Maternal and Child Health Services Title V Block Grant

Ohio

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

Christopher Dykton, MA
Acting Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Dykton:

I am pleased to submit Ohio's application for the Maternal and Child Health (MCH) Services Block Grant (BG) for Federal Fiscal Year 2022. The Title V MCH Program fully embraces the charge of improving health outcomes for populations it serves in Ohio. Included in this application are the Block Grant Annual Plan for FFY 2022 and the Block Grant Annual Report for FFY 2020.

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

The Title V MCH priorities and BG application are in alignment with the State Health Improvement Plan (SHIP). Alignment with this major public health plan further enables ODH to address the healthcare needs of MCH populations in Ohio.

If you have any questions, please contact:

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Sincerely,

Bruce Vanderhoff, MD

Bruce Vanderhoff, MD, MBA
Director of Health

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The State of Ohio is an Equal Opportunity Employer and Provider of ADA Services.

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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

To identify Ohio's MCH priority focus areas for 2021-2025, MCH led a collaborative and comprehensive needs assessment process with internal and external MCH experts, agency partners, families, and consumers in alignment with the SHA, SHIP, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment. Since completion of the 2020 needs assessment, the COVID-19 pandemic has underscored the importance of the resulting priorities:

- Decrease risk factors contributing to maternal morbidity
- Increase mental health support for women of reproductive age
- Decrease risk factors associated with preterm births
- Support healthy pregnancies and improve birth and infant outcomes
- Improve nutrition, physical activity, and overall wellness of children
- Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
- Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use
- Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services
- Prevent and mitigate the effects of adverse childhood experiences
- Improve healthy equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

A Five-Year Action Plan drives the development and implementation of strategies and activities aligning the National Performance Measures, National Outcome Measures, Evidence-Based Strategy Measures, and state MCH priorities within six population health domains: women/maternal health, perinatal/infant health, child health, CYSHCN, adolescent health, and cross-cutting/systems building. The Ohio MCH program uses an Action Group structure to manage its MCH priorities and implement strategies within the Five-Year Action Plan. Each priority Action Group is comprised of staff, stakeholders, and consumers including representatives from state agencies, local health departments, health care organizations, managed care organizations, insurance, consumers, parent and family groups representing CYSHCNs, universities, and community agencies. The Action Groups update the Five-year Action Plan, assess performance measure outcomes, implement and monitor strategies to impact the performance and outcome measures, and create or identify an evaluation plan to assess whether or not the interventions have been successful. In addition to the Action Groups, MCH program administrators utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes.

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

A summary of each domain and strategies from the 2021-2025 Action Plan are included below. The descriptions represent key initiatives but do not reflect the entirety of work being implemented across the state and in collaboration with stakeholders.

Women/Maternal Health

The MCH priorities reflect ongoing need to address maternal morbidity, mental health for women of reproductive age, and risk factors associated with pre-term births. To address all three priorities, the Action Group will continue to work with a diverse set of partners to improve the outcomes for women before, during, and after pregnancy.

While the rate of severe maternal morbidity in Ohio is lower than the U.S. rate, the rate for Hispanic, non-Hispanic Asian/Pacific Islander, and non-Hispanic Black women is higher than the rate for non-Hispanic white women. Preconception care continues to be prioritized as prevention for maternal morbidity, and an opportunity to improve overall women's health. Title X clinics implement Reproductive Life Plans for all clients of child-bearing age and have increased Long-Acting Reversible Contraception use among clients. Preconception health efforts also include community needs assessments to identify pre- and interconception issues and barriers to inform plans to implement culturally relevant community, clinical, or community-based services. The Oral Health Program is increasing the integration of oral health education, assessment, and referral into prenatal care. The Pregnancy Associated Mortality Review (PAMR) program leads multiple initiatives to address maternal morbidity, including AIM safety bundles, urgent maternal warning signs education, telehealth and obstetric emergency training, and the Ohio Council to Advance Maternal Health (OH-CAMH). OH-CAMH will focus the efforts of over 80 stakeholder organizations to improve maternal health outcomes, address gaps, and implement strategies that translate knowledge and recommendations into practice through a statewide Maternal Health Strategic Plan.

Women in Ohio experience unmet mental health needs and more Ohio women experience postpartum depression compared to the U.S. Preliminary evidence indicates that the COVID-19 pandemic has further increased mental health needs for women while also decreasing opportunities to screen and access services. The Action Group is focused on addressing mental health for all women, including through screening and referral of women of child-bearing age through Title X, increasing trauma informed care in community-based health and mental health settings, providing culturally relevant peer support behavioral health services for high risk pregnant and postpartum women, and postpartum depression/anxiety screening during pediatric well visits. The Fetal Alcohol Spectrum Disorders (FASD) Steering Committee updates a strategic plan annually and conducts trainings on FASD prevention, screening for FASD, and treatment. Ohio's rate of fetal alcohol exposure is nearly 20% lower than the U.S. rate.

Pre-term birth continues to be the leading cause of infant mortality in Ohio, and the risk factors associated with preterm birth include and extend beyond interventions for pregnant women. Ohio's rate of women who smoked cigarettes during pregnancy has decreased but remains two times higher than the rate for the overall U.S. Over 20% of infants who died in Ohio in 2019 were born to a mother who reported smoking in 3 months prior to pregnancy or during the first 3 months of pregnancy. Ohio aims to reducing smoking and substance use among pregnant women, including through the Moms Quit for Two program and Practice and Policy Academy participation to inform plans of safe care.

Perinatal/Infant Health

The MCH priority is to support healthy pregnancies and improve birth and infant outcomes. The Action Group will continue to focus on breastfeeding and safe sleep as key methods for improving infant outcomes, as well as advancing initiatives to address Black infant mortality.

While the number of infants who died before their first birthday has decreased in the last ten years, the disparity in birth outcomes continues with Black infants dying at nearly three times the rate of white infants. In December 2020, Governor Mike DeWine announced the formation of the Eliminating Racial Disparities in Infant Mortality Task Force, with members charged to work with local, state, and national leaders to identify needed changes to reduce infant mortality and eliminate racial disparities by 2030. To address the complex issues and systems, Ohio implements several large, data-driven initiatives employing evidence-based strategies. These include implementing the Ohio Equity Institute: Working to Achieve Equity in Birth Outcomes program in nine targeted high-risk metro areas; increasing evidence-based home visiting; increasing screening and referral via the integrated Pregnancy Risk Assessment Form in partnership with the Ohio Department of Medicaid; and enhancements in newborn screenings focusing on system linkage to increase and improve identification and referrals. Ohio ensures newborns receive appropriate screening, diagnostic testing, referral, and intervention through programs including the newborn screening for Critical Congenital Heart Disease, Comprehensive Genetic Services Program, Sickle Cell Services, Infant Hearing, and Ohio Connection for Children with Special Needs Birth Defects Surveillance program.

Over the past five years, Ohio has made significant improvements in performance measures for breastfeeding and safe sleep. Title V Breastfeeding and Ohio First Steps for Health Babies support breastfeeding in hospitals, worksites, and childcare facilities, improve breastfeeding continuity of care, and provide women direct support through 24/7 breastfeeding hotline and virtual lactation consultants. Focus groups conducted with African American and Appalachian mothers will guide efforts to improve strategies aimed at increasing breastfeeding initiation and duration. MCH coordinates safe sleep education and crib distribution to remove barriers and assist families with safely sleeping their children. Each year, nearly 99% of families receive safe sleep education during their maternity stay in Ohio's hospitals, over 6,400 families receive a

crib and safe sleep education through a Cribs for Kids partner, and safe sleep campaigns deliver over 57 million impressions to parents and grandparents in high infant mortality areas of Ohio.

Child Health

The MCH priority for children represents a comprehensive approach to children's health: Improve nutrition, physical activity, and overall wellness of children. To address the priority of improving overall child health, efforts must address a broad range of issues impacting children. Pediatric primary care visits represent a key opportunity for monitoring and addressing the comprehensive needs of children's health, including the critical role of developmental screening in monitoring and supporting child development. The Action Group continues to implement strategies to ensure all components of the well-child visit, including important screenings (Bright Futures, developmental, lead, hearing, vision, oral health, immunizations, BMI, social determinants of health, and ACEs), are included for every child. Ohio has rates comparable to the U.S. for developmental screening but has not seen an improvement in this outcome overall; however, the Home Visiting program has improved the rates of developmental screening among children served. The Early Childhood Health and Ohio Healthy programs continue to improve child care and obesity efforts in the state. Compared to the U.S., Ohio has a lower rate of obesity among 2-4-year-olds, but a higher rate among ages 10-17 with lower income children experiencing disparities. Ohio performs similarly to the U.S. on several metrics related to nutrition and physical activity: fruit and vegetable consumption, access to exercise opportunities, and physical activity among children.

Adolescent Health

The MCH priorities: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate; and Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use. The Action Group is coordinating initiatives across both priorities with partners to support adolescent health.

Adolescent and young adult suicide has increased by more than half since 2009. The rate of adolescents with a major depressive episode in the past year has increased since 2011 and the percent of adolescents who bully others and who report being bullied is higher in Ohio than the U.S. MCH is working with partners to support implementation of the Ohio Suicide Prevention Plan among the target youth population. Multiple MCH programs support adolescent resiliency through grant-funded community specific projects, coordination on prevention workgroups and coalitions including anti-Harassment Intimidation and Bullying, and supporting professionals and communities in preventing violence and identifying and responding to victims of violence. The Action Group continues to continue to focus on adolescent preventive medical visits, which provide key opportunities for screening, education, and referral on numerous topics including mental health and substance use. Ohio's rates of adolescent well-visits compare with the national rates, and improvements have been observed with nearly 80% of adolescents obtaining a well-visit. Collaborative efforts include training to pediatricians and school nurses, School Based Health Care initiatives, and cross-program prevention opportunities.

Children with Special Health Care Needs (CYSHCN)

The MCH priority, to increase the prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services, is being implemented using a transition focus to ensure CYSHCN are prepared to actively participate in their care as adults.

Ohio's Title V efforts to address CYSHCN includes Ohio Revised Code 3701.023 requiring ODH to review eligibility for medically handicapped children (CMH) that are submitted to the department by city and general health districts and physician providers approved in accordance with the code. The eligibility will be extended from age 21 to age 22 in SFY 22 and age 23 in SFY 23. MCH convenes a state-wide workgroup comprised of representatives from ODH, the Ohio Department of Medicaid, clinicians specializing in treatment of CYSHCN, parents of CYSHCN, hospitals, condition-specific advocacy groups, and members of the ODH CMH Parent Advisory Committee. The CMH program works directly with more than 40,000 families of CYSHCN annually. In Ohio, CYSHCN have a similar rate of receiving care in a well-functioning system and a higher rate of receiving care in a medical home compared to the U.S. The Action Group continues to focus on coordinating with partners to improve clinical and non-clinical service delivery systems, including hospital-based service coordination, parent-to-parent mentoring, and emergency preparedness for CYSHCN.

