Ohio State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Decrease risk factors contributing to maternal morbidity	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) Increase the percent of uninsured women who are enrolled in or referred to enrollment in health insurance within Title X clinics.	By 2025, increase percent of women with a preventive medical visit by 5%.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Percent of birthing hospitals implementing AIM hypertension model* ESM 1.2: 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	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

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					NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations 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
Decrease risk factors contributing to maternal morbidity	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 in WIC, Home Visiting, and Healthy Start programs 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)	By 2025, reduce the rate of severe maternal morbidity by 12%.			SOM 1: Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women
Decrease risk factors contributing to	Expand data collections for COVID-19 for maternal population (SOARS, OPAS, ODRS linking to birth certificate)	By 2025, develop expanded maternal health surveillance to allow for adequate monitoring and	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in	***Inactive -*** *ESM 1.1: Percent of birthing hospitals implementing*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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maternal morbidity	Enhance surveillance for maternal morbidity through PAMR program Develop protocols for systemic data into action	tracking to inform programmatic interventions.	the past year	*AIM hypertension model* ESM 1.2: 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	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: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

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					NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Increase mental health support for women of reproductive age	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	By 2022, develop plan to increase coordination, referral, and uptake of mental health services for women 18-44.			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	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 Implement Women's Behavioral Health Learning Collaborative within family medicine practices to improve postpartum visits (added FY 22)	Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44.	SPM 1: Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year		
Decrease risk factors associated with preterm births	Develop plan to re-engage partnerships and identify strategies for 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)	By 2025, reduce the proportion of 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.	SPM 2: Percent of women ages 18-44 who smoke		

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	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				
Perinatal/Infant Health					
Support healthy pregnancies and improve birth and infant outcomes	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)	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%.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies	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: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Support healthy pregnancies and improve birth and infant outcomes	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 Partner with local infant mortality collaboratives to tailor statewide safe sleep messaging to better reflect experiences of communities of color (added FY 23) Revise safe sleep educational materials to reflect infant safe sleep recommendation updates, once released by the American Academy of Pediatrics	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%.	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	ESM 5.1: Number of families provided with a crib and safe sleep education through Cribs for Kids	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: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Support healthy pregnancies and improve birth and infant outcomes	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	By 2022, develop plan for enhancing coordination of pregnancy and post-partum supports and messaging.			

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Support healthy pregnancies and improve birth and infant outcomes	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) Data to examine variations in cause of infant death by race and ethnicity to inform data to action	By 2025, reduce Black infant mortality rate to 6.0 per 1,000 live births.			SOM 7: Black Infant Mortality Rate (per 1,000 live births)
Support healthy pregnancies and improve birth and infant outcomes	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	By 2022, assess need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-baby visit.			
Child Health					
Improve nutrition, physical activity, and overall wellness of children	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	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.			SOM 3: Percent of children ages 0-5 with confirmed elevated blood lead levels

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	QI initiative for vision screening billing and use results to inform efforts on other billing codes)				
Improve nutrition, physical activity, and overall wellness of children	Support MIECHV and other home visiting programs to provide developmental screening using Ages and States Developmental Screening tool Educate parents about developmental screening tools	By 2025, increase the percent of children, ages 9-35 months, that receive developmental screens via home visiting programs by 10%	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	ESM 6.1: Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening	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
Adolescent Health					
Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate	Implement evidence-based adolescent resiliency projects through 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	By 2025, reduce risk and increase protective factors for adolescents.	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	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	By 2022, develop a plan for MCH to support implementation of Ohio Suicide Prevention Plan among targeted youth population	SPM 3: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000		
Increase	Continue collaborative efforts to convert sports physicals to comprehensive	By 2025, increase percent of	NPM 10: Percent of	***Inactive -*** *ESM 10.1:*	NOM 16.1: Adolescent mortality

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protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	well-visits Partner with payors to incentivize the well-visit 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)	adolescent with a preventive medical visit in past year by 3%.	adolescents, ages 12 through 17, with a preventive medical visit in the past year.	*Percent of adolescents (12-17) served by Medicaid with adolescent well visit* ESM 10.2: Percent of middle and high schools with a school-based health center that offers health services to students	rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health 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) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have

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					received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	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 uptake of high-quality well-visit	By 2022, develop plan for promoting comprehensive adolescent well-visit that includes:			SOM 4: Percent of high school students who have used alcohol within the past 30 days
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent	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	By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use			SOM 5: Percent of high school students who have used marijuana within the past 30 days

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substance use	Continue trauma informed care efforts with public health partners (SADVPP)				
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance 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)	By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use			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, behavioral, developmental, and mental health services	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 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	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%.	NPM 12: 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	ESM 12.1: Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Increase prevalence of children with special health care needs receiving integrated	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	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	NPM 12: 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	ESM 12.1: Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	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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physical, behavioral, developmental, and mental health services					
Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	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	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%.	NPM 12: 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	ESM 12.1: Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Cross-Cutting/Systems Building					
Prevent and mitigate the effects of adverse childhood experiences	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)	By 2022, enhance data collection to inform ACEs prevention and intervention	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	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)	By 2025, reduce the number of children 0-17 who experience two or more ACEs by 10% through integration of ACEs throughout	SPM 4: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood		

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childhood experiences	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 each population Action Plan (added FY 22)	each population Action Plan. Cross-strategies with other priorities:	experiences (ACEs)		
Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes	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	By 2025, implement plan to developed by bureau Health Equity Committee to build system to advance health equity in MCH staff and programs	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	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)	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	SPM 4: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)		

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	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)				