Ohio State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Decrease risk factors contributing to maternal morbidity	By 2025, increase percent of women with a preventive medical visit by 5%.	Provide well-woman visits within Title X clinics following ACOG guidelines Community needs assessment on barriers to pre- and inter-conception care through MP subgrant Implement culturally relevant community, clinical, or community-based services to address unique pre- and inter-conception issues for women 18-44 through MP subgrant Implement education and awareness for pre-conception and reproductive health targeting high-risk women through MP subgrant Find and review data on quality and comprehensiveness of preventative medical visits as well as feasibility and evidence-based practices for promoting standards (include mental health, health behaviors, dental, social determinants, referrals) Work with partners to develop plan to increase coordination, referral, access, and uptake of high-quality services for at-risk women 18-44 Distribute guidelines on managing oral health care during pregnancy to perinatal and dental care providers Integrate oral health education, assessment and referrals for dental care into community-based health care systems that serve women of reproductive age (e.g., FQHCs, WIC, Home Visiting)	***Inactive -*** *ESM WWV.1 - Percent of birthing hospitals implementing AIM hypertension model* ESM WWV.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Decrease risk factors contributing to maternal morbidity	By 2025, reduce the rate of severe maternal morbidity by 12%.	Increase use of AIM safety bundles in healthcare systems for at-risk pregnant women. Develop a statewide strategic maternal health plan through the Ohio Council to Advance Maternal Health (OH-CAMH) Increase the percent of pregnant and postpartum women who receive urgent maternal warning signs education. Train emergency department providers to recognize, triage, and treat obstetric emergencies Train maternal health care providers on how to conduct effective telehealth encounters (project ended in September 2022) Increase women's health screenings during pediatric well visits Gestational Diabetes QI projects to improve postpartum visit and testing rates (project ended January 2022) Implement a quality improvement project focused on improving the compassionate care provided by maternal health providers.			SOM 1: Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women
Decrease risk factors contributing to maternal morbidity	By 2025, develop expanded maternal health surveillance to allow for adequate monitoring and tracking to inform programmatic interventions.	Expand data collections for COVID-19 for maternal population (SOARS, OPAS, ODRS linking to birth certificate) (project ended 2023) Enhance surveillance for maternal morbidity through PAMR program Develop protocols for systemic data into action	***Inactive -*** *ESM WWV.1 - Percent of birthing hospitals implementing AIM hypertension model* ESM WWV.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

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					NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

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					NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
Increase mental health support for women of reproductive age	By 2022, develop plan to increase coordination, referral, and uptake of mental health services for women 18-44.	Develop plan in coordination with other state agencies to increase coordination, referral, and uptake of mental health services for women of reproductive age Continue to build trauma informed care into interventions in community-based settings for mental health Continue screenings for mental health/ substance abuse and provide referrals through Title X program			SOM 2: Percent of women ages 19-44 with 14 or more mentally distressed days in past month
Increase mental health support for women of reproductive age	Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44.	Implement culturally relevant peer support behavioral health services for high risk pregnant and postpartum women through MP subgrant Implement programs and strategies to decrease alcohol use during pregnancy Continue Practice and Policy Academy participation to inform implementations of plans of safe care Increase women's postpartum depression/anxiety screening during pediatric well visits		SPM 1: Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year	
Decrease risk	By 2025, reduce the proportion of	Develop plan to re-engage partnerships and identify strategies for		SPM 2: Percent of women	

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factors associated with preterm births	women of reproductive age smoking by 15%. By 2025, increase enrollment of high-risk populations in evidence-based home visiting programs by 10% each year.	addressing smoking use among women of reproductive age (including 5 A's strategies and provider training through RHWP, WIC, HV, TUPCP) Improve cross-referrals among programs addressing tobacco use (e.g., Quit Line refer to Baby and Me Tobacco Free) Identify and leverage cross promotional/marketing opportunities (media, partner collaborations) Continue to provide supports for pregnant women to quit smoking through Moms Quit for Two program Implement home visiting services for at risk pregnant and postpartum women		ages 18-44 who smoke	
	By 2025, increase percent of women who attended a postpartum checkup within 12 weeks after giving birth by 5%.	Work with domain groups to determine strategies for the next 5-year cycle.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Support healthy pregnancies and improve birth and infant outcomes	By 2025, increase the percent of infants who are ever breastfed to 90.8% and percent of infants who are breastfeed exclusively through 6 months to 31.2%.	Continue implementation and expand promotion of 24/7 breastfeeding hotline and virtual lactation consultants Continue breastfeeding initiatives in hospitals, worksites, and childcare facilities Improve breastfeeding continuity of care Address disparities in lactation care and breastfeeding rates (added FY 23)	ESM BF.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live

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					births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Support healthy pregnancies and improve birth and infant outcomes	By 2025, increase the percent of infants placed to sleep on their back to 93%, alone on separate approved sleep surface to 53.1%, and without soft objects or loose bedding to 76.5%.	Continue implementation of the Cribs for Kids Program to provide safe sleep education and safety-approved cribs to families Continue implementation of the annual safe sleep campaign to provide consistent messaging on safe sleep practices to families Revise safe sleep educational materials to reflect infant safe sleep recommendation updates, once released by the American Academy of Pediatrics	ESM SS.1 - Number of families provided with a crib and safe sleep education through Cribs for Kids	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Support healthy pregnancies and improve birth and infant outcomes	By 2022, develop plan for enhancing coordination of pregnancy and post-partum supports and messaging.	Enhance partnerships with state agencies, local organizations, and stakeholders to improve coordination of pregnancy and postpartum services Enhance partnerships with state agencies to improve coordination of state funding for local MCH activities Explore coordination of safe sleep, breastfeeding, and smoking cessation messaging			
Support healthy pregnancies and improve birth and infant outcomes	By 2025, reduce Black infant mortality rate to 6.0 per 1,000 live births.	Increase access to clinical and social services through outreach and identification of Black pregnant women Increase use of social support services among high-risk Black pregnant women to address social determinants of health Support local community-driven policy and practice change addressing social determinants of health that impact poor birth outcomes Improve access to basic needs resources for pregnant and postpartum women (e.g., Cribs for Kids)			SOM 7: Black Infant Mortality Rate (per 1,000 live births)

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		Data to examine variations in cause of infant death by race and ethnicity to inform data to action			
Support healthy pregnancies and improve birth and infant outcomes	By 2022, assess need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-baby visit.	Assess need for and explore opportunities to educate/train providers on enhanced screenings and education during well-baby visit (Bright Futures, including lead, hearing, vision, oral health, immunizations, safe sleep) Explore cross-program support opportunities through partnership with State Immunizations program			
Child Health					
Improve nutrition, physical activity, and overall wellness of children	By 2025, coordinate across programs to implement the planned strategies below to increase rates of primary care providers conducting quality comprehensive well child visits that include developmental and other screenings.	Increasing provider education/training for comprehensive well visits (Bright Futures, screenings and referrals to include: developmental screenings, lead, hearing vision, oral health, immunizations, BMI, social determinants of health, and ACEs) Partnership between programs that can mutually promote comprehensive well visit (e.g., state immunization) Explore opportunities to support/implement evidence-based models for pediatric primary care Increase the awareness of the need for developmental screenings and other screenings among parents and caregivers Educate primary care providers on billings for provision of services (expand QI initiative for vision screening billing and use results to inform efforts on other billing codes)			SOM 3: Percent of children ages 0-5 with confirmed elevated blood lead levels
Improve nutrition, physical activity, and overall wellness of children	By 2025, increase the percent of children, ages 9-35 months, that receive developmental screens via home visiting programs by 10%	Support MIECHV and other home visiting programs to provide developmental screening using Ages and States Developmental Screening tool Educate parents about developmental screening tools	ESM DS.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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	By 2025, Increase percent of children with and without special care needs, ages 0 through 17, who have a medical home by 5%.	Work with domain groups to determine strategies for the next 5-year cycle.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate	By 2025, reduce risk and increase protective factors for adolescents.	Implement evidence-based adolescent resiliency projects through Adolescent Health Resiliency (previous MP) grant Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation and Bullying Initiative Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease HIB Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP		SPM 3: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000	
Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate	By 2022, develop a plan for MCH to support implementation of Ohio Suicide Prevention Plan among targeted youth population	Increase MCH representation on State Suicide Plan implementation team Identify gaps in state programming that would fit within MCH work Explore programs that MCH can support Coordinate work within MCH to align with state plan and external partner programs		SPM 3: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000	
Increase protective factors and improve	By 2025, increase percent of adolescent with a preventive medical visit in past year by 3%.	Continue collaborative efforts to convert sports physicals to comprehensive well-visits Partner with payors to incentivize the well-visit	***Inactive -*** *ESM AWV.1 - Percent of adolescents (12-17) served by Medicaid*	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

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systems to reduce risk factors associated with the prevalence of adolescent substance use		Partner with Medicaid and Education to support School Based Health Care initiatives Increase the number of schools in Ohio with school-based health centers (added FY 23)	*with adolescent well visit* ESM AWV.2 - Percent of middle and high schools with a school-based health center that offers health services to students	the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6

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					months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Increase protective factors and improve systems to reduce risk factors associated with the	By 2022, develop plan for promoting comprehensive adolescent well-visit that includes:	Provider education/training for comprehensive well-visit emphasizing the connection between physical health and mental health, substance use including tobacco, trauma, and appropriate screenings and referrals to services (Bright Futures) Partnership between programs that can mutually promote comprehensive well-visit (e.g., state immunization) Reviewing state/systems-level policies to assure equitable access to and			SOM 4: Percent of high school students who have used alcohol within the past 30 days