Ohio adolescents ages 12-17, with and without special health care needs, are less likely than U.S. peers to receive the services necessary to transition to the adult healthcare system. The Action Group is working to increase adult and pediatric provider capacity, family and teen knowledge and support, and planning that identifies and addresses social determinant barriers to medical transition. The group is also committed to identifying opportunities to support transitions to adulthood outside of health care for CYSHCN.

Cross-cutting

Ohio continues to experience significant disparities in health outcomes. The priorities established to support all Ohioans in achieving their full health potential focus on adverse childhood experiences (ACEs) and health equity. These priorities are

incorporated into each population domain and also addressed from a systems-level. MCH is coordinating with partners to advance ACEs prevention and mitigation through the lens of shared risk and protective factors. The Health Equity Committee is advancing health equity in internal MCH organization/staff and in policy, program, grant, and contract administration.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Title V funding provides critical support for the implementation of evidenced-based strategies aimed to improve population health outcomes through a life course approach and by addressing social determinants of health. Title V supports state-level public health infrastructure and population-based services, and Ohio's MCH administers Title V in conjunction with other federal and state funds in alignment with our state's priorities. Ohio Governor Michael DeWine created the Office of Children's Initiatives in order to elevate the importance of children's programming and drive improvements within the many state programs that serve children. The Initiative is charged to improve communication and coordination across all state agencies; engage local, federal, and private sector partners to align efforts and investments; advance policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health; and initiate and guide enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems. Title V funding complements the implementation of this initiative as well as other strategic plans to improve health outcomes, such as the State Health Improvement Plan (SHIP). The SHIP's three priority topics are maternal and infant health, mental health and addiction, and chronic disease with priority factors of community conditions, health behaviors, and access to care. Title V supports implementation by state agencies, local health departments, hospitals, and other community partners engaged in community health improvement planning, education, housing, employers, transportation, and criminal justice.

III.A.3. MCH Success Story

Women/Maternal Health
The Ohio Council to Advance Maternal Health (OH-CAMH), established as Ohio's Maternal Health Task Force with over 80 stakeholder organizations, drafted the state strategic plan aimed at reducing preventable maternal mortality and severe maternal morbidity.

Perinatal/Infant Health
Ohio Equity Institute: Equity in Birth Outcomes program's Neighborhood Navigators increased efforts to identify women less connected to services in the nine counties with the highest Black infant mortality. Neighborhood Navigators identified 3,500 women (224% increase over the previous year; 75% African American) with 15,538 social and clinical support needs, and 97% of needs were met with a referral with over 9,500 of the referrals becoming services that were received (63%). Over 65% of women did not have a safe place to sleep for their baby, and 96% were referred to Cribs for Kids or another safe sleep organization in their community. Neighborhood Navigators identify each woman's needs and provide referrals to increase enrollment in programs proven to have positive outcomes and provide protective factors (e.g., WIC, Home Visiting, Medicaid).

Child Health
The Ohio Healthy Homes and Lead Poisoning Prevention Program implements multiple initiatives to increase screening and prevent lead poisoning in children. The 2019 data indicated the program surpassed the State Health Improvement Plan's 2028 target for percent of children aged 0-5 with confirmed elevated blood lead levels (down from 2.8% in 2017 to 2.1% in 2019).

Adolescent Health
Adolescent health has leveraged collaborative efforts with state and local partners to expand into new areas of programming. MCH is supporting existing efforts aimed at preventing youth suicide and identifying gaps to fill with new programming. Adolescent health participated in the ASPIRE project (see Cross-cutting) to enhance collaboration on ACEs and suicide. MCH has also successfully partnered to address youth homelessness, with particular emphasis on youth who are pregnant, and supported services not typically covered, including enhancing COVID-safety and purchasing phone minutes and bicycles to assist with connection and transportation.

Children and Youth with Special Health Care Needs (CYSHCN)
The MCH Parent Consultants have worked to diversify the CMH Parent Advisory Committee (PAC) by increasing recruitment, revising the PAC application to increase accessibility, and updating the PAC By-Laws to reflect a stronger emphasis on health equity and diversity.

Cross-cutting
MCH established the bureau Health Equity Committee (HEC), and a HEC subcommittee was accepted into the National MCH Workforce Development Center's 7-month cohort to address transformational change by centering equity in the bureau's sub-granting processes. A team of state-level organizations participated in the ASPIRE Project (ACEs and Suicide Prevention in Remote Environments Learning Institute) and set the foundation for further partnership and strategic planning to address ACEs across the state through shared risk and protective factors.

III.B. Overview of the State

Public health in Ohio has undergone many changes since 1886 when the State Board of Health was established to help coordinate the fight against tuberculosis. In 1917, the Ohio Department of Health (ODH) was created by the Ohio General Assembly to control the spread of all infectious diseases.

Today, ODH is a cabinet-level agency, its director reports to the Governor and serves as a member of the Executive Branch of Ohio's government. The Administration's health and human services (HHS) cabinet agencies are tasked with goals to improve services to Ohioans, reduce cost, and increase efficiency.

The ODH executive team helps the Director of Health formulate the agency's strategic policy goals and objectives. The team is composed of Deputy Directors, the Medical Director, and the General Counsel. These leaders, along with agency senior-level managers and supervisors, work in tandem to ensure the state health department is responsive to the needs of Ohio's 11.7 million residents.

ODH's mission is to protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality care. ODH fulfills its mission through collaborative relationships, including with Ohio's 113 local health departments. ODH's strategic agenda is informed by a State Health Assessment (SHA) and a State Health Improvement Plan (SHIP) to address key health issues identified in the assessment. Key health issues identified include infant mortality, prevention of infectious disease, and Ohioans' access to primary care. ODH became an accredited health department by the Public Health Accreditation Board (PHAB) in 2015.

In 2020, ODH developed a strategic plan for 2020-2022 to serve as a roadmap to guide Ohio toward achieving our vision of a modern, vibrant public health system that creates conditions where all Ohioans flourish. The plan includes guiding principles, four strategic priorities, and a set of associated outcomes, performance measures, and strategies for implementation. The strategic priorities include strategic partnerships, flexible and sustainable funding, organizational capacity and infrastructure, and community conditions/social determinants.

The State Health Assessment (SHA) released in 2019 is a comprehensive and actionable picture of health and wellbeing in Ohio. The SHA informed the identification of priorities for the 2020-2022 state health improvement plan (SHIP). Developed with input from many state and local-level stakeholders, the SHIP serves as a strategic menu of priorities, objectives, and evidence-informed strategies to be implemented by a wide range of public and private partners and includes an evaluation plan to track and report progress. The 2020-2022 SHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape health with identified priority factors of community conditions, health behaviors, and access to care, and priority health outcomes of mental health and addiction, chronic disease, and maternal and infant health. The 2020 Title V Five-Year Needs Assessment and Maternal, Infant and Early Childhood Needs Assessment were conducted in coordination and alignment with the SHA and SHIP processes.

The Title V Maternal and Child Health Block Grant provides vital funding and infrastructure to ODH by supporting the overall goals and strategies of public health and is an asset to improving maternal and child health outcomes. The Bureau of Maternal, Child, and Family Health (BMCFH) administers and houses the majority Title V MCH Block Grant programs, now including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Children with Medical Handicaps Program (CMH). The Title V Director and Director of Children with Special Health Care Needs reside within the BMCFH.

The BMCFH is a coordinated effort to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, children, youth, and families in Ohio. Using evidenced-based and data-driven practices, we support the delivery of direct services, linkages and referrals, population-based supports, education, monitoring and quality oversight, and policy and systems development.

Ohio's BMCFH priority needs identified through the comprehensive needs assessment process for 2021-2025 include:

- Decrease risk factors contributing to maternal morbidity
- Increase mental health support for women of reproductive age
- Decrease risk factors associated with preterm births
- Support healthy pregnancies and improve birth and infant outcomes
- Improve nutrition, physical activity, and overall wellness of children
- Increase the prevalence of children with special health care needs receiving integrated physical, mental, and developmental services
- Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
- Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use
- Prevent and mitigate the effects of adverse childhood experiences
- Improve healthy equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

The Children with Medical Handicaps Program (CMH) serves Children and Youth with Special Health Care Needs (CYSHCN), including a Diagnostic, Treatment, and Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia and Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and helping families navigate the health care system. CMH utilizes vital committee/council structures to foster open dialogue and receive input and feedback regarding CYSHCN needs across the state.

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

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

COVID-19

The COVID-19 pandemic has had profound impacts on Ohio since the emergence of the novel coronavirus in 2020. MCH populations experienced dramatic shifts in their lives including the loss of jobs and income, remote schooling, limited childcare, stresses to mental and behavioral health, and reduced access to health care. From the beginning of the pandemic to July 14, 2021, 1.1 million cases, 61,008 hospitalizations, and 20,411 deaths have been reported in Ohio. The COVID-19 pandemic has disproportionately affected certain communities, including racial and ethnic minorities, and others face increased risk from the virus, including older Ohioans and those living with a chronic condition. Starting in March 2020, the state of Ohio quickly adapted to address COVID-19 and remains committed to addressing inequities in these areas and across all health-related topics. MCH services were transitioned to telehealth/remote options to ensure access to MCH programs and many MCH staff have supported the response. As of July 2021, most MCH staff have returned from COVID-19 response duty and MCH programs have provided guidance for the resumption of face-to-face services where appropriate.

Ohio Demographic Information

The 2019 population of Ohio was estimated at 11,693,217, a net increase of approximately 153,768 since 2010. It is the seventh most populous state in the United States. The capital of Ohio is Columbus, which is Ohio's most populous city with a population of 903,852 and the fourteenth largest city in the United States (2019 data). It is located in Franklin County in Central Ohio. The most densely populated area of the state is the northeast corner which encompasses Cleveland, Akron, Youngstown, and Canton. The least densely populated area of the state is the Appalachian region which follows the line of the Appalachian Mountains from Lake Erie to the Ohio River. The most populous of Ohio's 88 counties are presented in Table 1.

Table 1: Most Populous Counties in Ohio, 2019

County	Population
Franklin	1,324,624
Cuyahoga	1,227,883
Hamilton	817,985
Summit County	538,866
Montgomery County	531,610
Lucas County	428,294
Butler County	385,648
Stark County	369,772
Lorain County	312,172
Warren County	238,412

Population Distribution

According to U.S. Census Bureau, females 15-44 years comprise 18.9% of Ohio's population. Children and young adults through age 24 years accounted for 31.1% of the population. The foreign-born (anyone who was not a U.S. citizen at birth) share of Ohio's population rose from 3.0% in 2000 to 4.8% in 2019. According to the American Immigration Council, 5% of Ohioans were native-born with at least one immigrant parent. The largest proportion of foreign-born residents come from Asia (42.8%), followed by Latin America (20.1%), Africa (17.1%), and Europe (17.1%). One in eight Ohioans working in the life, physical, or social sciences is an immigrant. Sixty-two percent of foreign-born residents speak a language other than English. Of those, 42.7% speak English less than 'very well'. The most common language spoken in Ohio other than English is Spanish.

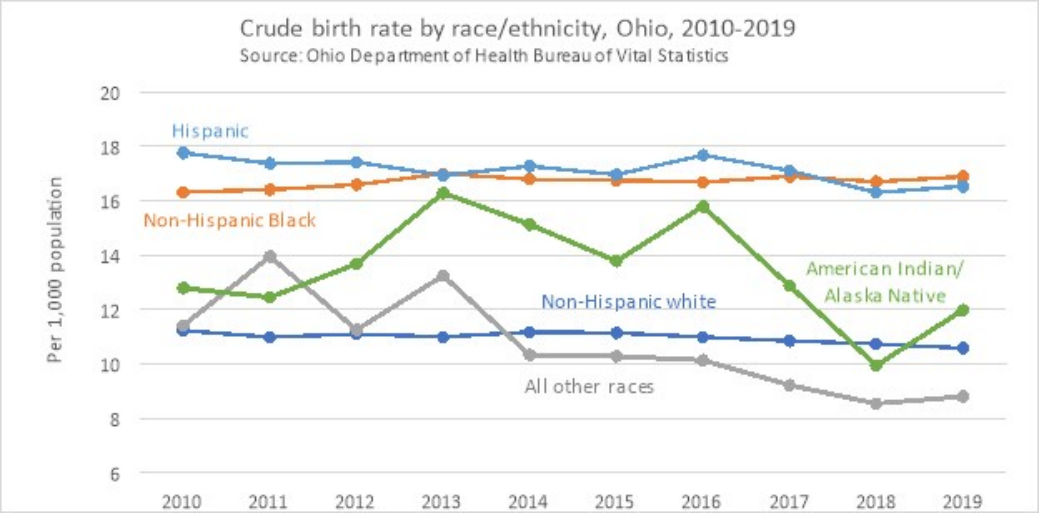
Almost 13% of Ohio's population is Black or African American. Hispanic or Latino people (of any race) make up 4% of the population. The percentage of the population that is Black is about the same as the U.S. percentage. However, the Asian and Hispanic population percentages are substantially lower than in the U.S. population. Table 2 presents a breakdown of Ohio's population by race.

Table 2: Ohio and U.S. Population by Ethnicity and Selected Races, 2019

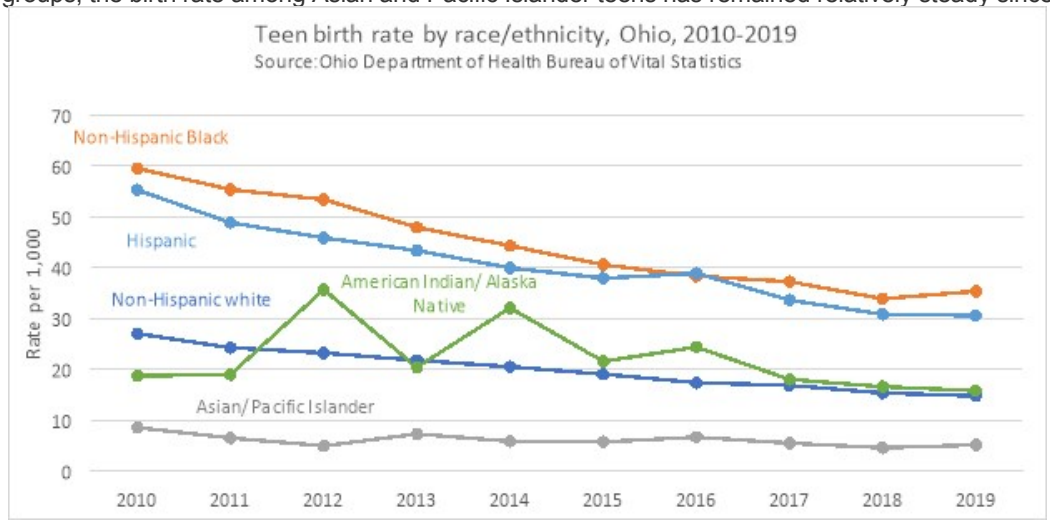
Race	Ohio (Count)	Ohio (%)	U.S. (%)
White	9,452,650	80.9	72.0
Black or African American	1,467,331	12.6	12.8
Asian	274,585	2.3	5.7
American Indian or Alaska Native	23,544	0.2	0.9
Two or more races	343,341	2.9	3.4
Ethnicity			
Hispanic or Latino (all races)	467,589	4.0	18.4
Non-Hispanic or Latino	11,221,511	96.0	81.6

Birth Rates

Between 2010 and 2019, Ohio's crude birth rate has decreased from 12.0 to 11.5 per 1,000 persons (data not shown). Hispanic births declined 7.3% from 2010 to 2019 (from 17.8 to 16.5 per 1,000), as did non-Hispanic white births (a 7.8% drop from 11.5 to 10.6) over the same period. While smaller numbers among non-Hispanic American Indians and Alaska Natives, and those of other races (Asian, Native Hawaiian, Pacific Islander, and unknown race) mean we are less certain about the reliability of these birth rates, they appear to be declining as well. In contrast, non-Hispanic Black birth rates increased from 16.3 in 2010 to 16.9 in 2019.



Ohio's teen birth rate (ages 15-19 years) has shown a steady decline (Figure 2), but substantial disparities exist by race/ethnicity. Teen births are highest among Hispanic and non-Hispanic Black teens. The rate of births among non-Hispanic white teens is half that of Hispanic teens and almost 60% lower than that of non-Hispanic Black teens. Unlike other groups, the birth rate among Asian and Pacific Islander teens has remained relatively steady since 2014.



Ohio's Disability Population

Each year, Cornell University publishes a disability status report to inform policy makers and the public on demographic and economic statistics on those with disabilities. Information is summarized from the U.S. Census Bureau's American Community Survey. The 2019 report states that 14.0% of Ohioans have a disability. Percentages of disability type are presented in Table 3.

Table 3: Disability Type as Percent of Population, 2018

Disability Type	Percent of Population
Vision	2.3
Hearing	3.7
Ambulatory	7.4
Cognitive	5.9
Self-Care	2.6
Independent Living	6.2
Any Disability	14.0

Children ages 4 years and under have a 0.6% prevalence rate of visual and/or hearing disability. The overall rate of disability for children ages 5 to 17 was 6.7% and 7.5 percent for older adolescents and young adults 16 to 20 years of age. Among

those under age 18, cognitive disability was the most common disability, affecting 5.3% of this population.

The prevalence of disabilities among Hispanic Ohioans of all ages was 11%, lower than the prevalence for non-Hispanic Ohioans. Among those between the ages of 18 to 64, Black and Native American/Alaska Native Ohioans were more likely to report a disability (15.4% and 17.1%, respectively) compared to white and Asian Ohioans (11.4% and 4.4%, respectively).

Ohio's Social and Economic Indicators

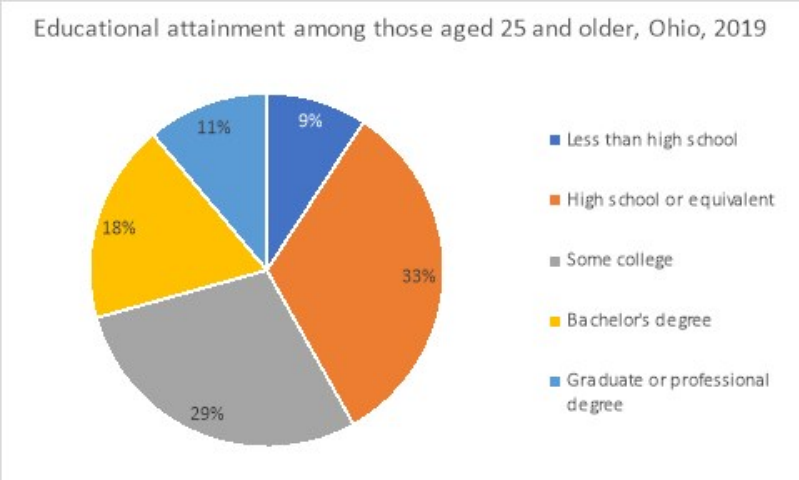
Hospitals

Ohio has six children's hospitals serving children from all 88 counties, all 50 states, and many international countries. According to the Ohio Children's Hospital Association, Ohio ranks 47th in the nation in costs per member per month for pediatric Medicaid expenditures and Ohio's spending is 20% below the national average for Covered Families and Children population. Ohio's Children's Hospitals created the first ever and largest repository of asthma patient information. Additionally, their efforts to reduce infant mortality include:

- Working to predict, treat and prevent narcotic-dependent infants, which saved $13 million in costs for hospital stays with new protocols for treatment
- Preventing prematurity through the Ohio Perinatal Quality Collaborative
- Preventing child abuse through research on sentinel injuries
- Promoting safe sleep with the Ohio Chapter, American Academy of Pediatrics
- Researching new diagnosis and treatment protocols for pediatric pneumonia, the leading cause of death in children under age 5

Education

Approximately 9.2% of Ohioans aged 25 and older have less than a high school diploma, and about one-third (32.6%) have only a high school diploma. Figure 3 presents a breakdown of educational attainment in Ohio.



The percentage of women with a bachelor's degree or higher (29.9%) is comparable to the percentage of men with a bachelor's degree or higher (28.6%). However, there is a gender gap when we look at Black women (19.3%) compared to Black men (15.3%). When examining educational attainment by race and ethnicity, Asian adults were much more likely to have a bachelor's degree or higher (62.5%) when compared with white (30.2%), Hispanic (20.2%), and Black (17.5%) adults. The poverty rate for persons who have less than a high school diploma is 26.1% compared with 3.8% with a bachelor's degree or higher.

According to the Ohio Department of Education, in school year 2020-2021, 15.4% of students enrolled in public schools (K-12) had a disability. Almost half (47.0%) of the students were economically disadvantaged.

Economic Overview

According to the Ohio Development Services Agency, Ohio's Gross Domestic Product (GDP) for 2018 is initially estimated at $676.2 billion, up 4.7% from 2017, and growing for nine consecutive years. Ohio has over 12,000 new business filings each month, according to the Ohio Secretary of State. Ohio is one of the nation's leading sources for primary and fabricated metal products, as well as plastic, rubber, and non-metallic mineral products, machinery, electrical equipment and appliances, and transportation equipment – especially motor vehicles and the associated parts, trailers, bodies and accessories. According to the National Science Foundation, Ohio ranks 11th nationally in Research and Development

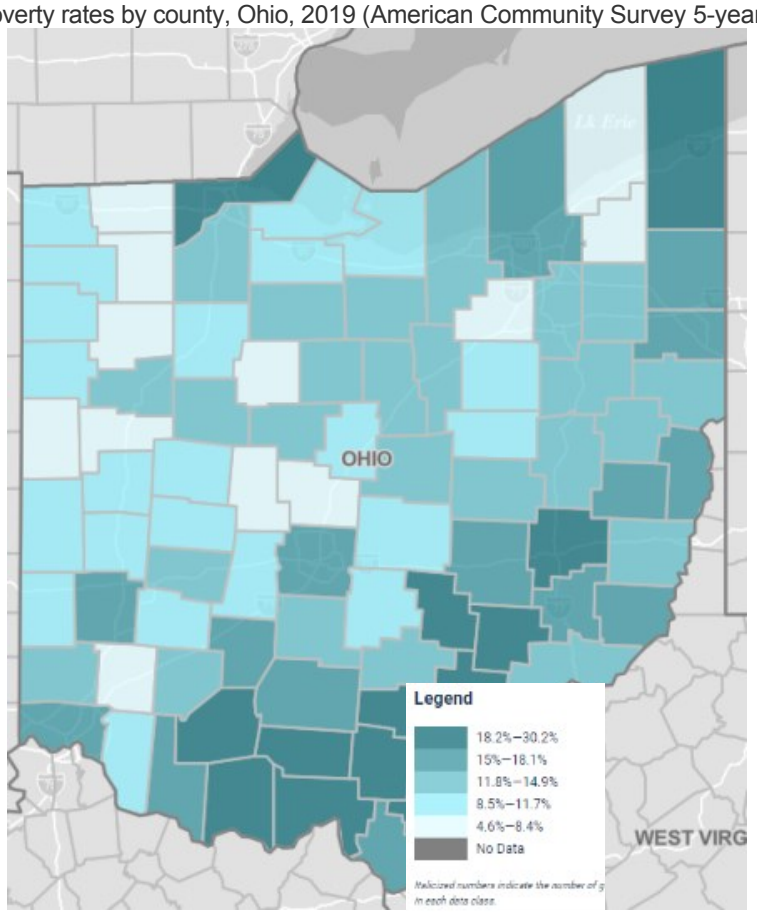
contracts, and Ohio State University, Case Western Reserve University, and the University of Cincinnati receive more than a combined $150 million in federal research grants.

The 2019 median household income in Ohio is $58,642, up from $54,021 in 2016. Despite the growth, Ohio's median annual income is still less than that of the United States which is $65,712. As of May 2021, the Ohio Department of Job and Family Services reported Ohio's unemployment rate as 5% compared to 5.8% for the United States. These unemployment rates are almost half of what they were in June 2020, when employment was strongly affected by the COVID-19 pandemic. The 88 counties unemployment ranged from a low of 2.6% in Holmes County to a high of 7.7% in Erie County.

Poverty

According to 2019 American Community Survey estimates, 13.1% of Ohioans live in poverty, slightly higher than the national rate of 12.3%. The latest American Community Survey data show that 29 of Ohio's 88 counties had poverty rates equal to or higher than 15% (Figure 4). Many counties with high poverty rates are located in the Appalachian region of Ohio, a band of 32 counties stretching across the eastern and southern regions of the state.

Figure 4: Poverty rates by county, Ohio, 2019 (American Community Survey 5-year estimates)



Children experience higher rates of poverty than the population overall. Seventeen percent of Ohioans under age 18 live below the poverty level, about the same as the U.S. estimate of 16.8%. For younger children, the poverty rate is even higher: in Ohio, more than one in five children under age 5 (21.3%) live below the poverty level. Families with children had poverty rates ranging from 3.5% among married couples to 28.4% percent for those headed by a female single parent.

Women were more likely than men to experience poverty (14.3% vs. 11.7%, respectively). Black Ohioans were more than twice as likely as white and Asian Ohioans to experience poverty, and disparities appear to be more pronounced in Ohio than in the U.S. overall (Table 4).

Table 4: Poverty status by race, Ohio and United States, 2018

Race	Ohio (%)	U.S. (%)
White	10.4	10.3
Black or African American	27.3	21.2
American Indian or Alaska Native	26.4	23.0
Asian	10.7	9.6
Two or more races	24.5	15.2
Hispanic or Latino (all races)	23.0	17.2

Public Assistance
According to the Ohio Department of Job and Family Services (ODJFS), about 1.6 million persons received benefits from Supplemental Nutritional Assistance Program (SNAP) in the June 2020. This is an increase of over 200,000 individuals from the same time period in 2019, likely a results of income losses associated with the COVID-19 pandemic. About 43% of those served through the food assistance program are children.

In 2010, Ohio launched nutrition incentive programming at farmers' markets and a decade later has expanded to over 95 locations. Product Perks seeks to increase access to fresh and healthy food options for families shopping with SNAP benefits by matching the value of SNAP benefits $1 for $1 when purchasing fruit and vegetables, which can then be used to buy more produce. The program is offered at both farmers' markets and grocery stores. In 2020, Produce Perks pivoted operations to safely continue programming at farmers' markets and grocery stores while also administering the increases to monthly SNAP benefits, an influx of SNAP beneficiaries, and the Pandemic Electronic Benefit Transfer in response to the COVID-19 pandemic.

In 2021, 26 counties in Ohio have farmers' markets that are currently accepting the Ohio Direction Card. This includes 85 farmers' markets that offer food assistant recipient the ability to purchase fresh, locally grown food. Food Assistant recipients receive information regarding farmers' markets on their eligibility notices. The 2021 Farmers' Market Directory is accessible at www.odjfs.state.oh.us/forms/num/JFS00569/pdf/. Over 70% of participating farmers' markets offer "double bucks," which allows families to purchase twice as much produce for every dollar spent.

ODJFS also administers Ohio Works First (OWF), which is the financial assistance portion of Ohio's Temporary Assistance to Needy Families (TANF) program. In the June 2020, OWF provided benefits to 104,404 individuals, 87% of which were children. OWF and the food assistance program have work requirements. Many of the adult recipients were provided employment training programs.

In January 2014, Ohio extended Medicaid coverage to adults making less than 138 percent of the federal poverty level. According to the Ohio Medicaid Assessment Survey, Patterns and Trends in Health Insurance in Ohio, between 2008 and 2017, the percentage of working adults in Ohio with employer sponsored insurance dropped from 62.6% to 52.4%, with the largest decrease occurring between 2008 and 2010. This drop coincided with the recession in the United States. The percentage of adults on Medicaid increased from 8.9% to 22.0% between 2008 and 2017, by which time 1,539,400 had Medicaid. The greatest increase was seen between 2012 and 2015 and coincided with Medicaid expansion in Ohio. The uninsured rate also dropped over time, from 17.5% in 2008 to 9.3% in 2017. In 2017, an estimated 648,000 adults were uninsured in Ohio (https://grc.osu.edu/sites/default/files/inline-files/Insurance_2017OMAS.pdf). Preliminary data from January 2021 show the total enrollment for Medicaid and CHIP was 2,976,549, an increase of almost 40% since the first Marketplace Enrollment Period and related changes from 2013 (www.medicaid.gov).

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

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

Managed Care
Ohio was an early adopter of managed care for its Medicaid program, with a voluntary program that began in the 1970s and a mandatory program initiated in the 1990s. The current managed care program was implemented in 2005, phasing in various mandatory and voluntary populations over time. The state's Medicaid managed care model now provides all acute, primary, specialty, and mental health and substance abuse services in the State Plan through five Managed Care Plans (MCPs). More than 90% of the three million Ohio residents receiving health care coverage through Ohio Medicaid receive coverage though the MCPs. The MCPs include both local and national health plans and represent both the for-profit and

non-profit sectors: Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage, and UnitedHealthCare Community Plan. Managed care has transformed Ohio's Medicaid program from a payer of claims to a purchaser of value. MCPs have increased population wellness and outcomes for priority populations by working with providers to identify and close gaps in recommended care and improve overall quality.

Managed care's focus on quality have identified "high-impact" populations to use a pay for value system while targeting specific metrics and outcomes. The MCPs must meet targets to receive incentive payments. The five populations include:

- Women, particularly those who are pregnant
- Individuals with chronic conditions such as cardiovascular disease and diabetes
- Individuals with primary behavioral health conditions
- Healthy children
- Healthy adults

MCPs design and implement strategies to improve performance in alignment with the Ohio Department of Medicaid (ODM) Quality Strategy. For example, MCPs identify the highest need and highest cost members and provide them with high-touch, person-centered care coordination to ensure timely access to appropriate, integrated care. The plans address social determinants of health, such as nutrition, employment, and housing needs, recognizing the significant impact of these needs on health outcomes. MCPs also work with providers to ensure delivery of evidence-based care and to integrate physical and behavioral healthcare (https://oahp.org/wp-content/uploads/2019/11/OAHP-Value-Report-11.7.2019.pdf). These improvement strategies are improving outcomes for the Title V population.

Throughout 2021, Ohio Medicaid will work with incoming MCO to prepare for the beginning of services under the new program in January 2022. The hallmarks of Ohio's next generation Medicaid managed care program include:

- Improving wellness and health outcomes through a unified approach to population health that includes a new emphasis on defined principles to address health inequities and disparities.
- Emphasizing a personalized care experience through a seamless delivery system for members, providers, and system partners.
- Supporting providers in better patient care by reducing administrative burdens and promoting consistency.
    - A centralized credentialing system eliminates the need to perform a unique credentialing process with each MCO.
    - The fiscal intermediary serves as a central clearinghouse for provider claims and prior authorization requests.
- Improving care for children and adults with complex needs, including the establishment of OhioRISE, a comprehensive and coordinated behavioral health services approach for eligible children under the age of 21.
    - OhioRISE is designed to provide comprehensive and highly coordinated behavioral health services for children with serious/complex behavioral health needs involved in, or at risk for involvement in, multiple child serving systems.
- Increasing program transparency and accountability through increased sharing and consistency of data across all entities involved in the Ohio Medicaid system and increased use of tools to monitor and oversee performance.
    - Through a statewide Single Pharmacy Benefit Manager (SPBM), the next generation of managed care addresses a duplicative and opaque pharmacy benefit system that exists under the prior generation of managed care. Instead of each MCO managing a unique contractual relationship with one or more respective pharmacy benefit managers, the next generation approach gives the SPBM responsibility for providing and managing pharmacy benefits for all individuals enrolled in Ohio Medicaid managed care. The SPBM will be governed by a single set of clinical and prior authorization policies and claims process, and provide a standard point of contact, reducing the administrative burden on providers.

Each of these goals is also supported through the procurement of and transition to new MCO contracts.

Governor's Priorities and State Budget SFY 2022-2023

Ohio's Governor, Mike DeWine, has a long history of public service with an emphasis on protecting children and families. Prior to serving as Governor, he was the Attorney General of Ohio and has previously been elected to serve as Greene County Prosecutor, Ohio State Senator, U.S. Congressman, Ohio Lt. Governor, and U.S. Senator.

The State 2022-2023 biennial budget continues and expands on the significant investments in children and families across multiple state agencies and initiatives. The budget maintains the Medicaid Maternal and Infant Support Program initiatives enacted in the previous budget aimed at reversing Ohio's infant mortality rate and providing newborns and mothers care during critical stages of development. In addition, Medicaid coverage was extended for postpartum women from 60 days to 12 months. The budget supports the Governor and ODM's vision of focusing on the individual by investing in the Next Generation of Medicaid Managed Care which includes: enhanced managed care procurement process to renegotiate

contacts between MCOs and ODM; selection of a fiscal intermediary as single point of entry for providers; the Single Pharmacy Benefit Manager to manage contracts and pharmacy benefits; OhioRISE coordination for children with behavioral health needs; and centralized credentialing via ODM.

The budget added a requirement for hospital licensure to be managed by the Ohio Department of Health (ODH). As of 2020, Ohio had 189 acute care hospitals, 23 long-term acute care, 28 psychiatric/ rehabilitation/ specialty surgical, ten children's, 33 critical access, and 51 teaching hospitals. ODH will develop the rules for licensure over the next ear and then hospitals will have three years to obtain a license. Licensure will give the state specific powers and duties to protect patients within facilities, and one of the state's key roles will be setting standards for quality and the health, safety, and welfare of patients.

The Children with Medical Handicaps program eligibility will be extended from up to 21 to up to 22 years of age in 2022 and 23 years of age in 2023. Home Visiting, now available in all 88 counties, has additional funding to serve more families and the statute has been adjusted to allow for children to be served until 5 (from 3) when the funding and model allows it. Further provider agreement changes will create higher rate for Registered Nurses and add a teacher license for an enhanced rate. The Ohio Equity Institute: Equity in Birth Outcomes will add Lorain county for a total of 10 funded local initiatives, and will support replication of Queen's Village, a supportive community of powerful Black women centering Black women's voices on changing not just racial disparities in birth outcomes but also the conditions that drive inequity in maternal and infant health. An additional $5 million in SFY will support programming by community and local faith-based service providers that invest in maternal health programs, supports pregnant mothers, and improves both maternal and infant health outcomes.

Ohio Healthy Homes and Lead Poisoning Prevention Program budget was increased to: fund high-risk communities to advance childhood lead poisoning prevention efforts at the local level; train and license new lead workers to increase the available workforce; assist families with controlling lead hazards in their homes; provide lead hazard abatement and primary prevention activities for pregnant women and children through State Children's Health Insurance Program (SCHIP); and reimburse local health departments for completing lead investigations for children not eligible for ODM reimbursement.

Ohio will continue the investment to address youth homelessness by creating a network of agencies that address youth homelessness as well as addressing pregnancy and homelessness. The previous budget invested in innovative approaches to addressing housing needs of homeless youth, especially homeless pregnant youths, as well as their behavioral, physical, educational/vocational, and social needs.

The biennial budget continues to require Preschool Special Education and Early Childhood Education (Ohio's publicly funded preschool program) programs to participate in Step Up to Quality (SUTQ), the quality rating system for Early Childhood Education that is jointly administered by the Ohio Departments of Education (ODE) and Job and Family Services (ODJFS). The budget combines Student Wellness and Success funds and Economically Disadvantaged funding into Disadvantaged Pupil Impact Aid funding, and districts are still required to develop implementation plans with a community partner for use of the funds. Starting July 1, 2023, and annually thereafter, each Ohio school district will provide annual training covering suicide awareness and prevention, safety training and violence prevention, and social inclusion in grades 6-12.

The Department of Developmental Disabilities (DODD) received new funding for multi-system youth, including flexible funds to support youth in homes and communities, creating a multi-disciplinary team of experts to provide technical assistance for complex needs, and in-home regional team. The funding will support the existing, successful partnership with Ohio Department of Mental Health and Addiction Service (OhioMHAS) and local agencies providing early childhood mental health consultation to local EI teams. DODD will focus its federally required state systemic improvement plan (SSIP) on improving children's outcomes related to social-emotional development of the next five years. The EI program received a budget increase to fund services for children with elevated blood lead levels.

OhioMHAS budget continues funding for multiple initiatives for children including: Early Childhood Mental Health consultation services in partnership with both ODE and DODD for early childhood program consultants, teachers, and EI teams to assist in addressing complex social and emotional and mental health issues and provide trainings; Strong Families which engages local systems to identify community-driven solutions that highlight collaboration across agencies to develop better outcomes for children in crisis; OhioSTART to address Sobriety, Treatment, and Reducing Trauma by approaching substance use disorders with compassion, understanding, and hope for recovery; Infant-Mental Health credentialing; and added funding for a pediatric mental health expansion to better serve children. The Infant-Mental Health Credential (IMHC) is an important strategy for the Ohio Early Childhood system partners including providers of child care, early learning and education, home visiting, early intervention, maternal and infant and early childhood mental health. The IMHC supports the identification of the social and emotional needs of very young children and build skill level to connect parents and caregivers to needed mental health services. The Early Childhood Mental Health (ECMH) initiative is aimed at promoting health social and emotional development (i.e., good mental health) of youth children (birth to six years) by focusing on ensuring children can thrive through addressing their behavioral health care needs, which increases their readiness for school and later academic success. The ECMH Training Institute provides Ohio approved training for Ohio's Early Childhood mental health

professionals. Ohio's Trauma Informed Care Certificate was launched in 2020 to provide an opportunity to better respond to trauma in children and their families. The certificate program is a collaboration between OhioMHAS and ODJFS designed to move staff from being Level (I) Trauma Aware; Level (II) Trauma Informed; Level (III) Trauma competent.

The Ohio Department of Job and Family Services (ODJFS) budget expanded eligibility for families and kinship care, and ODJFS will be using additional federal funds to assist with stabilizing and sustaining the child care program, improve workforce recruitment and retention, and increase access for families. A study committee has been established to evaluate both publicly funded child care and SUTQ. ODJFS is also using additional state and federal funds to enhance the befit bridge to create Top Up Funding approaches to support families when they experience a life event or loss of benefits and support and expand peer mentor support. The budget also supports the Governor's Imagination Library, inspired by Dolly Parton's initiative, for a statewide expansion to provide children with books monthly from birth to age five to support early childhood literacy and kindergarten readiness.

Emerging Issues and Efforts to Improve Population Health Outcomes

Health Equity – Ohio populations continue to experience disparate health outcomes and the Ohio Department of Health is advancing health equity at ODH and across state agencies through the leadership of the Health Opportunity Officer. The goal of the Office of Health Opportunity at ODH is to eliminate population level health disparities in Ohio, establish health equity at the center of public health, and to improve clinical care, provide interventions for the most vulnerable, and elevate and address the social determinants of health. The Health Opportunity Officer leads multiple initiatives including: an interagency workgroup to increase equity across the state enterprise; health equity grants from COVID-19 and CDC funding to increase local capacity to address disparities among populations at high risk and underserved, including racial and ethnic minorities and rural communities; and the Eliminating Racial Disparities in Infant Mortality Task Force charged with developing actionable recommendations for eliminating the racial disparity in infant mortality by 2030. The Office of Health Opportunity is starting a health opportunity lead program to further expertise within each office/bureau of ODH, and within the BMCFH, the Health Equity Committee has taken steps to assess and make plans to address both the internal culture and capacity for health equity in implementation of programs, grants, contracts, and policy.

Well Visits – Well visits for children and adolescents decreased alarmingly during the COVID-19 pandemic, with adolescent cohorts most impacted, and substantial efforts are needed to achieve "catch-up". Well visits are essential for many reasons, including preventive care and getting routine recommended vaccinations. According to Unity, children under age one have made significant progress in catching-up, lagging only -6% compared to the three-year historical averages as of June 2021. However, adolescent well visits lag more than -25% for ages 13-17 and -31% for ages 11-12, and vaccines for adolescent have larger gaps than those primarily given to younger children. Further, the CDC reports a slower recovery in the public sector as compared to the private sector for Vaccine for Children doses from March 2020 to June 2021. Throughout the pandemic, Ohio participated in the #WellChildWednesday campaign, and continues efforts with partners to increase access to these critical well visits.

Key State MCH Statutes

- The Ohio Department of Medicaid requires supported enhanced care management for women in high-risk neighborhoods and engages leaders in those neighborhoods to connect women to care (ORC 5167.17); maintained current Medicaid eligibility levels for pregnant women (ORC 5163.06); covered additional services in home visitation for pregnant women and newborns, including cognitive behavioral therapy and depression screenings (ORC 5167.16); required the Health Director to identify and report on performance of programs to reduce infant mortality (ORC 3701.95); improved the administration of Progesterone for at-risk mothers (ORC 289.20); required additional disease screenings for newborns (ORC 3701.501); provided funding for evidence-based tobacco cessation programs for pregnant women in areas with high infant mortality rates (ORC 289.20, 289.33, 3794.07); and conducted safe infant and child fatality reviews (ORC 121.22, 2151.421, 3701.70).

- Ohio is working to make homes lead-safe for children and families by advertising lead-free homes to families, abating and remediating lead contamination, and demolishing lead-blighted homes; increasing the supply of lead hazard control workers; and providing a lead abatement tax credit, allowing eligible individuals to receive an income tax credit worth up to $10,000 for costs related to home lead abatement. (ORC 737.15)

- Language codified to strengthen the role of Fetal Infant Mortality Review Boards (ORC 121.22, 149.43, 3701.049, 3707.70, 3707.71, 3707.72, 3707.73, 3707.74, 3707.75, 3707.76, and 3707.77) and Pregnancy-associated Mortality Review Boards (ORC 121.22, 149.43, 3738.01, 3738.02, 3738.03, 3738.04, 3738.05, 3738.06, 3738.07, 3738.08, and 3738.09) to review cases and share data aimed at addressing root causes of infant and maternal death in geographies that experience a disproportionate burden of deaths.

- An appropriation was included in the State Biennial Budget (House Bill 166) to develop a Prescription Produce

Intervention for Maternal Health Program to improve maternal health, nutrition, and infant mortality rates. As well as funds to develop a program to address homelessness in youth and pregnant women by providing assertive outreach to provide stable housing, including recovery housing. (ORC 291.20)

- House Bill 11 was signed into law in June 2020 and prescribed a package of legislation changes to tobacco cessation and prenatal initiatives including:
  - Requires state employee health care benefit plans, the Medicaid program, and Medicaid managed care organizations to cover certain tobacco cessation medications and services. (ORC 5164.10 and 5167.12)
  - Requires the Ohio Department of Health to establish a $5 million grant program for the provision of group-based prenatal health care services to pregnant Medicaid recipients residing in areas with high preterm birth rates. (ORC 3701.615)
  - Permits the Ohio Department of Medicaid (ODM) to establish a dental program under which pregnant Medicaid recipients may receive two dental cleanings a year. (ORC 5162.73)
  - Requires ODH to develop educational materials concerning lead-based paint and distribute them to families who participate in its Help Me Grow Program and reside in homes built before 1979. (ORC 5162.73)

- Senate Bill 332 (SB 332) was passed in 2017 based on recommendations of the Infant Mortality Commission and public testimony. Key initiatives include requirements for state agencies to publish timely data; provide training; ban the sale of crib bumper guards; requires the creation of a comprehensive tobacco plan; increases access to long-acting, reversible contraception (LARC); and created a Home Visiting Consortium and task force to examine the impacts of the social determinants of health on infant mortality. Effective July 1, 2018 new rules for implementing evidenced-based home visiting, the new data collection system and reporting went into effect. The Central Coordination system functions as a coordinated, community-based single point of entry with access to local services that promote family-centered programs for expectant parents, newborns, infants, toddlers, including those with disabilities and their families in collaboration and cooperation with other state and local agencies. Activities conducted through the Early Childhood Central Intake shall specifically provide centralized intake and referral services for all home visiting programs operating in the state of Ohio, including early childhood focused Community Health Worker Initiatives, as well as Part C Early Intervention services facilitated by the Department of Developmental Disabilities. This new model is in its fourth year and is being successfully implemented in partnership with Bright Beginnings based in Northeast, Ohio.

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

- In 2020, Governor DeWine signed House Bill 12, which created the Children's Behavioral Prevention Network Group. Members have been tasked with coordinating and planning a comprehensive learning network that will support young children in their social, emotional, and behavioral development and reducing behavioral health disparities. Ohio's Title V MCH Director serves as a member alongside representatives of state agencies, organizations, and a parent representative.

- Amended Substitute House Bill 110 extended the Home Visiting eligibility in statute to age 5, from age 3, when the funding and model allow it. The expansion will assist in efforts to prevent child abuse/neglect as part of ODH's partnership with ODJFS.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Ongoing Needs Assessment Activities and Partnership Updates
The Title V program uses an Action Group structure to manage its MCH Priorities and implement strategies within the 5-Year Action Plan. Each Priority Action Group include two co-leads, epidemiologist(s), and program researcher(s) to guide the work of a diverse stakeholder group. These stakeholders are made up of internal and external subject matter experts in the priority topics. The Action Group Co-Leads are responsible for working with the stakeholder group to: update the 5-year Action Plan, assess performance measures outcomes, implement and monitor strategies to impact the performance and outcome measures, and create or identify an evaluation plan used to assess whether or not the interventions have been successful. In addition to the population Action Groups, program managers utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes. External stakeholders involved in the Action Groups include sister state agencies, medical associations, providers, insurance, parent and family groups representing CYSHCNs, universities, local health departments, and community agencies.

Over the last year, the Action Groups have worked to operationalize the 5-year needs assessment through the development of workplans detailing implementation of the Action Plan. Each Action Group utilized the public comments from the 2021 survey to identify additional partners and ensure alignment with stakeholder feedback during planning and implementation. The Title V epidemiologist developed a MCH BG measures tool to serve as a centralized source for all MCH BG required measures including data trends and disaggregated data to monitor disparate outcomes to inform both previous year evaluation efforts and future year planning by the Action Groups.

The BMCFH has furthered the use of the Results Based Accountability (RBA) framework for performance management. Over 20 BMCFH staff have been trained in RBA and the Clear Impact software, and programs are developing contributing program scorecards to track program performance toward the State Health Improvement Plan (SHIP) Infant Mortality (IM) population indicator. To ensure these scorecards are useful as we specifically strive to eliminate the Black IM disparity, each program is including disaggregated measures by race and county. The bureau's efforts align with the overall agency's adoption of RBA and Clear Impact, and future efforts will focus on expanding to additional SHIP metrics for contributing program scorecards, as well as additional planning for RBA use by the MCH BG Action Groups and across the BMCFH.

Following the 2020 needs assessment, the BMCFH established the bureau's Health Equity Committee (HEC) to assess and improve both the bureau's internal culture and capacity to address health equity through program, grant, and contract administration. After reviewing other state's methods, the HEC developed a plan to assess staff competency through a survey, program capacity through facilitated reviews, and community engagement through a subrecipient assessment. The three-pronged assessment approach is discussed in more detail in in the III.E.2.c. Cross-Cutting Annual Report. Results from the staff competency survey and program review pilot are driving the HEC's activities.

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

- Eliminating Racial Disparities in Infant Mortality Task Force listening sessions– Governor Mike DeWine formed the Task Force to create actionable recommendations for interventions, performance and quality improvement, data collection, and policies to reduce infant mortality rates and eliminate racial disparities by 2030. Ohio's Black and African American communities serve as the Task Force's greatest resource for recommendation development. Families shared their expertise and knowledge on experiencing a poor birth outcome or loss of an infant or participating in a program or receiving support that improved the health of their pregnancy or postpartum experience. The Task Force plans to share the recommendations back to the families who participated in listening sessions to gather further feedback on planning and input for tailored design and implementation.
- Breastfeeding focus groups for Black or African American and Appalachian women in Ohio– In March 2021, Professional Data Analysts, Inc. (PDA) created two reports, *Breastfeeding Experiences of Black or African American Women in Ohio* and *Breastfeeding Experiences of Appalachian Women in Ohio,* based on quantitative and qualitative data from focus groups. PDA also identified future collaborations, topics for discussion, and strategies to implement to improve breastfeeding initiation and duration, particularly focusing on African American and Appalachian women. ODH will engage partners to identify new strategies and activities as well as improve and enhance current activities.
- OPAS for Dads– The Ohio Pregnancy Assessment Survey (OPAS) is Ohio's PRAMS-like survey. In 2019 ODH initiated implementation of a stillbirth survey (SOARS) with methodology identical to OPAS but the target population from fetal death certificates rather than live birth certificates. In another expansion, OPAS for Dads will collect data on new and expectant fathers' behaviors and attitudes towards pregnancy, and the health of men during their reproductive years. The data will provide insight into gaps and disparities in male health care services and

use, ultimately supporting men and improving the family's health outcomes.
- COVID-19 data modules– In response to the COVID-19 pandemic, data collection has been expanded for maternal populations through additional questions on SOARS and OPAS and linking of birth certificate data to the Ohio Disease Reporting System. This data is used to understand the impact of the pandemic on Ohio's MCH population.
- ACES on YRBS– ODH received funding from CDC to add 16 questions on Adverse Childhood Experiences (ACEs) to the Youth Risk Behavior Survey (YRBS) for the Fall 2021 administration.

The following are key updates to existing partnerships and new partnerships to support implementation of the five-year action plan:

- Eliminating Racial Disparities in Infant Mortality Task Force– Task force members will work with local, state, and national leaders to identify needed changes to eliminate Ohio's racial disparities in infant mortality. Jamie Carmichael, Chief Health Opportunity Advisor, ODH, and Kristi Burre, Director of Children's Initiatives for the Governor's Office co-chair the task force with members from state agencies, public health agencies and organizations, health plans, advocacy organizations, and family members with lived experience. The Task Force facilitators represent the Kirwan Institute at OSU, BUILD Initiative, and AMCHP.
- OH-CAMH– The Ohio Collaborative to Advance Maternal Health was established in spring 2020 as a statewide membership organization to develop and implement a statewide strategic plan for maternal health. The Pregnancy Associated Mortality Review program convenes over 80 stakeholders representing clinical providers, local public health, community services, state agencies, advocacy organizations, and women with lived experience (i.e., near misses for maternal mortality).
- CMH PAC recruitment– The Children with Medical Handicaps Parent Advisory Committee is continuing efforts to diversify the PAC by increasing targeted recruitment, revising the PAC application to increase accessibility, and updating the PAC By-Laws to reflect a stronger emphasis on health equity and diversity.
- Birth Defects Advisory Board– The Ohio Connections for Children with Special Needs, birth defects surveillance program, is planning to re-establish a birth defects advisory committee representing both internal and external stakeholders who will bring knowledge and perspectives from parents, hospitals, physicians, genetic centers, and other vested stakeholders. The original advisory committee provided essential guidance for establishing birth defects surveillance in Ohio in 2008.
- Child Fatality Review Advisory Committee– With the goal of reducing the incidence of preventable child deaths, the CFR program oversees CFR review boards in each of Ohio's counties who review the deaths of children under eighteen years of age. The CFR program is planning to re-establish the state advisory committee to further support the work of the county review boards by reviewing compiled state data compiled, identifying trends, providing expertise in understanding factors related to child deaths, and making recommendations for the prevention of future deaths at the state level.

Changes in Health Status, Needs, and Emerging Public Health Issues

Since the completion of the 2020 Needs Assessment, the COVID-19 pandemic has had profound impacts on Ohio. MCH populations experienced dramatic shifts in their live including the loss of jobs and income, remote schooling, limited childcare, stresses to mental and behavioral health, and reduced access to health care. As described above and throughout the application, data collection activities were expanded to better understand and address the pandemic's impacts on Ohio's MCH populations. MCH services were transitioned to telehealth/remote options to ensure access to MCH programs and many MCH staff have supported the response. MCH programs have provided guidance for the resumption of face-to-face services where appropriate, and continue to assess and work to address the COVID-19 pandemic's disproportionate impact on certain communities, including racial and ethnic minorities, and individuals living with a chronic condition. Throughout the pandemic, the MCH program participated in the #WellChildWednesday campaign to promote well child visits and MCH programs are working with partners to address the lag in catch-up visits for adolescents. In addition, The COVID-19 pandemic has exacerbated previously identified needs for mental health supports for adolescents and women and underscored the MCH priorities for both populations.

Title V Program Capacity

Organizational Structure

ODH is a cabinet-level agency that reports to the Governor's Office. As a cabinet-level agency, the ODH Director Bruce Vanderhoff reports to the Governor's Office. ODH is organized by Offices/Bureaus as depicted in the organizational chart (see ODH TO in section V. Supporting Documents; note the organizational chart updates were in process at time of submission and do not reflect the recent appointment of the new director). ODH is organized according to our core public

health responsibilities:

- Eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, children, youth, and families in Ohio – Bureau of Maternal, Child, and Family Health
- Prevent and control the spread of infectious diseases – Bureau of Infectious Diseases
- Provide direction, support and coordination in preventing, preparing for and responding to events that threaten the public's health – Bureau of Health Preparedness
- Build strong communities to enable Ohioans of all ages and abilities live disease and injury-free – Bureau of Health Improvement and Wellness
- Address health inequities and disparities, and support access to comprehensive, integrated healthcare for all to achieve the best possible outcomes – Office of Performance and Innovation
- Assess and monitor environmental factors that potentially impact public health including air, water, soil, food, and physical and social features of our surroundings – Bureau of Environmental Health and Radiation Protection
- Assure quality in health care facilities, health care services, and environmental health through smart regulation to protect the health and safety of Ohioans – Bureau of Survey and Certification and Bureau of Regulatory Operations

Additionally, there are several Offices and Bureaus within the agency that assist with internal and external operations, including the Bureau of Vital Statistics, Bureau of Public Health Laboratory, Office of the Medical Director, Office of Management Information Systems, Office of Human Resources, Office of Financial Affairs, Office of Government Relations, Office of Communications, and the Office of General Counsel.

The Ohio Department of Health employs a total of 1,273 employees. The majority of ODH employees work in the ODH central office located in Columbus, Ohio, and approximately 240 employees work in the field at district or remote locations across Ohio. ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCH BG) in Ohio. The Bureau of Maternal, Child, and Family Health (BMCFH) is responsible for MCH programs at the state/local level. The BMCFH is designed to improve the health status of women, infants, children, adolescents, and CYSHCN in Ohio by identifying needs and implementing programs and services to address those identified needs. The BMCFH capacity to address the five population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders.

Programs administered and housed within the BMCFH supported by Title V funding include: Children with Medical Handicaps (CMH) Program, Title X Reproductive Health and Wellness, Perinatal Quality Improvement programs, Infant Mortality, Ohio Equity in Birth Outcomes Institute (OEI), Group Prenatal Care Initiatives, Fetal Alcohol Spectrum Disorders Program, MCH smoking cessation, Infant Safe Sleep, MP Subsidy program (Adolescent Resiliency, Pregnancy and Postpartum Peer Behavioral Health, and Pre/Inter-conception care), Breastfeeding, Genetics Services and Sickle Cell Services related to newborn bloodspot screening for 36 metabolic, endocrine, and genetic conditions, Newborn Screening for Critical Congenital Heart Disease, Ohio's Birth Defects Surveillance System, the Universal Newborn Hearing Screening (UNHS), the Infant Hearing Program, Children's Hearing and Vision, Early Childhood Comprehensive Systems (ECCS) program, School Nursing, Adolescent Health, Oral Health, Help Me Grow (HMG) Home Visiting Moms and Babies First (MB) Ohio's Black Infant Vitality Program, and MCH data and surveillance including Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Ohio Study of Associated Risks of Stillbirth (SOARS), Ohio Pregnancy Assessment Survey (OPAS), Pregnancy Associated Mortality Review (PAMR), Sudden Infant Death Syndrome (SIDS) Program, and the Youth Risk Behavior Surveillance System (YRBS).

BMCFH also houses the Asthma, Save Our Sight (SOS) children's vision programs, non-Title V Home Visiting including Maternal Infant and Early Childhood Home Visiting (MIECHV), Infant Vitality Community Intensive, Sexual Risk Avoidance Education, Choose Life, and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and WIC Farmers' Market Nutrition (WIC FMNP) programs.

Programs with close working relationships and Title V funding outside of the BMCFH include Ohio Healthy Homes and Lead Poisoning Prevention Program, Primary Care Office, State Office of Rural Health, Violence and Injury Prevention, and Sexual Assault and Domestic Violence Prevention. The Title V program also has plans to strengthen programmatic relationships with the Tobacco Use Prevention and Cessation Program and Immunization Program.

Agency capacity

The BMCFH maintains a map of all programs within the bureau that specifies program characteristics including MCH population(s) served, service level, service area, funding sources, types of partner organizations, inclusion of health equity activities, and if the program is required by Ohio statute. Key partner programs receiving Title V funds outside of the bureau are also included in this program map to represent the full scope of the MCH BG funds. The program map details the number of programs serving each of the populations and the breadth of partnerships with external organizations. Additional information on partnerships was reported in the Five-Year Needs Assessment Summary section b.iii. Title V Program Partnerships, Collaboration, and Coordination. Updates to partnerships were provided in the preceding section and are included throughout the application. The Program Map is available in section V. Supporting Documents.

The Children with Medical Handicaps (CMH) program serves CYSHCN and administers a diagnostic, treatment, and hospital-based service coordination program, supporting team-based service coordination for conditions such as spina bifida and hemophilia; and community-based service coordination, supporting public health nurses in local health departments who assist families in linking to local resources and helping families navigate the health care system. CMH utilizes vital committee/council structures to foster open dialogue, receive input and feedback regarding CYSHCN needs across the state. One of these committees is the Medical Advisory Council (MAC), whose members are appointed by the Director of Health, and represents various geographic areas of Ohio, medical disciplines, and treatment facilities involved in the treatment of children with medically handicapping conditions. CMH also convenes the Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise CMH. The mission of the PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CYSHCN. The 2022-2023 biennial budget extended the age of eligibility for the CMH program from 21 years of age to 22 in 2022, and 23 in 2023, with the ultimate aim to extend the age to 26.

BMCFH also utilizes the medical expertise of highly skilled physicians and a dentist who serve as subject matter experts in addressing issues directly impacting MCH populations. Bruce Vanderhoff, MD, serves as Director of ODH and previously served as Chief Medical Officer for ODH. Dr. Vanderhoff previously served for more than a decade as senior vice president and chief medical officer at OhioHealth. He has years of experience leading large teams in successfully dealing with important healthcare issues in Ohio and prepared OhioHealth to deal with the threat of Ebola and the H1N1 flu pandemic. Dr. Vanderhoff oversees the agency and it's response to medical issues with the goal of developing and implementing public health policies to improve the health of all Ohioans.

James Duffee, MD, MPH, FAAP, has spent his life advocating for the needs of Ohio's most disadvantaged children and has served as the chair of the CMH MAC. During COVID-19, BMCFH secured a contract with Dr. Duffee to act an as advisor for response activities. BMCFH renewed Dr. Duffee's contract to leverage his clinical expertise on BMCFH initiatives to improve access and care for children and adolescents.

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

Dr. Homa Amini, DDS, MPH, MS provides general supervision, training, and technical assistance to the ODH Oral Health Program staff. This includes advising and training on program planning, clinical oral health practices, and program implementation. Dr. Amini also provides training to local School-based Dental Sealant Program staff.

MCH Workforce Capacity

The BMCFH has 223 positions in the ODH organizational chart and as of August 2021 employs 179 individuals. Many BMCFH staff are supported by multiple funding sources. Across all bureaus, 139 staff receive Title V funding for a total of 86 FTEs funded by the MCH BG. Across ODH, 400 staff are eligible for retirement within the next five years. Among the 179 BMCFH staff, 39 are eligible for retirement within the next five years.

Starting in March 2020, the state of Ohio quickly adapted to address COVID-19 and remains committed to addressing inequities in these areas and across all health-related topics. MCH services were transitioned to telehealth/remote options to ensure access to MCH programs and many MCH staff have supported the response. During the COVID-19 outbreak, nearly 50 BMCFH staff have contributed to the state's response. Specifically, BMCFH staff have been assigned full-time or volunteered part-time for Ohio's COVID-19 call centers, participated on state workgroups to develop guidance for sectors operating safely, participated in the Minority Health Strike Force, led the data team responsible for creating the Ohio Public Health Advisory System, and provided support for the state's population study of coronavirus infection. Staff not involved in the COVID-19 response have assumed additional duties to continue non-COVID-19 operations. As of July 2021, most MCH staff have returned from COVID-19 response duty and MCH programs have provided guidance for the resumption of face-to-face services where appropriate.

ODH and BMCFH maintain resources for recruiting, training, and retaining a qualified workforce. Plans for addressing workforce capacity are in section III.E.2.b.i MCH Workforce Development.

Bruce Vanderhoff, MD, serves as director of the agency. Director Vanderhoff's previous experience includes serving as Chief Medical Officer for ODH and more than a decade as senior vice president and chief medical officer at OhioHealth.

Jamie Carmichael serves as the Chief Health Opportunity Officer leading initiatives to advance equity at ODH and across state agencies. Jamie previously served as deputy director of public affairs for the Ohio Department of Mental Health and Addiction Services.

Jenifer Voit serves as Chief of Health Programs, which in addition to the BMCFH, includes the Bureaus of Environmental Health and Radiation Protection, Health Preparedness, and Health Improvement and Wellness. Jennifer previously served as Director of Complex Care, Healthy Weight and Nutrition, for Nationwide Children's Hospital, and Vice President of Programs for Big Brothers Big Sisters of Central Ohio.

Dyane Gogan Turner, MPH, RD/LD, IBLCLC, serves as the Title V Director and Chief of the Bureau of Maternal, Child, and Family Health. She has more than 25 years of public health experience working with the Supplemental Nutrition Program for Women, Infants, and Children (WIC), Child and Adult Food Care Program, and Title V Maternal and Child Health programs.

Anna Starr serves as the Assistant Chief for the Bureau of Maternal, Child, and Family Health and has previously served as Interim Chief as well as section administrator for Child and Specialty Health. Anna has over 35 years of experience in maternal and child health.

Patrick Londergan and is the Director of Children and Youth with Special Health Care Needs. Patrick has over 20 years of experience in the Children with Medical Handicaps Program, serving as the administrator of the program for 15 years.

Kirstan Duckett, MPH, CHES, serves as the Title V Maternal Child Health Block Grant Coordinator and previously served as the Birth Defects Surveillance System Coordinator within the BMCFH.

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

Johnnie Chip Allen serves as the BMCFH Health Equity Manager, acting as leader, advisor, and providing strategic direction for the bureau's health equity policy and initiatives. Chip most recently served as the Director of Health Equity at ODH developing agency-wide goals, objectives, and strategies to advance health equity for all Ohio residents.

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

Two parent consultants joined the BMCFH in 2020 with the goal of improving integration of family perspective within programs. Kimberly Mathews is the parent of a child with special health care needs and has extensive background leading CYSHCN patient and family advisory boards and community organizations. Kimberly previously served as the chair for CMH Parent Advisory Committee. Melissa James is also the parent of a child with special health care needs and has extensive background in nonprofits and community organizations. Melissa leads the Pediatric Cancer Work Group for Ohio's Cancer Plan. Both consultants will work throughout the bureau programs and assist with engaging parent perspectives in our work, materials, and activities. In addition, they lead specific projects around transition for CYSHCN, working to improve diversity in the Parent Advisory Committee, and speaking directly with parents in Ohio to provide assistance and mentoring. The parent consultants have created a flier, available in section V. Supporting Documents.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

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

In compliance with Title V legislation, every five years ODH is required to assess the needs of the MCH population, identify gaps in services, and ensure the state's capacity to meet these needs. In alignment with state and national health objectives, the MCH needs assessment process serves as the driver in determining state Title V program priority needs and developing a five-year Action Plan to address them. Ohio's needs assessment findings helped inform the selection of the state's ten highest priority needs for its MCH and CSHCN populations.

In September 2018, the ODH entered into contract with the Health Policy Institute of Ohio to lead a large, multi-faceted needs assessment and state planning process to include the State Health Assessment (SHA), development of the State Health Improvement Plan (SHIP), the Title V Needs Assessment, and the Maternal, Infant, and Early Childhood Home Visiting Needs Assessment (MIECHV). Alignment of needs, increasing efficiency and capacity, and greater utilization of stakeholders were foundational to the joint needs assessment process. The project was managed through a SHA/SHIP Steering Committee and MCH/MIECHV Steering Committee working alongside ODH staff throughout the prioritization and decision-making process.

A strategic mixed-method approach was used to identify MCH needs. Multiple methods for obtaining stakeholder input included regional forums and an online survey, key informant interviews, feedback from the CMH Parent and Medical Advisory Committees, feedback from MCH/MIECHV Steering Committee, and feedback from ODH BMCFH staff. Priorities were discussed through the lens of health outcomes, social determinants of health, prevention and health behaviors, and healthcare system and accessibility. In addition, a review of data was conducted using data from the National Outcome Measures (NOMS), National Performance Measures (NPMS), and over 500 metrics compiled in the ODH online SHA.

Top priorities were identified through a crosswalk of stakeholder feedback and data analysis based upon Ohio's performance in comparison to the United States. Prioritization criteria for the five population domains included the ability to track progress, potential for impact, nature of the problem, and alignment. Additional details for the MCH Needs Assessment are provided in the subsequent sections of the Process Description and the full MCH Needs Assessment Report, which is attached to the application in section V. Supporting Documents. The MCH Needs Assessment data were key to the finalization of priorities, selection of performance measures to drive improvement, and development of the Action Plan, with additional details on this process presented in III.C.2.c. Identifying Priority Needs and Linking to Performance Measures.

Qualitative Data and Stakeholder Involvement
The MCH Needs assessment process relied on five sources of qualitative data to include a wide representation of stakeholders.

Regional forums and online survey- HPIO facilitated five regional forums in October 2018 and conducted an online survey that was completed by forum attendees and other stakeholders. The purpose of the forums and online survey was to gather information on priorities and needs across the five MCH population domains, MCH strengths and challenges, and equity needs for addressing drivers of gaps in health outcomes to ensure all children and families achieve their full health potential. Overall, 692 stakeholders participated in either a regional forum or completed the online survey. Regional forum attendees and online survey respondents represented a variety of organizations, sectors, and perspectives, including MCH advocates, health care, public health, behavioral health, community residents, and consumer groups. Each regional forum began with a brief overview and summary report of Ohio's performance on key maternal and child health indicators followed by two rounds of small group discussions. Regional forum attendees were seated in small groups with an assigned facilitator and asked to provide feedback on a series of questions. During the first round, discussion focused on community maternal and child health strengths, challenges, and equity, and participants were grouped by county type. During the second round, participants were asked to sit at a table representing one of the five MCH population health domains and participants completed a worksheet ranking a set of issues based on what they viewed as the biggest needs. The online survey was structured similarly to the worksheets completed by forum participants to rank issue and also asked respondents to identify the groups experiencing the worst health outcomes within the population domains. Regional forum attendees were invited to complete the online survey for population domains other than those for which they provided feedback at the regional forum. All of Ohio's 88 counties were represented by online survey respondents.

Informant interviews- HPIO conducted 15 key informant interviews to assess the quality and capacity of early childhood home visiting in the state. Of the 15 organizations interviewed, 13 were home visiting providers or funders/payers of home

visiting services, five were state agencies or commissions, one was a health plan and one was a statewide advocacy organization. Interviewees provided information on barriers and challenges faced by women and families in accessing home visiting services.

MCH-MIECHV Steering Committee- HPIO and ODH convened the Steering Committee to inform the identification of MCH priority needs and performance measures and provide input into the state's MIECHV needs assessment. The Steering Committee included 35 maternal and child health and home visiting experts representing 27 organizations from around the state including representatives from the following state agencies, commissions, and advisory groups: Ohio Departments of Health, Medicaid, Developmental Disabilities, Mental Health and Addiction Services, Education, Job and Family Services, and Ohio Commission on Minority Health, Ohio Children's Trust Fund, Governor's Office of Children's Initiatives, and Ohio Family 2 Family.

CMH MAC and PAC- ODH conducted focused conversations in December 2018 and May 2019 with members of the Children with Medical Handicaps Medical Advisory Council and Parent Advisory Committee to garner additional feedback on the needs of children and youth with special health care needs (CYSHCN). MAC and PAC inform ODH and other entities on policy, system, and program structures to support and improve physical, social, and emotional outcomes for CYSHCN and their families.

BMCFH Staff- HPIO gathered input from ODH BMCFH staff at two points during the needs assessment process. In January 2019 HPIO presented the preliminary findings from the regional forums and online survey and gathered feedback on the health priority needs that were identified and whether other priority needs that did not rise to the top should be explored further. In June 2019 HPIO presented the top ranked health priority needs based on stakeholder input and secondary data analysis and gathered feedback on identifying a final set of health priority needs and potential performance measures.

Quantitative Data
To assess the health status of Ohio's MCH population, HPIO took a comprehensive approach to analyzing secondary data reflecting the modifiable factors that influence health and grouped data findings into categories of health outcomes, community conditions, health behaviors, and access to care. The secondary data analysis identified notable findings based on one or more of the following factors: Ohio's performance was better than the U.S. by 10% or more, Ohio's data trend improved, Ohio's performance was worse than the U.S. by 10% or more, Ohio's data trend worsened, or Ohio experienced large disparities/inequities by race, ethnicity, income, geography, or other characteristic. HPIO analyzed data from the national outcome measures (NOMs) and national performance measures (NPMs) provided by the Health Resources Services Administration (HRSA) and metrics compiled by ODH in the Ohio Online State Health Assessment (SHA) and Summary Report. Data sources included health surveys (such as the Behavioral Risk Factor Surveillance System), Vital Statistics (birth and death records), healthcare system utilization data, and data from sectors beyond health (e.g. housing, transportation, education). A full list of metrics is available in appendix C of the MCH Needs Assessment report attached in section V. Supporting Documents.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

The full report (available in section V. Supporting Documents) prepared by HPIO describes in detail the findings from the quantitative and qualitative analyses, including strengths and challenges for the MCH populations, health inequities and disparities, differences in stakeholder input by regions, and alignment between the identified MCH priority needs and priority areas in Ohio's 2020-2022 State Health Improvement Plan (SHIP). A summary of overall MCH findings and summaries by population domain are presented below. MCH programs are included in the population summaries (only listed in one population despite serving multiple) and a full listing of programs (and all populations served) is available in the Program Map in section V. Supporting Documents. The resulting priorities are also listed and additional details on the process for selecting priorities and measures is available in section III.C.2.c. Identifying Priority Needs and Linking to Performance Measures.

The top three maternal and child health strengths identified by stakeholders in Ohio were strong collaboration and partnerships at the local level, prevention and public health programs and policies geared towards maternal and child health, and strong focus on prevention and social determinants of health. The top three challenges were identified as transportation, funding and capacity limitations, and lack of healthcare access. The sub-populations most-frequently identified as having the largest maternal and child health disparities for Ohio overall are low-income Ohioans, African American/Black Ohioans, residents of rural or Appalachian areas, and people with disabilities. Stakeholders identified the top drivers of gaps in health outcomes as poverty/income, educational attainment, transportation, and family stability. The most common response to needs for achieving health equity was coordination and collaboration among state- and local-level partners as well as improvements in educational attainment, employment opportunities, and healthcare provider access. Opportunities for systems change identified include improved data sharing and outcome tracking, improved coordination among state agencies, and identification of women and families most in need.

Women/Maternal Health
The rate of severe maternal morbidity per 10,000 delivery hospitalizations in Ohio was nearly 18% lower than the U.S. rate

in 2015. However, the maternal morbidity rate for Hispanic, non-Hispanic Asian/Pacific Islander, and non-Hispanic Black women was higher than the rate for non-Hispanic white women (2.3, 1.8, and 1.7 times higher, respectively). