Ohio State Action Plan Table 2026 Application/2024 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 2030, increase percent of women with a preventative medical visit by 5%.	Provide well-woman visits within Title X clinics following national standards of care. Work with Title X clinics to increase coordination, referral, access, and uptake of high-quality services for at-risk women 19-44. Provide education and increase awareness for preconception and reproductive health focusing on high-risk women. Increase the percent of uninsured women who are enrolled in or referred for enrollment in health insurance within Title X clinics. Distribute guidelines on managing oral healthcare during pregnancy to perinatal and dental care providers. Integrate oral health education, assessment, and referrals for dental care into primary care and community-based health systems for prenatal patients.	***Inactive -*** *SPM ESM 1.1 - 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* SPM ESM 1.2 - Percent of birthing hospitals implementing the AIM patient safety bundle	SPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	**Linked NOMs:** Severe Maternal Morbidity **Linked SOMs:** 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 2030, reduce the rate of severe maternal morbidity by 10%.	Increase use of Alliance for Innovation on Maternal Health (AIM) patient safety bundles in birthing hospitals. Develop a statewide maternal health strategic plan through the Ohio Council to Advance Maternal Health (OH-CAMH). Train emergency department providers to recognize, triage, and treat obstetric emergencies. Implement a quality improvement project in birthing hospitals focused on building capacity to provide respectful maternity care. Statewide education of urgent maternal warning signs education.	ESM PPV.1 - 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 - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety **Linked SOMs:** SOM 2 - Percent of women who experience postpartum depressive symptoms

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		Center the experiences of women in the co-design of program interventions, ensuring a trauma-informed approach.			
Decrease risk factors contributing to maternal morbidity.	By 2030, develop expanded maternal health data monitoring and analyses.	Create recommendations for state use of severe maternal morbidity (SMM) data. Prioritize and disseminate Pregnancy-Associated Mortality Review (PAMR) recommendations.	ESM PPV.1 - 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 - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety **Linked SOMs:** SOM 2 - Percent of women who experience postpartum depressive symptoms
Decrease risk factors contributing to maternal morbidity.	By 2030, increase the percentage of all women who attend a postpartum checkup within 12 weeks after giving birth to 95%. (2023: overall 91%, NH White 93.4%, NH Black 86.2%, Hispanic 81.7%)	By 2028, analyze Ohio Pregnancy Assessment Survey (OPAS) data to inform program decision-making on interventions needed to improve postpartum visits. Create and implement the Maternal Outreach Movement 365 (M.O.M. 365) training package. Develop a fourth-trimester toolkit. Encourage Title X clinics to offer postpartum visits and ask all women if they have been pregnant or delivered within the past 12 months. If yes, screen for urgent maternal warning signs and refer for supportive services, if appropriate.	ESM PPV.1 - 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 - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety **Linked SOMs:** SOM 2 - Percent of women who experience postpartum depressive symptoms
Increase behavioral health support for women of reproductive age.	By 2030, develop plan to increase access, coordination, referral, and uptake of behavioral health services for women 19-44.	Develop plan in coordination with other state agencies to increase coordination, referral, and uptake of mental health services for women of reproductive age. Support health, public health, and behavioral health systems to be more trauma-informed as organizations/workplaces, allowing for improved staff support and retention and leading to more trauma-informed interventions for patients/clients. Continue screenings for mental health/substance use and provide referrals through Title X program.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year	**Linked SOMs:** SOM 2 - Percent of women who experience postpartum depressive symptoms SOM 3 - Percent of women ages 19-44 with 14 or more mentally distressed days in past month

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		Improve identification of and treatment for women of childbearing age with depression and/or anxiety. Implement coordinated peer support behavioral health services for high-risk pregnant and postpartum women through the Perinatal Behavioral Health Peer Support (PB) subgrant program. Implement programs and strategies to decrease alcohol use during pregnancy. Strengthen prenatal use of Plans of Safe Care for pregnant women with substance use as supported by the Comprehensive Addiction and Recovery Act (CARA) Child Abuse Prevention and Treatment Act (CAPTA) state grant. Promote interconception care by identifying maternal risk through assessments at well-child visits and providing treatment and/or referrals to help moms improve interconception health. Implement AIM Care for Pregnant and Postpartum Women with Substance Use Disorder (SUD) patient safety bundle in birthing hospitals.			
Perinatal/Infant Health					
Support healthy pregnancies and infants to reach their first birthdays.	By 2030, reduce the proportion of women of reproductive age smoking to 4.3%.	Develop a plan to re-engage partnerships and identify strategies for addressing smoking use among women of reproductive age (including provider training through RHWP, WIC, OCHIDS, and TUCP). Increase collaboration among programs addressing tobacco use (e.g., ODH, DCY, MHAS). Identify and leverage cross-promotional/marketing opportunities (media, partner collaborations). Provide supports for pregnant women to quit smoking during pregnancy and improve birth outcomes.	SPM ESM 3.1 - Percent of high-risk women enrolled in evidence-based home visiting programs	SPM 3: Percent of women who smoke during pregnancy	**Linked NOMs:** Preterm Birth Infant Mortality **Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Support healthy	By 2030, increase enrollment of	Implement home visiting services for at risk pregnant and postpartum	ESM BF.1 - Percent	NPM - Breastfeeding	**Linked NOMs:**

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pregnancies and infants to reach their first birthdays.	high-risk populations in evidence-based home visiting programs by 10% each year.	women.	of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies		Infant Mortality Postneonatal Mortality SUID Mortality **Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Support healthy pregnancies and infants to reach their first birthdays.	By 2030, increase the percent of infants who are ever breastfed to 83.8% and percent of infants who are breastfed exclusively through 6 months to 32.5%.	Continue implementation and expand promotion of 24/7 breastfeeding hotline and virtual lactation consultants. Continue breastfeeding initiatives in hospitals, worksites, and child care facilities. Improve breastfeeding continuity of care. Address differences in lactation care and breastfeeding rates.	ESM BF.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality **Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Support healthy pregnancies and infants to reach their first birthdays.	By 2030, increase the percent of infants placed to sleep on their backs to 88.9%, alone on separate approved sleep surface to 59.1%, and without soft objects or loose bedding to 79.0%.	Continue implementation and expansion of the Cribs for Kids Program to provide safe sleep education and safety-approved cribs to all counties in Ohio. Continue implementation of the annual safe sleep campaign to provide consistent messaging on safe sleep practices to families. Create, revise, and disseminate safe sleep educational materials to reflect infant safe sleep recommendation updates released by the American Academy of Pediatrics. Update and disseminate annual safe sleep training for providers, parents/grandparents, children's services, Cribs for Kids partner agencies, etc.	ESM SS.1 - Percent of Ohio counties served by Cribs for Kids ***Inactive -*** *ESM SS.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids*	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality **Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Support healthy pregnancies and infants to reach their first birthdays.	By 2030, assess the need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-	Assess need for and explore opportunities to educate/train providers on enhanced screenings and education during a well-baby visit (Bright Futures, including lead, hearing, vision, oral health, immunizations, and safe sleep).	ESM SS.1 - Percent of Ohio counties served by Cribs for Kids ***Inactive -*** *ESM SS.2*	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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	baby visits.	Explore cross-program support opportunities through partnership with the State Immunization Program.	*- Number of families provided with a crib and safe sleep education through Cribs for Kids*		**Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Support healthy pregnancies and infants to reach their first birthdays.	By 2030, reduce the ratio of the Non-Hispanic Black infant mortality rate to the Non-Hispanic White infant mortality rate to 2.0, with the ultimate goal of parity.	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 factors influencing health. Support local community-driven policy and practice change addressing factors influencing health that impact poor birth outcomes. Improve access to basic needs resources for pregnant and postpartum women (e.g., Cribs for Kids). Leverage surveillance data, including Child Fatality Review, Fetal Infant Mortality Review, and Pregnancy-Associated Mortality Review, to inform the preventability of perinatal and infant deaths, to inform data-to-action.	ESM SS.1 - Percent of Ohio counties served by Cribs for Kids ***Inactive*** *- ESM SS.2 - Number of families provided with a crib and safe sleep education through Cribs for Kids*	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality **Linked SOMs:** SOM 4 - Ratio of Non-Hispanic Black to Non-Hispanic White infant mortality rate per 1,000 live births
Child Health					
Improve/increase support systems to promote growth and development of children to support positive health outcomes.	By 2030, collaborate and coordinate across programs to implement the planned strategies below to educate and increase rates of children with medical homes that conduct quality comprehensive child visits that include developmental and other screenings.	Increase provider education/training for comprehensive well visits (Bright Futures, screenings, and referrals to include developmental screenings, lead, hearing, vision, oral health, immunizations, BMI, factors influencing health, food insecurity, mental health, and ACEs). Partnership between programs that can mutually promote comprehensive well visit (e.g., state immunization, Early Childhood Education (ECE) programs, CHWs, etc.). Explore opportunities to support/implement evidence-based models for pediatric primary care. Increase awareness of the need for developmental screenings and other screenings among parents and caregivers. Educate and expand care coordination efforts for all.	ESM MH.1 - Number of ODH-funded School-Based Health Centers that are in Health Professional Shortage Areas	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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		Reduce barriers and improve systems to increase access to healthcare for all (promote awareness, collaboration, and review policies through programs like asthma, vision, oral, and hearing). Gather, educate, and share resources on various screening tools and information on different diagnoses, such as Fetal Alcohol Spectrum Disorders (FASD). Collaborate and share resources from the Pediatric Mental Health Care Access Program (PMHCA) and other ECE mental health programs. Provide resources, technical assistance, and professional development to support professionals in school and early childhood settings.			
