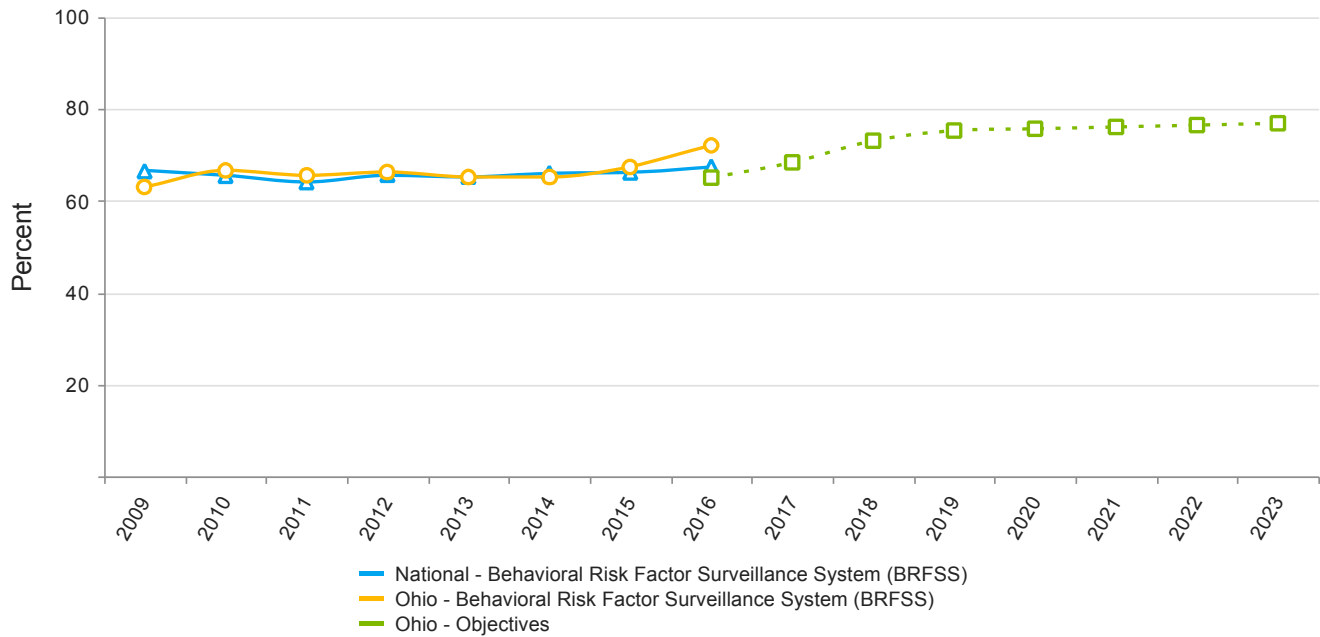
#### **Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	118.3	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	19.2	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.4 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	25.5 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	7.1	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.2	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.8	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.4	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	267.8	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	110.6	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	6.4 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	11.6	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.4 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	21.8	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	16.2 %	NPM 1



## National Performance Measures

### NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year Baseline Indicators and Annual Objectives



#### Federally Available Data

#### Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017
Annual Objective	65	68.3
Annual Indicator	67.4	72.0
Numerator	1,305,840	1,407,811
Denominator	1,936,363	1,954,874
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

#### Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.2	75.6	76.0	76.4	76.8

## Evidence-Based or –Informed Strategy Measures

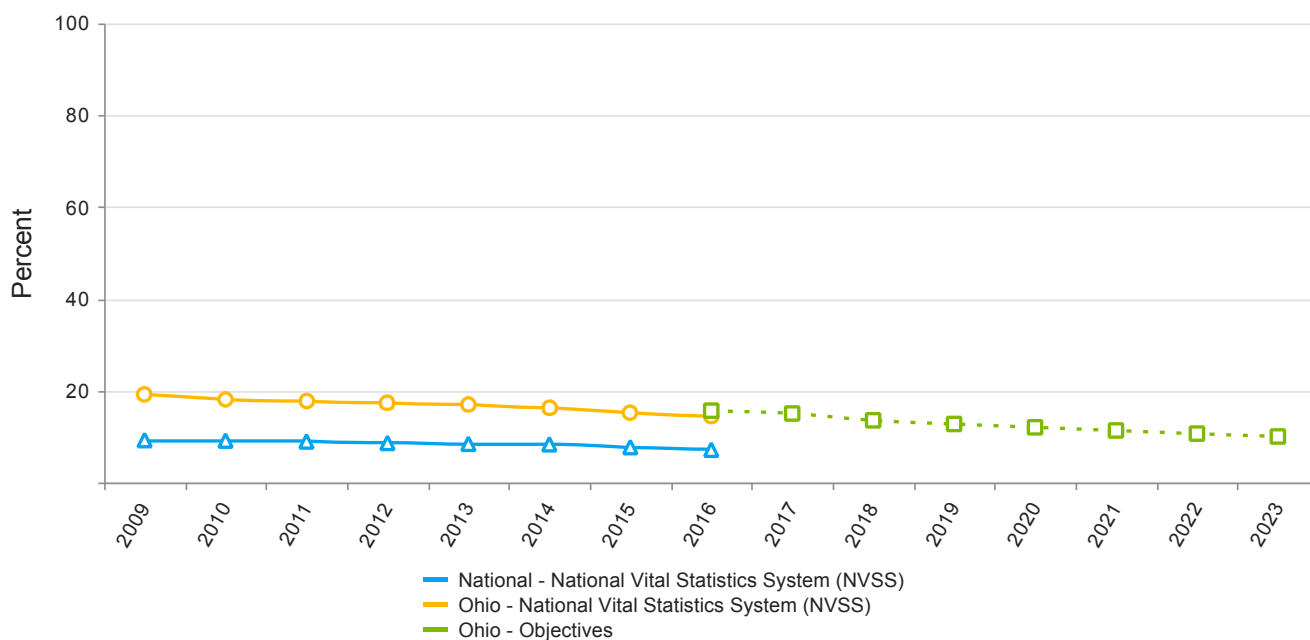
**ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		66.5
Annual Indicator	64.6	65.2
Numerator	18,653	18,672
Denominator	28,865	28,623
Data Source	Ahlers Title X Database	Ahlers Title X Database
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	67.2	69.2	71.3	73.4	75.6	77.9

**NPM 14.1 - Percent of women who smoke during pregnancy**  
**Baseline Indicators and Annual Objectives**



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	2017
Annual Objective	15.7	15.1
Annual Indicator	15.2	14.4
Numerator	21,150	19,764
Denominator	138,801	137,722
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	13.6	12.8	12.1	11.4	10.7	10.1

**Evidence-Based or –Informed Strategy Measures****ESM 14.1.1 - Number of publicly funded programs newly trained to implement the 5As.**

<b>Measure Status:</b>	<b>Inactive - Completed</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		15
Annual Indicator	64	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

**ESM 14.1.2 - Number of pediatric and obstetric-gynecologic providers newly trained to implement the 5 As**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>					
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	18.0	18.0	18.0	18.0	18.0

## State Action Plan Table

### State Action Plan Table (Ohio) - Women/Maternal Health - Entry 1

#### Priority Need

Increase the prevalence of women receiving preconception care

#### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

#### Objectives

- A. Strengthen comprehensive preconception health care services that are provided to clients of child bearing age.
- B. Increase the utilization of reproductive life plans (RLP) for clients of child bearing age.
- C. Increase provider utilization of evidenced based, culturally-competent, preconception care.
- D. Partner with stakeholders and relevant health care providers to increase the prevalence of women receiving preconception care.
- E. Utilize social media to promote preconception care and targeted health messages.
- F. Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits.
- G. Improve the socio-emotional health and addiction needs of reproductive age women.
- H. Support trauma informed practices and programming for women before, during, and after pregnancy.

## Strategies

A1) Provide comprehensive reproductive health and wellness direct health care services per nationally recognized standards of care to 30,000 women, men and adolescents via sub recipients. A2) Ensure all Reproductive Health and Wellness Program (RHWP) sub recipients offer at least one type of Long Acting Reversible Contraceptive (LARC) onsite. A3) Provide motivational interviewing training for sub recipients. A4) Develop work plan to roll out Ohio LARC First Initiative to all RHWP. Sub-recipients, starting with those in OEI counties. A5) Identify/train trainers for LARC First training. A6) Provide LARC First training to ALL RHWP sub-recipients. A7) Implement data collection from statewide Ohio LARC First Initiative.

B1) Develop work plan for RLP project. B2) Identify existing tool kits on the importance and implementation of RLP. B3) Personalize and/or develop toolkits on the importance and implementation of RLP. B4) Disseminate toolkit to all ODH funded safety net providers who interact with women and men of childbearing age.

C1) Develop plan for implementing LARC First QI process with non-RHWP providers and partners with a focus on LARC First. C2) Implement Wave 1 LARC First QI process with FQHC providers; C3) Expand existing GDM post-partum QI work by contracting with vendor to: 1) sustain interventions in Waves 1 & 2; 2) recruit and implement interventions with Wave 3; 3) implement evaluation plan. C4) Implement Wave 3 GDM post-partum QI work C5) Collaborate with Medicaid to expand the GDM post-partum QI work

D1) Provide TA and training opportunities to sub recipients about Medicaid and Marketplace enrollment. D2) Monitor program data to identify sites with potentially eligible women who do not have Medicaid/insurance coverage.

E1) Implement LARC First media campaign targeted to high volume RHWP communities using the Power to Decide creative materials E2) Provide training to RHWP sites on developing and implementing local outreach campaigns E3) Identify target audience for preconception messaging E4) Identify appropriate messaging including encouragement for target audience to set goals/changes they will make which they then share through the #PicturePerfectHealth campaign E5) Facilitate implementation of messaging

F1) Work with partners to identify barriers. F2) Develop strategies for addressing barriers and possible solutions.

G1) Work with MCH sub-grantees to implement the MCH behavioral health strategy related to mental health and addiction of reproductive age women.

H1) Provide training to health care providers on trauma informed care for adult survivors of abuse and violence, to include training on sexual and domestic violence, human trafficking, and adult survivors of child abuse. H2) Support programming in local communities for both professionals and community members.

## ESMs

## Status

ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics

Active

## NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth



## State Action Plan Table (Ohio) - Women/Maternal Health - Entry 2

### Priority Need

Reduce the rate of maternal smoking and substance abuse by pregnant women.

### NPM

NPM 14.1 - Percent of women who smoke during pregnancy

### Objectives

A. Increase the number of pregnant and post-partum women completing of smoking cessation programs in collaboration with the Ohio Partners for Smoke Free Families.

B. Build local infrastructure to implement grant programs to reduce maternal smoking and second-hand smoke exposure

C. Reduce the number of alcohol exposed pregnancies

D. Reduce opiate exposed pregnancies

## Strategies

A1) Train publicly funded maternal and child health programs to implement 5As evidence-based tobacco cessation interventions for pregnant smokers and women of childbearing age using quality improvement science. A2) Provide information and education to the general public, high-risk populations and providers. A3) Identify assets available for those affected by tobacco use and provide resources and supports for individuals as well as family members. A4) Build knowledge and capacity of health, social service and educational professionals to ask, advise, assess, assist and arrange for follow up. A5) Implement quality improvement activities to ensure fidelity of implementation and improve quality of implementation. A6) Collect data from programs implementing interventions. A7) Provide on-going resources and technical assistance to programs implementing interventions. A8) Target communities with high perinatal smoking rates and poor birth outcomes for targeted interventions.

B1) Implement the evidence-based smoking cessation intervention program, Baby & Me-Tobacco Free (a smoking cessation program created to reduce the burden of tobacco use in the pregnant and post-partum population) through the grant programs (Maternal and Child Health Program and Moms Quit for Two). B2) Identify high risk communities implement the evidence-based smoking cessation intervention program, Baby & Me-Tobacco Free. B3) Develop outreach plan to recruit providers serving the most at risk. B4) Providers provide smoking cessation counseling and monitor smoke free status using carbon monoxide (CO monitoring. B5) Diaper vouchers are distributed to women who are confirmed smoke free. B6) Collect data and share through monthly technical assistance collaborative. B7) Train Tobacco Treatment Specialists (TTS). B8) Identify high risk communities with high perinatal smoking rates and high preterm and low birth weight rates.

C1) Raise awareness and availability of services by supporting the Strategic Plan for Ohio's Fetal Alcohol Spectrum Disorders (FASD) Initiative. C2) Identify a state champion lead for FASD (physician, state official, parent, person with a lived experience, media). C3) Identify and collect data. C4) Provide information and education to the general public, high-risk populations and providers. C5) Identify assets available for those affected by FASD and provide resources and supports for individuals with FASD, as well as parents and caregivers supporting an individual with FASD. C6) Build knowledge and capacity of health, social service and educational professionals to identify individuals with a possible FASD. C7) Build knowledge and capacity of health, social service and educational professionals to screen for substance abuse. C8) Implement ASBI in WIC program. C9) Increase the awareness and implementation of the SBIRT.

D1) Support the Maternal Opiate Medical Support (M.O.M.S.) Project. D2) Implement interventions and treatments to improve outcomes while reducing the cost of specialized care through grant funding. D3) Develop an integrated maternal care practice model with timely access to appropriate mental health and addiction services that extend postpartum including intensive home-based or residential treatment. D4) Identify best practices for obstetrical services before, during and after delivery and develop a toolkit to support clinical practice. D5) Conduct a pilot and evaluation with promising practices at 2-3 sites that will integrate the model into standard practices.

## ESMs

## Status

ESM 14.1.1 - Number of publicly funded programs newly trained to implement the 5As.

Inactive

ESM 14.1.2 - Number of pediatric and obstetric-gynecologic providers newly trained to implement the 5 As

Active

## NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

---

NOM 5 - Percent of preterm births (<37 weeks)

---

NOM 6 - Percent of early term births (37, 38 weeks)

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NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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NOM 9.1 - Infant mortality rate per 1,000 live births

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NOM 9.2 - Neonatal mortality rate per 1,000 live births

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NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies

### Women/Maternal Health, FY 2017 Annual Report

#### Ohio Department of Health Priority:

Increase the prevalence of women receiving preconception care

The Ohio Department of Health's Reproductive Health and Wellness Program (RHWP) Action Group is comprised of MCH-funded programs that serve the women/maternal health population. The workgroup includes representatives from a wide variety of ODH programs serving women of reproductive age including Adolescent Health, Birth Defects, Maternal and Child Health, Pregnancy Associated Mortality Review, Reproductive Health and Wellness, Sexual Assault and Domestic Violence Prevention, and Assessment and Planning. Stakeholders from outside ODH include representatives from Medicaid, the Department of Mental Health and Addiction Services, local Federally Qualified Health Centers (FQHCs) and Medicaid Managed Care Plans, Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction Services. The group keeps updated on data and services related to women's/maternal health, review the literature for evidenced-based best practices, and discuss challenges and barriers regarding Ohio's data and current practices. Based upon discussions and findings, the group has updated the action plan that will guide the course of the work for this Performance Measure.

Strategies identified in the five-year action plan continue to include: 1) Ensure comprehensive preconception health care services are provided; 2) Align MCH funded programs that serve reproductive age women and men to improve access, quality, and increase availability of preconception health services; 3) Increase provider utilization of evidenced based, culturally-competent, preconception care; 4) Partner with stakeholders and relevant health care providers to increase the prevalence of women receiving preconception care; 5) Utilize social media to promote preconception care and targeted health messages; 6) Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits; 7) Ensure that the socio-emotional health and addiction needs of reproductive age women are met; 8) Increase the number of health care providers who have received training in trauma informed care to reduce the extent to which experience of trauma is a barrier to women receiving preconception health care; and 9) Increase the number of health care providers and community members receiving training on violence prevention and on appropriate response to victims of sexual and domestic violence and human trafficking.

FY 17 updates include the following:

- For those served by the Ohio Department of Health RHWP, 65.2% of female, unduplicated clients had primary care coverage. This is a 47.5% increase since the same time in FY2012 when only 44.2% of women had primary care coverage.
- ODH RHWP sites provided 59,210 visits to 35,050 unduplicated clients in 70 sites in 50 counties. These sites include local health departments, community action organizations and non-profit agencies providing family planning direct care. The ODH RHWP staff compiled LARC and Most-moderately Effective Reports to monitor the percent of women at RHWP agencies/clinics utilizing these contraceptive methods on a quarterly basis. Thirty-seven RHWP sub recipients offered at least one type of LARC on site; in FY17 it was reported that 5,980 clients chose LARC as a means of contraception.
- Client insurance data was reviewed and discussed with RHWP sub recipients during site visits; In FY17, statewide 15,523 of 35,050 unduplicated clients in RHWP clinic sites were covered by public insurance; 12,607 were uninsured and 6,150 had private health insurance. As of April 1, 2016 local RHWP sites were required to ensure that a Certified Application Counselor (CAC) or Navigator was available to assist Title X clients with Marketplace enrollment as well as ensuring eligible Title X clients are assisted with enrollment into

Medicaid.

- In FY17, ODH began monitoring 37 RHWP sub recipients using the nationally recognized Contraceptive Care Performance Measures. In the first quarter of FY17, 11.4% reported using LARC while in the final quarter of FY17, 12.8% reported using LARC.
- ODH supported the Ohio Perinatal Quality Collaborative (OPQC) who partnered with Cicatelli Associates Inc (CAI), the Ohio Association of Community Health Centers (OACHC) the Ohio Department of Medicaid (ODM) and the Ohio Colleges of Medicine Government Resource Center (GRC) to implement the “Infant Mortality Reduction-Federally Qualified Health Centers” project. The aim of this initiative was to improve infant vitality and maternal health by empowering women with information and services to optimize timing and spacing of their pregnancies. The project involved nine clinical sites of five FQHC networks. The Client-Centered Care framework we used, developed with CAI and OPQC content and implementation expertise, aimed to improve patient care and outcomes by training teams on evidence-based clinical practices, long-acting reversible contraceptives (LARC) stocking and financing, workflow, and contraceptive counseling. Data showed an improvement from a baseline of 55% to nearly 100% of visits where a woman is screened for her pregnancy intentions; improvement from the baseline to the end of the project for the % of visits where Contraceptive Counseling occurred; and improvement across all the sites at a system level for % of visits where women were leaving with the most/moderately effective form of contraception
- Developed a collaborative Change Package for FQHCs in partnership with CAI.
- ODH continued to submit monthly data to Informing Change for LARC First Initiative. Informing Change is using state data for data analysis. This work is being done in conjunction with local family planning providers, Community Solutions, Upstream USA and the Gund Foundation and LARC First NE Ohio.
- ODH entered into a contract with the OSU Government Resource Center for work with the ODH Gestational Diabetes Collaborative in September 2016. This contract sustained work with Wave 1 and 2 and spread the strategy to Wave 3 sites. GRC completed an assessment of Waves 1 and 2 (including 25 clinical care sites representing 237 individual physicians, nurse practitioners, and midwives) which used Medicaid claims data and found an increase in postpartum visit rates and in early GDM screening for high risk women.
- ODH also launched wave 3 of the QI work, which expanded the clinical obstetrical sites geographically into more rural sites.
- ODH and Medicaid together in July 2017 executed a contract for Wave 4 of the QI work, which focuses on primary care clinics and adds new patient and provider resources for this population
- Nine (9) Maternal and Child Health programs were awarded funding to implement the MCH behavioral health strategy related to mental health and addiction of reproductive age women in a variety of ways to assist with better screening, follow-up, and referral.
- Presentation to staff at February 2017 “End Slavery” conference on integrating human trafficking prevention into services (about 25 participants)
- Presentation on human trafficking to new school nurses at their fall 2017 training (about 100 participants)
- Training for state employees on bystander intervention (offered twice; total of about 50 participants) and how managers can support staff who are experiencing or causing harm in their relationships (offered once) (about 25 participants; Spring/Summer 2017)
- Five ODH staff attended OMAS sponsored “Train the Trainers” on trauma informed care. (September 2017)
- Three ODH staff attended “The New Playbook” on working with men to end gender based violence (July 2017)
- Non-MCHBG funding provided dollars for ODH to funded seven sexual assault crisis services grant recipient agencies for work including training health care providers and community members on appropriate responses to victims of sexual and domestic violence and human trafficking.
- Bi-monthly meetings of the Action Group were held to further develop the action plan and identify collaborative opportunities across the members to improve adolescent health.

## Priority Measures:

NPM 1: Percent of women with a past year preventive visit

- According to the HRSA Federally Available Data (FAD), in 2016 68.3% of women 18-44 years old in Ohio received a past year preventive visit. Between 2009 and 2016, there was a significant increase of about 1.3% per year. Women who are insured are more likely to have had a preventive visit than those who are not (73.5% versus 46.0%). Women with a household income of less than <\$15k are more likely to have had a past year preventive visit than those with a household income of \$15k-\$24K and \$25k-\$49K. Although there may be many reasons for this, one explanation is that being covered by Medicaid increases the likelihood that a woman will receive preventive care. We hope to see this continue to increase with our efforts to get more women primary health care coverage. However, these efforts may be hampered by policy changes and budget cuts at the federal and state level.

NOM 1: Percent of pregnant women who receive prenatal care beginning in the first trimester

- According to the FAD, in 2016 the percent of women in Ohio who received prenatal care beginning in the first trimester was 75.4%. Since 2009, there has been a significant increase of about 0.6% per year. Although the percentage of women with Medicaid receiving prenatal care in the first month was lower than those with private insurance (66.8% versus 85.9%), it is higher than those who are uninsured (45.6%). As more women receive insurance coverage, we expect the number of women receiving early prenatal care to increase.

## Maternal Mortality Review

Ohio's Pregnancy Associated Mortality Review (PAMR) Committee convened in 2010. The committee has 30 members; meets three times per year; and reviews all pregnancy-associated cases. The goal of the Ohio PAMR is to identify and review all pregnancy-associated deaths in Ohio to develop effective interventions to reduce maternal mortality. All case reviews are complete for 2008 through 2014. There were 408 pregnancy-associated deaths in Ohio 74% occurred in postpartum period, up to one year after pregnancy, with 39% of those occurring within six weeks of pregnancy. Data through 2016 will be released in the Fall of 2018.

In 2014, a needs assessment was completed by all Ohio birthing facilities with a goal of identifying resources needed to reduce maternal morbidity/mortality and improve patient safety. Birthing facilities with Level I nurseries identified their top need to be support for conducting simulation training. Ohio PAMR developed the simulation training program as an intervention in response to needs identified via the survey and through its case reviews. Simulation trainings occurred at three pilot sites between Fall, 2014 and Spring, 2015. Evaluation occurred through a series of three tests disseminated to participants before, immediately following, and one month after the training. Results demonstrated improvement in overall knowledge of obstetric complications and self-efficacy/confidence levels in management of emergencies. This training program is remarkable because it targeted low-resource birthing centers, bringing the supplies and personnel needed for simulation trainings directly to sites.

Due to a desire to develop a program with the potential for greater impact, Part II of simulation training was developed as a Train the Trainer course for nurse educators from Level I and Level II birthing centers across the state to give them the tools to independently deliver effective simulation training to their own obstetrics nursing staff in their own facility.

Building on prior trainings, Part III, a multi-faceted program that included didactic and skills-building components, was offered in 2017. Two direct trainings were held in southeastern Ohio for labor and delivery nurses and obstetric providers. Providers in this part of the state had not been well represented in prior trainings. The direct trainings had 64 participants; 80% represented Level I facilities, most participant's facilities were in southeast Ohio, and 48% had prior simulation training. Among follow-up respondents (67% response rate), 83% agreed they had utilized at least one new skill since the training and 43% had shared resources with other staff. Confidence levels for 11 skills (e.g., placing a Bakri balloon) significantly increased pre- to post-training and remained higher at follow-up.

Next, two Train-the-Trainer Part I sessions were held for obstetric nurse educators and managers who learned to independently deliver simulation training to staff at their own facility. The simulated scenarios were obstetric

hemorrhage, hypertensive emergency, and opiate overdose. Post-training, participants indicated the following intentions: develop a more formal and scheduled simulation program, increase simulation participation within and across departments, increase the frequency of simulation exercises, integrate simulators into exercises, and improve communication skills.

PAMR then held two sessions of a newly developed Advanced Train-the-Trainer program where participants worked in small groups and focused on developing simulation scenarios for a clinical problem. Didactic and skills building sessions supplemented these trainings. This program was developed for the participants of the four prior Train the Trainer sessions to increase their bandwidth in independently using simulation as a teaching tool in their institutions. Questionnaires were administered at registration, pre- and immediately post-training, and at 12 months after the training. The final component of Part III was the Patient Safety Webinar Series. Five webinars were held in August and September 2017 and they are currently archived on the Ohio PAMR website.

### **Ohio Department of Health Priority:**

Reduce the rate of maternal smoking and substance abuse by pregnant women

#### Smoking

The Ohio Partners for Smoke Free Families (OPSFF) was developed by the Bureau of Child and Family Health Services at the Ohio Department of Health (ODH) in collaboration with the Smoke Free Families National Dissemination Office in Chapel Hill, North Carolina. OPSFF is a collaboration of programs from across ODH plus external partners. The goal of OPSFF is to reduce smoking among Ohio women before, during and after pregnancy and to reduce exposure to second-hand smoke by increasing the adoption, reach and impact of evidence-based behavioral cessation programs. OPSFF promotes and facilitates implementation of evidence based smoking cessation models by providing training and resources. The program has been integrated into different health care setting including the Supplemental Nutrition Program for Women, Infants, and Children (WIC), Maternal Child and Health (MCH), Help Me Grow (HMG), Ohio Infant Mortality Reduction Initiative (OIMRI), Reproductive Health and Wellness Program (RHWP), and Federally Qualified Health Centers (FQHCs).

The BABY & ME – Tobacco Free (BMTF) is a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population. Women who quit smoking are less likely to have premature and low-birth weight babies and reduce the damaging effect of secondhand smoke on their children. The program's design has proven effective in decreasing the number of women who smoke during and after pregnancy.

The program uses a unique approach, combining cessation support specific to pregnant women, offering practical incentives, targeting low-income women (the largest group of smokers during pregnancy), and monitoring success. The BMTF collaborates with local agencies that provide prenatal services to our target audience.

BMTF is implemented in twenty- six sites throughout the state and new this year the program has included partner eligibility. The partner must remain smoke-free to qualify for the program incentives. The Moms Quit for Two Program which began in January 2016 expands the reach of the BMFT to increase smoking cessation among pregnant and postpartum women. Both programs are a part of a larger effort to promote smoking cessation and reduce secondhand smoke exposure among Ohio's most vulnerable population. Both programs support the core State Health Improvement Plan and the Ohio Department of Health Strategic Plan components.

The Ohio Department of Health continued our contract work with Ohio University Voinovich School of Leadership and Public Affairs to promote our smoking cessation campaign in six counties with high perinatal smoking rates. Those counties include Lawrence, Scioto, Ross, Gallia, Pike and Jackson counties. The promotion included a media campaign in these six counties and in nine Ohio communities that comprise the Ohio Equity Institute. Outreach and recruitment plans were developed to increase coalition members in these high-risk communities to act as local liaisons. There are twenty-nine providers implementing the 5A's throughout Southeast Ohio.



The Ohio Department of Health contracted with Ohio Colleges of Medicine Government Resource Center (GRC) to engage public health sites in a quality improvement (QI) collaborative to enhance 5A's implementation. The Ohio Colleges of Medicine Government Resource Center (GRC) continued distribution of the practitioner and patient focused toolkit to assist program sites with 5A's implementation. Currently, there are ninety-four sites implementing the 5A's throughout the state. In an effort to engage those in the community, a satisfaction survey was conducted and a recruitment plan was developed to encourage community input on program planning. Development of a new website was completed this year and is available at:

URL: <http://ohiosmokefreefamiliescpefmctpcv.devcloud.acquia-sites.com/>

The Ohio Collaborative to Prevent Infant Mortality (OCPIM) has a strategic focus to reduce smoking before, during and after pregnancy. Specific activities include increasing access to evidence-based cessation services and resources for families, increase access to tobacco prevention education for youth, implement policies to support cessation, and increase public awareness of avoidance of smoking and nicotine in childbearing years and infant and youth exposure to tobacco.

### Alcohol

Fetal Alcohol Spectrum Disorders (FASD) is term that describes a range of birth outcome and potentially lifelong effects that can result if a mother drank alcohol during her pregnancy. The effects include physical, mental, behavioral, and/or learning disabilities. Per the Center for Disease Control and Prevention, up to sixteen of 1,000 children are estimated to be affected by FASD. "Not a Single Drop" is Ohio's Fetal Alcohol Spectrum Disorders FASD initiative. FASD Steering Committee efforts are led by the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Health (ODH.) The Steering Committee has reorganized and meets monthly, the strategic plan was updated, and the ODH secured funding to assist with hosting the 1<sup>st</sup> Annual FASD forum. Funding for a public service announcement was secured through the ODH, and a draft for the public service announcement was completed. Recommendations for rebranding and updating the current "Not a Single Drop" logo were discussed. From that discussion, the Ohio Department of Mental Health and Addiction Services secured funding for a contract to update the logo and rebranding. Recruitment efforts led to membership of a neuropsychologist, collaboration with the Ohio Supreme Court, Ohio Department of Rehabilitation and Corrections and other non-profit organizations. The co-chairs presented to the members of the Ohio's Women (OWN) regarding FASD prevention efforts.

### Opiates

The State of Ohio has worked with various healthcare leaders, stakeholders, and medical professionals to identify promising treatment practices, including Medication Assisted Treatment (MAT), for opioid dependent pregnant mothers eligible for or enrolled in Medicaid during and after pregnancy.

The goal of the collaborative, called Maternal Opiate Medical Supports (MOMS) is to improve maternal and fetal health outcomes, improve family stability, and reduce costs of Neonatal Abstinence Syndrome (NAS) to Ohio's Medicaid program by providing treatment to pregnant mothers with opiate issues during and after pregnancy through a Maternity Care Home (MCH) model of care. The MCH model is a team based healthcare delivery model that emphasizes care coordination and wrap-around services engaging expecting mothers in a combination of counseling, MAT, and case management.

To achieve these goals, a Statewide Clinical Advisory Panel developed a toolkit, which sets forth guidelines and best practices for establishing a Maternity Care Home for opioid dependent pregnant women in Ohio. In four pilot sites across the state, teams of healthcare professionals utilized the tool kit to identify processes in their practices that can

be improved. Over a two-year period beginning in August 2013, the State invested over \$2 million to improve health outcomes for these moms and their babies. The program concluded in June 2016 and is currently being evaluated.

#### Priority Measures

ESM 14.1: Number of publicly funded programs (e.g. WIC, home visiting, RHWP, etc.) newly trained to implement the 5A's.

A total of one-hundred forty programs has been trained. No additional programs were trained during FY 16 as the focus of the program has changed to working with pediatric and obstetric-gynecologic practices. Our ESM has been updated accordingly to "Number of pediatric and obstetric-gynecologic providers newly trained to implement the 5 As". We anticipate training 18 practices during FY 17.

#### NPM 14.1 Percent of women who smoke during pregnancy

In 2016, 14.4% of women smoked while they were pregnant. This exceeds our objective of 15.1%. From 2009-2014 there was an average decrease of 3.1% per year ( $p < 0.05$ ). We saw an accelerated change from 2014-2016 with an average of 6.0 percent per year. This change could be attributed to the promotion of a smoking cessation campaign in six counties with high perinatal smoking rates, marketing expansion to Ohio counties with the highest infant mortality rates, expansion of 5A's implementation in state funded programs and the creation of a practitioner and patient focused quality improvement toolkit to assist program sites with 5A's implementation. Unfortunately, despite these gains, we are still well above the national rate of 7.2%. The rate varied by region type of the county of residence. Women who live in non-metro areas, such as the Appalachian counties targeted in our saturation project, have the highest rates of smoking at 19.6%.

#### NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

From 2008-2015, the rate of infants born with neonatal abstinence syndrome (NAS) more than quadrupled from 2.6 per 1,000 delivery hospitalizations to 11.6. Babies born to mothers who reside in non-metro areas are more likely to be born with NAS (15.4) when compared to those that live in large metro areas (9.6) and small/medium metro areas (12.8). However, there has been a significant increase in these areas. Rates were much higher in infants born to non-Hispanic white women (14.9) when compared to non-Hispanic black women (3.0).

**Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies**  
**Women/Maternal Health, Plan for FY 2019**

**Ohio Department of Health Priority:**

Increase the prevalence of women receiving preconception care

Preconception care involves identifying and altering risks that affect a woman's health, as well as her future pregnancies. Enhancing and increasing preconception care is vital to improving birth outcomes in the United States. Many birth defects occur in the first weeks after conception, often before the woman is aware that she is pregnant. Almost half of live births nationally are the result of an unintended pregnancy, which means improving the health of all women in their childbearing years is a crucial part of improving birth outcomes and infant health. Additionally, women who are obese, use tobacco or alcohol, or have been diagnosed with certain medical conditions before they become pregnant are at increased risk of negative birth outcomes such as preterm delivery and low birth weight. Implementing interventions and providing assistance for women with risk factors such as these before pregnancy are important to improve the health of both mother and child. A statewide consortium has formed to address promoting the most effective use of contraceptives in all types of provider settings and to promote the use to consumers. The activities listed below will be coordinated with this group.

The vast majority of the workplan for this priority remains the same. Many of the activities for strategy 3 were completed in FY 17. Activities for strategy E: "Utilize social media to promote preconception care and targeted health messages" have been refined to include:

- 1) Implement LARC First media campaign targeted to high volume RHWP communities using the Power to Decide creative materials
- 2) Provide training to RHWP sites on developing and implementing local outreach campaigns
- 3) Identify target audience for preconception messaging
- 4) Identify appropriate messaging including encouragement for target audience to set goals/changes they will make which they then share through the #PicturePerfectHealth campaign
- 5) Facilitate implementation of that messaging

ODH now has access to the creative for the national "Power to Decide" campaign and is distributing that to local RHWP sites. ODH is also providing training for those sites on how best to use these materials.

Preconception and LARC work can potentially impact all Maternal and infant health outcome objectives. Directly tied to MIH4. Providing family planning curriculum across providers in targeted zip codes.

Messaging for both the LARC and the preconception work are strongly supported by the Ohio Collaborative to Prevent Infant Mortality as well as the statewide Ohio LARC First workgroup. In addition, multiple local efforts to reduce infant mortality will be able to use these messaging campaigns to support local work.

**Strategies**

- A. Strengthen comprehensive preconception health care services are provided.
- B. Increase the utilization of reproductive life plans (RLP) for clients of child bearing age.
- C. Increase provider utilization of evidenced based, culturally-competent, preconception care.
- D. Partner with stakeholders and relevant health care providers to increase the prevalence of women receiving preconception care.
- E. Utilize social media to promote preconception care and targeted health messages.
- F. Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits.
- G. Improve the socio-emotional health and addiction needs of reproductive age women.
- H. Support trauma informed practices and programming for women before, during, and after pregnancy.

**Activities/Objectives**

- Years 1-5: Provide comprehensive reproductive health and wellness direct health care services per nationally recognized standards of care to 30,000 women, men and adolescents via sub recipients
- Years 1-5: Ensure all Reproductive Health and Wellness Program (RHWP) sub-recipients offer at least one

type of Long Acting Reversible Contraceptive (LARC) onsite

- Years 1-5: Monitor program data to identify sites with potentially eligible women who do not have Medicaid/insurance coverage
- Years 1-5: Provide training to health care providers on trauma informed care for adult survivors of abuse and violence including training on sexual and domestic violence, human trafficking, and adult survivors of child abuse
- Years 1-5: Support programming in local communities for professionals and community members on preventing violence and on identifying and responding to victims of violence
- Years 2-3: Develop work plan to roll out Ohio LARC First Initiative to all RHWP sub-recipients, starting with those in OEI counties
- Years 2-4: Work with MCH sub-grantees to implement the MCH behavioral health strategy related to mental health and addiction of reproductive age women
- Year 3: Identify/train trainers for LARC First Training to all RHWP sub-recipients
- Year 3: Provide LARC First training to ALL RHWP sub-recipients
- Year 3: Personalize and/or develop toolkits on the importance and implementation of RLP
- Year 3: Disseminate toolkit to all ODH funded safety net providers who interact with women and men of childbearing age
- Year 3: Collaborate with Medicaid to expand the gestational diabetes post-partum QI work.
- Year 3: Provide TA and training opportunities to sub-recipients about Medicaid and Marketplace enrollment
- Years 3-5: Implement data collection from statewide Ohio LARC First Initiative
- Year 1: Survey various types of health care providers who serve women of reproductive age about their use of Reproductive Life Plans
- Year 2-3: Reviewed several existing tool kits from other states (South Carolina, Texas, etc.)
- Year 2-3: Currently mapping out tool kit content and target audience
- Year 2-3: Develop tool kit specific to Ohio
- Year 4: Share tool kit with all providers throughout Ohio
- Year 5: Provide standardization in LARC education through use of a toolkit
- Year 3-5: Support home visiting pre-natal enrollment and post-delivery monitoring of health care visits including pregnancy planning, gestational diabetes monitoring and progesterone.

#### **Ohio Department of Health Priority:**

Reduce the rate of maternal smoking and substance abuse by pregnant women

The Ohio Partners for Smoke Free Families (OPSFF) was developed by the Bureau of Child and Family Health Services at the Ohio Department of Health (ODH) in collaboration with the Smoke Free Families National Dissemination Office in Chapel Hill, North Carolina. OPSFF is a collaboration of programs from across ODH plus external partners. The goal of OPSFF is to reduce smoking among Ohio women before, during and after pregnancy and to reduce exposure to second-hand smoke by increasing the adoption, reach and impact of evidence-based behavioral cessation programs. OPSFF promotes and facilitates implementation of evidence based smoking cessation models by providing training and resources. The Ohio Department of Health and the Ohio Department of Medicaid has contracted with Ohio Colleges of Medicine Government Resource Center (GRC) to engage pediatric and obstetrician-gynecologist providers in the implementation of the 5A's brief tobacco intervention. GRC will work with the Ohio Chapter- American Academy of Pediatrics (OhioAAP) to reduce the use of tobacco among Medicaid women postpartum and the exposure to second-hand smoke of their infants and other family members using evidence-based practices in a pediatric setting. GRC will also work with Cincinnati Children's Hospital Medical Center (CCHMC) to reduce the use of tobacco among Medicaid women during pregnancy and to improve birth outcomes for their infants.

The Ohio Department of Health will maintain their contract with the Ohio University Voinovich School of Leadership

and Public Affairs to promote our smoking cessation campaign in six counties with high perinatal smoking rates to build sustainability.

Ohio's State Improvement Plan (SHIP) includes specific cross-cutting outcomes that influence for state and local partners. Among the cross-cutting outcomes, tobacco use stands out because it negatively affects all of the chronic disease and maternal and infant health outcomes. For these reasons and in response to the high rates of tobacco use and secondhand smoke exposure in Ohio documented in the 2016 State Health Assessment (SHA), the SHIP includes tobacco prevention and cessation strategies for all three priority topics (mental health and addiction, chronic disease, and maternal and infant health).

Alcohol- Fetal Alcohol Spectrum Disorders (FASD) is term that describes a range of birth outcome and potentially lifelong effects that can result if a mother drank alcohol during her pregnancy. The effects include physical, mental, behavioral, and/or learning disabilities. Per the CDC, up to 16 out of a 1,000 children are estimated to be affected by FASD. Not a Single Drop is Ohio's Fetal Alcohol Spectrum Disorders FASD initiative. FASD Steering Committee efforts are led by the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, and the Ohio Department of Developmental Disabilities. The strategic plan has been updated and trainings on FASD prevention are being conducted throughout the state. Focus groups are currently being conducted to assist with selecting the new logo and branding concept. A resource guide has been drafted to assist stakeholders with referrals on learning more about prevention, screening, and intervention options. Planning for the 2nd Annual Fetal Alcohol Syndrome Disorder forum will continue.

Opiates- The State of Ohio has worked with various healthcare leaders, stakeholders, and medical professionals to identify promising treatment practices for opioid dependent pregnant mothers eligible for or enrolled in Medicaid. The project, Maternal Opiate Medical Supports (MOMS), is a team-based delivery model emphasizing care coordination and wraparound services, engaging pregnant women in a combination of MAT and case management. The care team is led by care coordinators who ensure communication between the client and all program partners and among the program partners themselves—obstetrician-gynecologists, behavioral health providers, MAT providers, social service workers, insurer case managers, and other service providers involved in supporting client recovery.

Ohio Department of Mental Health and Addiction Services (OhioMHAS) and other MOMS partner organizations have evaluated the findings, and results showed that MOMS is a promising practice. For example, compared to the matched Medicaid comparison cohort, women enrolled in the project had better prenatal engagement and treatment retention rates before and after delivery. Infants experienced shorter stays in the neonatal intensive care unit when given MAT in the third trimester. Some of these findings were likely influenced by the collaboration with Medicaid managed care plans. Four out of the five plans covering women enrolled in MOMS integrated their own staff into the MOMS care team meetings.

All plans eliminated prior authorization requirements for prescribing of MAT medications and three out of five plans provided transportation to 12-step meetings. Some plans also provided transportation for other purposes, including transportation to court for custody hearings or other type of court proceedings, or to probation appointments.

The state also recently received federal funding through the 21st Century Cures Act of 2016 and has renewed its investment in the MOMS project. OhioMHAS has contracted with six opioid treatment programs the first grant year, and it will contract with nine programs the second year of the grant. Opioid Treatment Programs (OTP) are required to co-locate OB/GYN services and provide the typical array of services for women with opioid use disorder (e.g., case management, counseling, and MAT). In addition to costs associated with co-location, covered start-up costs may include hiring of clinical care coordinators, treatment costs not otherwise covered by Medicaid or third-party insurers, child care, and some infant supplies. All grant funded sites are expected to collaborate with Medicaid managed care plans, comprehensive primary care centers, and accountable care organizations for care collaboration and to sustain system changes.

## Strategies

- Partner with the Ohio Partners for Smoke Free Families to develop and implement plan for reducing maternal smoking
- and second-hand smoke exposure.
- Build local infrastructure to implement grant programs to reduce maternal smoking and second-hand smoke exposure
- Reduce alcohol exposed pregnancies.
- Reduce opiate exposed pregnancies.

## Perinatal/Infant Health

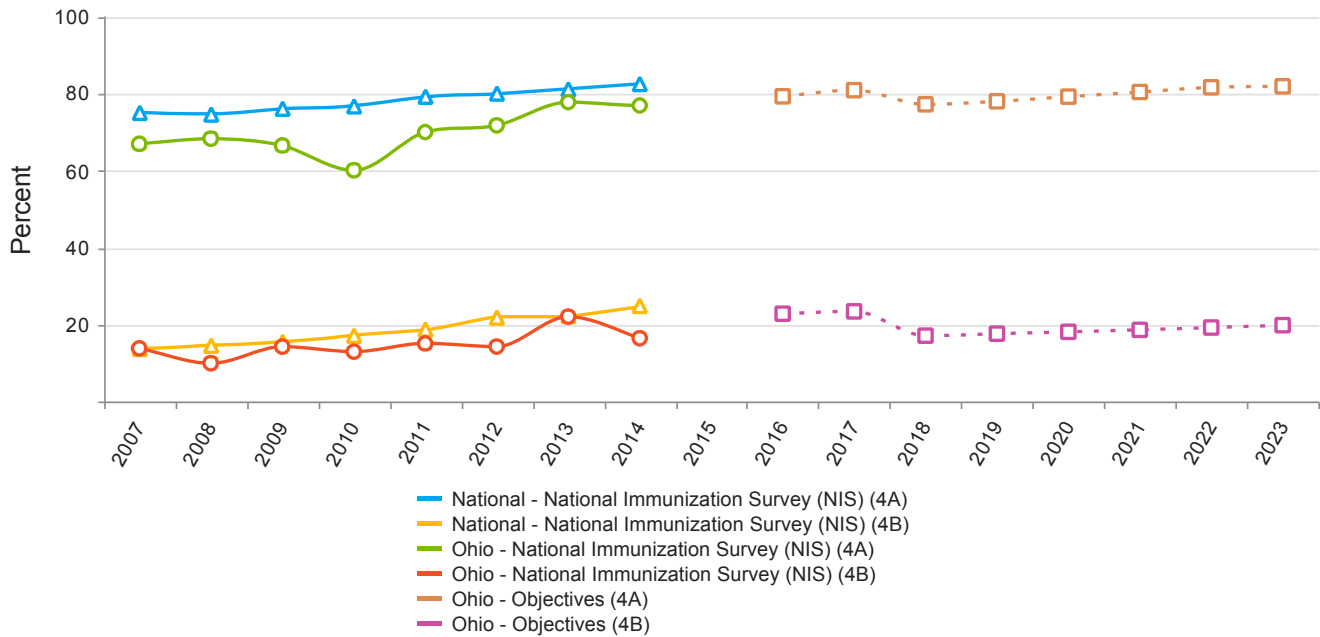
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.2	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.4	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	110.6	NPM 4 NPM 5



## National Performance Measures

### NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Baseline Indicators and Annual Objectives



### NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	79.3	80.9
Annual Indicator	77.7	76.8
Numerator	101,883	101,413
Denominator	131,148	132,017
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	77.2	78.0	79.2	80.4	81.6	81.9

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	22.9	23.5
Annual Indicator	22.3	16.7
Numerator	27,862	21,279
Denominator	125,021	127,543
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.2	17.7	18.2	18.7	19.3	19.9

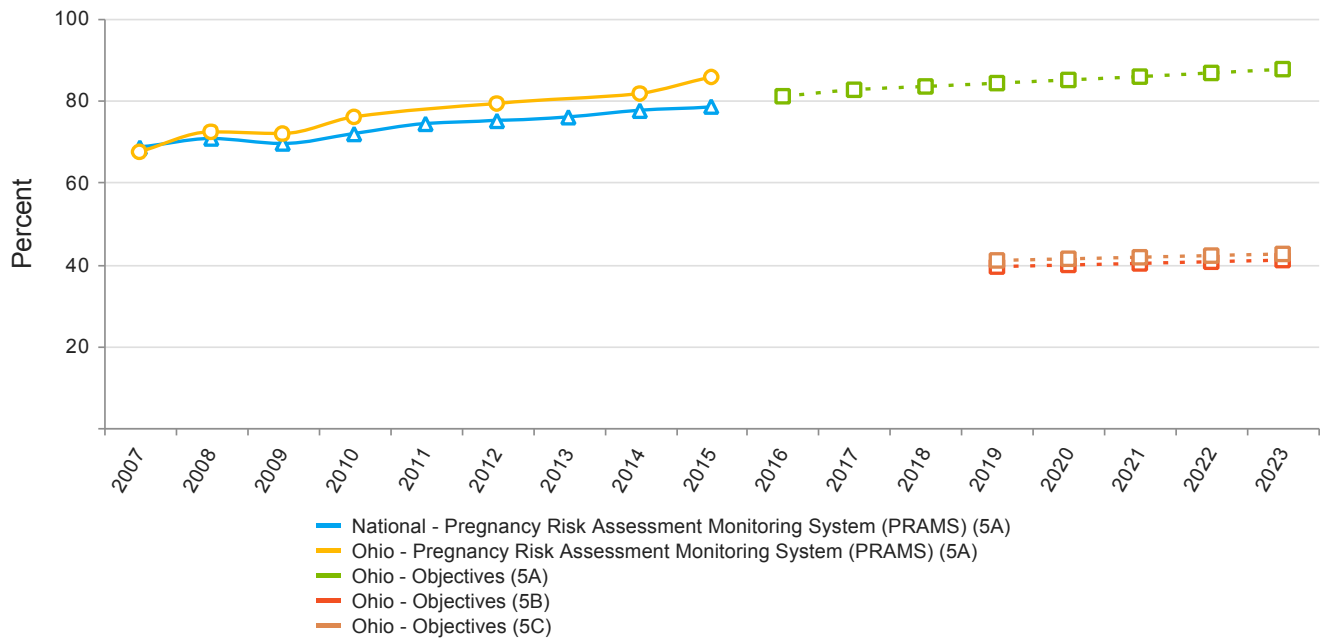
**Evidence-Based or –Informed Strategy Measures****ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		66
Annual Indicator	49.1	67.9
Numerator	52	72
Denominator	106	106
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	72.6	77.3	77.3	77.3	77.3	77.3

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**  
**Baseline Indicators and Annual Objectives**



**NPM 5A - Percent of infants placed to sleep on their backs**

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	80.9	82.5
Annual Indicator	79.3	85.5
Numerator	100,183	111,358
Denominator	126,366	130,239
Data Source	PRAMS	PRAMS
Data Source Year	2012	2015

State Provided Data		
	2016	2017
Annual Objective	80.9	82.5
Annual Indicator		82.7
Numerator		
Denominator		
Data Source		OPAS
Data Source Year		2016
Provisional or Final ?		Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	83.3	84.1	84.9	85.7	86.6	87.5

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface****FAD for this measure is not available for the State.**

State Provided Data	
	2017
Annual Objective	
Annual Indicator	39
Numerator	
Denominator	
Data Source	OPAS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	39.4	39.8	40.2	40.6	41.0

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding****FAD for this measure is not available for the State.**

State Provided Data	
	2017
Annual Objective	
Annual Indicator	40.9
Numerator	
Denominator	
Data Source	OPAS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	40.9	41.3	41.7	42.1	42.5



## Evidence-Based or –Informed Strategy Measures

**ESM 5.1 - Percent of birthing hospitals that have received formal training on safe sleep practices and the number of non-birthing hospitals trained on safe sleep practices.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
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State Provided Data		
	2016	2017
Annual Objective		10
Annual Indicator	0	0
Numerator	0	0
Denominator	106	106
Data Source	Program data	Program data
Data Source Year	FFY 16	FFY 17
Provisional or Final ?	Final	Final

## ESM 5.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids

<b>Measure Status:</b>	<b>Active</b>
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,000.0	4,000.0	4,000.0	4,000.0

## State Performance Measures

### SPM 1 - Black Infant Mortality Rate (per 1,000 live births)

<b>Measure Status:</b>	<b>Inactive - This is being changed to an SOM and we will continue to monitor.</b>
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State Provided Data		
	2016	2017
Annual Objective		13.3
Annual Indicator	15.1	15.2
Numerator	367	369
Denominator	24,288	24,315
Data Source	ODH Vital Statistics	ODH Vital Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

### SPM 4 - Percent of infants who are exclusively breastfed at hospital discharge

<b>Measure Status:</b>	<b>Inactive - We are using NPM 4 and will continue to monitor this SPM and report progress in Annual Reports.</b>
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State Provided Data		
	2016	2017
Annual Objective		53.5
Annual Indicator	52.7	52.2
Numerator	66,616	70,391
Denominator	126,361	134,739
Data Source	ODH Vital Statistics	ODH Vital Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

**SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	3
Annual Indicator	4
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	FFY 2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	5.0	6.0	7.0	7.0	7.0	7.0

## State Outcome Measures

### SOM 1 - Black Infant Mortality Rate (per 1,000 live births)

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	15.5	15.2	14.0	13.8	13.6

## State Action Plan Table

### State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 1

#### Priority Need

Increase Access to Early Infant Care and Wellness

#### NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

#### Objectives

- A. Increase the number of birthing hospitals meeting all or part of the Ten Steps to Successful Breastfeeding through the First Steps for Healthy Babies initiative
- B. Adapt culturally appropriate trainings and tools to increase breastfeeding rates among Black and Appalachian mothers and babies
- C. Increase access to breastfeeding friendly environments
- D. Increase community awareness to promote and support breastfeeding
- E. Establish a breastfeeding designation program for child care providers.

#### Strategies

- A1) Provide and develop trainings based on components of the Ten Steps to Successful Breastfeeding. A2) Establish Maternity Care Best Practice Awards. A3) Establish a 24/7 breastfeeding hotline. A4) Create a database to track hospital progress and awards received.
- B1) Identify virtual lactation consultants for underserved areas B2) Increase the number of breastfeeding peer helpers B3) Implement Breast for Success curriculum in Home Visiting Programs.
- C1) Establish linkages between maternity hospitals, birthing centers, and community-based breastfeeding support programs to promote post-discharge support C2) Provide training and technical assistance to community-based breastfeeding organizations, hospitals, clinics, and worksites C3) Increase opportunities for breastfeeding education and certification
- D1) Create and implement a statewide breastfeeding public awareness campaign
- E1) Research existing child care breastfeeding recognition/designation programs. E2) Create a breastfeeding designation program to recognize child care providers that are breastfeeding-friendly. E3) Implement program. E4) Evaluate program.

ESMs	Status
ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 2

### Priority Need

Reduce the rate of Infant Mortality and disparities statewide

### NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

### Objectives

B. Increase Safe Sleep Initiatives

### Strategies

B1) Implement strategies to reduce sleep related deaths. B2) Increase the number of families provided with a crib and safe sleep education through the ODH-funded Cribs for Kids® program as reported in the Cribs for Kids® grant reporting requirements. B3) Increase the percent of families screened for a safe sleep space per data reported as required by ORC safe sleep screening mandate. B4) Increase the number of impressions achieved through ODH Safe Sleep media campaign as provided by ODH Communications.

### ESMs

### Status

ESM 5.1 - Percent of birthing hospitals that have received formal training on safe sleep practices and the number of non-birthing hospitals trained on safe sleep practices. Inactive

ESM 5.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids Active

### NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births



## State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 3

### Priority Need

Increase comprehensive newborn screens: Improve Ohio's newborn screening system

### SPM

SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system

### Objectives

A. Improve newborn screening (NBS) data

B. Improve pediatric primary care providers (pediatricians, family practice) knowledge of newborn screening and their role in NBS follow up

C. Improve messaging to parents about newborn screening

### Strategies

A1) Explore the feasibility of linking newborn bloodspot screening data with Vital Statistics records. A2) Explore HL7 messaging for all 3 types of newborn screenings. A3) Calculate number of unduplicated newborns who receive all 3 newborn screenings, including the number of parents/caregivers who opt out of one or more newborn screenings. A4) Monitor and report data from all 3 newborn screening programs for # screened; # screen positive; # diagnosed; # receiving treatment/intervention. A5) Explore other medical specialties voluntarily reporting in the Genetics NBS Data system (e.g. endocrinologists, immunologists).

B1) Survey physicians and parents regarding barriers in NBS follow-through. B2) Explore feasibility of coordinating all 3 newborn screening results for primary care providers, parents.

C1) Develop consolidated newborn screening brochure that incorporates all 3 newborn screenings.

## State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 4

### Priority Need

Reduce the rate of Infant Mortality and disparities statewide

### SOM

SOM 1 - Black Infant Mortality Rate (per 1,000 live births)

### Objectives

A. Implement and expand quality improvement (QI) initiatives via the Ohio Perinatal Quality Collaborative (OPQC)

C. Decrease the birth rate among 13-19 year olds

D. Increase the identification of at-risk women and connect them to services. Reach 4,660 new, unique women not currently receiving services.

E. Increase the # of at risk women and infants that receive a comprehensive assessment of risk factors & evidence based/best practice interventions to address them.

### Strategies

A1) Decrease the rate of premature births in Ohio less than 37 weeks by 10%, and less than 32 weeks by 10%. A2) Increase the number of provider partnership with OPQC.

B1) Implement strategies to reduce sleep related deaths. B2) Increase the number of families provided with a crib and safe sleep education through the ODH-funded Cribs for Kids® program as reported in the Cribs for Kids® grant reporting requirements. B3) Increase the percent of families screened for a safe sleep space per data reported as required by ORC safe sleep screening mandate. B4) Increase the number of impressions achieved through ODH Safe Sleep media campaign as provided by ODH Communications.

C1) Increase by 10% the number of middle schools participating in the Sexual Risk Avoidance Program Initiative

D1) Improve the infrastructure to support Ohio Equity Institute (OEI) counties as leaders in birth outcome disparity reduction strategies directly impacting the social determinants of health. D2) Implement the Fetal Infant Mortality Review (FIMR) using NFIMR and ODH guidelines and use findings to drive interventions aimed at reducing inequities in birth outcomes. D3) Enhance epidemiologic capacity by utilizing the OEI epidemiologist to continually review and analyze MCH data critical for addressing infant mortality. D4) Pilot three place-based, community intensive initiatives in identified high-risk communities aimed at reducing inequities in birth outcomes. D5) Build authentic community engagement by providing consistent technical assistance to build capacity. D6) Build evaluation capacity of OEI entities by providing consistent technical assistance.

E1) Training and implementation on a comprehensive risk assessment screening tool

## Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies

### Perinatal/Infant Health, FY 2017 Annual Report

#### Ohio Department of Health Priority:

- Reduce the rate of infant mortality and disparities statewide
- Increase comprehensive newborn screens and improve Ohio's newborn screening system
- Increase access to early infant care and wellness

#### **Reduce the rate of infant mortality and disparities statewide**

The current state budget dedicates nearly \$50 million to improving birth outcomes and reducing racial and ethnic disparities, and builds on almost \$87 million in investments made during the past six years. The majority of state funding is dedicated to supporting local community-driven proposals to combat infant mortality in high-risk areas. Nine metropolitan areas accounted for 59 percent of all infant deaths, and 86 percent of African American infant deaths, in Ohio in 2016. In these communities, local infant mortality coalitions are pursuing promising practices to reduce infant mortality supported by state and federal funding. During the next two years, additional community-based pilot programs with proven track records in reducing infant mortality will be launched, and the evidence-based CenteringPregnancy® group prenatal care model will be expanded.

Continuing to build upon a comprehensive range of initiatives that have addressed infant mortality, Ohio is implementing proven and new initiatives to tackle the leading causes of infant mortality, focus resources where the needs are the greatest and implement system changes that will help save babies' lives. The Ohio Department of Medicaid (ODM) counties to invest \$26.8 million in State Fiscal Years 2016-2017 to support community-driven proposals leveraging evidence-based interventions to combat poor birth outcomes and infant mortality at the local level in the nine Ohio Equity Institute (OEI) counties. Evaluation of these evidence-based interventions as well as the coordination of the OEI efforts at the local and state levels are being conducted. Ohio Equity Institute counties are implementing the following interventions: CenteringPregnancy®, smoking cessation, safe sleep, breastfeeding, family planning/LARC, progesterone, fatherhood, peer advocates, health education curriculum, evidence-based home visiting, Pathways Community HUB and authentic community engagement. The Ohio Pregnancy Assessment Survey (OPAS) was designed in a partnership with the Ohio Department of Health (ODH), ODM and the Government Resource Center at the Ohio State University (GRC) to develop a statewide, ongoing, targeted population-based survey aimed at identifying groups of women and infants at high-risk for health problems. The 2016 data was synthesized to provide information to Ohio Equity Institute counties to improve intervention selection and implementation; as well as monitor statewide progress in maternal and infant health initiatives and infant mortality risk factors. Initial findings include:

- There is little difference in postpartum visits between non-OEI and OEI counties.
- Women residing in OEI counties were more likely to have a home visitor after delivery compared to those who do not live in OEI counties.
- There is no difference in babies who slept in a crib by geography.

The Infant Mortality Research Partnership (IMRP), a collaboration between the ODH, ODM, Office of Health Transformation and GRC, continued to use big data to better understand how we can lower infant mortality in Ohio. The IMRP leveraged a diverse array of data methods to answer three questions: 1) where, should interventions be targeted, 2) to whom, should they be targeted and 3) how, should interventions be implemented. The second phase of this work aimed to improve upon and expand the previously developed models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. Supported by ODH and ODM, The Ohio Perinatal Quality Collaborative's (OPQC) progesterone project continues to expand to all of Ohio's Federally Qualified Health Centers. Development and launch of an OPQC data infrastructure project to record and track performance of quality improvement measures continues.

Governor John R. Kasich signed into law Senate Bill 332 in January 2017, enacting recommendations of the Ohio Infant Mortality Commission. The new law's requirements include giving funding priority to infant vitality initiatives to areas most affected by infant mortality. As a result of SB 332, the Ohio Department of Health released its first quarterly infant mortality scorecard in an effort to ensure timely access to data for partners and established a Home Visiting Consortium to serve as the state's advisory body on home visiting. Ohio's first Home Visiting Summit was hosted in April 2018.

Within the Title V 5-Year Action Plan there are four strategies of focus to support the reduction of infant mortality.

Strategy 1: Implement and expand quality improvement (QI) initiatives via the Ohio Perinatal Quality Collaborative (OPQC) and the Government Resource Center (GRC)

The Ohio Perinatal Quality Collaborative (OPQC) is a statewide consortium of perinatal clinicians, hospitals, and policy makers and governmental entities that aims, through the use of improvement science, to reduce preterm births and improve birth outcomes across Ohio. OPQC involves subject matter experts, uses successful evidence-informed strategies, and employs data-driven quality improvement methods and well-accepted project management processes. Success comes from a collaborative approach that builds upon an established network of OPQC-member hospitals with a history of executing successful statewide quality improvement initiatives.

Preterm birth is the leading cause of infant mortality in Ohio. Among states, Ohio consistently falls at the bottom of the rankings for infant mortality and prematurity. Further, Ohio's rates for African-American prematurity are consistently worse than the rates for Caucasian prematurity, indicating underlying disparities in health and care. Infant mortality and prematurity are conditions that are devastating for families, and incur significant health care costs. Being born prematurely has lifelong impact. OPQC has several past and current projects that address both preterm birth and infant mortality in an effort to promote the best outcomes for Ohio's mothers and babies. Continued implementation of NICU Grads Project, the Progesterone Project and the Neonatal Abstinence Syndrome Project maintain Ohio's focus on reducing prematurity, particularly among high-risk populations.

Strategy 2: Increase safe sleep initiatives

As reported in The Ohio Child Fatality Review 17th Annual Report, among infant death reviews from 2012 through 2016, 714 were related to sleeping or the sleep environment, accounting for 15 percent of the 4,680 infant death reviews. If all sleep-related deaths were eliminated, the Ohio infant mortality rate for 2016 would have been reduced by 1.2, from 7.4 to 6.6 deaths per 1,000 live births. If the sleep-related deaths of black infants were eliminated, the black infant mortality rate for 2016 would have been reduced by 2.2, from 15.2 to 13.0 deaths per 1,000 live births. The Ohio Infant Safe Sleep Law was enacted by Am. Sub. S. B. 276 of the 130th Ohio General Assembly in May 2015. Ohio Revised Code 3701.67 requires birthing centers and hospitals, excluding critical access hospitals, to screen new parents and caregivers prior to discharge to determine if the infant has a safe sleep environment at their residence. If the infant is determined not to have a safe sleep environment, per this screening, the facility must assist the family in obtaining a safe crib at no charge.

The Ohio Department of Health (ODH) developed a model screening form for facilities to use to identify parents and caregivers who do not have a safe sleep environment for their infants. Beginning January 1, 2017, a new tab was added within the state's Integrated Perinatal Health Information System (IPHIS) to capture infant safe sleep environment screening data. ODH conducted six regional trainings between November and December 2016 in Akron, Athens, Cincinnati, Cleveland, Columbus, and Toledo on the topic of infant safe sleep and entering safe sleep environment screening data into the new IPHIS tab. Facilities with IPHIS access are expected to report safe sleep environment screening data in IPHIS. These data, along with demographic data, are extracted by ODH to monitor the need for safe sleep environments and appropriate action taken by facilities to connect families in need with a safe crib.

In 2017 there were over 46 million television and radio impressions, over 26 million billboard and transportation ads impressions (viewings), and 18 million social media type (mobile display, digital radio, Native Ad, Facebook, Instagram, and Twitter) impressions and over 69,000 engagements/clicks. In 2018 the media campaign continues, and includes smoke-free environment messages, targeting mothers and fathers ages 16-45 years old, and grandparents in the 42 high risk Ohio counties.

Strategy 3: Decrease the birth rate among 13-19 year olds

The 2016-2017 Personal Responsibility Education Program (PREP) Program Year was still recovering from a loss of staff/high staff turnover and an inability to administer trainings youth in Foster Care and Juvenile Justice Systems.

Transition of PREP to the Ohio Department of Youth Services (DYS) has occurred over the last year with the transition complete as of 8/1/17. PREP participants are comprised of 35% females and 65% males, of whom 30% are within the foster care system and 70% within the juvenile justice system. In 2017, ODH contracted with Ohio University's Voinovich School of Leadership and Public Affairs to be the external evaluator. After four years of program implementation, Ohio PREP collected a variety of data to inform program performance and fidelity to the

evidence-based model. These data include youth entry and exit survey data, program fidelity and youth attendance records, and focus group interviews, as well as youth and agency staff opinions collected on surveys.

Primary Evaluation Findings are as follows: Since inception, 3,664 Ohio youth attended at least one PREP session, and the majority (76%) entered the program through the juvenile justice system. A total of 2,371 youth completed 75% of the 15- to 16-hour PREP programming. Overall, Ohio youth engaged in PREP not only show increased knowledge of sexual health, prevention of pregnancy and STIs, but they also show improved intentions to use condoms and hormone-based birth control.

Using a train-the-trainer model, over 1,400 Ohio social service and health workers participated in PREP facilitator training or retraining from program inception through July 2017. Among the facilitators trained to provide the intervention, Ohio PREP is increasing knowledge of STIs and knowledge of the rights of youth related to accessing reproductive health care.

#### Strategy 4: Target resources to known high-risk areas to decrease health disparities

As outlined in the State Health Improvement plan, Ohio's target is to achieve fewer than 6.0 infant deaths per 1,000 live births in every racial and ethnic group. Ohio's All Races Infant Mortality Rate was 7.4 in 2016, up slightly from 7.2 in 2015. Ohio's infant mortality rates for white and black infants as well as for infants of Hispanic ethnicity all increased from 2015 to 2016, with black infants dying at nearly three times the rate as white infants. In 2013, the Ohio Department of Health began partnering with nine Ohio communities to improve overall birth outcomes and reduce the racial disparities in infant mortality. The Ohio Equity Institute, mostly commonly known as OEI, is a data-driven, community-led, high-visibility movement by nine urban Ohio counties. In 2016, participating counties accounted for 59% of all infant deaths in Ohio and 86% of the state's black infant deaths.

The structure of OEI is based on: 1) Race, racism and inequities in birth outcomes, 2) Epidemiology of birth outcomes, 3) Evidence-based interventions for vulnerable populations, 4) Leadership and 5) Evaluation. Through data-driven decisions specific to target populations in participating communities, OEIs have coordinated the availability and awareness of evidence-based strategies shown to improve birth outcomes. Some of these strategies include group facilitated prenatal care, safe sleep practices, smoking cessation and safe birth spacing. 2017 began the fifth year of this project and ODH is independently leading communities to expand data informed and outcome driven implementation of interventions utilizing more intentional evaluation.

ODH also helped OEI teams build capacity for infant mortality data analysis by funding an epidemiologist in each of the nine targeted high-risk metropolitan areas. This data analysis support helps communities in planning, implementing and evaluating infant mortality activities at the local level.

Relaunch of a multi-layer safe sleep media campaign to educate mothers, fathers and grandparents in high-rate infant mortality areas in Ohio on the importance of practicing the ABCs of safe sleep: Alone. On Their Back. In a Crib.

Continuing the re-design of Home Visiting to an evidenced-based model, including the use of vital statistics data to fund programs in communities at higher risk for poor birth outcomes. ODH also leveraged state and federal funding to expand the use of evidenced-based home visiting approaches in Ohio's most at-risk communities. Deploying evidenced-based home visiting models, the agency served nearly 10,500 families in 2016 with emphasis on prenatal enrollment as an infant mortality strategy.

#### **Increase comprehensive newborn screens and improve Ohio's newborn screening system**

Newborns in Ohio are screened for disorders (authorized by legislative mandate) through three methods: 1) bloodspot screening, where blood is drawn from the baby's heel, collected on a filter paper card and sent to the ODH Newborn Screening Laboratory for analysis for 38 disorders; 2) newborn hearing screening, where infants are tested using physiologic screening methods; and 3) newborn screening for critical congenital heart disease (CCHD) using pulse oximetry. Bloodspot screening samples are sent to the ODH Newborn Screening Laboratory for analysis and follow-up. Hearing screening and CCHD screening are both non-invasive, point of care screenings with results known immediately. All three newborn screening programs focus on ensuring: 1) newborns are screened and that physicians receive timely notification of screening results; 2) those newborns with abnormal (out of range) screening results receive diagnostic testing; and 3) those diagnosed with disorders are referred or have access to appropriate treatment or intervention.

Newborn screening data are collected through different systems in Ohio and not linked with each other in any way. Hearing and CCHD screening are linked with vital statistics birth records; bloodspot screening data are not. Work to address this important newborn health data priority is focused on improving the linkages, integration of, and/or interoperability of data between Ohio's three newborn screening programs and with vital records for a population-based denominator. There are efficiencies to be gained in streamlining common data elements between the programs, as well as making timely and comprehensive (i.e., from all 3 screenings) results available to primary care providers responsible for working with parents on follow-up testing that may be needed. Superimposed on this priority measure is the use of technology and IT solutions to streamline data availability and use at the Ohio Department of Health, as well as the interface with electronic medical records from the birth and children's hospitals, and local pediatricians.

This is a complex and very nuanced project that required much thought and foundation building. During fiscal year 2017, we built on the foundation set in FFY2016 and completed the following activities:

- 1) Each newborn screening program continued to collect, monitor, evaluate and report data for number of infants screened; number of infants with abnormal screening results requiring diagnostic testing; and number of infants diagnosed with disorders who receive appropriate treatment and intervention services. Each newborn screening program area monitors their data and works on improvement.
- 2) ODH hired a contractor to conduct a comprehensive evaluation and exploration study to assess the current state of the 3 newborn screening systems, identify gaps and desires for requirements and capabilities for a new system; and to determine the requirements for a comprehensive integrated system between the three newborn screening programs, including linkages with vital statistics birth records for population health calculations. The contractor assessed the current state of all 3 newborn screening systems; developed a list of specifications for the "desired" system; and coordinated demonstrations from multiple vendors with products related to newborn screening or laboratory systems which were scored based on ODH desired components.
- 3) An internal ODH work group was convened to provide guidance and feedback to the contractor. This group included ODH staff from the Newborn Screening Lab; Genetics/Sickle Cell/CCHD/Hearing; Office of Management Information Systems (OMIS); and Bureau of Informatics. Significant staff time was spent working with the contractor during the 3 activities of the contract, i.e., assessment of the current state; requirements for the desired state; and evaluation of demonstrations of products currently on the market.
- 4) Staff in bloodspot, hearing and CCHD screening jointly developed an integrated newborn screening brochure. The brochure is available online <http://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/phl/newborn-screening-program/Resources/Current-Brochures/Brochure-English-2017.pdf?la=en> and is also available in multiple languages.
- 5) Reconciled data from the Newborn Screening Lab with Genetics Program data for babies with metabolic disorders. This data was shared with the Genetic Center Directors group to improve the quality of data reported in the Genetics Data System, as well as to ensure that appropriate specialists are managing the care of these individuals.

## DATA

### Screenings:

- In 2016<sup>1</sup>, the ODH Newborn Screening Laboratory reported results for 140,255 infants. Of those not screened, the lab was notified of 66 religious objections.
- In 2016, 135,504 infants had documentation of a hearing screening, or 98% of Ohio births. Of the 3,200 who did not receive a screening: 1,514 were home births and not subject to mandatory newborn hearing screening; 279 parents declined the screening; 401 infants were transferred from the birth hospital before screening could take place
- In 2017, 131,616 Ohio resident infants were screened for CCHD. During 2017, 6,921 infants had a valid reason for not being screened (CCHD screening has 5 valid reasons for not screening including: parent objection; known prenatal diagnosis; newborn transferred out of birth hospital before screening could take



place; newborn discharged home on oxygen; hospital screening equipment malfunction.)

#### Diagnoses:

- In 2016, the ODH lab sent alerts for 3,660 infants (excluding Hemoglobin trait) and confirmed 253 infants with a disorder, confirmed 466 with other, confirmed 2,623 as not affected. An additional 3,422 infants were alerted for hemoglobin trait and sent to the Regional Sickle Cell Projects for follow-up.
- Of the infants who received a hearing screening, 3,805 did not pass the screening and after additional testing, 202 had documented permanent identified hearing loss. These infants were referred to early intervention services (EI), and 104 were enrolled in EI.
- In calendar year 2017, 52 infants were reported as having failed the three-tiered CCHD screening algorithm. Following screening, 34 had normal echocardiograms; 14 had abnormal echocardiograms and were diagnosed heart problems that were not one of the 7 CCHDs targeted in newborn screening; and 3 infants were diagnosed with a CCHD. Most infants diagnosed with a CCHD were identified prenatally.

<sup>1</sup> As described in the introduction, the screenings are documented in different ways. In addition, the screenings work on varying calendars, based on the calendar year, federal fiscal year, and state fiscal year. For these reasons, the totals may differ based on the reporting mechanism.

#### Increase access to early infant care and wellness

The *Ohio First Steps for Healthy Babies* is a voluntary breastfeeding designation program co-led by the Ohio Department of Health (ODH) and the Ohio Hospital Association (OHA) that recognizes maternity centers in Ohio for taking steps to promote, protect, and support breastfeeding in their organization. A star is awarded for every two steps achieved in the *Ten Steps to Successful Breastfeeding*, as defined by the World Health Organization and Baby-Friendly USA. Hospitals can earn five stars as a part of this effort. The initiative encourages maternity centers across the state to promote and support breastfeeding one step at a time along with the option to select which steps, some or all, to adopt.

The initiative launched in March 2015, with the first round of applications accepted in July 2015. Throughout FFY17, there were 4 rounds of applications. In total, there have been 11 rounds of applications at the end of FFY17 and 67.9% (72 of 106) hospitals were recognized. This is an increase of 20 hospitals from FFY16 which exceeded our goal of adding 5 additional hospitals. Hospitals continue to apply as they achieve more steps.

In late 2014, ODH Bureau of Vital Statistics added a question to the birth certificate about exclusive breastfeeding at discharge. In 2016 the percent of women who were breastfeeding exclusively at discharge was 52.2%. Although this was a statistically significant decrease ( $p < .05$ ) from 52.2% in 2015, it does not represent a substantial population change. Furthermore, the exclusive breastfeeding variable was missing on nearly 10% of birth certificates in 2015 and on only about 3% of birth certificates in 2016. Non-Hispanic white women were significantly more likely to exclusively breastfeed when compared to non-Hispanic black or Hispanic women (57.0% vs. 35.0% and 43.9% respectively,  $p < .0001$ )

The *Ohio First Steps for Healthy Babies*, in partnership with the Ohio Breastfeeding Alliance (OBA) and the Ohio Lactation Consultant Association (OLCA), accepted applications and presented awards for the **"Maternity Care Best Practice Award 2016"** bag free recognition in March 2017. This award recognizes hospitals for removal of free infant formula samples and formula company branded diaper bags and goods. This supports hospitals in progress towards practices that align with Baby-Friendly USA certification requirements, as well as the overall goal of reducing infant mortality in Ohio. Fifty-nine (of 106) hospitals received recognition for 2016. In 2015, 51 hospitals received recognition.

The core team for *First Steps* is made up of 7 individuals representing ODH, OHA, Ohio Chapter of American Academy of Pediatrics, OBA, OLCA, and Baby-Friendly USA designated hospitals. Given the objectives for priority 9 are closely aligned with the breastfeeding objective in Ohio's Plan to Prevent and Reduce Chronic Disease (increase the percent of babies who are breastfed while in the hospital), the larger workgroup is a collaboration between Maternal and Child Health and Chronic Disease.

As part of the ongoing education and support for birthing hospitals, the *First Steps for Healthy Babies* team hosted seven monthly webinars related to the *Ten Steps to Successful Breastfeeding*. Topics included: father/partner



engagement, data collection, Step 3, clinical skills lab and disparities. Average attendance for each webinar was 75 attendees. The webinars were recorded and made available online.

The *First Steps* core team also created materials around father/partner engagement and breastfeeding and safe sleep. In collaboration with Nevada, the materials were translated to Spanish and have been shared nationally.

The Appalachian Breastfeeding Network provided a 3-month pilot of an After Hours Breastfeeding Hotline for the Southeast Region of Ohio. During the 3-month pilot period, ABN provided an on-call and back-up person each night from 4:30 pm to 8:30 am. Follow-up phone calls were performed weekly for the 13-week period. Approximately 143 calls were received and 45 follow-up calls were completed. Highest call volumes were from 8pm through midnight.

The FY17 (10/1/16 through 9/30/17) Maternal and Child Health (MCH) grant included a new strategy to increase access to breastfeeding friendly environments by: establishing linkages between maternity hospitals, birthing centers, and community-based breastfeeding support programs to promote post-discharge support; providing training and technical assistance to community-based breastfeeding organizations, hospitals, clinics and worksites; and, increasing opportunities for breastfeeding education and certification. Nine subgrantee agencies implemented the strategy for a total of 76 community-based trainings and 10 new Certified Lactation Counselor (CLC) staff.

According to HRSA's Federally Available Data (FAD), the percent of infants outside of Metropolitan Statistical Areas (MSA) in 2009-2011 are less likely to ever been breastfed (58.4 vs. 68.8). Additionally, 2015 ODH birth data shows that 65.3% of women in Appalachian counties are breastfeeding at time of discharge compared to 77.9% in suburban counties, 74.8% in rural, non-Appalachian counties, and 72.6% in urban counties. In an effort to address the low breastfeeding rates in Ohio's Appalachian counties, a survey was created and sent to WIC clinic staff in this region to understand the barriers to breastfeeding initiation. A poster was created and displayed at the annual OLCA Breastfeeding Conference. Results from this survey will be used for planning culturally appropriate interventions in the future.

Over 135 WIC Peer Helpers are funded, representing all 74 WIC funded projects throughout all 88 counties.

Our priority group has chosen National Performance Measure (NPM) 4a) percent of infants who are ever breastfed and 4b) percent of infants breastfed exclusively through 6 months. *Breastfeeding Report Card: Progressing Toward National Breastfeeding Goals* reports that of Ohio infants born in 2014, 76.8% were ever breastfed and 16.7% were exclusively breastfed for 6 months. Ohio was below the national rate for ever breastfed (76.8% vs. 82.5%) and for exclusively breastfed for 6 months (16.7% vs. 24.9%). Although this shows a slight decline in breastfeeding from the previous year (77.7% in 2013), we have still seen an average annual percent change of 2.4% ( $p < .05$ ) since 2007. The percent of infants who were exclusively breastfed also declined, down from 22.3% in 2013. However, it is above the level it was in 2010 and 2011 (14.5% and 15.5% respectively). We hope that this indicates an overall upward trend. We will continue to monitor to ensure that our program activities are having the desired effect and that the trend is not changing.

**Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies**

**Perinatal/Infant Health, Plan for FY 2019**

**Ohio Department of Health Priorities:**

- Reduce the rate of infant mortality and disparities statewide
- Increase comprehensive newborn screens and improve Ohio's newborn screening system
- Increase access to early infant care and wellness

**Reduce the rate of infant mortality and disparities statewide**

Strategy 1: Implement and expand quality improvement (QI) initiatives via the Ohio Perinatal Quality Collaborative (OPQC) and the Government Resource Center (GRC)

The Ohio Perinatal Quality Collaborative (OPQC) strives to use improvement science methods to reduce preterm births & improve outcomes of preterm newborns in Ohio as soon as possible. Progesterone is an evidence-based therapy that can significantly decrease the chance of preterm birth in women with a previous preterm birth and/or short cervix. The Ohio Department of Health (ODH) and Ohio Department of Medicaid (ODM) asked OPQC to improve the use of progesterone in Ohio. OPQC began this effort by working closely with 23 prenatal care clinics associated with Ohio's 20 largest hospitals from 2014 - 2016 to test strategies and implement interventions to promote treatment of women at risk. ODH and ODM have now asked that these successful strategies be shared with all maternity care providers who treat Medicaid patients throughout Ohio in 9 Ohio Equity Institute (OEI) communities. The spread project will:

- Assist maternity care providers in implementing the new electronic NurtureOhio Pregnancy Risk Assessment Form (PRAF 2.0) for all pregnant women insured by Medicaid by the end of 2018. This form will facilitate communication among pregnant women, their care providers, Medicaid Managed Care Plans, pharmacies, home health services and the Ohio Department of Job and Family Services. The information will also be shared with the ODH for follow-up in Home Visiting and Baby and Me Tobacco Free.
- Partner with the Ohio Association of Community Health Centers (OACHC) to spread the success of 4 pilot Federally Qualified Health Centers to additional Centers;
- Share the Progesterone Change Package concepts at each maternity care provider site using Quality Improvement methodology;
- Work with key stakeholders at the system level (insurers, specialty pharmacies, health systems) to ensure that all eligible women have prompt access to Progesterone; and
- Remove communication barriers among clinics, pharmacies, home health care services, and managed care plans about initiating and maintaining progesterone treatment.

**Strategy 2: Increase safe sleep initiatives**

Activities supporting the Title V Action Plan for increasing safe sleep initiatives include:

- Increasing the number of families provided with a crib and safe sleep education through the ODH-funded Cribs for Kids® (CFK) program
- Increase the percent of families screened for a safe sleep space as required by Ohio Revised Code 3701.67 – safe sleep screening mandate
- Increase the number of impressions achieved through ODH safe sleep media campaign

In completing a safe sleep environment screening, birthing facilities must indicate whether a crib or referral was provided for families in need, including whether the facility made referrals to an ODH designated site. ODH will continue to fund the Cribs for Kids® (CFK) program to provide free Graco Cribettes to families who would otherwise be unable to afford safe cribs for their infants. Additionally, the Ohio Commission on Fatherhood's New Beginnings

for New Fathers Program will continue to provide CFK Cribettes in Clark, Cuyahoga, Franklin, Hamilton, and Montgomery counties. ODH is considering developing an online referral portal for CFK partners to enter and track data while reducing duplication. In 2018-19, we intend to improve tracking of education and Cribettes with non-funded agencies; include smoke free environment messages in our media campaign; improve our annual Safe Sleep training to an online format; implement mandatory screening before, during and after birth within Home Visiting; and improve and increase the provision of technical assistance to funded agencies to improve outreach and collaboration efforts.

Furthermore, Sub. S. B. 332 of the 131st Ohio General Assembly requires ODH to provide annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in the infant mortality priority areas. A training is in the development process and will be made available in FY19.

ODH will continue to build upon the media campaign with radio and television impressions, social media displays on mobile devices, digital radio, Facebook, Instagram and Twitter.

### Strategy 3: Decrease the birth rate among 13-19 year olds

#### Activities:

- Increase by 10% the number of middle schools participating in the Sexual Risk Avoidance Program Initiative

ODH utilizes a multi-pronged approach to reduce the birth rate among 13-19 year olds. The physical, cognitive and psychosocial developmental processes of puberty can be overwhelming and confusing as adolescents strive to define who they are. Participation in risky behaviors is frequently part of the normal developmental process. Because adolescents do not always anticipate the consequences of their behavior, particularly as they relate to their reproductive health, there can be adverse consequences. Communication is critical between families and teens. Providing resources to support teens and their families is important to help guide youth in making healthy and informed choices.

The following initiatives outline some ODH's efforts to address reproductive health issues for adolescents and young adults:

The Sexual Risk Avoidance Program (formerly called Abstinence Education Program) reflects the commitment of the Ohio Department of Health (ODH) to facilitate programming that is designed to meet the distinct and unique needs of local communities. Teenage pregnancy is a complex social issue which has far-reaching consequences in the lives of teen parents, their children, and the entire State of Ohio. The goal of Ohio's Sexual Risk Avoidance is to increase the number of youth who abstain from sexual activity and other related risky behaviors to reduce out-of-wedlock births and sexually transmitted infections.

The Sexual Risk Avoidance Program currently funds organizations who oversee and facilitate Sexual Risk Avoidance Education programming across four geographical regions. The Ridge Project is Ohio's sub recipient in Region 1, which covers northwest Ohio cities and communities. Relationships Under Construction is Ohio's second sub recipient and they reach Regions 2, 3 and 4, which covers the remainder of the state. Currently, each region is awarded \$642,123 for Sexual Risk Avoidance Programming.

Sub Grantees partner with local school districts to provide Sexual Risk Avoidance curriculum through health classes and afterschool programs. Some sub grantees offer Summer camps and Spring Break camps with an emphasis on Sexual Risk Avoidance programming.

The sub recipients operate by contracting with local agencies to build upon the strategy of local control, community collaboration and evidence supported program design. They each focus on specific priority counties with high rates of teen pregnancy or birth rates in their regions. In addition, the program targets youth ages 11-14, ensuring that prevention and positive youth development messages that promotes good decision making and positive healthy behaviors that reaches youth early in their lives.

The Personal Responsibility Education Program (PREP) has transitioned to the Ohio Department of Youth Services. ODH will remain an advisor to the PREP advisory board. ODH will support training for PREP providers in Human Trafficking and Trauma Informed Care.

The Reproductive Health and Wellness Program (RHWP) funds local health departments, community action groups and nonprofit agencies to address contraception, sexually transmitted infections, and health education including teen pregnancy prevention and prevention of sexual coercion/relationship violence.

The ODH Immunization Program seeks to reduce and eliminate vaccine-preventable diseases among Ohio's children and adolescents through the federally-funded Vaccines for Children (VFC) program. The vaccination schedule provides an opportunity for providers to discuss reproduction health issues with adolescents and parents/guardians.

New to FY18 and 19 is an initiative to identify and increase positive youth development activities for adolescents, particularly girls ages 10-14. In an effort to impact upstream efforts to reduce infant mortality and reduce overall risk behavior, including teen pregnancy, ODH hosted community forums in the nine OEI communities to examine positive youth development activities for middle school age girls. Youth and their parents/guardians also provided insight through focus groups. Community leaders identified needs and possible actions to improve access to care, increase the availability of extra-curricular activities and increase health literacy. ODH will receive final reports from The Ohio State University, who facilitated the forums and focus groups, in July 2018 and will utilize the information to develop future plans for addressing infant mortality, teen pregnancy and overall adolescent health needs.

#### Strategy 4: Target resources to known high-risk areas to decrease health disparities

Beginning October 1, 2018, each Ohio Equity Institute (OEI) subrecipient will be funded to leverage the resources and services developed and/or coordinated in the first iteration of OEI (SFY14-18) with the objective of connecting the most at-risk, pregnant women from target counties to evidence-based clinical and social service resources. Subrecipients will be responsible for serving eligible women and enacting systems change impacting the social determinants of health locally. Both strategies are aimed at addressing disparity in black and white premature birth and low birth weight rates in each of the OEI counties. Targeted in the nine counties with Ohio's greatest burden of black infant deaths, OEI 2.0 will identify high-risk women utilizing eligibility requirements aligned with Ohio's Moms and Babies First Black Infant Vitality Program. Eighty percent of women served must be African American.

OEI entities will also be receiving the support of community engagement training and technical assistance from an expert vendor to provide tailored support to each community to strengthen authentic engagement of infant vitality efforts with communities and partners. The Miami University has also been selected to provide direct, individual and statewide, evaluation of OEI to understand programmatic infrastructure and effectiveness.

Three communities have been selected to implement a community intensive pilot project, or place-based initiative, designed as a multi-pronged population health approach to produce direct, measurable improvements in birth outcomes and reduce disparities in birth outcomes and reduce the impacts of social determinants on pregnant women and infants. The initiatives focus in a high-risk community, defined by the community's infant mortality rate, preterm birth rate, low birth weight rate and disparity rate between black and white infant deaths. These projects promote a healthy environment and educate the communities on healthy practices. In addition, the projects encourage and communicate the importance of addressing individual needs and the support for individuals to make choices in their own best interest. Each project is implementing a community-driven approach to address infant mortality rates by reducing maternal behavioral and medical risk factors, thereby improving healthy birth outcomes for women and infants.

The state is receiving additional federal Home Visiting funding in 2018 to increase Ohio's capacity to serve parents at risk for infant mortality within high-risk communities. Ohio's Home Visiting program provides expectant and new parents at risk for poor birth outcomes with information and support in the comfort of their homes.

#### **Increase comprehensive newborn screens**

Newborns in Ohio are screened for disorders (authorized by legislative mandate) through three methods: 1) bloodspot screening, where blood is drawn from the baby's heel, collected on a filter paper card and sent to the ODH Newborn Screening Laboratory for analysis for 38 disorders; 2) newborn hearing screening, where infants are tested using physiologic screening methods; and 3) newborn screening for critical congenital heart disease (CCHD) using pulse oximetry. Hearing screening and CCHD screening are both non-invasive, point of care screenings with results known immediately. Bloodspot screening samples are sent to the ODH Newborn Screening Laboratory for analysis and follow-up. All three newborn screening programs focus on: 1) ensuring newborns are screened and that

physicians receive timely notification of screening results; 2) those newborns with abnormal (out of range) screening results receive diagnostic testing; and 3) those diagnosed with disorders have access to appropriate treatment or intervention. Currently in Ohio, approximately 98% of newborns are either screened or have a valid reason for not being screened through each newborn screening method. Reasons why a baby may not be screened included parent objection, known prenatal diagnosis of a CCHD, or baby to be discharged home on oxygen, making CCHD screening results invalid.

Newborn screening data are collected through different systems in Ohio and not linked with each other in any way. Hearing and CCHD screening are linked with vital statistics birth records; bloodspot screening data are not. Work to address this important newborn health priority is focused on improving the linkage/integration and/or inter-operability of data between Ohio's three newborn screening programs and with vital records for a population-based denominator. There are efficiencies to be gained in streamlining common data elements between the programs, as well as making timely and comprehensive (i.e., from all 3 screenings) results available to primary care providers responsible for working with parents on follow-up testing that may be needed. Overlaid in this priority measure is the use of technology and IT solutions to streamline data availability and use at the Ohio Department of Health, as well as the interface with electronic medical records from the birth and children's hospitals, and local pediatricians.

Healthy People 2020 goals were used to guide the strategies for the 5-year plan. HP2020 MCH-32.1 Increase the number of states that verify through linkage with vital records that all newborns are screened shortly after birth for conditions mandated by their state-sponsored screening program; HP2020 MCH-32.2 Increase the proportion of screen-positive children who receive follow-up testing within the recommended time period; and HP2020 MCH-1.7 Reduce the rate of infant deaths related to birth defects (congenital heart defects). Through these overarching goals, we will work during the coming year to build on the foundation developed through previous and the current year (FFY2018).

Strategies remain:

1. Improve the quality of newborn screening data
2. Improve pediatric primary care providers' (pediatricians, family practice) knowledge of newborn screening and their role in follow-up
3. Improve messaging to parents about newborn screening results

Activities for FFY2019:

- Finalize system requirements (ODH staff jointly with the Ohio Department of Administrative Services - DAS) and post funding opportunity for vendor hosted integrated newborn screening system
- Collaborate with DAS and ODH staff on review of proposals and selection of vendor
- Prepare for multi-year phased transition to integrated system
- Continue monitoring of all 3 newborn screening programs' data – number screened; number screened positive; number diagnosed; number of diagnosed who receive treatment/intervention; number lost to follow-up
- Repeat reconciliation analysis between Newborn Screening Lab data for metabolic disorders with Genetic Center Data
- Make enhancements to the MCHIDS data system to include Sickle Cell Education Event data

### **Increase access to early infant care and wellness**

#### **Early Childhood System of Supports**

Ohio has transformed evidenced-based Home Visiting and pairing it with a new a central intake and assessment process. Ohio's Comprehensive Home Visiting Integrated Data System (OCHIDS) will function as a coordinated, single point of entry to access services that promote family-centered programs for expectant parents, newborns, infants, toddlers, including those with developmental delays and/or disabilities and their families in collaboration with cooperation with other state and local agencies. OCHIDS provides centralized intake and referral services for all applicable Help Me Grow system activities, Moms & Babies First Community Health Worker programs and the Department of Developmental Disabilities (DODD) Early Intervention (EI) program. Utilizing the connection between Centralized Intake, Home Visiting Evidenced-Based Models the following activities will be conducted with families:



- Comprehensive assessment conducted by qualified personnel to assess a child and family's resources, strengths, priorities, needs, risks, and concerns.
- Administration of a department approved screening tool that is evidenced-based, or research-informed to generate needed community-based referrals. Approved screening may include, however not be limited to those instruments that inform the areas of child development, social-emotional growth, parent/caregiver depression, intimate partner violence (domestic/sexual violence and coercion), chemical and tobacco use and home safety.
- Development of a family goal plan that guides the development of activities, the identification of resources, and the successful achievements that build a family's resiliency and promote protective factors.
- Referrals to appropriate services and programs, as needed.

Data will be connected from multiple sources to track progress on indicators and benchmarks related to outcomes, and to inform CQI: planning, policy, and practice decisions. Cabinet-level stakeholders will collaborate and share data to reduce duplication of services and improve outcomes. The following are examples of connectivity across agencies:

- Medicaid: (well child/prenatal/post-partum visits, progesterone, depression, tobacco, asthma, etc.)
- Education: Kindergarten Readiness Scores
- Jobs & Family Services: Child welfare, TANF, Child Care, Fatherhood
- Mental Health: Opioid treatment and training
- Disabilities: ASQ scores and referrals
- Courts: Parenting education/support in the diversion program
- Health: WIC, Vital Stats, Immunizations

For example, within each visit the assessment asks about medical care, specifically comprehensive well care following the AAP's Bright Futures recommendations. Gaps in care will be flagged and notifications will be sent to ODM to assure providers address the needs of clients.

In addition, ODH has partnered with other state agencies to create an early childhood "data lake," where each agency will store maternal and child health outcomes and indicators. This will afford state health policy makers the opportunity to evaluate cross agency interventions and outcomes.

#### Ohio First Steps for Healthy Babies

The 5-year action plan outlines three major strategies to increase breastfeeding rates in Ohio: build upon the *Ohio First Steps for Healthy Babies* initiative that was launched in 2015; decrease the disparities in breastfeeding rates, with specific focus on African American and Appalachian women; and increase access to breastfeeding friendly environments. The goal is to increase collaboration among partners to protect, promote and support breastfeeding mothers and babies.

#### Strategies:

1. Build upon the *First Steps for Healthy Babies* initiative to help birthing hospitals meet all or part of the *Ten Steps to Successful Breastfeeding*
2. Adapt culturally appropriate trainings and tools to increase breastfeeding rates among Black and Appalachian mothers
3. Increase access to breastfeeding friendly environments
4. Increase community awareness to promote and support breastfeeding
5. Establish a breastfeeding designation program for child care providers

#### Activities/Objectives (Years 1-5):

- Provide and develop trainings based on components of the Ten Steps to Successful Breastfeeding.
  - Provide at least one webinar on each of the 10 Steps to Successful Breastfeeding and at least one webinar on fatherhood engagement
  - Provide hospital staff access to an online 20 hour training course required for healthcare staff to meet Step 2 of the 10 Steps

- Establish a coaching team to provide technical assistance to hospitals. Team may provide on-site visit, conference call “office hours”, creative coaching, mock assessments, etc.
- Establish Maternity Care Best Practice Awards.
  - Implement the “Bag Free” award yearly
  - Establish Breastfeeding Friendly Employer Awards
- Establish a 24/7 breastfeeding hotline.
  - Establish a 24/7 breastfeeding hotline for Ohio moms
  - Track the number of calls, time of call, wait time, referral source, etc.
  - Engage stakeholders across Ohio to promote and refer to the hotline (i.e. home visiting programs, WIC, hospitals, community-based organizations, worksites)
- Create a database to track hospital progress and awards received (as funds become available)
  - Establish a database to track hospital participation in First Steps and Maternity Care Best Practice Awards
- Explore virtual lactation consultants for underserved areas
  - Provide access to virtual lactation consultants in underserved areas, such as Appalachia
- Increase the number of breastfeeding peer helpers
  - Train breastfeeding peer helpers to provide individual and/or group support that reflects their community-specific culture
- Implement *Breast for Success* curriculum training in Home Visiting Programs
- Establish linkages between maternity hospitals, birthing centers, and community-based breastfeeding support programs to promote post-discharge support
  - Establish drop-in Baby Cafés in counties that are staffed by trained breastfeeding professionals and open to all women in the community (as funds become available)
  - Promote and support breastfeeding classes that are convenient for family members to attend
  - Support local infrastructure to connect breastfeeding mothers to resources within their community
- Provide training and technical assistance to community-based breastfeeding organizations, hospitals, clinics, and worksites.
  - Offer The Business Case for Breastfeeding training to worksites and provide support on how to implement tool-kit
  - Provide breastfeeding-related professional development/training opportunities to existing staff
  - Incorporate lactation services into existing community-based programs
- Increase opportunities for breastfeeding education and certification
  - Provide training opportunities, such as CLC, CLS, or CBS, to increase the number of lactation professionals in hospitals, clinics, and physician offices
- Create and implement a statewide public awareness campaign (In collaboration with WIC)
  - Increase public breastfeeding awareness by creating and implementing a media campaign (including billboards, social media, TV and/or radio spots)
- Establish a breastfeeding designation program for child care providers.
  - Research existing child care breastfeeding recognition/designation programs
  - Create a breastfeeding designation program to recognize child care providers that are breastfeeding-friendly
  - Implement and evaluation the program



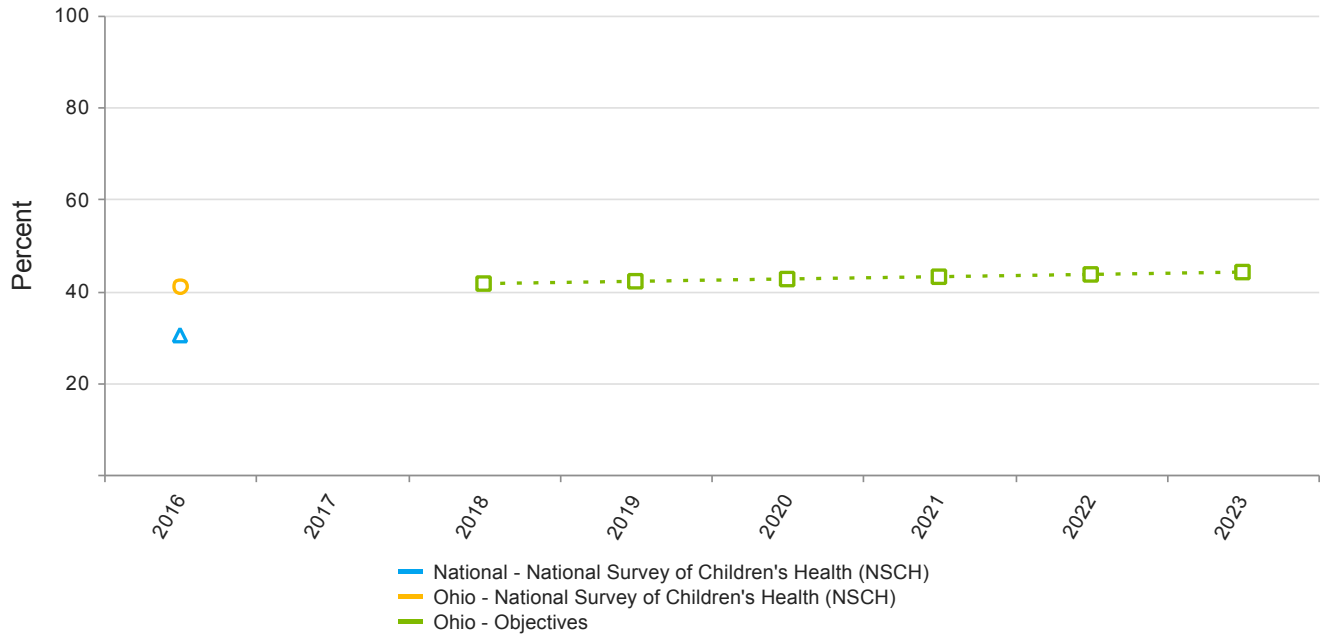
## Child Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.4 %	NPM 6

## National Performance Measures

### NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year Baseline Indicators and Annual Objectives



#### Federally Available Data

#### Data Source: National Survey of Children's Health (NSCH)

	2016	2017
Annual Objective		
Annual Indicator		41.1
Numerator		114,362
Denominator		278,232
Data Source		NSCH
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

#### Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	41.6	42.1	42.6	43.1	43.6	44.1

**Evidence-Based or –Informed Strategy Measures****ESM 6.1 - Number of new pediatric practices and family practices participating in the learning collaborative**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		0
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

**ESM 6.2 - Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>					
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	50.0	51.0	52.0	53.0	54.0

## State Performance Measures

### SPM 2 - Percent of children 0-17 years with a preventive medical visit in the past 12 months

<b>Measure Status:</b>	<b>Inactive - This measure does not fit the activities identified in the Action Plan.</b>
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State Provided Data		
	2016	2017
Annual Objective		90
Annual Indicator	87.7	83.6
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2011-12	2016
Provisional or Final ?	Final	Final

### SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day

<b>Measure Status:</b>	<b>Active</b>
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	17.2	16.2	15.2	14.2	13.2

## State Action Plan Table

### State Action Plan Table (Ohio) - Child Health - Entry 1

#### Priority Need

Increase the prevalence of children receiving integrated physical, behavioral, mental and developmental health services

#### NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

#### Objectives

- A. Increase number of providers conducting quality comprehensive well child visit in accordance to best-practice standards and guidelines that include developmental screenings.
- B. Work with diverse stakeholders to explore the implementation of comprehensive well child visits through best-practice standards and guidelines that include developmental screenings.
- C. Identify a shared data system to share and track information on screening, referral and follow-up services.
- D. Identify reimbursement models and standard reporting options.

#### Strategies

- A1) Inventory quality improvement projects focusing on components of the well child visit. A2) Create best practice training for healthcare providers regarding comprehensive well child visits. A3) Promote and implement best-practice training for healthcare providers conducting well child visits. A4) Monitor screening rates and compliance with standardized recommendations.
- B1) Partner with diverse stakeholder group to promote well-care. B2) Implement evidenced-based education for families and children. B3) Implement evidenced-based education for providers.
- C1) Identify the feasibility for data linkages or integration between screening data systems and include projections for return on investment, and recommendations for next step integration or linking. C2) Develop plan to pilot comprehensive reporting of screening data through new linkage/integrated system.
- D1) Identify the modernization of payment models for comprehensive health services to ensure that children's insurance routinely covers appropriate evidence based treatments. D2) Explore reimbursements to providers to improve the access that children and families have to the vital treatments that support quality outcomes. D3) Identify standard reporting for comprehensive well child visits amongst diverse stakeholders

ESMs	Status
ESM 6.1 - Number of new pediatric practices and family practices participating in the learning collaborative	Inactive
ESM 6.2 - Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## State Action Plan Table (Ohio) - Child Health - Entry 2

### Priority Need

Reduce the rate of childhood obesity

### SPM

SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day

### Objectives

A. Increase the number of at-risk children and youth birth – 5 years receiving interventions to prevent and manage obesity through health practitioners.

B. Increase the number of licensed early child and school-aged child care providers that have adopted organizational healthy eating/active living (HEAL) policies

### Strategies

A1) Develop and disseminate guidelines for the use of evidence-based interventions to prevent and manage obesity. A2) Implement Parenting at Mealtime and Playtime (PMP) QI opportunities or learning collaborative with healthcare practitioners in Ohio. A3) Promote use of interventions to healthcare practitioners\*\* through partnerships with hospitals, foundations and other stakeholders.

B1) Work with state partners, including the Ohio Early Childhood Health Network (OECN), to include adoption of HEAL policies as a component of Ohio's quality rating and improvement system (QRIS), "Step Up to Quality". B2) Through the Maternal and Child Health Program (MP) grantees, formerly CFHS, train and provide technical assistance to licensed early child and school-aged child care providers to become Ohio Healthy Program (OHP) designated. B3) Expand OHP training opportunities through the creation of advanced topic-specific content for staff and providers engaged in OHP.

**Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies**

**Child Health, FY 2017 Annual Report**

**Ohio Department of Health Priorities:**

- Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services
- Reduce the rate of childhood obesity

**Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services**

The Maternal and Child Health Block Grant (MCHBG) Child Health Priority work group was created to bring a diverse group of public health programs, medical professionals, family organizations and non-profit organizations together to discuss the priority to increase the prevalence of children receiving integrated physical, behavioral and mental health services. This group represents a multi-disciplinary approach to promote well care throughout the state through the use of core and supporting members to ensure all components of the well child visit were incorporated into each visit for every child.

According to the 2016 National Survey for Children's health (NSCH) 83.6% of Ohio children ages 0 to 12 years old received a preventive checkup during the last 12 months. Children ages 0-5 years were more likely to have had a preventive visit when compared to children ages 6-11 years (90.5% vs. 82.8%). Since more children attend the well child visit during the 0-5 age range, targeting physicians who serve children in older age groups may be considered by the group.

The National Performance Measure 6 for Developmental Screening: Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool serves as the NPM for the child health priority two work group. According to the 2016 NSCH, 41.1% of Ohio parents indicated their children ages 9-35 months received a developmental screening using a parent-completed screening tool. However, this data should be interpreted with caution due to the estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.

Initially the group selected the ESM 6.1 (Number of new pediatric and family practices participating in the learning collaborative). Funding was requested to plan, develop and implement a learning collaborative project that would assist in the development of evidenced-based interventions that can be standardized across physician offices utilizing the Plan, Do, Study and Act (PDSA) intervention model during the reporting period. The learning collaborative project proposed to incorporate trainings for healthcare providers that included best-practice/evidenced based approaches for components of the comprehensive well child visit. Expected outcomes for the learning collaborative project duration were increase the number of providers who are appropriately trained, equip and identify resources for follow up/treatment care; increase in screening rates and compliance with standards; increase appropriate referrals; and increase children receiving follow up care and treatment. At this time, it does not appear that we will be able to fund the learning collaborative. Therefore, we have changed the ESM to Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening.

The group met quarterly through the FFY17 to further partnership and collaborative opportunities. During these meetings, presentations were provided to members such as the overview of the work of the Children in the



Vanguard, a non-profit and state agency partnership that includes a focus on improving EPSDT. According to National Academy for State Health Policy (NASHP), Children in the Vanguard is an initiative of the that focuses on children's coverage in the context of health care reform. Under this initiative, NASHP brings together state Medicaid, CHIP and Title V officials with advocates from a diverse group of states in a collaborative learning network to focus on continuing progress on children's coverage as health care reform is implemented. The project also aims to foster complementary relationships between state officials and state advocates in working toward common goals around improving children's health coverage. Participating states learn and share promising practices in improving eligibility, enrollment and retention of children in coverage, and work to analyze and address health care reform related policy and operational challenges for children and youth.

In addition, a presentation on the ODH Home Visiting data system that will include data tracking of developmental screenings and reporting of well child visits. The Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS) is a statewide, web-based central intake and home visiting data system that serves three key functions such as electronic Health record, data reporting system and system of payment for Home Visiting services. These functions ensure the capability of capturing data related to assessments, screening tools, progress notes as well as family goal plans. The system offers on demand reporting/dashboarding at the state and local level, as well as communication with other state agencies/systems. The system also serves as a system of payment for Home Visiting services. The OCHIDS data system is exploring linkages or integration between data systems and may serve as a pilot for future work regarding integration between screening data systems to decrease duplication of services and increase data sharing data.

During the reporting period, the Ohio Department of Medicaid conducted the five-year rule review of its **Early Periodic Screening Diagnostic Treatment (EPSDT/Healthcheck)** coverage and payment rules. Stakeholders were provided the opportunity to provide feedback prior to the rule change. The rules were revised to reflect adherence to the standards of medical practice in accordance with the American Academy of Pediatricians Bright Futures. This revision assisted in the standardization of well child visits regardless of insurance type.

Trainings for healthcare providers that incorporated best practice/evidenced-based approaches for separate components of the comprehensive well child visit were conducted during the reporting period. Trainings included the provision of educational and follow up resources for providers and families. However, trainings and provision of resources continue to be disjointed.

A total of 1,065 health care professionals received vision screening training during the reporting period. Those who received the evidenced based training reported to have a projected 187,708 children that will be impacted after receiving the in-person training. A total of 2,672 students and healthcare professionals participated in the various online trainings that were offered during the reporting period with a projected impact of 385,980 children. There has been a 70.2 percent increase from baseline of healthcare professionals receiving evidenced-based vision screening as compared to the baseline of 748. Aggregate data is not available for the reporting of total children screened, children were rescreened, children were referred for follow up and children who received follow up treatment.

A total of 926 health care professionals received hearing screening training during the reporting period. Those who received the evidenced based training reported to have a projected 167,508 children that will be impacted after receiving the in-person training. A total of 1,982 students and healthcare professionals participated in the various online trainings that were offered during the reporting period with a projected impact of 279,652 children. There has been a 72.8 percent increase from baseline of healthcare professionals receiving evidenced-based vision screening as compared to the baseline of 675. Data submitted through the 2016-2017 Annual Hearing Screening Report indicated that a total of 684,103 children were screened, 44,675 of those children were rescreened, 18,632 children were referred for follow up and only 27.6 percent of those children received follow up treatment.

Lead testing in Ohio has increased by 2.8 percent from the baseline of 162,338 to 166,924. Follow-up services include having a public health lead investigation completed to identify the probable source of the child's lead exposure. Follow up also includes comprehensive case management services for the child. The program educates health care professionals on following Ohio's targeted testing plan and their responsibilities within that plan. Children tested more than once in a grant-year are shown only once. Blood lead levels reflect the highest confirmed test during this year if a confirmed test exists for a child, or the highest test for the year, otherwise.

Dental sealants prevent the most common type of tooth decay seen in children. Tooth Assessment Trainings were conducted to ensure quality assurance in selecting the correct teeth to apply sealants for identified children to increase dental sealants for children in Ohio. A total of 27,921 children received dental sealants as identified as baseline and a total of 26,961 children received dental sealants during the reporting period.

Developmental screenings are required to be completed during the identified intervals within the Home Visiting Program. Screening data is recorded for each child enrolled within the data system and referral and follow up is monitored by the home visitors.

Trainings for healthcare providers to increase their knowledge of mental health issues that arise in childhood were promoted throughout 3 counties in Ohio through the Maternal and Child Health grant. These trainings were to assist with increasing screening, referral, and treatment rates of children. Throughout the 3 counties at least 9 trainings were held with various practitioners. The number of children who were screened throughout the 3 counties combined were 7, 817, with 830 being referred for treatment, and 439 being treated.

Overall, the work group is large and all-encompassing and this became more of a barrier during FFY17. Members are still committed to the global effort to improve quality during the well child visits and increase the number of children who receive developmental screenings and be able to appropriately track screening results, referrals, follow up and treatment services. This commitment is evidenced by the accomplishments and improvements from baseline data that occurred during FFY17. However, strategies and activities for this performance measure will need to adapt and be more targeted to withstand the rapid changes that have occurred during FFY17 and slated to occur during FFY18 including possible changes to Medicaid funding, unknown barriers and assessment of core and supporting members on the work group.

### **Reduce the rate of childhood obesity**

Ohio has many interventions in place to address childhood obesity. Strategies integrated within the Title V Action Plan include: A) increase the number of at-risk children birth – 5 years receiving interventions to prevent and manage obesity through health practitioners, B) increase the number of licensed early child and school-aged child care (ECE) providers that have adopted healthy eating/active living (HEAL) policies; C) support local communities to identify nutrition/physical activity needs and gaps, create an action plan, and work with facilities (including schools) to increase nutrition education, access to healthy food choices, and/or physical activity; and D) collaborate with the Oral Health Program to conduct a BMI surveillance within child care centers in Ohio public and private preschools. During FFY 2017, significant progress was made in all these strategies.

Strategy A: increase the number of at-risk children birth – 5 years receiving interventions to prevent and manage obesity through health practitioners.

Efforts focused on 1) launching an online physician learning collaborative on obesity risk assessment and counseling, 2) planning and piloting an early childhood obesity prevention program among home visitors, 3) marketing and organizing regional obesity prevention trainings for WIC providers and other practitioners, and 4)

building partnerships with hospitals and other agencies to expand an obesity prevention program (including assessment and counseling) into primary care.

After 4-6 months of planning and development, the online physician learning collaborative was launched September 2016 with twenty-one practices and twenty-two pediatricians enrolled. Fourteen physicians completed the entire QIDA program. Those fourteen physicians increased documentation of weight status (increased 25%), growth trajectory (increased 38.2%), nutrition counseling (increased 21.9%), physical activity counseling (increased 22.1%), motivational interviewing (increased 60%), and goal setting (increased 27%). The participating practices provide care for an estimated 0-5 year old patient population of 25,470 children, 35% of whom receive Medicaid. Directly participating physicians provide care for approximately 5,810 of those children.

The home visiting obesity prevention pilot was planned during the FFY2016 and launched September 2016 with 11 home visitors in two counties. Program materials and healthy eating, active living counseling were used with 116 families during the ten-week pilot. This equated to home visitors using the program in 43% of their home visits. In the spring of 2017, plans were made to launch the program statewide in FFY2018. During FFY2016, regional obesity prevention trainings were marketed and scheduled to begin March 2017. In the spring of 2017, trainings were delivered to WIC dietitians and administrators, along with physicians in their region. These trainings were hosted regionally all over Ohio, reaching 433 WIC professionals and 53 physicians.

To expand obesity prevention assessment and counseling into Ohio's primary care systems, ODH has built partnerships across the Ohio Chapter of the American Academy of Pediatrics, ODH's WIC program, ODH's Help Me Grow program, several local health departments and non-profit agencies that employ home visitors, the Cleveland Clinic Quality Improvement team, and PDA Stats, Inc., who will assist with evaluation on the all the interventions.

Strategy B: increase the number of licensed early child and school-aged child care (ECE) providers that have adopted healthy eating/active living (HEAL) policies.

Efforts focused on updating and continuing support for the Ohio Healthy Program (OHP). Work began to transition OHP trainings from in-person to online. The 4 trainings in Session 1 will be self-paced, online modules while Sessions 2 and 3 will be live webinar trainings. Pilot and launch of the online trainings will begin in FFY18. Over FFY2017, 438 OHP trainings were held across the State with 4,724 participants. 165 ECE sites spread throughout 36 counties earned state recognition because of the HEAL policies and system changes they adopted after these trainings. An analysis of 110 sites revealed that they implemented 957 HEAL policies and 414 menu improvements. The Maternal and Child Health (MCH) program (formerly Child and Family Health Services) is one entity providing OHP trainings and technical assistance. The MCH program reached 12 counties and provided 197 training sessions in FFY17.

Sandy Oxley, Title V Director, is a member of the Governor's Early Childhood Advisory Committee. Activities of the committee include work to ensure HEAL and health policies are in the ECE Strategic Plan.

Ohio's Pediatric Obesity Collaborative (CollN) team revised recommendations from subject matter experts for adding healthy eating and active living standards into Ohio's quality rating system for early care and education facilities. The cross-walk of recommendations was presented to stakeholders, including Early Childhood Education (ECE) providers, Family Child Care providers (FCC), and quality rating specialists, through focus groups. There were nine targeted focus groups, which included 66 total participants. Those were facilitated by a contracted specialist who also collated the feedback for the CollN team to make revisions. The CollN team will finalize recommendations and submit to Ohio Department of Job and Family Services (ODJFS) and Ohio Department of Education (ODE) in FFY18.

Strategy C: support local communities to identify nutrition/physical activity needs and gaps, create an action plan,

and work with facilities (including schools) to increase nutrition education, access to healthy food choices, and/or physical activity.

In FFY17, the Child and Family Health Services program changed its name to Maternal and Child Health and its grant structure to a deliverable-based model. A new MCH grant strategy was added to conduct a nutrition and physical activity needs assessment within a community. Thirty-five sub-grantee agencies conducted the needs assessment and submitted results and an action plan. In addition to the needs assessment, MCH sub-grantee agencies had the option to continue to implement evidence-based and/or best practice nutrition education program in facilities (including schools) to increase nutrition education and/or physical activity. Approximately 14,485 students were reached through various nutrition education and/or physical activity programs in schools [ESM #8.1]. In addition, 533 classrooms were served in 128 schools with 137 family engagement activities provided.

**Strategy D:** collaborate with the Oral Health Program to conduct a BMI surveillance within child care centers in Ohio public and private preschools.

The School and Adolescent Health Program, in collaboration with the Oral Health Program, has been overseeing the Body Mass Index (BMI) surveillance data collection. The statewide BMI survey of preschool children was completed in May 2017. Eighty-two sites were surveyed—18 public preschool programs and 64 Early Childhood Education Centers. 3,098 children ages 2-5 were measured for height and weight for BMI assessment. The data will be cleaned, analyzed and distributed in FFY18.

### **Priority Measures**

**NOM 20:** Percent of children ages 2-4 years who are overweight or obese (BMI at or above 95th percentile)

According to the FAD, in 2014, 13.1% of 2-4 year-old Ohio WIC participants were obese. The prevalence in 2014 was significantly higher than the prevalence in both 2008 (12.4%) and 2010 (12.6%). Hispanic children had the highest prevalence, at 18.7%, followed by non-Hispanic white children (13.3%) and non-Hispanic black children (11.3%). These prevalence's were all statistically significantly different from one another. While Hispanic children comprise less than 10% of Ohio's WIC population, their proportion is growing and the disparity related to obesity is concerning.

While not directly comparable to the FAD, Ohio also has 2011-2016 data available on WIC participant obesity through an agreement with the state of Michigan, wherein PedNSS-like procedures are used. Among 2-5 year-old children in 2016, the patterns by race and ethnicity are identical to the patterns observed within the FAD for 2014. Recent temporal trends however are more promising. Annual prevalence from 2011 through 2016 were: 13.3, 12.7, 12.8, 13.0, 12.3, and 12.5. An increasing trend not detected but rather at the annual percent change was -1.14 (p-value =0.08). These data indicate that obesity is no longer increasing among this population and may be starting to decrease.

**NPM 8:** Percent of children ages 6 - 11 years and adolescents ages 12 - 17 years who are physically active at least 60 minutes per day

Because Ohio is focusing efforts on obesity prevention efforts among preschool-aged children and not older children, the state proposes within this application to drop this NPM and details a new SPM related to sugar-sweetened beverage consumption among 2-5 year-old children. The focus on younger children, due to the opportunity to make a larger impact on health of the population, has been consistent since the beginning of the 5-year block grant cycle and the new SPM will bring Ohio's measures into alignment with the state's efforts.

Looking at the NPM, no updated YRBSS data are available to the state since Ohio did not meet the minimum response rate in 2015. From 2013, 25.9% of adolescents in grades 9-12 were physically active at least 60 minutes a

day. These older data indicate that few Ohio adolescents met physical activity recommendations and we have no reason to believe that there has been a major recent shift in this behavior.

ESM 8.1 Percent of school aged children exposed to (taught using) evidence-base (or evidence informed) nutrition education and physical activity curriculums:

From October 1, 2016 – September 30, 2017, the FY17 grant cycle for the Maternal and Child Health Program [formerly Children and Family Health Services (CFHS)], 14,485 school aged children were taught using an evidence-based and/or best practice nutrition education program. Per ODE, there were 1,974,887 children enrolled in Ohio schools (public and private) in grades K-12 during the 2016-2017 school year. That makes a total of less than 1% of Ohio school children that were exposed to an evidence-based and/or best practice nutrition education program.

This group has created a new ESM to better measure our activities, percent of children in child care attending an Ohio Healthy Program (OHP) designated child care site. At the end of SFY 17 (July 1, 2016 – June 30, 2017), 4.7% of children that were attending a licensed child care center were in a OHP designated site. This includes 10,400 kids in 165 sites. We anticipate we will reach 5.9% by the end of SFY 18. Since we dropped NPM 8 in favor of a more appropriate SPM, we are not able to link this ESM to an appropriate NPM. Therefore, we are unable to create Form 10c (ESM Detail Sheet) or Form 10a in the Title V Information System (TVIS). We will report on this ESM in the narrative portion of the annual report/application.

#### References:

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## Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies

### Child Health, Plan for FY 2019

#### Ohio Department of Health Priorities:

- Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services
- Reduce the rate of childhood obesity

#### **Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services**

According to the 2011/2012 National Survey of Children's Health, 93.9% of Ohio children aged 0-5 received one or more preventive medical care visit. Eight-six percent of Ohio children aged 6-11 received one or more preventive medical care visit. Screening and well-child visits provide an opportunity for periodic assessment of core health status components including behavioral and mental health, developmental, dental, hearing or visual impairment and to identify and prevent elevated blood lead levels. Early detection and referral leads to earlier treatment & promotes proper management of the conditions. A systematic approach to quality improvement science should result in increasing the percent of children receiving timely, age-appropriate screening & improving the system overall to ensure children receive the care that they need. Comprehensive well child visits is a child health benefit for children under the age of 21. Services are intended to screen, diagnose, and treat children to avoid or minimize childhood illness. A 2010 Office of Inspector General's report found that children were not receiving all of the required EPSDT screening. (Office of Inspector General Report, November 2014). It is estimated that 1 out of 5 children in Ohio under the age of six are at moderate or high risk for developmental, behavior or social delays. Through EPSDT, a child is identified early through the screening process and is more likely to find appropriate treatment so children are school ready (EPSDT & Developmental Screening, Voices for Ohio's Children). According to the Resources for Title V Action Planning, Developmental Screening Strategies and Measures, screening for healthy development can reduce the likelihood of a child developing other delays if provided the appropriate screening, referral and follow up treatment. Strategies and activities target increasing the quality of care provided during a well child visit to decrease duplication of efforts while increasing the collaboration and efficiency of stakeholders.

According to the Ohio Department of Job and Family Services data from 2013-2017, health and safety issues have consistently been in the top Serious Risk Noncompliance (SRNC) rule violations most cited in licensed child care programs in the state. This strategy will improve the delivery of integrated physical, behavioral, mental, and developmental services in the early childhood care and education settings in a safe environment. Strategy E outlines the creation of online health and safety professional development trainings that address the needs of the early care and education programs throughout the state.

Strategies A-D have been slightly revised to more accurately reflect the purpose and representation of the Action Plan workgroup. The following summarizes the revisions and plans for years 4-5.

Strategy A: Increase number of providers conducting quality comprehensive well child visit in accordance to best-practice standards and guidelines that include developmental screenings.

A3) Promote and implement best-practice trainings for healthcare providers conducting well child visits.

Years 3-5 Implementation of trainings for healthcare providers that incorporate best-practice/evidenced based approaches for components of the comprehensive well child visit.

A4) Monitor screening rates and compliance with standardized recommendations.

Years 1-5: Monitor screening rates and compliance with standardized recommendations.

Strategy B: Work with diverse stakeholders to explore the implementation of comprehensive well child visits through best-practice standards and guidelines that include developmental screenings.

B1) Partner with diverse stakeholder group to promote well care.

Years 1-5: Collaborate with diverse stakeholder groups to promote well care.

B3) Implement evidenced-based education for families and children.



Years 1-5: Access to follow up treatment and family support is available.  
Years 1-5: Engage families in importance of screening, follow up and treatment.  
Years 1-5: Explore evidenced based prevention activities for children.

B4) Implement and evaluate the evidenced-based education for providers.

Years 1-5: Access to follow up treatment and provider support is available.  
Years 1-5: Engage providers in importance of screening, follow up and treatment.

Strategy C: Explore a shared data system to share and track information on screening, referral and follow-up services.

C1) Explore the feasibility for data linkages or integration between screening data systems and include projections for return on investment, and recommendations for next step integration or linking.

Years 4-5: Develop plan to pilot comprehensive reporting of screening data through new linkage/integrated system.

Strategy D: Explore reimbursement models and standard reporting options.

D1) Explore the modernization of payment models for comprehensive health services to ensure that children's insurance routinely covers appropriate evidence based treatments.

Years 2-5: Payment models for comprehensive health services were explored and implemented where appropriate.

D2) Explore reimbursements to providers to improve the access that children and families have to the vital treatments that support quality outcomes.

Years 2-5: Explore reimbursement models that have led to quality outcomes and assess implementation feasibility.

Years 4-5: Explore opportunities to revise reimbursement for well child visits.

D3) Explore standard reporting for comprehensive well child visits amongst diverse stakeholders

Years 4-5: Explore the feasibility of HEDIS and non-HEDIS measurement reporting for the comprehensive well child visit including developmental screenings.

Strategy E: Create and deliver health and safety trainings for early childhood programs

Year 4: Based on needs assessment, develop and pilot first health and safety training for early childhood care and education staff.

Years 4-5: Create 4-6 online professional development trainings for early care and education staff per year available based on health and safety needs of early childhood programs, as well as three half-day live conferences around the state.

## **Reduce the rate of childhood obesity**

Obesity has reached epidemic levels in Ohio; 14.1% of low income preschool-aged (2 to 5 years) children are overweight and 11.6% are obese and Ohio is not seeing a decrease in obesity among this age group. Since the Early Childhood Obesity Prevention Program started in 2013, several initiatives now address this epidemic. This program is working with healthcare practitioners in clinical settings, community health workers and home visitors, and early childcare education providers in public preschools, licensed child care centers and family homes. Ohio's Maternal and Child Health (MCH) program funded local health departments to conduct needs assessments and implement findings around obesity prevention. The MCH program also funds local health departments to address childhood obesity through work with early care and education providers. The strategies and activities described below encompass these multiple venues as well as BMI surveillance for preschool children. Preventing childhood obesity is an objective in the State Health Improvement Plan, Ohio Chronic Disease Plan, the CDC Chronic Disease Cooperative Agreements, the HPIO Report on Population Health, and the *Bold Beginning!* Early Childhood Success Plan.

## Strategies

- A. Increase the number of at-risk children and youth, birth – 5 years, receiving interventions to prevent and manage obesity through health practitioners
- B. Increase the number of licensed early child and school-aged child care providers that have adopted organizational healthy eating/ active living (HEAL) policies
- C. Conduct BMI surveillance within child care centers throughout Ohio.

## Activities/Objectives

- Years 1-5: Implement Parenting at Mealtime and Playtime (PMP) Quality Improvement opportunities or learning collaborative(s) with healthcare practitioners in Ohio, e.g. dietitians, physicians, home visitors, community health workers and nurses
  - Annually (on state fiscal year) set up learning collaborative(s) or QI opportunities
  - Annually recruit practitioners, estimate market to 100 to 200 practitioners annually
  - Annually train practitioners, estimate train 60-80 practitioners
- Years 1-5: Maintain and disseminate current guidelines for the use of evidence-based interventions to prevent and manage obesity
  - Annually review and update guidelines based on current research
  - Annually disseminate guidelines
- Years 1-5: Promote use of interventions to healthcare practitioners through partnerships with hospitals, foundations and other stakeholders.
  - Support the Ohio Early Childhood Health Network healthcare subcommittee
  - Build partnerships with hospitals, foundations and other stakeholders through participation in the subcommittee meetings and strategies
  - Annually promote use of interventions
- Years 1-5: Facilitate operation of OECHN so that it aligns activities to support and improve early childhood health outcomes throughout the state.
  - Convene quarterly OECHN meetings
  - Quarterly update and maintain membership lists, website and materials
  - Support OECHN subcommittees with related communication or facilitation needs
- Years 1-5: Train and provide technical assistance to licensed early child and school-aged child care providers to become Ohio Healthy Program (OHP) Designated.
  - MCH grants developed by ODH and awarded
  - ODH will administer the grant to assure the following occurs:
- Years 2-3: Funded communities conduct a needs assessment, form a local coalition, and submit an action plan.
  - ODH will administer grant to assure that MCH sub-grantee agencies:
- Years 1-3: Implement (through school/ facility personnel) evidence-based and/or best practice nutrition education program in schools to increase nutrition education, access to healthy food choices, and/or physical activity
  - ODH will administer grant to assure that MCH sub-grantee agencies:
  - Measure the changes in student knowledge based on the nutrition education/physical activity education program selected
- Year 1: Have sample selected for statewide preschool BMI surveillance program, create materials needed for program, hire screening staff and train them on program protocol.
- Year 2: Conduct BMI data collection
- Year 3: Interpret findings, develop report, print, and distribute findings from BMI survey of 2- 5 year olds.



- Years 4-5: Plan and conduct BMI surveillance for 2-5 year olds.

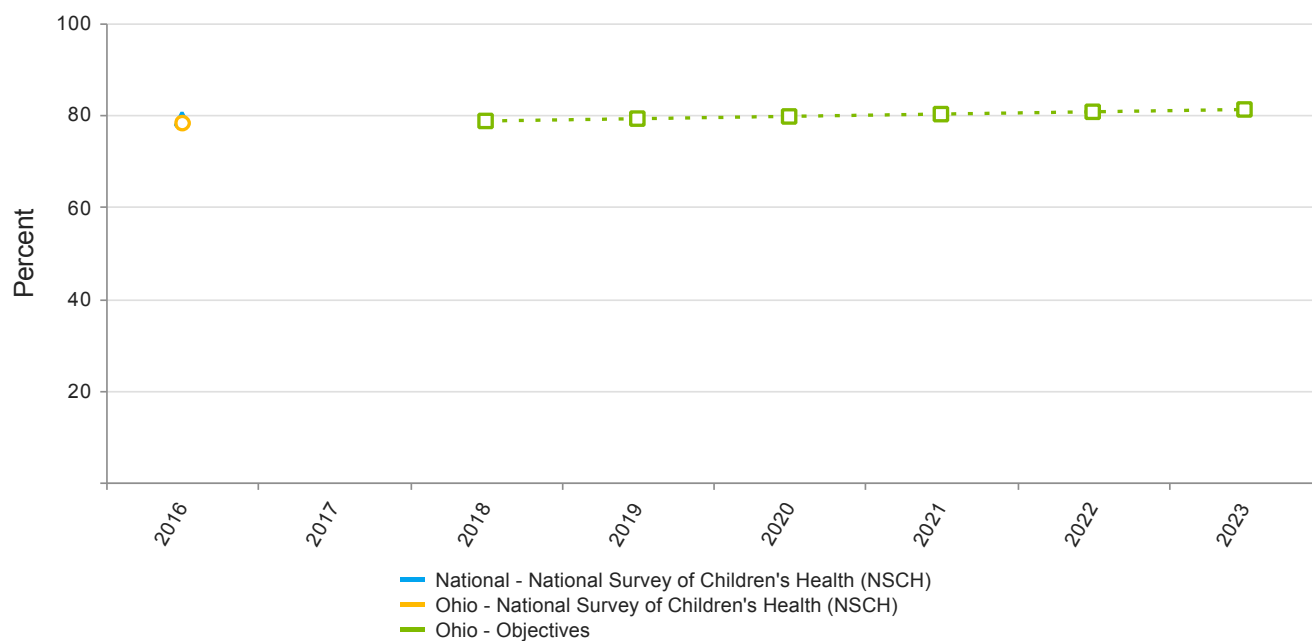
## Adolescent Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	32.5	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	11.4	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	9.1	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	53.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.4 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	18.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	13.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	13.0 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	51.5 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	57.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	55.0 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	90.8 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	79.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	21.8	NPM 10

## National Performance Measures

### NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Baseline Indicators and Annual Objectives



#### Federally Available Data

#### Data Source: National Survey of Children's Health (NSCH)

	2016	2017
Annual Objective		
Annual Indicator		78.1
Numerator		694,854
Denominator		889,704
Data Source		NSCH
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	42.6	43.9
Numerator	137,032	144,230
Denominator	321,606	328,769
Data Source	Ohio Mediciad	Ohio Medicaid
Data Source Year	SFY 15	SFY 16
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.6	79.1	79.6	80.1	80.6	81.1

**Evidence-Based or –Informed Strategy Measures****ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	50	77
Numerator		
Denominator		
Data Source	Training registration logs	Training registration logs
Data Source Year	2016	FFY 2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

## State Action Plan Table

### State Action Plan Table (Ohio) - Adolescent Health - Entry 1

#### Priority Need

Reduce barriers, improve access, and increase the availability of health services for all populations

#### NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

#### Objectives

A. Increase provider utilization of evidenced based, culturally-competent, adolescent friendly preventive care

B. Partner with stakeholders and adolescent medicine practices to increase the proportion of adolescents with a documented well-visit exam

C. Utilize social media to promote adolescent well-care and targeted health messages

#### Strategies

A1) Create, promote and deliver trainings that focus on increasing visits, improving quality of care provided and increasing adolescent friendly practices through partners and provider groups.

B1) Develop plan for implementing QI process with providers and partners. B2) Identify 5 new providers per year to enter QI process that includes implementation of strategies for increasing visits and improving quality of care.

C1) Work with provider groups and health plans to develop a coordinated, targeted social media campaign. C2) Identify and disseminate best practice guidelines for the use of social media to promote services and appointment times.

#### ESMs

#### Status

ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations. Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

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NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females



## Adolescent Health - Annual Report

### Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies Adolescent Health, FY 2017 Annual Report

#### Ohio Department of Health Priority:

Reduce barriers, improve access, and increase the availability of health services for all populations

Over the course of two years, a diverse group of MCH-funded programs that serve the adolescent population, leading adolescent physicians from across the state, the Ohio Chapter of the American Academy of Pediatrics, Ohio Department of Medicaid, and the Ohio Department of Mental Health and Addiction Services have met to guide the adolescent health action plan. The group has reviewed adolescent preventive services data, supported the implementation of well-visit improvement strategies, and discussed challenges and barriers regarding Ohio's data and current practices. Based upon discussions and findings, the group has continued to plan strategies that align with the five-year action plan and guide the course of the work for this Performance Measure.

Strategies identified in the five-year action plan include: 1) Developing a diverse stakeholder group to develop a statewide plan for improving adolescent well-care, focusing on Medicaid eligible youth, 2) Increase provider utilization of evidenced-based, culturally-competent, adolescent-friendly preventive care, 3) Partner with stakeholders and adolescent medicine practices to increase the proportion of adolescents with a documented well-visit exam, 4) Utilize social media to promote adolescent well-care and targeted health messages, 5) Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits, 6) Align MCH funded programs that serve the adolescent population with the adolescent well-visit initiatives to improve access, quality, and increase availability of health services.

The Ohio Department of Medicaid provided a second year of data regarding the rates of adolescent well-visits. Between July 2015- June 2017, the percent of Ohio Medicaid eligible adolescents receiving a well-visit increased from 42.6% to 43.9%. In the previous year, it was noted that that rural counties had lower participation rates. The new report reflected twenty-eight counties increased visits by between 3-9%. The top five counties were all rural and had an increase of over six percent. The data also reflects adolescents between the ages of 12-14 had higher participation rates, girls had higher rates for the age group 15-17, and pediatricians were the provider/specialty type conducting the majority of the reported well-visits. ODH staff and members of the adolescent well-visit action group have utilized this data to plan outreach and education activities and the data will continue to be monitored for improvements.

Building upon the previously implemented strategies, the FY2017 activities and accomplishments include:

- Bi-monthly meetings of the Action Group were held to further develop the action plan and identify collaborative opportunities across the members to improve adolescent health.
- In October 2016, a stakeholder meeting was held to identify strengths and opportunities for increasing and improving well-visits by impacting the provider practices, reimbursement, educating parents and adolescents and aligning state-level resources.
- Contracted with the Ohio Chapter, American Academy of Pediatrics to increase medical practitioner knowledge of strategies to increase and improve adolescent well-visits in counties with lower rates of participation from Medicaid-eligible adolescents. The OH-AAP conducted two webinars in the Spring of 2017, each with over seventy-five participants from the targeted counties.
- The OH-AAP continued to implement their TALK program in select pediatric practices, which is a quality improvement process to increase well-visit participation through practice improvement strategies.
- Continued to participate in the United States Department of Health and Human Services, Region V Adolescent Health Learning Collaborative quarterly calls.
- The State Adolescent Health Resource Center selected Ohio to participate in a 6-part learning collaborative focusing on marketing strategies for health care improvement in adolescents and young adults. The series took place May–December 2016. ODH staff member Laura Rooney and Dr. Michele Dritz from the OAHP participated.

- Developed a request for proposal that will be funded in FY2018 for implementing quality improvement strategies in practices with high rates of Medicaid enrollees.

In the Fall of 2016 over fifty stakeholders representing state agencies, including Medicaid, medical providers and agencies, managed care plans, parents, schools, community agencies, and universities participated in a facilitated discussion to conduct a Strength, Weakness, Opportunities and Threats (SWOT) analysis on improving outcomes for adolescent well-visits. The SWOT was conducted for the following topics: increasing visits, reimbursement, clinical provisions, and confidentiality. Notes were captured by stakeholder type: community, state agency, insurance and clinicians. Items of interest include:

- Coding education that helps understand how it can improve reimbursement
- Increased frequency of adolescent well care visit (i.e. 2x per year) to improve comprehensiveness
- Increase education to families to understand Early Periodic Screening Diagnostic Treatment (EPSDT) system is zero co-pay and available for Medicaid and private insurance
- Leverage sports physicals and school-based healthcare
- Improve teen friendly environments and communication
- Increase health literacy and improve provider/patient communication

The SWOT discussion items will be incorporated into future strategies for improvement and collaboration.

During the Spring webinars seventy-seven practitioners received information on the utilization of Bright Futures, GAPS and SBIRT in well-visits. In addition, ODH and the OH-AAP presented well-visit learnings during a national webinar for the State Adolescent Health Resource Center. Feedback from practitioners highlights the need for utilizing electronic medical records to harness chart related data, increase clinic time and adjust scheduling for quality visits, and capitalize on medical education needs to incentivize practices to participate in system-based changes.

## Priority Measures

**NPM 10** Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year:

According to the 2016 National Survey of Children's Health (NSCH), 78.1% of Ohio adolescents received a preventive visit in the past year. Since the NSCH was revised in 2016, this data is not comparable to previous estimates and 2016 will serve as the baseline for which we measure our progress in increasing the number of adolescents who receive a preventive medical visit. Our goal is to increase the percent of adolescents receiving preventive care by 0.5% a year.

**ESM 10.1** Number of clinical providers in Ohio trained on Bright Futures clinical recommendations:

During FFY 17, 77 clinical providers were trained on Bright Futures.

## Adolescent Health - Application Year

### Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies Adolescent Health, Plan for FY 2019

#### Ohio Department of Health Priority:

Reduce barriers, improve access, and increase the availability of health services for all populations

The purpose of this work is to increase the number of adolescent well visits conducted per year with particular focus on Medicaid eligible youth. Initiatives will focus on increasing awareness to the benefit and purpose of visits, professional development for clinicians and practice staff to increase the quality of adolescent specific care, increase coordination and collaboration among adolescent health stakeholders, and improve outcomes through policy adoption.

In FY19, ODH, along with stakeholders, will continue examine policy and system-level improvement needs for long-term, sustainable change to increase and improve well-visits. Specific areas of focus include bundled payments, code clarification, leverage sports physicals by increasing use of “Bright Futures” recommendations, increase adolescent perspective/voice at the practice level, and increase awareness of comprehensive visit benefits to parents and agencies supporting youth.

#### Strategies and Activities:

- A. Partner with state agencies, Ohio Adolescent Health Partnership, Ohio Chapter of the American Academy of Pediatrics (AAP), Ohio Academy of Family Physicians, Federally Qualified Health Centers (FQHCs), and other stakeholders to develop statewide plan for improving adolescent well-care, focusing on Medicaid eligible youth.
  - a. Utilize provider and consumer survey results, best practices and research to draft a state plan for increasing well visit
    - o Years 1-5: Convene diverse stakeholder group to promote well care
    - o Years 3: Assess strategies, gain support from stakeholders
    - o Year 4: Disseminate the plan
- B. Increase provider utilization of evidenced-based, culturally competent, adolescent friendly preventive care
  - a. Provide training to providers on Bright Futures Clinical Recommendations and adolescent friendly clinic strategies that increase well visits and quality of care.
    - o Years 3-5: Promote and deliver professional development to at least 100 providers per year.
    - o Years 3-5: Evaluate transference of knowledge and change in practice
- C. Partner with stakeholders and adolescent medical practices to increase the proportion of adolescents with a documented well-visit exam
  - a. Through a quality improvement process, increase proportion of adolescents with a documented well-child exam among practices.
    - o Years 3: Release request for proposal to establish contract relationship with appropriate provider. Implement quality improvement process with at least 5 provider practices.
    - o Years 3-5: Provide technical assistance to contractor and practices, as needed.
    - o Years 3-5: Based upon lessons learned from QI implementation, disseminate strategies to adolescent providers.
    - o Years 3-5: Support practices in implementing strategies and assess reach.
- D. Utilize social media to promote adolescent well-care and targeted messages
  - a. Develop at least one media campaign and one set of educational materials for parents, caregivers,

and adolescents that promote the importance of adolescent well-visits and include targeted health messages.

- Years 4: Identify and develop initial message to increase visits and educate on difference of sports physical versus comprehensive visit.
- Years 4-5: Develop plan for subsequent messages and age ranges.

E. Develop documentation on solution to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits

- a. Increase policies and provider practice changes that strive to overcome barriers in conducting comprehensive visits, including financial compensation and increase allowable visits.
- Years 5: Track policy suggestions and adoption.
- Year 4: Engage stakeholders to identify specific policy to improve/adopt for increasing well-visits

F. Align MCH funded programs that serve the adolescent population with the adolescent well visit initiatives to improve access, quality, and increase availability of health services

- a. Align MCH funded programs that serve adolescent population with the adolescent well-visit initiative to improve access, quality, and increase availability of health services.
- Years 1-5: Partner with other Ohio Department of Health programs that support adolescent health.
- Years 4-5: Share information between programs for quality improvement.
- Years 4-5: Leverage resources through sister state agencies to increase well-visits.

## Children with Special Health Care Needs

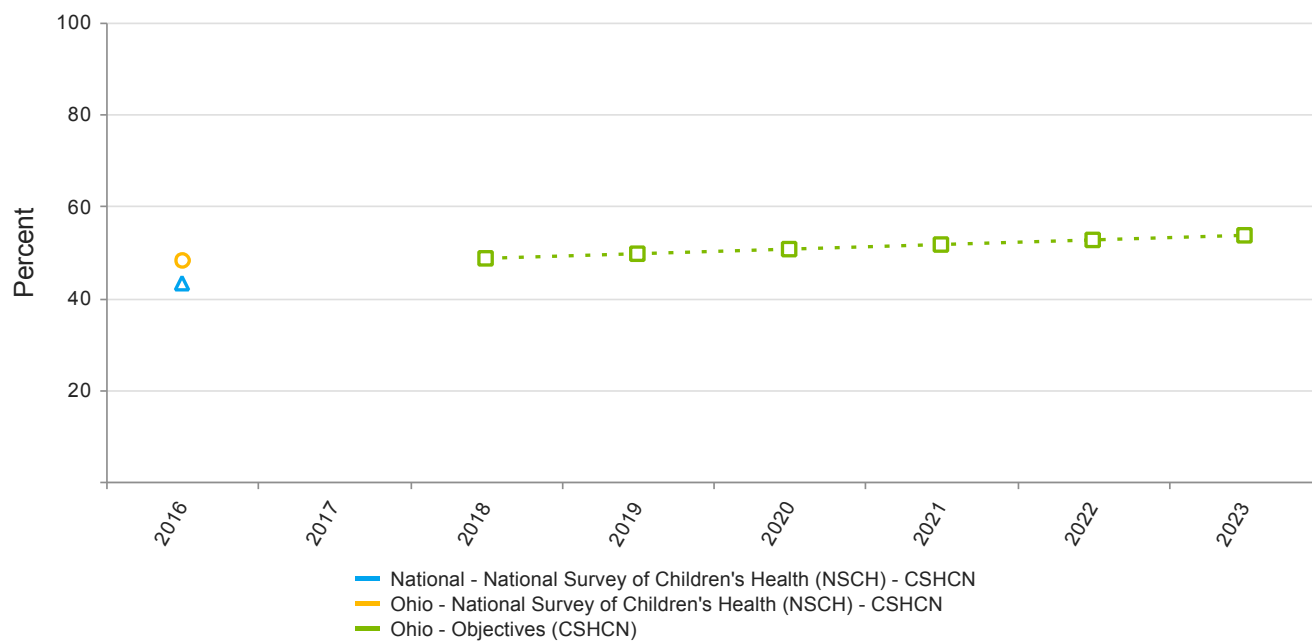
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	14.9 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	53.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.4 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	3.0 %	NPM 11

## National Performance Measures

### NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

#### Baseline Indicators and Annual Objectives



### NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		48.2
Numerator		288,652
Denominator		598,389
Data Source		NSCH-CSHCN
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	38	
Numerator		
Denominator		
Data Source	Ohio Medicaid Assessment Survey	
Data Source Year	2015	
Provisional or Final ?	Final	

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	48.6	49.6	50.6	51.6	52.6	53.6

## Evidence-Based or –Informed Strategy Measures

**ESM 11.1 - Number of new stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs (CYSHCN).**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	2.0	2.0	2.0	2.0	2.0



## State Action Plan Table

### State Action Plan Table (Ohio) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Increase access to care via PCMH for Children with Special Healthcare Needs

#### NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

#### Objectives

A. Increase education opportunities for the following stakeholders about the importance of getting CSHCN into medical homes: • Families of CSHCN (e.g., components of a medical home like care coordination that they deserve to have) • Specialists who can refer families to a PCMH • BCMH public health nurses who can educate families • School and Head Start nurses who can share the information with families • Health professional students (e.g., nursing, medical, physical therapy, community health worker, social workers, medical assistants)

#### Strategies

A1) Disseminate existing resources that can be used to educate stakeholders including: • Region 4 Genetics Collaborative – Partnering with your Doctor: The Medical Home Approach • Guiding People through Systems (GPS) • Hand in Hand Parenting module titled, Medical Home: What, Why and How to Connect using Listening with Connection A2) Develop informational piece, including FAQs, to make available, in electronic format, to stakeholder groups, and via ODH website for continuous public access. A3) Leverage existing partnerships to disseminate information referenced in #1 and 2 above, and to educate stakeholders on the PCMH model and benefits. A4) Continuous follow up with stakeholder groups to assess needs and progress.

#### ESMs

#### Status

ESM 11.1 - Number of new stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs (CYSHCN).

Active

## NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

## Children with Special Health Care Needs - Annual Report

### Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies

#### Children with Special Health Care Needs, FY 2017 Annual Report

##### Ohio Department of Health Priority:

Increase access to care via Patient Centered Medical Home (PCMH) for children with special healthcare needs (CSHCN)

There are existing initiatives in Ohio that focus on transforming primary care practices (e.g., family practice, general pediatrics, and general internal medicine). For example, three regional health improvement collaboratives and many health systems in Ohio have initiated practice transformation. The southeast Ohio and northern Kentucky region was selected as a region for the Centers for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care initiative, which facilitated the transformation of 64 primary care practice sites in southwest Ohio. CMMI then selected Ohio as a region for the Comprehensive Primary Care Plus initiative, which will involve more primary care practices throughout Ohio in transformation and payment reform efforts. In December 2014, Ohio received a State Innovation Model (SIM) testing grant to support project which test new payment and service delivery models for PCMHs and episode-based payments. The SIM focusses on expanding the PCMH model throughout Ohio aims to improve existing primary care in Ohio by incentivizing more primary care practices to become medical homes. Because there are existing initiatives aimed at transforming primary care practices, facilitating practice transformation is not focus of this MCH block grant workgroup. Rather, this MCH block grant workgroup is focusing on educating families of CSHCN about the importance and benefits of receiving patient centered, comprehensive, coordinated, accessible, and high-quality care in a medical home. This education will happen through working with and training key stakeholder groups to disseminate medical home resources to families of CSHCN.

Action Plan Strategy: Evaluate, select, modify (as necessary) and disseminate existing resources that can be used to educate stakeholders.

Year 2 Progress Summary: The workgroup previously identified eight resources (e.g. brochures, website) aimed at educating consumers about PCMH and the importance of medical homes. The group reviewed the resources and recognized the need for an informational piece which better addresses the unique concerns for families of CSHCN. After robust discussion regarding the most appropriate clinical setting for a PCMH providing care for CSHCN, the group determined there was need for broader input from families and clinicians. The workgroup engaged Ohio's Parent Advisory Committee for the Children with Medical Handicaps (CMH) Program as well as the representatives from the SIM project. Consensus from this stakeholder input was that, while a primary care practice is the traditional medical home setting, it may not always be the most appropriate setting for CSHCN. A common theme among the parents was that primary care physicians offer lack the specialize expertise needed to act as their child's PCMH. Examples given were: primary care physicians who are not equipped/willing to provide immunization services to children with hemophilia, families who utilize their specialist (i.e. a cystic fibrosis treatment center) as their primary care physician, challenges with locating/identifying a PCMH. While the PAC noted a number of challenges and concerns with a primary care physician serving as their child's PCMH, they were in agreement that the qualities of a PCMH are important for providers serving CSHCN. Further, they offered insights on how ODH could reach the CSHCN population to inform them about PCMHs and offered their support in disseminating such information.

In consideration of this feedback, the workgroup is in the final stages of developing an educational piece that includes a broader definition of PCMH which incorporates the option of a specialty clinic as a PCMH. This informational piece will be in electronic format such that it will be made available on websites for continuous access by the public. It will also be distributed to the more than 40,000 families currently enrolled in the CMH Program. New

families will receive PCMH materials as part of the enrollment process. The informational piece will also be distributed to a list of more than 100 key stakeholder groups which were identified by the workgroup. These stakeholder groups represent families of CSHCN, clinical and non-clinical providers, school personnel (including nurses, intervention specialists, social workers), condition-specific organizations (i.e. Ohio's Interagency Workgroup on Autism, Ohio Developmental Disabilities Council, Bleeding Disorder Council, Cystic Fibrosis Foundation, Epilepsy Foundation, etc.), state agencies, local health departments, and children's hospitals.

During FFY 2017, the workgroup met monthly and added relevant partners to the workgroup as they were identified. Participants from the Ohio Department of Health include staff from Health Access, School and Adolescent Health, Oral Health, and the Maternal, Child and Family Health, and Children with Medical Handicaps Programs. Other state government agency participants represent the Ohio Department of Medicaid, Ohio Department of Developmental Disabilities, and Ohio Department of Education. Several other partners and organizations are actively engaged in the workgroup, including the Ohio Colleges of Medicine Government Resource Center, Ohio Disability and Health Program, Ohio Chapter American Academy of Pediatrics, Akron Children's Hospital, CMH Parent Advisory Group, Ohio Family to Family, Ohio Center for Autism and Low Incidence, and Red Treehouse.

#### **Priority Measures:**

NPM 11: Percent of CSHCN needs having a medical home

- According to the NSCH, in 2017 48.2% of CSHCN (0-17 years) in Ohio had a medical home compared with 53.5% of non-CSHCN. This will serve as our new baseline to measure progress towards increasing percent of CSHCN having a medical home.

ESM: Number of stakeholder groups that share information about the importance of PCMH with families of CSHCN

- The workgroup learned, from further engagement with families of CSHCN, that the PCMH educational materials originally planned for dissemination did not address primary concerns for this, our primary stakeholder group for the priority. In order to provide education that is meaningful for families of CSHCN, and would best motivate them to seek a PCMH, the workgroup utilized the past year to engage with stakeholders and develop more appropriate materials. The workgroup developed a list of more than 100 groups, in addition to the 40,000 CMH client families who will receive the new informational piece.

#### **CSHCN and Managed Care Plans**

In January 2017, all Medicaid-covered CSHCN in Ohio were transitioned into coverage by managed care plans. In anticipation of this shift, the ODH CMH program assisted Medicaid in identifying and communicating with impacted families. During the year prior to the transition, a series of focus groups was held with CMH PAC members and the five managed care plans with the goal of continuity of care and services. In the months leading up to the transition, public forums were held throughout the state to provide information to families and providers. ODH and the managed care plans also participated in these forums. During the transition, ODH and ODM established a weekly meeting to review individual cases where families were experiencing challenges with coverages. This weekly conference continues today, with only a small number of complex cases requiring review, as many issues with managed care approvals have been remedied, and Medicaid policy clarified.

**Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies**

**Children with Special Health Care Needs, Plan for FY 2019**

**Ohio Department of Health Priority:**

Increase access to care via Patient Centered Medical Home (PCMH) for children with special health care needs (CSHCN).

The Ohio Department of Health (ODH) convenes a state-wide workgroup to address this priority. The workgroup is comprised of representatives from ODH, the Ohio Department of Medicaid, clinicians specializing in treatment of CSHCN, parents of CSHCN, hospitals, condition-specific advocacy groups, and members of the ODH CMH Parent Advisory Committee. In FY 2019, the workgroup will leverage partnerships with key stakeholder groups to educate families, specialists providing services to CSHCN, educators and other school personnel, and advocacy groups on the qualities and benefits of a PCMH. In addition to existing print materials (i.e. Hand in Hand Parenting module titled, Medical Home: What, Why and How to Connect using Listening with Connection), the workgroup will utilize an informational and FAQ piece, in electronic format, to inform stakeholders about the PCMH model. The ODH CMH Program that works directly with more than 40,000 families of CSHCN annually, including nurses providing service coordination at the local level, will utilize these materials to educate clients on the concept and benefits of a PCMH.

Members of the ODH PCMH workgroup, who identified the stakeholder list for this priority, will conduct follow up with those groups to assess needs and progress. Materials and stakeholder list will be updated as needed.

**Strategies:**

- Educate stakeholders about the concept of a PCMH and benefits of connecting CSHCN to a PCMH. Stakeholders include: families of CSHCN, specialists (who can refer families to a PCMH), CMH personnel and public health nurses, school personnel, and advocacy groups.
- Provide electronic informational piece via ODH website for continuous public access.

**Activities/Objectives:**

- Disseminate existing resources that can be used to educate stakeholders about the PCMH concept and the importance of connecting CSHCN to a PCMH.
- Develop an educational piece, including FAQs, regarding the PCMH concept and the importance of connecting CSHCN to a PCMH, in electronic format for dissemination to stakeholders.
- Leverage ODH PCMH workgroup members will perform on-going follow up with stakeholder groups to assess needs and progress.
- Update PCMH materials and stakeholder list as needed.

## **Cross-Cutting/Systems Building**

### **Cross-Cutting/Systems Building - Annual Report**

#### **Maternal and Child Health Services Title V Block Grant- State Action Plan and Strategies**

### **Cross-Cutting or Life Course, FY 2017 Annual Report**

#### **Overview of Other Programs**

##### Oral Health Program

Grants for School-based Dental Sealant Programs (SBSPs). - With Title V funds, the Ohio Department of Health (ODH) funded 17 dental sealant programs to provide dental sealants to students in 43 of Ohio's 88 counties. In FFY17, 24,958 children received sealants through school-based dental sealant programs, targeting schools with high participation in the Free and Reduced Meal Program. Tooth assessment training was conducted by ODH and Dr. Homa Amina, Director of the pediatric residency training program at Nationwide Children's Hospital, for 24 dental hygienists employed by ODH-funded sealant programs. The purpose of this annual training is to train hygienists to select teeth for sealant application following guidelines by the CDC Expert Panel on School-based Sealant Programs.

School-based Oral Health training was provided for 125 new school nurses on how to conduct an oral health screening in the school setting, along with an overview of the ODH Oral Health Program.

Safety Net Clinics - The Oral Health Program is a significant source of funding to safety net dental clinics, providing approximately \$725,000 (about one-third from Title V funds) to 13 operating more than 170 clinics in the state (operated primarily by FQHCs, local health departments, Community Action Agencies, hospitals, nonprofits and universities). Funds are awarded to help safety nets meet the costs of providing uncompensated care to those who are uninsured for dental care and who have low incomes ( $\leq 200\%$  of federal poverty guidelines). The program transitioned from grants to contracts to reimburse clinics for services rendered to this population in FFY16. In FFY17, there were 6,042 unduplicated patients who received care through the program. Funding amounts ranged from \$15,000 to \$125,000.

Statewide Oral Health Screening Survey of Preschool-Aged Children - During the 2016-17 schoolyear, the Oral Health Program completed a statewide oral health screening survey of preschool-aged children. Approximately 3,550 children ages 3-5 years were screened at 82 public preschool programs and Early Childhood Education Centers. Children were screened for untreated cavities, fillings or crowns, and extractions due to decay, and were assessed for how urgently they needed to see a dentist. Access to dental care was also measured via a questionnaire completed by parents.

School-based Fluoride Mouth Rinse Program - ODH follows the CDC recommendations in providing a targeted program in communities that are not served by fluoridated water systems. Students with parental consent rinse in the classroom once a week with a 0.2% solution of sodium fluoride, to help prevent tooth decay. In FFY17, 15,536 children in 84 schools participated in the Fluoride Mouth Rinse Program.

Dental OPTIONS/Case Management - ODH works in partnership with the Ohio Dental Association to assist Ohioans with special health care needs and/or financial barriers to obtain dental care through a network of 929 volunteer dentists. During FFY17, ODH was in the process of redesigning the program with limited case management duties being performed by ODH staff. The program is funded exclusively with state general revenue. In FFY17, nearly 600 people were helped through the program and dentists discounted or donated more than \$31,000 in dental care.

### Help Me Grow

Serving as lead agency, the Ohio Department of Health (ODH) facilitates one of the largest evidenced-based home visiting systems in the nation. ODH facilitates Help Me Grow, Central Intake, General Revenue Funded Fee for Service, the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), and the Moms & Babies First program.

Help Me Grow: Available in nearly every County in the state, Help Me Grow is Ohio's Evidenced-Based voluntary family support program for low income pregnant women or new parents. The program promotes healthy growth and development for babies and young children.

MIECHV: The federal home visiting program provides states, territories, and tribal entities with additional funding to expand evidenced-based services. Per statute, Ohio must give priority to families living in at-risk communities as identified by the statewide needs assessment.

Moms & Babies First: Utilizing a Community Health Worker (CHW) model, the program aims to prevent infant mortality by improving the health of low income African American mothers and babies. The program aims to reduce health disparities by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities.

During this fiscal period, ODH overhauled the state's home visiting system of services, creating a risk-based continuum of care designed to offer enhanced parent choice of a full spectrum of models and services. Ohio's evidenced-based service model will utilize the models Home Visiting Evidence of Effectiveness models: Healthy Families America, Nurse Family Partnership, and Parents as Teachers. Through the implementation of recognized models, every participant will receive:

- Family driven health & wellness assessment and screenings
- Research-informed parenting education curriculum
- Referral and linkage to needed medical and social supports
- Facilitated transition to an appropriate development-enhancing setting

The program measures the following components:

- |  |                                    |
|--|------------------------------------|
| • Parent-Child Interaction               | • Preterm Birth                    |
| • Early Language and Literacy Activities | • Low-Birth Weight                 |
| • Developmental Screening                | • Breastfeeding                    |
| • Completed Developmental Referrals      | • Depression Screening             |
| • Behavioral Concerns                    | • Completed Depression Referrals   |
| • Intimate Partner Violence Screening    | • Well-Child Visit                 |
| • Intimate Partner Violence Referrals    | • Postpartum Care                  |
| • Primary Caregiver Education            | • Substance Abuse/Tobacco Use      |
| • Continuity of Insurance Coverage       | • Substance Abuse/Tobacco Referral |
| • Inter-Pregnancy Interval               | • Safe Sleep                       |
|  | • Child Injury                     |
|  | • Child Maltreatment               |

This process began by collaborating with stakeholders to revise program rules and policy contained in Ohio Administrative Code 3701-8. These rule changes largely required providers of home visiting services to meet model fidelity standards, as well as expand eligibility by removing the first-time mother requirement. Additionally, the department enhanced relationships with the community and stakeholders by facilitating the first ever statewide home



visiting summit, as well as standing up the Ohio Home Visiting Consortium as the state's first every home visiting advisory body.

For this fiscal period, 11,997 families were served (7,959 = HMG, 2,173 = MIECHV, 1,865 = Moms & Babies First. 92% of families served were below 150% of the FPL; 539 days was the average length of stay for families enrolled prenatally; 57% had at least HS Diploma or GED at time of enrollment.

#### Ohio Women, Infants and Children (WIC)

WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. WIC helps income eligible pregnant and breastfeeding women, women who recently had a baby, infants, and children up to five years of age who are at health risk due to inadequate nutrition. The program improves pregnancy outcomes by providing or referring to support services necessary for full-term pregnancies; reduces infant mortality by reducing the incidence of low birth weight (infants under 5 ½ pounds are at greater risk of breathing problems, brain injuries and physical abnormalities), and provides infants and children with a healthy start in life by improving poor or inadequate diets. In federal fiscal year 2017, Ohio WIC served a monthly average of 221,746 participants, including 52,316 women, 71,531 infants, and 97,899 children. Of the women served, 22,681 were pregnant, 14,989 were breastfeeding, and 14,646 were postpartum.

Ohio WIC worked on several initiatives. These include *Mothers in Motion*, an education tool for mothers to help them learn how to deal with stressful situations; organize their lives; eat healthier; shopping wisely; and physical activity for themselves and their families as well as other topics. Local staff have been trained on the information and are developing methods for distributing the information to their participants.

Another initiative is partnering with the Ohio Chapter of the American Academy of Pediatrics (OAAP) to promote the *Parenting at Mealtime and Playtime*. WIC staff were trained on this program to provide continuity of care across the community so that participants are hearing the same message from providers. These trainings occurred regionally in the late winter and spring of 2017. The directors also received OAAP's *Every Baby Counts* materials to distribute to their pregnant participants during the fall WIC Directors meeting.

All WIC directors received information through the Ohio Center for Autism and Low Incidence (OCALI) on the Autism Spectrum. The OCALI representatives provided materials and referral sources as well as the opportunity for more in-depth trainings on their website.

There was no new legislation implemented associated with the Ohio WIC this past year.

WIC partnered with the 5A's program (Ask, Assess, Advise, Assist and Arrange) for the Perinatal Smoking Cessation Program. The odds of women quitting smoking during their pregnancy were higher after the WIC staff was trained on the 5A's.

In preparation for the potential outbreak of Zika, the Ohio Department of Health (ODH) developed a plan for the distribution of mosquito repellent to WIC clinics in areas where local Zika transmission has been identified. WIC clinics in affected areas provided enough repellent to give one 6 ounce bottle to each pregnant WIC participant in the affected area.

Ohio WIC promoted Birth Defects Prevention Awareness Month, National Nutrition Month, Breastfeeding Awareness Week and Month, Fetal Alcohol Spectrums Disorders Awareness Month, and National Literacy Month

Ohio WIC program followed the trend of the WIC programs across the country with average monthly participation



declining from 2016 to 2017 by 5.5 percent in Ohio compared to 5.3 percent nationally.

#### Ohio Healthy Homes and Lead Poisoning Prevention Program

There is no safe level of lead in the body. The primary source of lead exposure in children with elevated lead levels is deteriorated lead-based paint (dust). Other potential lead exposure sources include soil, water, and consumer products. The Ohio Department of Health (ODH) has administered a comprehensive statewide lead poisoning prevention program since 1991. The Ohio Lead Advisory Council (OLAC) provides the Director of Health with advice regarding the policies the childhood lead poisoning prevention program should emphasize, preferred methods of financing the program, and any other matter relevant to the program's operation. ODH's lead program provides guidelines on lead testing and medical management, educates healthcare providers, conducts surveillance and case management, conducts public health lead investigations (either directly or through local delegated boards of health), licenses the professional workforce, approves lead laboratories, and provides compliance assistance and monitoring. ODH receives funding for lead poisoning prevention from the U.S. Centers for Disease Control and Prevention, U.S. Department of Housing and Urban Development, U.S. Environmental Protection Agency, Ohio Development Services Agency, Ohio Housing Finance Agency and General Revenue Funds.

When a child under six years of age is identified with an elevated blood lead level (lead poisoning), ODH or its delegated authority conducts a public health lead investigation to determine the probable source of lead exposure. If an investigation identifies an existing lead hazard, a Lead Hazard Control Order is issued ordering the property owner to control the lead hazard. If a property owner refuses to control an identified lead hazard, an order to vacate the property is issued, declaring it unsafe for human occupation, especially for children younger than 6 years of age and pregnant women. The ODH Director of Health can delegate his authority to conduct public health lead investigations to local health jurisdictions in accordance with Ohio Revised Code 3472.34.

ODH continued working with ODH's delegated local health departments to strengthen efforts to investigate and close child lead poisoning cases and ensure that Ohio's children are not living in housing with known lead hazards. As part of this effort ODH updated the Public Health Lead Investigation Manual in the summer of 2017. The manual provides guidance and requirements for conducting investigations of children with elevated blood lead levels. A key update requires public health lead investigators to pursue additional avenues when attempting to locate a lead-poisoned child who has moved from a property subject to investigation. The updated guidance requires six unique contact attempts utilizing various government and medical resources to find accurate contact information for the child's parents or guardian. These resources include the child's primary healthcare provider who ordered the blood lead test, as well as any local Women Infant and Children's (WIC) program, Home Visiting program, Children with Medical Handicaps program, immunization program, dental clinics, and boards of education.

ODH continued its collaboration with the State Medical Board of Ohio to continue promoting an instructional video for physicians on "Ohio Child Lead Testing Requirements." Ohio law requires primary care providers to order a blood lead screening test for any child under six years old who is determined to be at risk of lead exposure based on their ZIP Code. The law also requires that a blood lead screening test be performed on all Medicaid-enrolled children at ages 1 and 2, and up to age 6 if a child is found not to have received a previous test. The video informs the medical profession on these requirements and provides recommendations on the medical management of child lead poisoning. The video is available at [https://www.youtube.com/watch?v=Qby\\_9Wh9Vcl&feature=youtu.be](https://www.youtube.com/watch?v=Qby_9Wh9Vcl&feature=youtu.be).

ODH collaborated with Ohio Department of Medicaid (ODM) to start a statewide lead abatement project. In December 2018, the Centers for Medicare & Medicaid Services approved a State Plan Amendment that permits Ohio to implement a health services initiative utilizing State Children's Health Insurance (SCHIP) funds to provide lead abatement services in the homes of low-income children and pregnant women. ODH and ODM will prioritize

services to property owners and families whose properties are subject to lead hazard control orders issued by ODH or one of its delegated boards of health. These prioritized properties have undergone a thorough lead investigation and lead risk assessment which has identified hazards contributing to an eligible child's elevated blood lead level of 10 micrograms/deciliter or higher.

**Maternal and Child Health Services Title V Block Grant – State Action Plan and Strategies**  
**Cross-cutting, Plan for FY 2019**

**Other Program Areas**

**Home Visiting and MIECHV**

Ohio's MIECHV program will continue the current expansion of high quality evidence- based home visiting services which target children and families who are most at-risk for poor birth or childhood outcomes. By way of the state's well-coordinated risk-based continuum of evidence-based home visiting programming, Ohio seeks to provide families with their choice of available programming. The state of Ohio has a long history of statewide early childhood collaboration to ensure that all children are born healthy and ready to succeed in school. With the introduction of MIECHV, and the state's most recent adoption of MIECHV operating protocols, the program has raised the level of care for Ohio's children and families. Listed as a key strategy in the state's health improvement plan to improve maternal and child health, Ohio will continue to leverage MIECHV formula funding to support twenty-one (21) Local Implementing Agencies (LIAs) who serve twenty-seven (27) at-risk communities identified by the statewide needs assessment. Ohio seeks to maintain a statewide capacity to 1,834 family slots through September 30, 2020.

Ohio Title V and MIECHV will jointly conduct a needs assessment in 2019 to provide a comprehensive assessment of the state's maternal and child health needs.

**Strategies and Activities:**

- Strengthen and improve statewide early childhood home visiting information, quality improvement, and evaluation systems.
  - Enhance Ohio's newly launched statewide Central Intake System to ensure children and families access appropriate available home visiting and identified support services available in their communities by October 1, 2019.
  - Incorporate CQI science principles and mechanisms to ensure the Central Intake System and Local Implementing Agencies assist in enhancing state/federally funded home visiting initiatives to support the health and well-being of participating infants, toddlers, and families.
- Strengthen the state infrastructure to support evidence-based home visiting programs through professional development and training.
  - Upgrade the capacity of the state's cross-system professional development infrastructure to build the skills of all professionals working with prenatal women and families with infants and toddlers by September 30, 2019.
- Maintain historic expansion high quality evidence-based home visiting services to at-risk communities.
  - Maintain the expansion of direct services so that at-risk families are participating in evidence-based home visiting as early in family development as possible by September 30, 2020.

Ohio will continue to require that all MIECHV LIA's implement either Healthy Families America (HFA) or Nurse Family Partnership (NFP) as the evidence-based model in the communities being served. The target populations, research and evidence of effectiveness of these two models best align with the three priority topics of Ohio's State Health Improvement Plan: 1. Mental Health and Addiction; 2. Chronic Disease; and 3. Maternal and Infant Health. These priorities were informed by the most recent State Health Assessment (SHA). Moreover, NFP and HFA's primary eligibility best aligns with current Ohio law effective July 1, 2018. Ohio Administrative Code 3701-8-02 requires that no less than 85% of an LIA's capacity be enrolled prenatally or within the first six months of life. Regarding MIECHV

funded LIAs, the expectation is that model fidelity is adhered to with NFP serving prenatally, and HFA enrolling no later than the first three months of life. Ohio Administrative Code 3701-8-05 requires all Ohio LIAs, regardless of funding, to implement an evidence based model to fidelity. ODH will monitor this by ensuring every state and MIECHV funded entity receives a site visit within this funding period. Site visits shall monitor and ensure that each LIA develops and implements policies that address enrollment, avoidance of dual enrollment, disengagement and re-enrollment of families that meet the expectations of the model being implemented. Ohio will not be implementing any promising approaches under this grant.

As part of any home visiting service, ODH seeks to empower the caregiver to make informed choices about their care, as well support them in navigating the complex health and social services available to them. As such, it has been prescribed into Ohio Administrative Code 3701-8-08 Rights and Privacy Practices, as well as 3701-8-10 Central Intake and Referral. Both Administrative Codes require that parents be informed of all available home visiting services in their area, and makes explicit that services are voluntary in nature.

Informed by the 2010 needs assessment, Ohio will continue to use MIECHV funds to maintain expansion of direct services in the twenty-seven (27) current MIECHV communities. Proposing no change in evidence-based models, ODH will continue to implement NFP and HFA to fidelity with a goal of improving maternal and newborn health; prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency room visits; improvement in school readiness and achievement; reduction in domestic violence; improvement in family economic self-sufficiency; and improvements in the coordination of and referrals for necessary community-based supports. Using available ODH Health Index data, Nielson data, WIC Ohio vital statistics data, and available Ohio Medicaid data, outreach and engagement shall be directed to the identified target populations with a goal of engagement and enrollment. As an example, ODH and the Ohio Department of Medicaid are in the process of entering into an agreement for all Electronic Pregnancy Risk Assessment Forms (EPRAF) to be sent to ODH's central intake and referral system to make contact with parents who have been identified as a high-risk pregnancy.

To establish appropriate linkage and supports to families that are enrolled in Ohio's home visiting system, ODH has created a central intake risk screen, as required by Ohio law (Ohio Revised Code 3701.611). ODH worked collaboratively with the Ohio Department of Medicaid, Department of Jobs and Family Services, and the ODH Office of Health Equity to develop the screen with weighted risk factors. While each parent will be presented all available options, to include Early Head Start where available, Central Intake staff will begin each discussion with the model that best meets the parents identified need. Additionally, LIAs will receive a copy of the risk screen via the data system, identifying additional community supports that are required (e.g. health insurance, housing, food assistance, progesterone, etc.). This process is continued by way of the new Ohio home visiting comprehensive assessment. Effective July 1, 2018, this process-document provides a wide-ranging snap shot of the family's challenges, needs, and the strengths they possess to help accomplish their goals. Assessing for items that range from food deserts to oral health, the required comprehensive assessment shall serve as a key indicator for necessary referrals and linkage.

### **Women, Infants and Children (WIC)**

Ohio's WIC program will implement the following strategies as part of their federal application for FY 2018 and beyond.

#### **Electronic Benefits Transfer (EBT) Goal**

Ohio implemented EBT statewide in FY2015. Ohio will continue to monitor and enhance EBT functions and processes for retailers, clinics and participants as required. Ohio will continue to provide technical assistance and

support to retailers converting their systems from v2 to v4, and will provide technical assistance and support to retailers converting from stand beside systems to integrated systems.

#### Split Tender Implementation Goal

To ensure compliance with 7 CFR 246.12(f)(4) and the USDA December 23, 2016 WIC Policy Memorandum #2017-2 "State Agency Compliance with Split Tender Implementation Requirements" the Ohio WIC program continues to provide technical assistance and support to retailers in the development and implementation of Split Tender and Benefit reversal functionality. Monthly reports are submitted to the Midwest Regional Office, showing the split tender status of Ohio vendors. If a vendor is not in compliance with the split tender requirement after October 1, 2017 Ohio will follow its policy contained in Appendix A of this State Plan.

#### Nutrition Risk Criteria Goal

Ohio converted all two-digit risk codes to the federally-required three-digit risk codes and implemented statewide. Ohio will continue to monitor revised risk code use and provide technical assistance to local projects, as needed. Additionally, Ohio continues to review and revise food packages with the intent to add yogurt and whole grain pastas as options; this revision will be done in collaboration with the finalization of the new WIC Certification System.

#### Certification System Goal

Ohio will finalize the rewrite and implementation of a new WIC Certification System. The new WIC Certification System will include new functionality (e.g., improve appointment scheduling capability). Additionally, the new system will allow for more robust data collection (e.g., ability to capture comprehensive breastfeeding data, to improve the accuracy and quality of the health, nutrition, and demographic data collected in our system).

#### Caseload Retention and Participation Increase Goal

Ohio will develop a comprehensive outreach and retention plan to organize and implement strategies that maximize opportunities to serve WIC-eligible women, infants, and children. The plan will include the creation of goals with corresponding action steps, as well an Ohio WIC logo and message to be included in all marketing materials (e.g., posters, print ads, referral cards, etc.) WIC participation and child retention will be used as measurements of the plan's success.

#### Nutrition Education Goal

Ohio implemented Mothers In Motion participant lifestyle behavior changes for healthy living. Regional Train the Trainers sessions for local agency planning were held during Spring 2017 with focuses on developing strategic plans and implementation. Additionally, a Motivate to Communicate workshop will be developed and presented to all local agency staff to assist in improving interviewing skills. Health Professional will determine who is appropriate to participate and incorporate the information into their mid-certification education. Projects will track the number of women provided the education and assess its effectiveness through survey results.

#### Breastfeeding Promotion and Support Goal

Ohio will work to decrease the percentage of fully formula-fed infants from 87% to 75%. This will be achieved through emphasizing the support person's role when providing breastfeeding education and outreach; the development and creation of breastfeeding materials specific to Dads and other support people; the revision of Ohio WIC infant food packages to coincide with USDA food packages; the completion and the rollout of the Breastfeeding Database; and, collaborating with outside agencies to identify partnership opportunities with area hospitals and healthcare providers. Evaluation will be conducted through the analysis of the USDA WIC Breastfeeding Local Agency Data report.

### **Oral Health**

ODH Oral Health program area is examining current strategies for efficiency and maximum reach within the current budget. To prioritize resources without compromising oral health of vulnerable populations, ODH will convene oral health experts and stakeholders to discuss the status of oral health services in the state, identify gaps and explore ways to provide quality programming under ODH purview in the most cost efficient and effective manner. Outcomes of the discussion will be used to inform the planning of oral health strategies within ODH for FY19 and beyond.

### III.F. Public Input

#### Title V Maternal and Child Health Block Grant Public Comment Feedback

Survey Data Collected June 4, 2018 – July 4, 2018

The Ohio Department of Health (ODH), Bureau of Maternal, Child and Family Health made the FFY19 Maternal and Child Health (MCH) Block Grant (BG) Priorities, Strategies, Activities, and Indicators available for public input by placing an announcement on its webpage, social media and twitter pages and sending email notifications to stakeholders, consumers and interested parties. A survey was created via Survey Monkey, allowing the public to provide feedback and input or simply comment on the content of Ohio's MCH BG Action Plan during a 30-day comment period.

Ohio's Title V Program uses an Action Group structure to manage its MCH Priorities. Each Priority Action Group is made up of two co-leads, an epidemiologist, and a program researcher who are charged with leading a group of diverse stakeholders to implement interventions for each priority. The Action Groups will remain engaged over the 5-year block grant cycle and have responsibility for overseeing a specific MCH population domain. The public comment feedback is given to each Action Group for consideration as they work on their interventions. ODH will post the results of the survey to its website and update stakeholders periodically.

Notification of the public comment survey was sent to ODH Advisory Committees and other stakeholders, e.g., Ohio Collaborative to Prevent Infant Mortality (OCPIM), local health departments, advocacy organizations, professional associations and consumer groups as a way of including them in the Maternal and Child Health Block Grant process. Preliminary results from the survey are outlined below.

#### Survey Overview

One hundred and eighty-four individuals submitted feedback on the MCH BG Priorities. Of those 184 responses, **25%** represented local health departments; **35%** represented parents, consumers, and parents of children with special health care needs; **11%** from community-based organizations, **31%** (up from 16% last year) were health care providers, and **8%** were from professional organizations (respondents could select multiple categories, so the total exceeds 100%). Other responders represented the following organizations: WIC programs; the state health department; school nurse programs; coroner's offices; business community; universities; FQHCs; Medicaid Managed Care Plans; advocacy groups; hospitals and other professional organizations. Statewide responders were represented geographically by the following: **33%** were located in metropolitan areas; **31%** were in rural locations; **24%** were from suburban areas and **12%** were from Appalachia.

Overall responder feedback indicates that **97%** of those completing the survey felt Ohio's 9 MCH priorities reflect the needs of their community. Organizations reported using MCH data in the following ways: **68%** for planning, **61%** for evaluation, **64%** for increasing public awareness, and **49%** for justification for funding requests. For each of the 9 priorities, over **95%** of responders felt that they understood the strategies and that the activities or objectives listed were applicable and would be useful in meeting the needs of MCH populations in Ohio.

Issues identified as not being reflected in the 9 priorities include; social determinants of health (housing, nutrition/food access, education, jobs, transportation, racism); addiction/substance abuse; violence/safety; access to women's health and contraceptive services; and mental health. Other needs were identified that are specific to an MCH population domain have been shared with the appropriate Action Group.





### **III.G. Technical Assistance**

#### **Technical Assistance**

The Title V Program within the Ohio Department of Health (ODH) is currently exploring options for technical assistance regarding evaluation needs. ODH currently contracts with external vendors to provide evaluation services. While this service is valuable, there are existing, over-arching needs that would benefit and strengthen the planning and implementation processes across all Title V programs and services. The additional training and technical assistance will strengthen domain managers ability to design strong planning processes and justifying conclusions through analysis, interpretation and developing recommendations. This will not only strengthen staff capacity but also leverage contracted services. ODH will be contacting the University of North Carolina at Chapel Hill, Department of Maternal and Child Health, Gillings School of Global Public Health for consultation of services regarding these needs.

The BMCFH is looking forward to the networking opportunities that will be generated through the new Region V MCH Block Grant Coordinator discussions. Dialogue regarding the management of the block grant components, supporting domain-specific program managers, data collection, budget alignment and strategic planning for the upcoming needs assessment will be beneficial.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Fully Executed A1819 ODH Master.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [BMCFH - Table of Organization 1st Tier - 6-4-18.pdf](#)

Supporting Document #02 - [2016-Ohio-Infant-Mortality-Report-FINAL.pdf](#)

Supporting Document #03 - [Quarterly-Infant-Mortality-Scorecard-for-Ohio-July-2018.pdf](#)

Supporting Document #04 - [Ohio-Regional-Scorecards-and-Definitions-Infant Mortality.pdf](#)

Supporting Document #05 - [Medicaid-Scorecards-by-Race-Ethnicity-or-Plan-Infant Mortality.pdf](#)

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [ODH Organizational Chart.pdf](#)

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

State: Ohio

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 21,289,200	
A. Preventive and Primary Care for Children	\$ 6,896,193	(32.3%)
B. Children with Special Health Care Needs	\$ 7,240,033	(34%)
C. Title V Administrative Costs	\$ 902,734	(4.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 15,038,960	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 57,518,051	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 57,518,051	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 23,812,983		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 78,807,251	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 171,656,028	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 250,463,279	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	\$ 700,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 7,492,473
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	\$ 10,857,686
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	\$ 430,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 222,491
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 6,517,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 137,239,180
Department of Justice > Office of Violence Against Women > Rural Domestic Violence, Dating Violence, Sexual Assault and Stalking Assistance Program	\$ 513,875
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 650,909
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	\$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 406,472
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,663,748
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 1,176,501

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,321,214
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > FLEX	\$ 650,909
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SMALL RURAL HOSP IMP PRGM	\$ 213,570



	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 22,103,900		\$ 20,956,572	
A. Preventive and Primary Care for Children	\$ 10,251,047	(46.4%)	\$ 9,631,750	(45.9%)
B. Children with Special Health Care Needs	\$ 8,095,167	(36.6%)	\$ 7,415,446	(35.3%)
C. Title V Administrative Costs	\$ 208,226	(.9%)	\$ 346,948	(1.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 18,554,440		\$ 17,394,144	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 30,537,961		\$ 50,653,681	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 43,143,110		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 73,681,071		\$ 50,653,681	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 23,812,983				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 95,784,971		\$ 71,610,253	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 177,844,914		\$ 214,292,432	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 273,629,885		\$ 285,902,685	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	\$ 180,000	\$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,891,894	\$ 1,714,618
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	\$ 65,000	\$ 70,292
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 16,009,896	\$ 3,963,553
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 151,472	\$ 105,899
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 171,598	\$ 104,104
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	\$ 613,750	\$ 325,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 222,491	\$ 223,395
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 88,957
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 127,747
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 4,422,000	\$ 4,846,451
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 147,643,914	\$ 192,765,594
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	\$ 3,231,610	\$ 0

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,663,748	\$ 3,152,256
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement for Zika		\$ 546,832
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Black Lung		\$ 434,488
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants		\$ 3,675,968
US Department of Education > Office of Early Learning (OEL) > Race to the Top - Early Learning Challenge		\$ 365,813
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)		\$ 29,247
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)		\$ 521,721
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)		\$ 326,083
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Program	\$ 232,167	\$ 163,060
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Hospital FLEX		\$ 710,657
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comp System		\$ 29,897

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> This difference of \$619,297 is due to ODH shifting payment structure to a deliverable-based model. Time was needed for sub-grantees to adjust to the new payment structure.	
2.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> In FY17, the Office of Health and Improvement and Wellness and the Bureau of Maternal and Child Health administrative staff were in the process of re-organization and the budget for FY17 was delayed during the re-organization process of the two areas.	
3.	<b>Field Name:</b>	<b>3. STATE MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> The state expenditures for FY17 totaled \$50,653,681 which is \$23,027,390 less than FY17 budget of \$73,681,071 because the FY17 budget included state funds that were used to meet Maintenance of Effort for Home Visiting program. Therefore, these expenditures related to Home Visiting were not included in the state expenditures for FY17. Historically, ODH has categorized state funds that were not used as match to the Title V in "Other Funds" and these funds are authorized by the Ohio Budget Bill. The expenditures related to Other Funds for FY17 is now included in the State MCH Fund expenditure for FY17.	
4.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Historically, ODH has categorized state funds that were not used as match to the Title V in "Other Funds" and these funds are authorized by the Ohio Budget Bill. The expenditures related to Other Funds for FY17 is now included in the State MCH Fund expenditure for FY17.	

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Ohio**

**I. TYPES OF INDIVIDUALS SERVED**

<b>IA. Federal MCH Block Grant</b>	<b>FY19 Application Budgeted</b>	<b>FY17 Annual Report Expended</b>
1. Pregnant Women	\$ 2,970,739	\$ 2,956,815
2. Infants < 1 year	\$ 3,091,994	\$ 605,613
3. Children 1 through 21 Years	\$ 6,896,193	\$ 9,631,750
4. CSHCN	\$ 7,240,033	\$ 7,415,446
5. All Others	\$ 187,507	\$ 0
Federal Total of Individuals Served	\$ 20,386,466	\$ 20,609,624

<b>IB. Non-Federal MCH Block Grant</b>	<b>FY19 Application Budgeted</b>	<b>FY17 Annual Report Expended</b>
1. Pregnant Women	\$ 3,281,085	\$ 7,072,802
2. Infants < 1 year	\$ 3,415,007	\$ 1,414,560
3. Children 1 through 21 Years	\$ 27,589,528	\$ 15,088,645
4. CSHCN	\$ 23,025,336	\$ 27,077,673
5. All Others	\$ 207,096	\$ 0
Non-Federal Total of Individuals Served	\$ 57,518,052	\$ 50,653,680
Federal State MCH Block Grant Partnership Total	\$ 77,904,518	\$ 71,263,304

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Ohio**

**II. TYPES OF SERVICES**

<b>IIA. Federal MCH Block Grant</b>	<b>FY19 Application Budgeted</b>	<b>FY17 Annual Report Expended</b>
1. Direct Services	\$ 4,935,424	\$ 3,823,323
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 3,760,940	\$ 2,361,414
B. Preventive and Primary Care Services for Children	\$ 674,484	\$ 854,036
C. Services for CSHCN	\$ 500,000	\$ 607,873
2. Enabling Services	\$ 7,237,557	\$ 7,720,806
3. Public Health Services and Systems	\$ 9,116,219	\$ 9,412,443
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 2,422,203
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 310,015
Dental Care (Does Not Include Orthodontic Services)		\$ 854,036
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Public Health Nurse Svcs., Nutrition Therapy/Dieti		\$ 237,069
Direct Services Line 4 Expended Total		\$ 3,823,323
<b>Federal Total</b>	<b>\$ 21,289,200</b>	<b>\$ 20,956,572</b>

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 36,609,600	\$ 30,220,210
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 2,294,830	\$ 1,174,233
B. Preventive and Primary Care Services for Children	\$ 2,294,830	\$ 3,174,777
C. Services for CSHCN	\$ 32,019,940	\$ 25,871,200
2. Enabling Services	\$ 2,804,792	\$ 3,864,201
3. Public Health Services and Systems	\$ 18,103,659	\$ 17,154,426
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 11,950,888
Physician/Office Services		\$ 1,748,911
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 6,995,641
Dental Care (Does Not Include Orthodontic Services)		\$ 582,970
Durable Medical Equipment and Supplies		\$ 3,206,336
Laboratory Services		\$ 0
Other		
Public Health Nurse Svcs., Nutrition Therapy/Dieti		\$ 5,735,464
Direct Services Line 4 Expended Total		\$ 30,220,210
<b>Non-Federal Total</b>	<b>\$ 57,518,051</b>	<b>\$ 51,238,837</b>



**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Ohio**

Total Births by Occurrence: 137,522

Data Source Year: 2017

**1. Core RUSP Conditions**

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	137,522 (100.0%)	2,875	251	251 (100.0%)

Program Name(s)				
3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Cystic fibrosis
Glutaric acidemia type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase synthase deficiency	Homocystinuria	Isovaleric acidemia
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)	Methylmalonic acidemia (methylmalonyl-CoA mutase)
Primary congenital hypothyroidism	Propionic acidemia	S, $\beta$ eta-Thalassemia	S,C disease	S,S disease (Sickle cell anemia)
Severe combined immunodeficiencies	$\beta$ -Ketothiolase deficiency	Trifunctional protein deficiency	Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency

## 2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Critical Congenital Heart Disease	122,695 (89.2%)	54	3	0 (0.0%)
Hearing Loss	135,504 (98.5%)	3,857	202	202 (100.0%)
Methylmalonic acidemia with homocystinuria	137,522 (100.0%)	44	0	0 (0%)
Isobutyrylglycinuria	137,522 (100.0%)	70	0	0 (0%)
2-Methylbutyrylglycinuria	137,522 (100.0%)	70	0	0 (0%)
3-Methylglutaconic aciduria	137,522 (100.0%)	18	1	1 (100.0%)
Krabbe Disease	137,522 (100.0%)	51	3	3 (100.0%)

## 3. Screening Programs for Older Children & Women

None

## 4. Long-Term Follow-Up

The Ohio Department of Health Genetic Services Program collects information on patients with disorders on Ohio's newborn bloodspot screening panel, that are managed by geneticists. This excludes endocrine disorders, hemoglobin disorders, CF, SCID, hearing loss, CCHD, etc. ODH-funded genetic centers report data on all patient visits, services received at those visits, basic information on whether the patient is compliant with the treatment plan, and whether patients under age 18 years have achieved developmental milestones for their age and disease state.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Total Births by Occurrence</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Total Births by Occurrence Notes</b>
	<b>Field Note:</b> The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.	
2.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b> The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.	
3.	<b>Field Name:</b>	<b>Critical Congenital Heart Disease - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b> Per Ohio Revised Code 3705.5010, ODH ensures newborns are screened for CCHD, but does not have a reporting requirement for confirmed cases or referrals for treatment. Additionally, the legislation allows for exemptions from CCHD screening including parent objection, discharge home on oxygen, transfer to another hospital before screening could be done; known prenatal diagnosis, etc.	
4.	<b>Field Name:</b>	<b>Critical Congenital Heart Disease - Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b> Per Ohio Revised Code 3705.5010, ODH ensures newborns are screened for CCHD, but does not have a reporting requirement for confirmed cases or referrals for treatment. Additionally, the legislation allows for exemptions from CCHD screening including parent objection, discharge home on oxygen, transfer to another hospital before screening could be done; known prenatal diagnosis, etc.	
5.	<b>Field Name:</b>	<b>Hearing Loss - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>

	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Newborn hearing screening data is from 2016.
6.	<b>Field Name:</b>	<b>Methylmalonic acidemia with homocystinuria - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	The actual number screened is 138,226. The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.
7.	<b>Field Name:</b>	<b>Isobutyrylglycinuria - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	The actual number screened is 138,226. The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.
8.	<b>Field Name:</b>	<b>2-Methylbutyrylglycinuria - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	The actual number screened is 138,226. The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.
9.	<b>Field Name:</b>	<b>3-Methylglutaconic aciduria - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	The actual number screened is 138,226. The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.
10.	<b>Field Name:</b>	<b>Krabbe Disease - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2017</b>

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<b>Column Name:</b>	<b>Other Newborn</b>
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**Field Note:**

The actual number screened is 138,226. The screening numbers do not take into account state of birth or residence of infant. Therefore, it may include infants not counted in the occurrence births (i.e. infants who were born out of state). Additionally, home births are not always included in the birth data from Vital Statistics.

**Data Alerts: None**

**Form 5a**  
**Count of Individuals Served by Title V**

**State: Ohio**

**Annual Report Year 2017**

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,672	53.9	0.0	6.5	39.6	0.0
2. Infants < 1 Year of Age	3,148	44.4	0.0	45.4	10.2	0.0
3. Children 1 through 21 Years of Age	80,811	56.5	0.0	24.4	4.4	14.7
3a. Children with Special Health Care Needs	41,264	57.0	0.0	43.0	0.0	0.0
4. Others	27,763	38.6	0.0	16.6	44.8	0.0
Total	115,394					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Calendar Year 2016. Women receiving services from the Ohio Infant Mortality Reduction Initiative (OIMRI) and the Reproductive Health and Wellness Program.
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Calendar Year 2016. Infants in Ohio Infant Mortality Reduction Initiative (OIMRI) and infants receiving follow-up services through the Infant Hearing Program.
3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Calendar Year 2016. Children/youth in Reproductive Health and Wellness (RHWP) Program, children receiving dental sealants and children receiving case management through the Lead Poisoning Prevention Program. There will be some unavoidable overlap of clients served in these programs because each provides different services.
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Number of children receiving services form Children with Medical Handicaps
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Men and women 22+ years old in Reproductive Health and Wellness (RHWP) program and those receiving services through the dental safety net program.

**Data Alerts: None**



**Form 5b**  
**Total Percentage of Populations Served by Title V**  
**State: Ohio**

**Annual Report Year 2017**

Populations Served by Title V	Total % Served
1. Pregnant Women	99
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	65
3a. Children with Special Health Care Needs	72
4. Others	3

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Mothers who receive safe sleep education message at the hospital. Numerator = 135,230 (Occurrence births that took place in the hospital, 2017). Denominator = 136,897 (Resident live births, 2017)
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Newborn screening. Numerator = 137,522 (occurrence births, 2017) Denominator = 137,522 (occurrence births, 2017)
3.	<b>Field Name:</b>	<b>Children 1 Through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Includes school-aged children (including CSHCN) screened for hearing and vision and supported through school nurse services in public, private and charter schools (2017-18 school enrollment numbers from ODE), pre-school aged children screened for lead (CY 2017), and females aged 18 through 21 who reside in counties targeted for smoking cessation saturation messages (census data). Numerator = 2,709,205 Denominator = 3,081,578
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Includes school-aged children (including CSHCN) screened for hearing and vision and supported through school nurse services in public, private and charter schools (2017-18 school enrollment numbers from ODE), pre-school aged children screened for lead (CY 2017), and females aged 18 through 21 who reside in counties targeted for smoking cessation saturation messages (census data). Numerator = 2,709,205 Denominator = 3,081,578
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	Includes number of family members of newborns receiving safe sleep education at time of delivery (1/2 hospital occurrence births), breastfeeding and post-partum women in WIC, women aged 22-44 who reside in counties targeted for tobacco cessation saturation messages and those receiving education through the genetics program. Numerator = 280,385 Denominator = 8,394,899

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

State: Ohio

Annual Report Year 2017

**I. Unduplicated Count by Race/Ethnicity**

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	137,522	98,962	22,330	7,501	114	4,414	60	3,404	737
Title V Served	137,522	98,962	22,330	7,501	114	4,414	60	3,404	737
Eligible for Title XIX	56,729	32,235	16,621	4,003	68	1,274	16	2,112	400
2. Total Infants in State	136,897	95,694	22,188	7,473	113	4,337	60	3,354	3,678
Title V Served	133,893	95,694	22,188	7,426	113	4,337	60	3,354	721
Eligible for Title XIX	57,170	31,641	16,553	4,000	67	1,268	16	2,101	1,524

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

State: Ohio

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 755-4769	(800) 755-4769
2. State MCH Toll-Free "Hotline" Name	Maternal, Child and Family Health Line	Maternal, Child and Family Health
3. Name of Contact Person for State MCH "Hotline"	Jye Brecknridge	Jye Brecknridge
4. Contact Person's Telephone Number	(614) 644-9243	(614) 644-9243
5. Number of Calls Received on the State MCH "Hotline"		21,943

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	<a href="http://www.odh.ohio.gov/odh_programs/cfhs">http://www.odh.ohio.gov/odh_programs/cfhs</a>	<a href="https://www.odh.ohio.gov/odh_programs/cfhs/cf_hlth/cfhs1.aspx">https://www.odh.ohio.gov/odh_programs/cfhs/cf_hlth/cfhs1.aspx</a>
4. Number of Hits to the State Title V Program Website		71,106
5. State Title V Social Media Websites	<a href="https://www.facebook.com/OHdeptofhealth">https://www.facebook.com/OHdeptofhealth</a>	<a href="https://www.facebook.com/OHdeptofhealth">www.facebook.com/OHdeptofhealth</a>
6. Number of Hits to the State Title V Program Social Media Websites		3,084,183

**Form Notes for Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Ohio**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Sandra Oxley
Title	Title V MCH Director
Address 1	Ohio Department of Health
Address 2	246 N High Street
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 728-6861
Extension	
Email	sandra.oxley@odh.ohio.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Shancie Jenkins
Title	Title V CSHCN Director
Address 1	Ohio Department of Health
Address 2	246 N High Street
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 644-7848
Extension	
Email	shancie.jenkins@odh.ohio.gov

### 3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	



**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: Ohio**

**Application Year 2019**

No.	Priority Need
1.	Reduce the rate of Infant Mortality and disparities statewide
2.	Increase the prevalence of children receiving integrated physical, behavioral, mental and developmental health services
3.	Increase the prevalence of women receiving preconception care
4.	Reduce barriers, improve access, and increase the availability of health services for all populations
5.	Increase access to care via PCMH for Children with Special Healthcare Needs
6.	Reduce the rate of maternal smoking and substance abuse by pregnant women.
7.	Reduce the rate of childhood obesity
8.	Increase comprehensive newborn screens: Improve Ohio's newborn screening system
9.	Increase Access to Early Infant Care and Wellness

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce the rate of Infant Mortality and disparities statewide	New	
2.	Increase the prevalence of children receiving integrated physical, behavioral and mental health services	New	
3.	Increase the prevalence of women receiving preconception care	New	
4.	Increase the rate of early detection and treatment of physical and mental health issues in youth	New	
5.	Increase access to care via PCMH for children with Special Healthcare Needs	New	
6.	Reduce the Rate of Maternal Smoking by Pregnant Women	New	
7.	Reduce the rate of childhood obesity	New	
8.	Increase Newborns Screened for Metabolic/Bloodspot Disorders, Hearing Impairment and Critical Congenital Heart Disease Who Receive Diagnostic Evaluation and Follow-Up for Those With Confirmed Disorder	New	
9.	Increase Access to Early Infant Care and Wellness	New	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

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**Field Name:**

Priority Need 2

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**Field Note:**

Ohio revised the priority to include "developmental" services.

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**Field Name:**

Priority Need 6

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**Field Note:**

In collaboration with our sister agency Ohio Department of Mental Health and Addiction Services, ODH is targeting substance abuse in pregnant women and has added "substance abuse" to the priority.

**Form 10a**  
**National Outcome Measures (NOMs)**

State: Ohio

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	75.4 %	0.1 %	102,674	136,189
2015	75.3 %	0.1 %	102,946	136,696
2014	74.4 %	0.1 %	101,765	136,840
2013	71.7 %	0.1 %	94,841	132,198
2012	72.8 %	0.1 %	94,837	130,334
2011	73.6 %	0.1 %	95,495	129,804
2010	73.4 %	0.1 %	94,320	128,486
2009	71.6 %	0.1 %	95,382	133,244

**Legends:**

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution


**NOM 1 - Notes:**

None

**Data Alerts: None**

**NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations****Data Source: HCUP - State Inpatient Databases (SID)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	118.3	3.5	1,193	100,841
2014	118.2	3.0	1,585	134,045
2013	111.3	2.9	1,480	132,984
2012	114.9	3.0	1,536	133,653
2011	110.3	2.9	1,457	132,099
2010	111.8	2.9	1,497	133,944
2009	111.3	2.8	1,557	139,854
2008	100.4	2.7	1,393	138,741

**Legends:** Indicator has a numerator ≤10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 2 - Notes:**

None


**Data Alerts: None**

**NOM 3 - Maternal mortality rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

## Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	19.2	1.7	133	694,235
2011_2015	20.3	1.7	141	694,068
2010_2014	20.9	1.7	145	693,932
2009_2013	25.3	1.9	177	699,306
2008_2012	24.1	1.8	171	709,191
2007_2011	22.5	1.8	162	721,587


**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.7 %	0.1 %	11,981	137,927
2015	8.5 %	0.1 %	11,807	139,089
2014	8.5 %	0.1 %	11,800	139,325
2013	8.5 %	0.1 %	11,808	138,786
2012	8.6 %	0.1 %	11,857	138,348
2011	8.6 %	0.1 %	11,901	137,776
2010	8.6 %	0.1 %	11,899	138,982
2009	8.6 %	0.1 %	12,378	144,670

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4 - Notes:**


None

**Data Alerts: None**



**NOM 5 - Percent of preterm births (<37 weeks)****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.4 %	0.1 %	14,388	137,967
2015	10.3 %	0.1 %	14,300	139,169
2014	10.3 %	0.1 %	14,302	139,362
2013	10.3 %	0.1 %	14,259	138,355
2012	10.5 %	0.1 %	14,438	138,075
2011	10.2 %	0.1 %	14,083	137,615
2010	10.3 %	0.1 %	14,308	138,719
2009	10.4 %	0.1 %	15,060	144,476

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5 - Notes:**

None

**Data Alerts: None**

**NOM 6 - Percent of early term births (37, 38 weeks)****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	25.5 %	0.1 %	35,200	137,967
2015	25.1 %	0.1 %	34,983	139,169
2014	24.8 %	0.1 %	34,491	139,362
2013	24.5 %	0.1 %	33,849	138,355
2012	24.7 %	0.1 %	34,084	138,075
2011	24.7 %	0.1 %	34,015	137,615
2010	25.4 %	0.1 %	35,282	138,719
2009	26.6 %	0.1 %	38,401	144,476

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 6 - Notes:**

None

**Data Alerts: None**

**NOM 7 - Percent of non-medically indicated early elective deliveries**

Data Source: CMS Hospital Compare

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

**Legends:** Indicator results were based on a shorter time period than required for reporting**NOM 7 - Notes:**

None


**Data Alerts: None**

**NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.1	0.2	994	139,710
2014	7.3	0.2	1,021	139,910
2013	7.6	0.2	1,059	139,396
2012	7.5	0.2	1,038	138,921
2011	7.7	0.2	1,064	138,365
2010	7.2	0.2	1,010	139,524
2009	6.7	0.2	974	145,217

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 8 - Notes:**

None


**Data Alerts: None**

**NOM 9.1 - Infant mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.2	0.2	1,000	139,264
2014	6.9	0.2	959	139,467
2013	7.3	0.2	1,019	138,936
2012	7.5	0.2	1,034	138,483
2011	8.0	0.2	1,102	137,918
2010	7.7	0.2	1,074	139,128
2009	7.7	0.2	1,116	144,841

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.1 - Notes:**

None

**Data Alerts: None**

## NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.8	0.2	663	139,264
2014	4.9	0.2	689	139,467
2013	5.2	0.2	724	138,936
2012	5.1	0.2	710	138,483
2011	5.3	0.2	735	137,918
2010	5.3	0.2	730	139,128
2009	5.2	0.2	755	144,841

#### Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

#### NOM 9.2 - Notes:

None

Data Alerts: None

### NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.4	0.1	337	139,264
2014	1.9	0.1	270	139,467
2013	2.1	0.1	295	138,936
2012	2.4	0.1	325	138,483
2011	2.7	0.1	367	137,918
2010	2.5	0.1	344	139,128
2009	2.5	0.1	361	144,841

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

#### NOM 9.3 - Notes:

None

Data Alerts: None

**NOM 9.4 - Preterm-related mortality rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	267.8	13.9	373	139,264
2014	278.2	14.1	388	139,467
2013	273.5	14.1	380	138,936
2012	290.3	14.5	402	138,483
2011	313.2	15.1	432	137,918
2010	295.4	14.6	411	139,128
2009	291.4	14.2	422	144,841

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.4 - Notes:**

None

**Data Alerts: None**



**NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	110.6	8.9	154	139,264
2014	91.1	8.1	127	139,467
2013	103.6	8.6	144	138,936
2012	108.3	8.9	150	138,483
2011	132.7	9.8	183	137,918
2010	120.8	9.3	168	139,128
2009	147.1	10.1	213	144,841


**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy****Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.4 %	0.8 %	8,459	132,677
2014	5.0 %	0.6 %	6,633	133,036
2012	6.0 %	0.7 %	7,779	130,109
2010	6.8 %	0.9 %	8,969	131,982
2009	7.4 %	0.9 %	10,154	137,557
2008	5.9 %	0.8 %	8,191	139,062
2007	5.2 %	0.8 %	7,337	140,215

**Legends:** Indicator has an unweighted denominator <30 and is not reportable Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.6	0.3	1,176	101,019
2014	10.6	0.3	1,423	134,581
2013	9.4	0.3	1,251	133,812
2012	8.0	0.3	1,076	134,168
2011	5.9	0.2	788	133,148
2010	4.7	0.2	639	135,587
2009	3.4	0.2	477	141,468
2008	2.6	0.1	360	140,146

**Legends:**

🚩 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**



**NOM 13 - Notes:**

None

**Data Alerts: None**

**NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.4 %	1.7 %	286,046	2,500,554
<b>Legends:</b>  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				


**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	20.8	1.3	264	1,272,482
2015	17.0	1.2	217	1,276,004
2014	15.8	1.1	202	1,281,460
2013	20.6	1.3	265	1,289,005
2012	18.4	1.2	238	1,296,123
2011	18.7	1.2	244	1,307,412
2010	20.2	1.2	268	1,329,703
2009	18.2	1.2	243	1,332,597

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 15 - Notes:**

None

**Data Alerts: None**

**NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	32.5	1.5	490	1,506,080
2015	33.8	1.5	514	1,518,794
2014	28.4	1.4	434	1,528,625
2013	26.8	1.3	413	1,540,846
2012	31.7	1.4	492	1,553,131
2011	31.2	1.4	490	1,573,090
2010	29.6	1.4	473	1,598,381
2009	32.2	1.4	519	1,612,480

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**





**NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	11.4	0.7	264	2,312,566
2013_2015	11.0	0.7	255	2,324,758
2012_2014	11.1	0.7	260	2,339,385
2011_2013	11.9	0.7	281	2,369,514
2010_2012	12.4	0.7	299	2,412,947
2009_2011	12.2	0.7	299	2,460,109
2008_2010	12.8	0.7	320	2,498,282
2007_2009	14.7	0.8	370	2,515,249

**Legends:**

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution


**NOM 16.2 - Notes:**

None

**Data Alerts: None**

**NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000****Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	9.1	0.6	211	2,312,566
2013_2015	8.0	0.6	185	2,324,758
2012_2014	7.4	0.6	174	2,339,385
2011_2013	8.5	0.6	201	2,369,514
2010_2012	9.0	0.6	218	2,412,947
2009_2011	8.7	0.6	214	2,460,109
2008_2010	8.5	0.6	213	2,498,282
2007_2009	8.5	0.6	214	2,515,249



**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	22.8 %	1.8 %	598,389	2,625,279
<b>Legends:</b>				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.9 %	2.9 %	88,999	598,389
<b>Legends:</b>  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.7 % ⚡	0.7 % ⚡	38,604 ⚡	2,247,514 ⚡
<b>Legends:</b> 🚩 Indicator has an unweighted denominator <30 and is not reportable ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.0 %	1.6 %	267,540	2,237,276
<b>Legends:</b>  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	53.4 % ⚡	6.5 % ⚡	153,089 ⚡	286,622 ⚡
<b>Legends:</b> 🚩 Indicator has an unweighted denominator <30 and is not reportable ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	90.4 %	1.5 %	2,365,370	2,616,471
<b>Legends:</b>				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

**NOM 19 - Notes:**

None

**Data Alerts: None**



**NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)**

**Data Source: WIC**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.1 %	0.1 %	10,631	81,440
2012	13.0 %	0.1 %	12,405	95,493
2010	12.6 %	0.1 %	13,000	102,803
2008	12.4 %	0.1 %	11,430	92,285

**Legends:**

🚩 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	13.0 %	1.2 %		
2011	14.7 %	1.5 %		
2007	12.3 %	1.1 %		
2005	12.7 %	1.4 %		

**Legends:**

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.6 %	2.7 %	209,408	1,125,170

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 20 - Notes:**

None


**Data Alerts: None**

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

Data Source: American Community Survey (ACS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.4 %	0.2 %	87,515	2,606,575
2015	4.3 %	0.2 %	113,587	2,622,951
2014	4.9 %	0.3 %	128,291	2,634,140
2013	5.1 %	0.3 %	133,687	2,642,435
2012	5.4 %	0.3 %	143,315	2,652,169
2011	6.1 %	0.3 %	164,248	2,686,075
2010	5.9 %	0.3 %	161,314	2,718,837
2009	6.4 %	0.3 %	173,264	2,713,290

**Legends:** Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution**NOM 21 - Notes:**

None


**Data Alerts: None**


**NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	68.0 %	3.9 %	135,356	198,971
2015	68.3 %	4.0 %	135,523	198,461
2014	68.1 %	3.9 %	134,305	197,250
2013	61.7 %	3.9 %	120,938	195,908
2012	66.8 %	3.5 %	132,975	199,080
2011	74.7 %	4.2 %	155,477	208,269
2010	62.5 %	3.9 %	132,658	212,365
2009	44.7 %	3.7 %	98,560	220,643

**Legends:**

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None


**Data Alerts: None**


**NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza**

**Data Source: National Immunization Survey (NIS) – Flu**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	51.5 %	1.8 %	1,260,087	2,447,246
2015_2016	55.1 %	2.1 %	1,380,323	2,503,760
2014_2015	54.3 %	1.9 %	1,362,796	2,511,140
2013_2014	54.5 %	1.8 %	1,383,400	2,538,022
2012_2013	54.1 %	2.2 %	1,381,635	2,551,792
2011_2012	50.9 %	2.6 %	1,281,153	2,517,652
2010_2011	50.3 %	2.4 %	1,281,995	2,548,697
2009_2010	44.2 %	3.5 %	1,162,894	2,630,981

**Legends:**

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

**NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

**Data Source: National Immunization Survey (NIS) - Teen (Female)**

**Multi-Year Trend**







Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	57.6 %	4.7 %	214,731	373,113
2015	61.0 %	5.1 %	229,067	375,560
2014	61.0 %	4.3 %	230,326	377,388
2013	54.9 %	4.8 %	207,308	377,973
2012	56.4 % ⚡	5.3 % ⚡	213,355 ⚡	378,287 ⚡
2011	45.5 %	4.4 %	173,658	381,478
2010	44.0 %	4.6 %	169,385	385,391
2009	40.6 %	4.7 %	157,759	388,919

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**Data Source: National Immunization Survey (NIS) - Teen (Male)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	55.0 %	4.9 %	214,695	390,619
2015	43.7 %	4.6 %	172,114	393,484
2014	36.8 %	4.1 %	145,537	395,524
2013	26.5 %	4.2 %	104,889	395,368
2012	15.2 %	3.4 %	60,301	395,949
2011	NR 	NR 	NR 	NR 
<b>Legends:</b>  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  Estimates with 95% confidence interval half-widths > 10 might not be reliable				


**NOM 22.3 - Notes:**

None

**Data Alerts: None**

**NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine****Data Source: National Immunization Survey (NIS) - Teen****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	90.8 %	2.2 %	693,729	763,732
2015	86.7 %	2.6 %	666,523	769,044
2014	83.0 %	2.4 %	641,602	772,912
2013	84.4 %	2.5 %	652,870	773,341
2012	73.8 %	3.4 %	571,542	774,236
2011	72.7 %	2.8 %	568,059	781,425
2010	60.3 %	3.1 %	474,966	787,989
2009	50.2 %	3.2 %	399,069	795,156

**Legends:** Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6 Estimates with 95% confidence interval half-widths > 10 might not be reliable**NOM 22.4 - Notes:**

None

**Data Alerts: None**



**NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	79.6 %	2.9 %	608,059	763,732
2015	76.1 %	3.1 %	585,470	769,044
2014	73.7 %	2.8 %	569,518	772,912
2013	69.2 %	3.1 %	535,214	773,341
2012	66.4 %	3.5 %	513,723	774,236
2011	66.0 %	3.1 %	515,872	781,425
2010	61.6 %	3.1 %	485,080	787,989
2009	53.7 %	3.2 %	427,204	795,156

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	21.8	0.2	8,151	374,550
2015	23.3	0.3	8,755	375,680
2014	25.2	0.3	9,473	376,461
2013	27.2	0.3	10,352	379,993
2012	29.7	0.3	11,437	384,554
2011	31.4	0.3	12,338	392,939
2010	34.3	0.3	13,752	401,420
2009	37.9	0.3	15,445	407,433

**Legends:**

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 23 - Notes:**

None

**Data Alerts: None**

**NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	16.2 %	1.5 %	21,399	132,529
2014	15.3 %	1.3 %	20,445	133,460
2012	13.2 %	1.1 %	17,150	130,094

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution



**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.0 %	0.9 %	78,102	2,597,517
<b>Legends:</b>				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

**NOM 25 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Ohio**

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	2017
Annual Objective	65	68.3
Annual Indicator	67.4	72.0
Numerator	1,305,840	1,407,811
Denominator	1,936,363	1,954,874
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.0	75.2	75.6	76.0	76.4	76.8

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Objective was updated because we have already exceeded 71.7%.

**NPM 4A - Percent of infants who are ever breastfed**

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	79.3	80.9
Annual Indicator	77.7	76.8
Numerator	101,883	101,413
Denominator	131,148	132,017
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	77.2	78.0	79.2	80.4	81.6	81.9

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Ohio First Steps for Health Babies initiative launched in March of 2015. Therefore, we would not expect to see effects of this program on babies born in 2014. We are hope to see an increase in infants born in 2015 and even more so in 2016 as the program rolled out to additional hospitals and more steps were achieved. Our goal is to meet the HP 2020 objective of 81.9% by FFY 2023 when we have NIS data on infants born in 2020.

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	22.9	23.5
Annual Indicator	22.3	16.7
Numerator	27,862	21,279
Denominator	125,021	127,543
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.2	17.7	18.2	18.7	19.3	19.9

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Ohio First Steps for Health Babies initiative launched in March of 2015. Therefore, we would not expect to see effects of this program on babies born in 2014. We are hope to see an increase in infants born in 2015 and even more so in 2016 as the program rolled out to additional hospitals and more steps were achieved. Our goal is to increase by 3% per year.

**NPM 5A - Percent of infants placed to sleep on their backs**

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	80.9	82.5
Annual Indicator	79.3	85.5
Numerator	100,183	111,358
Denominator	126,366	130,239
Data Source	PRAMS	PRAMS
Data Source Year	2012	2015

State Provided Data		
	2016	2017
Annual Objective	80.9	82.5
Annual Indicator		82.7
Numerator		
Denominator		
Data Source		OPAS
Data Source Year		2016
Provisional or Final ?		Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	83.3	84.1	84.9	85.7	86.6	87.5



**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Ohio no longer participates in PRAMS. However, we are conducting a similar survey, Ohio Perinatal Assessment Survey (OPAS). The first year of data from OPAS will be available sometime in June.	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> Ohio no longer participates in PRAMS. However, we are conducting a similar survey, Ohio Perinatal Assessment Survey (OPAS). The first year of data from OPAS recently became available.	
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b> Although we already exceeded the 2018 objective according to PRAMS, our OPAS data shows we have not yet met the 2018 objective but did meet the 2017 objective. Since we will be using OPAS to measure our success going forward, we are leaving the objectives the same.	

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface****FAD for this measure is not available for the State.**

State Provided Data	
	2017
Annual Objective	
Annual Indicator	39
Numerator	
Denominator	
Data Source	OPAS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	39.4	39.8	40.2	40.6	41.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding****FAD for this measure is not available for the State.**

State Provided Data	
	2017
Annual Objective	
Annual Indicator	40.9
Numerator	
Denominator	
Data Source	OPAS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	40.9	41.3	41.7	42.1	42.5

**Field Level Notes for Form 10a NPMs:**

None

**NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		41.1
Numerator		114,362
Denominator		278,232
Data Source		NSCH
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	41.6	42.1	42.6	43.1	43.6	44.1

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objectives were updated to reflect the new baseline.

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		78.1
Numerator		694,854
Denominator		889,704
Data Source		NSCH
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	42.6	43.9
Numerator	137,032	144,230
Denominator	321,606	328,769
Data Source	Ohio Medicaid	Ohio Medicaid
Data Source Year	SFY 15	SFY 16
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.6	79.1	79.6	80.1	80.6	81.1

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	These data only represent the Medicaid population.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	These data only represent the Medicaid population. Absolute percent change ranged from 8.9% to -10.9%. Nin of the 10 counties with the greatest improvement are either rural or Appalachian (as defined by the Appalachian Regional Commission).
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objectives updated to reflect the new baseline of 78.1%.

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		48.2
Numerator		288,652
Denominator		598,389
Data Source		NSCH-CSHCN
Data Source Year		2016

**i** Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	38	
Numerator		
Denominator		
Data Source	Ohio Medicaid Assessment Survey	
Data Source Year	2015	
Provisional or Final ?	Final	

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	48.6	49.6	50.6	51.6	52.6	53.6

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> The Ohio Medicaid Assessment Survey (OMAS) is an additional source of data that includes the percentage of CSHCN having a medical home. In 2015, OMAS estimated that 38% of CSHCN (0-18 years) had “care consistent with a PCMH” (CC-PCMH). Additionally, CSHCN who had CC-PCMH had fewer reports of fair/poor health compared to those who did not (6% versus 15%).	
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b> Objectives have been updated based on the new baseline.	



#### NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	2017
Annual Objective	15.7	15.1
Annual Indicator	15.2	14.4
Numerator	21,150	19,764
Denominator	138,801	137,722
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	13.6	12.8	12.1	11.4	10.7	10.1

#### Field Level Notes for Form 10a NPMs:

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

#### Field Note:

Objectives were updated to reflect that we have already exceeded the objective for next year. From 2009-2014 the was an average decrease of 3.1% per year ( $p < 0.05$ ). We saw an accelerated change from 2014-2016 with an average of 6.0 percent per year. We hope to maintain this trend going forward. Since we are still well above the national rate of 7.2, we feel this is realistic.

**Form 10a**  
**State Performance Measures (SPMs)**  
**State: Ohio**

**SPM 1 - Black Infant Mortality Rate (per 1,000 live births)**

<b>Measure Status:</b>	<b>Inactive - This is being changed to an SOM and we will continue to monitor.</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		13.3
Annual Indicator	15.1	15.2
Numerator	367	369
Denominator	24,288	24,315
Data Source	ODH Vital Statistics	ODH Vital Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10a SPMs:**

None

**SPM 2 - Percent of children 0-17 years with a preventive medical visit in the past 12 months**

<b>Measure Status:</b>	<b>Inactive - This measure does not fit the activities identified in the Action Plan.</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		90
Annual Indicator	87.7	83.6
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2011-12	2016
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> From the 2011-12 NSCH, 87.7% of Ohio children 0 to 12 years, and 84.4% (95% CI 83.8-84.9) of children nationwide received one or more preventive medical care visits during the past 12 months. Ohio is doing well on this measure and is above the nation as a whole. Since we are currently at about 90% of children receiving visits in the last 12 months, we expect improvements to be small. Additionally, we are focusing on quality of preventative medical care versus number of visits.	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> The annual indicator for 2017 is not comparable to the previous year and will serve as our new baseline. This is due to the revision of the National Survey of Children's Health (NSCH).	

#### SPM 4 - Percent of infants who are exclusively breastfed at hospital discharge

<b>Measure Status:</b>	<b>Inactive - We are using NPM 4 and will continue to monitor this SPM and report progress in Annual Reports.</b>
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State Provided Data		
	2016	2017
Annual Objective		53.5
Annual Indicator	52.7	52.2
Numerator	66,616	70,391
Denominator	126,361	134,739
Data Source	ODH Vital Statistics	ODH Vital Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

#### Field Level Notes for Form 10a SPMs:

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

#### Field Note:

In late 2014, ODH Bureau of Vital Statistics added a question to the birth certificate about exclusive breastfeeding at discharge. In 2015 the percent of women who were breastfeeding exclusively at discharge was 52.7%. The percent was higher among white, non-Hispanic women (56.5) when compared to black, non-Hispanic and Hispanic women (37.1 and 48.6 respectively). We expect these percentages to increase as more hospitals implement the Ten Steps to Successful Breastfeeding.

**SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	3
Annual Indicator	4
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	FFY 2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	5.0	6.0	7.0	7.0	7.0	7.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b> The following benchmarks have been completed: 1) Report of refusals across the three screenings completed and disseminated for discussion, 2) Development of a combined newborn screening brochure, 3) Hiring and onboarding a contractor to conduct a review of the three systems and provide a review of solutions, 4) Final report from contractor received, with review of Ohio newborn screening systems and analysis of potential solutions	
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b> Additional benchmark to be completed in FFY 18: Develop technical specifications and system requirements for competitive bid process with Ohio Department of Administrative Services to select vendor for system implementation.	

**SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>					
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	17.2	16.2	15.2	14.2	13.2

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

In 2015, 18.1% of 2-5 year olds in Ohio consumed 1 or more sugar sweetened beverages per day. This increased to 19.2% in 2017.

**Form 10a**  
**State Outcome Measures (SOMs)**

State: Ohio

**SOM 1 - Black Infant Mortality Rate (per 1,000 live births)**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>					
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	15.5	15.2	14.0	13.8	13.6

**Field Level Notes for Form 10a SOMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Preliminary data shows that rate for 2017 is 15.5 per 1,000. Given this information, we have set our objective to that value even though it represents an increase. In October 2018, changes to the Ohio Equity Institute will take effect. In part, the changes are meant to ensure that the program is reaching the most at risk women, especially those who are African American.



**Form 10a**  
**Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Ohio

**ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics**

<b>Measure Status:</b>	<b>Active</b>
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State Provided Data		
	2016	2017
Annual Objective		66.5
Annual Indicator	64.6	65.2
Numerator	18,653	18,672
Denominator	28,865	28,623
Data Source	Ahlers Title X Database	Ahlers Title X Database
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	67.2	69.2	71.3	73.4	75.6	77.9

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>  In FY16, for those served by the Ohio Department of Health RHWP, 64.6% of female, unduplicated clients had primary care coverage. This is a 46% increase since the same time in FY2012 when only 44.2% of women had primary care coverage. Of those with primary care coverage, 74.5% had public insurance and 25.5% had private. We believe this increase is related to two major factors. First, Ohio was one of 31 states that expanded Medicaid under the ACA. Additionally, as of April 1, 2016 local RHWP sites were required to ensure that a Certified Application Counselor (CAC) or Navigator was available to assist Title X clients with Marketplace enrollment as well as ensuring eligible Title X clients are assisted with enrollment into Medicaid.</p>	
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<p><b>Field Note:</b>  This represents a 47.6% increase since the same time in FY2012 when only 44.2% of women had primary care coverage.</p>	
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<p><b>Field Note:</b>  Objectives were updated to account for us not meeting the objective for of 66.5: this past year. Our aim is still to increase coverage 3% each year.</p>	

#### ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		66
Annual Indicator	49.1	67.9
Numerator	52	72
Denominator	106	106
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	72.6	77.3	77.3	77.3	77.3	77.3

#### Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	The Ohio First Steps for Healthy Babies initiative launched in March 2015, with the first round of applications accepted in July 2016. Throughout FFY16, there were 4 rounds of applications and 48.6% (52 of 106) hospitals were recognized. Hospitals continue to apply as they achieve more steps. Our goal is to add 5 hospitals each year. We are on track to meet that goal.
2.	Field Name:	2018
	Column Name:	Annual Objective
	Field Note:	Objective has been updated to reflect an increase of 5 hospitals in FFY18. Although we added 20 hospitals in FFY 2017, we believe this is a reasonable goal given that we are already close to 70% of hospitals participating in the program. We plan to add an additional 5 hospitals in FFY 19. At that point, we will reassess if we have achieved the desired amount of hospitals participating.



**ESM 5.1 - Percent of birthing hospitals that have received formal training on safe sleep practices and the number of non-birthing hospitals trained on safe sleep practices.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		10
Annual Indicator	0	0
Numerator	0	0
Denominator	106	106
Data Source	Program data	Program data
Data Source Year	FFY 16	FFY 17
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10a ESMs:**

None

**ESM 5.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids**

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,000.0	4,000.0	4,000.0	4,000.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 6.1 - Number of new pediatric practices and family practices participating in the learning collaborative**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
------------------------	----------------------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		0
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

At this time we plan to proceed with the learning collaborative. However, we are not sure we will have the funding to do so. This ESM will be updated if needed due to funding related program changes.

**ESM 6.2 - Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>					
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	50.0	51.0	52.0	53.0	54.0

**Field Level Notes for Form 10a ESMs:**

None



**ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	50	77
Numerator		
Denominator		
Data Source	Training registration logs	Training registration logs
Data Source Year	2016	FFY 2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

This is the first state-level initiative to track the number of providers being trained on Bright Futures Recommendations regarding adolescent health.

**ESM 11.1 - Number of new stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs (CYSHCN).**

<b>Measure Status:</b>	<b>Active</b>
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State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	2.0	2.0	2.0	2.0	2.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The workgroup is reviewing the resources and discussing the applicability for families of CYSHCN; by the end of FFY 2016, four of the eight identified resources had been reviewed and discussed. Additionally, the workgroup began building a list of stakeholders who could be approached to help in the dissemination of resources and education of families of CYSHCN about the importance of receiving care in a PCMH. By September 2016, the workgroup had identified more than 20 stakeholder organizations (e.g., Ohio Chapter-American Academy of Pediatrics) and groups (e.g., school nurses) that could be approached to assist in engaging families of CYSHCN.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	At this time, educational materials have not yet been finalized and we are working on enhancing our stakeholder list. We hope to start distributing information soon.



**ESM 14.1.1 - Number of publicly funded programs newly trained to implement the 5As.**

<b>Measure Status:</b>	<b>Inactive - Completed</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		15
Annual Indicator	64	0
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	There were 64 new publically funded programs trained to implement the 5A's this fiscal year, for a total of 140 programs trained.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Ohio Partners for Smoke Free Families (OPSFF) has shifted focus to working with pediatrician and OB providers.

**ESM 14.1.2 - Number of pediatric and obstetric-gynecologic providers newly trained to implement the 5 As**

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	18.0	18.0	18.0	18.0	18.0

**Field Level Notes for Form 10a ESMs:**

None

**Form 10b**  
**State Performance Measure (SPM) Detail Sheets**

**State: Ohio**


**SPM 1 - Black Infant Mortality Rate (per 1,000 live births)**

**Population Domain(s) – Perinatal/Infant Health**

<b>Measure Status:</b>	Inactive - This is being changed to an SOM and we will continue to monitor.	
<b>Goal:</b>	Decrease Ohio's overall infant mortality and racial disparity by decreasing the mortality rate among black infants.	
<b>Definition:</b>	<b>Numerator:</b>	Number of deaths of black infants under 1 year of age (birth to 364 days).
	<b>Denominator:</b>	Number of black live births to during the same period
	<b>Unit Type:</b>	Rate
	<b>Unit Number:</b>	1,000
<b>Healthy People 2020 Objective:</b>	Reduce the rate of all infant deaths (within 1 year). Target: 6.0 infant deaths per 1,000 live births.	
<b>Data Sources and Data Issues:</b>	Ohio Vital Statistics. Ohio birth and death files are usually not finalized until late summer of the following year. All statistics are preliminary until that time.	
<b>Significance:</b>	Although Ohio's IMR has declined over the past couple of decades, the state still ranks poorly among other states in the nation. In 2014, Ohio's IMR was 6.8 per 1,000 live births. This was above the national rate of 6.0 in 2013 and the Healthy People 2020 objective of 6.0. Additionally, black infants are about twice as likely to die as white infants. The Ohio Department of Health (ODH) has partnered with CityMatCH to form the Ohio Equity Institute (OEI) to improve birth outcomes and reduce the racial disparities in infant deaths. By focusing on the nine communities that make up the OEI, ODH aims to strengthen the scientific focus and evidence base for reducing racial and ethnic disparities in birth outcomes.	

**SPM 2 - Percent of children 0-17 years with a preventive medical visit in the past 12 months**  
**Population Domain(s) – Child Health**

Measure Status:	Inactive - This measure does not fit the activities identified in the Action Plan.									
Goal:	Improve quality of comprehensive age appropriate well child screening, follow up and referral									
Definition:	<table><tr><td>Numerator:</td><td>Number of children who received a preventive medical care visit in the past 12 months</td></tr><tr><td>Denominator:</td><td>Number of children ages 0-17 years</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of children who received a preventive medical care visit in the past 12 months	Denominator:	Number of children ages 0-17 years	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children who received a preventive medical care visit in the past 12 months									
Denominator:	Number of children ages 0-17 years									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	Reduce the occurrence of developmental disabilities. Reduce blood lead level in children aged 1–5 years. Reduce noise-induced hearing loss in children and adolescents aged 17 year and under. Increase the proportion of preschool children age 5 years and under who receive vision screening; Uncorrected visual impairment due to refractive errors; and Blindness and visual impairment in children and adolescents. Reduce the rate of child deaths. Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner. Increase the proportion of children, including those with special health care needs, who have access to a medical home. Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.									
Data Sources and Data Issues:	National Survey for Children’s Health. The most recent data available is from the 2011/12 survey. However, it is our understanding that the new survey will be available yearly starting 2016/17.									
Significance:	<p>According to the 2011/2012 National Survey of Children’s Health, 93.9% of Ohio children aged 0-5 received one or more preventive medical care visit. Eight-six percent of Ohio children aged 6-11 received one or more preventive medical care visit.</p> <p>Screening and well-child visits provide an opportunity for periodic assessment of core health status components including behavioral and mental health, developmental, dental, hearing or visual impairment and to identify and prevent elevated blood lead levels. Early detection and referral leads to earlier treatment &amp; promotes proper management of the conditions. A systematic approach to quality improvement science should result in increasing the percent of children receiving timely, age-appropriate screening &amp; improving the system overall to ensure children receive the care that they need.</p> <p>Comprehensive well child visits is a child health benefit for children under the age of 21. Services are intended to screen, diagnose, and treat children to avoid or minimize childhood illness. A 2010 Office of Inspector General’s report found that children were not receiving all of the required EPSDT screening. (Office of Inspector General Report, November 2014).</p> <p>It is estimated that 1 out of 5 children in Ohio under the age of six are at moderate or high risk for developmental, behavior or social delays. Through EPSDT, a child is identified early through the screening process and is more likely to find appropriate treatment so children are school ready (EPSDT &amp; Developmental Screening, Voices For Ohio’s Children).</p> <p>According to the Resources for Title V Action Planning, Developmental Screening Strategies</p>									



and Measures, screening for healthy development can reduce the likelihood of a child developing other delays if provided the appropriate screening, referral and follow up treatment.

Strategies and activities target increasing the quality of care provided during a well child visit to decrease duplication of efforts while increasing the



**SPM 4 - Percent of infants who are exclusively breastfed at hospital discharge**  
**Population Domain(s) – Perinatal/Infant Health**

Measure Status:	Inactive - We are using NPM 4 and will continue to monitor this SPM and report progress in Annual Reports.									
Goal:	To increase the proportion of infants who are exclusively breast fed at hospital discharge.									
Definition:	<table><tr><td>Numerator:</td><td>Number of infants being exclusively breastfed at discharge with no infant formula supplementation</td></tr><tr><td>Denominator:</td><td>Number of live births to Ohio residents that occur in Ohio</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of infants being exclusively breastfed at discharge with no infant formula supplementation	Denominator:	Number of live births to Ohio residents that occur in Ohio	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of infants being exclusively breastfed at discharge with no infant formula supplementation									
Denominator:	Number of live births to Ohio residents that occur in Ohio									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	<ul style="list-style-type: none"><li>• By 2020, increase the percent of infants who are ever breastfed to 81.9%</li><li>• By 2020, increase the percent of infants exclusively breastfed at 6 months to 25.5%</li></ul>									
Data Sources and Data Issues:	ODH Vital Statistics. Hospitals with a large number of births may have lower rates because they have infants being transferred to NICU and infants with medical issues that require supplementation. Breastfeeding information can only obtain data from births that occur in Ohio; therefore, this measure does not include Ohio residents giving birth in other states. Certain areas of the state are more likely to have residents that give birth out of state and would therefore be underrepresented. Ohio started collecting breastfeeding information on birth certificates in Fall 2014. Since this is a new reporting measure, there is an increased potential for data input error and/or missing values and lack of trend data.									
Significance:	<p>Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman’s ability to meet her child’s nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post-natal depression. Increased release of oxytocin while breastfeeding leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time. Mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer, and have a reduced risk of developing osteoporosis.</p> <p>Improving breastfeeding initiation and duration rates among all demographic groups can help to reduce infant morbidity and mortality.</p>									

**SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system**

**Population Domain(s) – Perinatal/Infant Health**

Measure Status:	Active	
Goal:	Newborns in Ohio are screened shortly after birth for a number of disorders through three methods: bloodspot screening, hearing screening, and screening for seven critical congenital heart defects (CCHD). The goal of this priority is to improve linka	
Definition:		
	Numerator:	The number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system.
	Denominator:	Total number of benchmarks (7)
	Unit Type:	Count
	Unit Number:	10
Healthy People 2020 Objective:	MICH-32 Increase appropriate newborn blood-spot screening and follow-up testing	
Data Sources and Data Issues:	Benchmarks include: 1. Report of refusals across the three screenings completed and disseminated for discussion. 2. Development of a combined newborn screening brochure. 3. Hiring and onboarding a contractor to conduct a review of the three systems and provide a review of solutions. 4. Consolidating reports of newborn screening results to providers. 5. Final report from contractor received, with review of Ohio newborn screening systems and analysis of potential solutions. 6. Develop technical specifications and system requirements for competitive bid process with Ohio Department of Administrative Services to select vendor for system implementation 7. Implement solution.	
Significance:	All three newborn screening programs focus on: 1) ensuring newborns are screened and that physicians receive timely notification of screening results; 2) that those newborns with abnormal (out of range) screening results receive diagnostic testing; and 3) those diagnosed with disorders have access to appropriate treatment or intervention. Work to address this important newborn health priority is focused on improving the linkage/integration and/or inter-operability of data between Ohio's three newborn screening programs and with vital records for a population-based denominator. There are efficiencies to be gained in streamlining common data elements between the programs, as well as making timely and comprehensive (i.e., from all 3 screenings) results available to primary care providers responsible for working with parents on follow-up testing that may be needed. Overlaid in this priority measure is the use of technology and IT solutions to streamline data availability and use at the Ohio Department of Health, as well as the interface with electronic medical records from the birth and children's hospitals, and local pediatricians.	

**SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day**  
**Population Domain(s) – Child Health**

Measure Status:	Active	
Goal:	Decrease the percent of 2-5 year old children consuming 1 or more sugar sweetened beverages (SSB) per day	
Definition:		
	Numerator:	# of 2-5 year olds consuming 1 or more SSB in a day, as reported by parents
	Denominator:	# of parents with 2-5 year old children
	Unit Type:	Percentage
	Unit Number:	100
Healthy People 2020 Objective:		
	NWS-1 Increase the number of States with nutrition standards for food and beverages to preschool-aged children in child care	
	NWS-10.1 Reduce the proportion of children aged 2 to 5 years who are considered obese	
	NWS-11.1 Prevent inappropriate weight gain in children aged 2 to 5 years	
	NWS-17 Reduce the consumption of calories from solid fats and added sugars in the population aged 2 years and older	
Data Sources and Data Issues:	Ohio Medicaid Assessment Survey (OMAS)	
	OMAS is a random digit dial telephone survey that first fielded in 1997. It is an Ohio-specific assessment that provides health care access, utilization, and health status information about residential Ohioans at the state, regional and county levels. The main topics for OMAS are health care access, health care utilization, insurance status, chronic and acute health conditions, mental health, health risk behaviors, and health demographics such as employment, income, and socioeconomic indicators. Data are weighted to be representative of the Ohio population.	
	This question is self-reported by parents, and is likely an underestimation of the number of sugar sweetened beverages children drink.	
Significance:	Sugar sweetened beverage intake has been linked to early childhood obesity. The American Academy of Pediatrics recommends that children aged 2-5 consumer no sugar sweetened beverages.	

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Ohio**

**SOM 1 - Black Infant Mortality Rate (per 1,000 live births)**  
**Population Domain(s) – Perinatal/Infant Health**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Decrease Ohio's overall infant mortality and racial disparity by decreasing the mortality rate among black infants	
<b>Definition:</b>	<b>Numerator:</b>	Number of deaths of black infants under 1 year of age (birth through 364 days)
	<b>Denominator:</b>	Number of live births to black mothers during the same period
	<b>Unit Type:</b>	Rate
	<b>Unit Number:</b>	1,000
<b>Healthy People 2020 Objective:</b>	Reduce the rate of all infant deaths (within 1 year). Target: 6.0 infant deaths per 1,000 live births	
<b>Data Sources and Data Issues:</b>	Ohio Vital Statistics. Ohio birth and death files are usually not finalized until late summer of the following year. All statistics are preliminary until that time.	
<b>Significance:</b>	<p>Although Ohio's IMR has declined over the past couple of decades, the state still ranks poorly among other states in the nation. In 2016, Ohio's IMR was 7.4 per 1,000 live births. This was above the national average of 5.9 per 1,000 and the HP 2020 objective of 6.0. Additionally, black infants are about twice as likely to die as white infants. The Ohio Department of Health (ODH) has formed the Ohio Equity Institute (OEI) to improve birth outcomes and reduce racial disparities in infant deaths. By focusing on the nine communities that make up OEI, ODH aims to strengthen the scientific focus and evidence base for reducing racial and ethnic disparities in birth outcomes.</p>	

**Form 10c**  
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**  
**State: Ohio**

**ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics**

**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	BMCH clinics are working to make sure women who are eligible are covered by private or public insurance. Tracking this measure will help us know if we are providing the support needed for women to access this coverage.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td><td>The number of women covered by either private or public insurance seen in ODH RHWP clinics</td></tr> <tr> <td><b>Denominator:</b></td><td>The total number of women seen in ODH RHWP clinics</td></tr> <tr> <td><b>Unit Type:</b></td><td>Percentage</td></tr> <tr> <td><b>Unit Number:</b></td><td>100</td></tr> </table>	<b>Numerator:</b>	The number of women covered by either private or public insurance seen in ODH RHWP clinics	<b>Denominator:</b>	The total number of women seen in ODH RHWP clinics	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The number of women covered by either private or public insurance seen in ODH RHWP clinics								
<b>Denominator:</b>	The total number of women seen in ODH RHWP clinics								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Ahler's & Associates Title X Database								
<b>Significance:</b>	This measure will be used to document whether women being seen in a Reproductive Health and Wellness Program clinics who do not currently have coverage for primary care services are being provided the support necessary to obtain such coverage. In 2012 the Kaiser Women's Health survey found that more than half of uninsured women ages 18-65 reported going without or delaying needed care because they could not afford the cost.								

**ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies**  
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

Measure Status:	Active									
Goal:	By tracking the percentage of hospitals receiving this recognition, we are able to measure our progress/success in obtaining buy-in from hospitals on fostering a breastfeeding friendly environment.									
Definition:	<table><tr><td>Numerator:</td><td>Number of Ohio hospitals who are recognized by the Ohio First Steps for Healthy Babies initiative.</td></tr><tr><td>Denominator:</td><td>Number of Ohio birthing hospitals</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of Ohio hospitals who are recognized by the Ohio First Steps for Healthy Babies initiative.	Denominator:	Number of Ohio birthing hospitals	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of Ohio hospitals who are recognized by the Ohio First Steps for Healthy Babies initiative.									
Denominator:	Number of Ohio birthing hospitals									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	<p>The source of the data will be from the Ohio First Steps for Healthy Babies review committee and their data tracking sheet.</p> <p>Limitations are that data are self-reported by the hospitals and some of the objectives can be based on estimates instead of chart reviews and patient interviews.</p> <p>The First Steps for Healthy Babies is a voluntary initiative—not all of Ohio’s birthing hospitals participate.</p>									
Significance:	<p>This measure is significant because it tracks overall hospital participation as well as the individual progress hospitals are making towards the Ten Steps to Successful Breastfeeding. When hospitals have more of the Ten Steps in place, mothers breastfeed longer. The goal of the First Steps initiative is to encourage and support hospitals to implement the Ten Steps to Successful Breastfeeding and become a Baby-Friendly USA designated hospital. Mothers who give birth at Baby-Friendly hospitals are more likely to initiate exclusive breastfeeding and more likely to sustain breastfeeding at six months and one year of age.</p>									

**ESM 5.1 - Percent of birthing hospitals that have received formal training on safe sleep practices and the number of non-birthing hospitals trained on safe sleep practices.**

**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

Measure Status:	Inactive - Replaced									
Goal:	ODH will work collaboratively with the Ohio Hospital Association and other stakeholders to integrate safe sleep practice into the community, develop a targeted media campaign for awareness, and provide safe sleep tools to hospitals and new families.									
Definition:	<table><tr><td>Numerator:</td><td>Number of Ohio birthing and non birthing hospitals that receive training on safe sleep practices</td></tr><tr><td>Denominator:</td><td>Number of Ohio birthing hospitals</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of Ohio birthing and non birthing hospitals that receive training on safe sleep practices	Denominator:	Number of Ohio birthing hospitals	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of Ohio birthing and non birthing hospitals that receive training on safe sleep practices									
Denominator:	Number of Ohio birthing hospitals									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	ODH will track these initiatives' processes and outcomes metrics through a regional score card approach to be developed.									
Significance:	Safe sleep education and outreach is a major priority for ODH, OCPIM, the Ohio Injury Prevention Partnership, Child Fatality Review (CFR), Fetal and Infant Mortality Review, Cradle Cincinnati, March of Dimes, the American Academy of Pediatrics (AAP), Ohio Medicaid and many other organizations. Using the local hospital as a focus for education and distribution, new mothers and their families will receive safe sleep counseling and products, such as a safe sleep jumper. More importantly, hospitals will be asked to participate in the campaign by naming an internal sleep champion, developing safe sleep committees and infrastructure, adopting (and auditing) in-hospital safe sleep practices and instructing employees, parents, families and the community on appropriate safe sleep practices.									

**ESM 5.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids**  
**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

Measure Status:	Active	
Goal:	To increase the number of infants who sleep in a safe sleep environment.	
Definition:		
	Numerator:	Number of families who were provided a crib and safe sleep education through the Cribs for Kids program.
	Denominator:	N/A
	Unit Type:	Count
	Unit Number:	10,000
Data Sources and Data Issues:	Reported by local grantees	
Significance:	Sleep-related infant deaths are the third leading cause of infant death in Ohio. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding.	



**ESM 6.1 - Number of new pediatric practices and family practices participating in the learning collaborative**  
**NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Measure Status:	Inactive - Replaced	
Goal:	Improve quality of comprehensive age appropriate well child screening, follow up and referral.	
Definition:	Numerator:	Committee established
	Denominator:	Number of new pediatric practices and family practices participating in the learning collaborative
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	The Committee member list and meeting notes will be kept by the Child Health workgroup at the Ohio Department of Health.	
Significance:	Screening and well-child visits provide an opportunity for periodic assessment of core health status components including behavioral and mental health, developmental, dental, hearing or visual impairment and to identify and prevent elevated blood lead levels. Early detection and referral leads to earlier treatment & promotes proper management of the conditions. A systematic approach to quality improvement science should result in increasing the percent of children receiving timely, age-appropriate screening & improving the system overall to ensure children receive the care that they need.	
	Comprehensive well child visits is a child health benefit for children under the age of 21. Services are intended to screen, diagnose, and treat children to avoid or minimize childhood illness. A 2010 Office of Inspector General’s report found that children were not receiving all of the required EPSDT screening. (Office of Inspector General Report, November 2014).	
	It is estimated that 1 out of 5 children in Ohio under the age of six are at moderate or high risk for developmental, behavior or social delays. Through EPSDT, a child is identified early through the screening process and is more likely to find appropriate treatment so children are school ready (EPSDT & Developmental Screening, Voices For Ohio’s Children).	
	According to the Resources for Title V Action Planning, Developmental Screening Strategies and Measures, screening for healthy development can reduce the likelihood of a child developing other delays if provided the appropriate screening, referral and follow up treatment.	
	Strategies and activities target increasing the quality of care provided during a well child visit to decrease duplication of efforts while increasing the collaboration and efficiency of stakeholders.	

**ESM 6.2 - Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening**

**NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Measure Status:	Active									
Goal:	Increase the number of children in a home visiting program that receive a developmental screening.									
Definition:	<table><tr><td>Numerator:</td><td>Number of children, ages 9 through 35 months, receiving home visiting services that have received a developmental screening by a home visitor.</td></tr><tr><td>Denominator:</td><td>Number of children, ages 9 through 35 months, receiving home visiting services.</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of children, ages 9 through 35 months, receiving home visiting services that have received a developmental screening by a home visitor.	Denominator:	Number of children, ages 9 through 35 months, receiving home visiting services.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children, ages 9 through 35 months, receiving home visiting services that have received a developmental screening by a home visitor.									
Denominator:	Number of children, ages 9 through 35 months, receiving home visiting services.									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS) – currently under development.									
Significance:	<p>Many children with developmental delays or behavior concerns are not identified as early as possible. As a result, these children must wait to get the help they need to do well in social and educational settings (for example, in school, at home, and in the community).</p> <p>According to the CDC, in the United States, about 1 in 6 children aged 3 to 17 years have one or more developmental or behavioral disabilities, such as autism, a learning disorder, or attention-deficit/hyperactivity disorder. In addition, many children have delays in language or other areas that can affect how well they do in school. However, many children with developmental disabilities are not identified until they are in school, by which time significant delays might have occurred and opportunities for treatment might have been missed.</p>									

**ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations.**  
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Measure Status:	Active									
Goal:	Improved uptake of preventative visits and quality of care during adolescent preventative medical visits. Track characteristics of trained providers (e.g., geographic distribution, characteristics of patients served race, etc.).									
Definition:	<table><tr><td>Numerator:</td><td>Number of physician or registered nurse clinicians (including pediatric, adolescent medicine, family practice) who are trained in Bright Futures clinical recommendations.</td></tr><tr><td>Denominator:</td><td>The state hopes to train at least 100 clinicians/providers per year on the Bright Futures Clinical Recommendations and on strategies for creating adolescent-centered environments. This training is evidence informed.</td></tr><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of physician or registered nurse clinicians (including pediatric, adolescent medicine, family practice) who are trained in Bright Futures clinical recommendations.	Denominator:	The state hopes to train at least 100 clinicians/providers per year on the Bright Futures Clinical Recommendations and on strategies for creating adolescent-centered environments. This training is evidence informed.	Unit Type:	Count	Unit Number:	100
Numerator:	Number of physician or registered nurse clinicians (including pediatric, adolescent medicine, family practice) who are trained in Bright Futures clinical recommendations.									
Denominator:	The state hopes to train at least 100 clinicians/providers per year on the Bright Futures Clinical Recommendations and on strategies for creating adolescent-centered environments. This training is evidence informed.									
Unit Type:	Count									
Unit Number:	100									
Data Sources and Data Issues:	The data source will be training registration data maintained by the training contractor and shared with ODH.									
Significance:	This measure is significant because it will inform the state on progress towards having a workforce trained in adequate provision of preventative medical visits to adolescents. A trained clinician will be a clinician who has registered for and completed a training (provided by a contractor to the state) on the Bright Futures Clinical Recommendations and adolescent-centered environments.									

**ESM 11.1 - Number of new stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs (CYSHCN).**

**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

Measure Status:	Active									
Goal:	Increase access to care via PCMH for CYSHCN by educating families of CSHCN about the importance and benefits of receiving patient-centered, comprehensive, coordinated, accessible, and high quality primary care in a medical home.									
Definition:	<table><tr><td>Numerator:</td><td>Number of new or additional stakeholders who share information about medical homes with their clients/patients</td></tr><tr><td>Denominator:</td><td>Stakeholders are groups who work with CYSHCN such as physician and other health professional associations and patient/consumer advocacy groups.</td></tr><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of new or additional stakeholders who share information about medical homes with their clients/patients	Denominator:	Stakeholders are groups who work with CYSHCN such as physician and other health professional associations and patient/consumer advocacy groups.	Unit Type:	Count	Unit Number:	100
Numerator:	Number of new or additional stakeholders who share information about medical homes with their clients/patients									
Denominator:	Stakeholders are groups who work with CYSHCN such as physician and other health professional associations and patient/consumer advocacy groups.									
Unit Type:	Count									
Unit Number:	100									
Data Sources and Data Issues:	The data will be tracked by the workgroup as contacts are made with stakeholder groups.									
Significance:	In order to increase awareness for families of CSHCN about the importance of receiving care through a PCMH, it will be necessary to work with stakeholders who serve families to educate them about the importance of PCMHs for families with CSHCN. Through better informing stakeholders and providing them with the training and resources to educate families with CSHCN, it is hoped that there will be a significant increase in the number of CSHCN who receive comprehensive coordinated care through PCMHs. This education will happen through working with and training key stakeholder groups to disseminate medical home resources to families of CSHCN. Working with a diverse group of stakeholders who work with CSHCN will enable us to get the message about the benefits of PCMH to many Ohio families with CSHCN.									

**ESM 14.1.1 - Number of publicly funded programs newly trained to implement the 5As.****NPM 14.1 – Percent of women who smoke during pregnancy**

<b>Measure Status:</b>	Inactive - Completed	
<b>Goal:</b>	To reduce the rate of maternal smoking and substance abuse by pregnant women.	
<b>Definition:</b>	<b>Numerator:</b>	Number of programs trained in the 5A's
	<b>Denominator:</b>	Programs trained will include publicly funded programs (e.g., WIC, home visiting, RHWP, etc.) .
	<b>Unit Type:</b>	Count
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Data will be collected from the trainers and maintained by ODH program staff.	
<b>Significance:</b>	Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications including placenta previa, placental abruption, premature rupture of the membrane, preterm delivery, restricted fetal growth, and sudden infant death syndrome [SIDS]	
	Women covered by Medicaid are more than five times more likely to smoke in the last three months of pregnancy than women without Medicaid. Among these women, almost half smoked prior to becoming pregnant and 1 in 3 women smoked throughout their pregnancy.	

**ESM 14.1.2 - Number of pediatric and obstetric-gynecologic providers newly trained to implement the 5 As**  
**NPM 14.1 – Percent of women who smoke during pregnancy**

Measure Status:	Active	
ESM Subgroup(s):	Pregnant Women, All Children 0 through 17	
Goal:	To reduce the rate of smoking among pregnant women, women of childbearing age, and caregivers to children.	
Definition:	Numerator:	Number of providers trained
	Denominator:	Providers will be part of the quality improvement initiative Ohio Smoke Free Families
	Unit Type:	Count
	Unit Number:	50
Data Sources and Data Issues:	Data will be collected in program data base	
Significance:	Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications including placenta previa, placental abruption, premature rupture of the membrane, preterm delivery, restricted fetal growth, and sudden infant death syndrome [SIDS]. Secondhand smoke exposure causes numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, and ear infections. The chemicals in secondhand smoke appear to affect the brain in ways that interfere with its regulation of infants' breathing and increases risk for SIDS.	

**Form 11**  
**Other State Data**  
**State: Ohio**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)