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prevalence of adolescent substance use		uptake of high-quality well-visit			
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use	Identify existing collaboratives and build MCH representation and support Collaborate with partners to conduct an environmental scan of current community prevention work, including risk and protective factors, at state and local levels, including youth led prevention programs Explore with partners development of system for tracking and supporting mental health provider partnerships in schools Analyze existing data to identify priority populations and disparities Continue trauma informed care efforts with public health partners (SADVPP)			SOM 5: Percent of high school students who have used marijuana within the past 30 days
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use	Explore cross-program opportunities with TUPCP for youth tobacco use prevention and cessation (e.g., cross-program referrals; cross-program promotional/marketing opportunities) Increase youth voice and engagement in ODH youth-serving programs (added FY 22)			SOM 6: Percent of high school students who have used cigarettes, smokeless tobacco, cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days
Children with Special Health Care Needs					
Increase prevalence of children with special health care needs receiving integrated physical,	By 2025, Increase percent of Ohio's adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care by 10%.	Work with adult and pediatric medical providers to assure knowledge and awareness of transition Work with partners to increase the number of adult providers that serve CYSHCN population and participate in transition planning Work with partners such as the CMH parent advisory committee and ODH youth advisory committees to assure family and teen knowledge and support	ESM TR.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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behavioral, developmental, and mental health services		regarding transition Support children's and adult hospital systems in the same geographic area to conduct pilot transition projects Identify social determinant barriers in medical transition and require transition planning model to address		NPM 12) - TR	
Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	By 9/30/2024, Implement plans for increasing the percent of Ohio's adolescents with special health care needs, ages 12 through 17, who received services to support transitions to adulthood outside health care	Explore non-health care transition resources and methods of sharing, including in health care transition planning and education (including identifying and educating those who will be responsible for sharing resources with individuals and families) Explore mechanisms for automatic referrals for children at certain age to those other programs that would help transition to other supports/ systems	ESM TR.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	By 2025, Increase percent of Ohio's children with special health care needs, ages 0-17, who receive care in a well-functioning system by 10%.	Work with partners to coordinate services within clinical and non-clinical service delivery systems (e.g., explore interagency agreements, automatic referral protocols, coordinated outreach, and education) Strengthen partnerships with children's hospitals who provide Hospital-Based Service Coordination (HBSC) for CYSHCN enrolled in the CMH program to embed service coordination plans in electronic medical records for access/use by all clinicians and caregivers Seek ways to expand HBSC for CYSHCN not enrolled in CMH Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems Work with partners including the CMH parent advisory committee and ODH youth advisory committee to develop action team to examine previous preparedness workbook and develop new plan for increasing resources to develop emergency preparedness plans among CYSHCN	ESM TR.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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	By 2025, Increase percent of children with and without special health care needs, ages 0 through 17, who have a medical home by 5%.	Work with domain groups to determine strategies for the next 5-year cycle.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
Prevent and mitigate the effects of adverse childhood experiences	By 2022, enhance data collection to inform ACEs prevention and intervention	Apply for funding from CDC to add ACEs questions to the Youth Risk Behavior Survey (YRBS) Coordinate YRBS and OHYes data collection efforts Develop and implement a plan to share YRBS data (including ACEs) to inform state and local programming (added FY22)		SPM 4: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)	
Prevent and mitigate the effects of adverse childhood experiences	By 2025, reduce the number of children 0-17 who experience two or more ACEs by 10% through integration of ACEs throughout each population Action Plan. Cross-strategies with other priorities:	Explore opportunities to support/implement evidence-based models for pediatric primary care to identify and address ACEs exposure with brief screening and assessments and referral to intervention services and supports (Child) Implement evidence-based adolescent resiliency projects through MP grant (Adolescent) Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation and Bullying Initiative (Adolescent) Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease HIB (Adolescent) Support programming in local communities and Ohio Health Improvement Zones for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP (Women & Adolescent) Support MCH programs to further integrate ACEs and Health Equity within		SPM 4: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)	

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		each population Action Plan (added FY 22)			
Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes	By 2025, implement plan to developed by bureau Health Equity Committee to build system to advance health equity in MCH staff and programs	Select and implement health equity-increasing strategies in all state priority areas Develop plan for improving internal MCH organization equity and staff capacity through the Bureau Health Equity Advancement Team (HEAT) Develop plan to institutionalize health equity in policy, program, grant, and contract administration through bureau workgroup Build diversity in CMH Parent Advisory Committee		SPM 5: Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities	
Prevent and mitigate the effects of adverse childhood experiences	By 2025, develop and begin implementation of a plan to build a state system that prevents ACEs, increases resiliency, and heals traumatic health outcomes resulting from ACEs	Leverage and expand the state team from the ASPIRE project to continue strategic planning on ACEs (project ended FY22) Provide support to both ODH and other health/public health organizations by promoting organizational shifts in culture that support a trauma responsive approach to clinical and public health services. (added FY23) Continue coordination of efforts around shared risk and protective factors with a focus on “connection to a caring adult, as this is resonating with existing work within multiple MCH programs related to outreach to providers and caregivers. (added FY23)		SPM 4: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)	