Improve/increase support systems to promote growth and development of children to support positive health outcomes.	By 2030, 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, educate, and share developmental screening using the Ages and Stages Developmental Screening tool. Educate parents about developmental screening tools. Educate the ECE community and other professionals on screening tools. Support and educate the community on home visiting to increase enrollment to enhance screenings. Use screenings and visits to connect families with resources. Gather, educate, and share resources on a variety of screening tools and information on different diagnoses, such as FASD.	ESM DS.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status **Linked SOMs:** SOM 5 - Percent of children ages 0-5 with confirmed lead poisoning (BLL ≥ 10 µg/dL)
Improve/increase support systems to promote growth and development of children to support positive health outcomes.	By 2030, increase healthy environments for children through more educational opportunities and resources for families around nutrition, physical activity, and overall wellness and be accessible for all to reduce childhood obesity.	Develop partnerships between programs that can mutually promote wellness, including trauma-informed care, early intervention, and school supports for all children. Increase provider education/training for professionals working with families and children. Explore policy change around physical activity, nutrition, and overall health.	ESM PA-Child.1 - Percent of licensed early education programs who are designated by Ohio Healthy Program	NPM - Physical Activity - Child	**Linked NOMs:** Children's Health Status Child Obesity

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		Engage community and agency stakeholders to utilize a Community of Practice approach to share resources, build support, and collaborate. Develop and launch a social media campaign around obesity awareness and prevention, healthy eating, and active living. Promote awareness of asthma management through community engagement to reduce barriers and support healthy living environments.			
Adolescent Health					
Increase developmental approaches, protective factors, and improve systems to reduce risk factors to improve youth behavioral health.	By 2030, reduce risk and increase protective factors for adolescents to decrease the effects of and prevent adverse childhood experiences (ACEs).	Implement evidence-based adolescent resiliency projects that support protective factors which will prevent or mitigate ACEs through the Adolescent Health Grant, Youth Homelessness, and Youth Suicide Prevention Grant. Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio School Safety, Violence Prevention Workgroup Youth Homelessness Subcommittee, and the Tobacco-Free Ohio Alliance Youth Workgroup. Decrease risk factors and increase protective factors by implementing the Sexual Risk Avoidance program in high-risk Ohio counties and supporting the parent involvement component within the program. Provide resources, technical assistance, and professional development to health professionals working in the school and early childhood level to support resiliency and decrease harassment, intimidation, and bullying (HIB). Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through the Sexual Assault Domestic Violence Prevention Program (SADVPP) and continue trauma-informed care efforts with public health partners. Explore cross-program opportunities with the Tobacco Use Prevention and Cessation Program (TUPCP) for youth tobacco use prevention and	SPM ESM 4.1 - Percent of enrolled providers who completed a consultation with the OPPAL program	SPM 4: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 10-19, per 100,000	**Linked NOMs:** Adolescent Suicide

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		cessation (e.g., cross-program referrals; cross-program promotional/marketing opportunities).			
Increase developmental approaches, protective factors, and improve systems to reduce risk factors to improve youth behavioral health.	By 2030, support the implementation of the Ohio Suicide Prevention Plan.	Coordinate work within MCH to align with state plan and external partner programs. Support the Child Injury Action Group (CIAG) Youth Suicide Subcommittee. Expand and support Store it Safe (SIS) efforts.	SPM ESM 4.1 - Percent of enrolled providers who completed a consultation with the OPPAL program	SPM 4: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 10-19, per 100,000	**Linked NOMs:** Adolescent Suicide
Increase developmental approaches, protective factors, and improve systems to reduce risk factors to improve youth behavioral health.	By 2030, support and expand the Ohio Pediatric Psychiatry Access Line (OPPAL) and Ohio's Pediatric Mental Health Care Access (PMHCA) program.	Provide child psychiatry consultation, education, and resources to pediatric primary care providers and health professionals to improve behavioral health capacity for youth.	SPM ESM 4.1 - Percent of enrolled providers who completed a consultation with the OPPAL program	SPM 4: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 10-19, per 100,000	**Linked NOMs:** Adolescent Suicide
Increase developmental approaches, protective factors, and improve systems to reduce risk factors to improve youth behavioral health.	By 2030, increase youth voice and engagement efforts to improve adolescent health programs.	Continue to recruit and implement the Teen Wellness Team. Hold at least seven required sessions with the teens to increase youth voice in MCH programs. Hold the first annual Adolescent Health Summit (AHS) to showcase ODH programs that work on adolescent health. Explore working with the Teen Wellness Team to plan and participate in the AHS.	SPM ESM 4.1 - Percent of enrolled providers who completed a consultation with the OPPAL program	SPM 4: Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 10-19, per 100,000	**Linked NOMs:** Adolescent Suicide
Reduce barriers and improve systems to increase access to healthcare for youth.	By 2030, increase percent of adolescents with a preventive medical visit in the past year to 82.6%.	Partner with state and local agencies to support School-Based Health Care (SBHC) initiatives. Provide technical assistance to schools and health partners to implement SBHC. Increase the number of school districts that have access to School-Based Health Centers (SBHC).	ESM AWV.1 - Percent of middle and high schools with a school-based health center that offers health services to students	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity

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		Enhance collaboration between school nurses, healthcare providers, and community organizations to improve health outcomes for adolescents. Improve SBHC data collection and analysis.			Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Reduce barriers and improve systems to increase access to healthcare for youth.	By 2030, expand promoting comprehensive adolescent well-visits in alignment with Bright Futures.	Provider education/training for comprehensive well-visit emphasizing the connection between physical health and mental health, substance use, including tobacco/nicotine, trauma, and appropriate screenings and referrals to services. Partnership between programs that can mutually promote comprehensive well-visit (e.g., state immunization, asthma program). Collaborate to establish innovative partnerships with other ODH programs, community partners, and other state agencies to work on Healthy Eating Active Living (HEAL) initiatives and strategies for adolescents.	ESM AWV.1 - Percent of middle and high schools with a school-based health center that offers health services to students	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Reduce barriers and improve systems to increase access to healthcare for youth.	By 2030, develop a strategy for integrating school and community health programs (including asthma management, dental disease prevention and oral health promotion, vision health screenings, and hearing screenings).	Create school-based health education/training programs to promote awareness of the above health programs, ensuring a comprehensive understanding of how these areas connect to overall physical and mental well-being. Establish a network of services for the above health programs by increasing collaboration between schools, community health organizations, and local providers to improve resource use and navigation by community members. Review and revise policies and school health guidelines to ensure optimal access to preventive services, including the above health programs.	ESM AWV.1 - Percent of middle and high schools with a school-based health center that offers health services to students	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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Children with Special Health Care Needs					
Increase the prevalence of children with special health care needs receiving integrated care by improving targeted efforts to enhance accessibility and care coordination throughout the lifespan.	By 2030, increase percent of Ohio's children and youth with special healthcare 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 ensure knowledge and awareness of transition. Work with partners to increase the number of adult providers who serve the CYSHCN population and participate in transition planning. Work with partners such as the Complex Medical Help (CMH) program, the CMH Parent Advisory Committee, and ODH Youth Advisory Committees to ensure 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 barriers in medical transition and require a transition planning model to address.	ESM TAHC.1 - Percent of CSHCN ages 17 and older enrolled in Complex Medical Help with a transition plan in place	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Increase the prevalence of children with special health care needs receiving integrated care by improving targeted efforts to enhance accessibility and care coordination throughout the lifespan.	By 2030, increase percent of Ohio's children and youth with special healthcare 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 including schools, school-based health centers, and school nurses. Share trauma-informed resources with and coordinate transitional services (e.g., explore interagency agreements, coordinate outreach, address ACEs, and education). Strengthen collaboration with family navigation programs to help caregivers access current resources and services. Promote Ohio Parent-to-Parent (Ohio P2P) mentoring model through active engagement with community-based organizations, faith-based organizations, family support organizations, and other nontraditional partnerships to assist parents with navigating complex medical systems. Work with partners, including the CMH Parent Advisory Committee and ODH Youth Advisory Committees to examine and or update materials and previous preparedness workbook. Assess the current plan for increasing resources to develop emergency preparedness plans among CYSHCN.	ESM MH.1 - Number of ODH-funded School-Based Health Centers that are in Health Professional Shortage Areas	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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Increase the prevalence of children with special health care needs receiving integrated care by improving targeted efforts to enhance accessibility and care coordination throughout the lifespan.	By 2030, increase percent of children and youth with special healthcare needs receiving care within a medical home by 10%.	Offer ongoing professional development opportunities for providers to strengthen family-centered care within a medical home. Work with partners to develop partnerships with providers, specialists, and community organizations to improve the automatic referral process. Seek ways to expand Hospital-Based Service Coordination (HBSC) for CYSHCN not enrolled in CMH. Strengthen partnerships with children's hospitals who provide 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.	ESM MH.1 - Number of ODH-funded School-Based Health Centers that are in Health Professional Shortage Areas	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Cross-Cutting/Systems Building					
Prevent and mitigate the effects of adverse childhood experiences.	By 2030, enhance data collection to inform ACEs prevention and intervention.	Continue to implement plans to share Youth Risk Behavior Survey (YRBS) data (including ACEs) to inform state and local programming. Continue to coordinate YRBS and OHYes data collection efforts.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: 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 2030, reduce the number of children 0-17 who experience two or more ACEs by 10% through integration of prevention of ACEs throughout each population domain's Action Plan. Cross strategies from other population domains.	Increase provider education/training for comprehensive well visits (Bright Futures, screenings, and referrals to include developmental screenings, lead, hearing, vision, oral health, immunizations, BMI, factors influencing health, food insecurity, mental health, and ACEs). (Child) Work with partners to coordinate services within clinical and non-clinical service delivery systems (including schools, school-based health centers, and school nurses) who can share trauma-informed resources with and coordinate transitional services (e.g., explore interagency agreements, coordinated outreach, address ACEs, and education). (Child) Implement evidence-based adolescent resiliency projects that support protective factors, which will prevent or mitigate ACEs through the Adolescent Health Grant and Youth Suicide Prevention Grant. (Adolescent) Support programming in local communities for professionals and	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)	

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		community members on preventing violence and identifying and responding to victims of violence through SADVPP. (Adolescent) Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease harassment, intimidation, and bullying (HIB). (Adolescent) Support MCH programs to further integrate prevention of ACEs and support optimal health opportunities within each population Action Plan.			
Prevent and mitigate the effects of adverse childhood experiences.	By 2030, begin implementation of a plan to build a state system that prevents ACEs, increases resiliency, and heals traumatic health outcomes resulting from ACEs.	Work with the state trauma-informed care team led by Ohio Mental Health Addiction Services (OHMAS) to contribute to a statewide trauma-informed care plan. Work internally across ODH bureaus to identify current and potential efforts to address trauma-informed care, both internally and in coordination of trauma-informed approaches within and/or across health areas – for example, coordination of efforts around shared risk and protective factors. Provide support to other health/public health organizations by promoting organizational shifts in culture that support a trauma-responsive approach to clinical and public health services. Increase access to trauma-informed clinical and social services through outreach and identification of Black pregnant women. (Infant) Develop partnerships between programs that can mutually promote wellness including trauma-informed care, early intervention, and school supports for all children. (Child) Support health, public health, and behavioral health systems to be more trauma-informed as organizations/workplaces, allowing for improved staff support and retention and leading to more trauma-informed interventions for patients/clients. (Woman, Adolescent) Work with partners to coordinate services within clinical and non-clinical service delivery systems including schools, school-based health centers,	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)	

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		and school nurses, who can share trauma-informed resources with and coordinate transitional services. (CYSHCN)			
Address social conditions and environmental hazards that impact family health outcomes by improving health opportunities.	By 2030, support collaborative efforts led by the Bureau of Health Opportunity Committee to advance health opportunities across all MCH staff and programs.	Select and implement health opportunity strategies in Ohio Health Improvement Zones priority areas to enhance the quality and satisfaction of programmatic efforts and increase optimal health outcomes. Improve internal MCH organization and staff capacity through the Bureau's collaborative efforts. Institutionalize methods to advance our community engagement, data, and surveillance, and grant efforts to better serve families through bureau workgroups.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 6: Percent of performance measures that include at least one strategy focused on factors influencing health, at-risk populations, or health disparities	
Foster coordination between agencies/systems to better serve the community.	By 2030, Promote state efforts to foster coordination locally for local impact.	Explore collaborative opportunities between agencies and systems to better serve the community. Identify opportunities for looking at data to better understand cross-system usage of services.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 7: Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance	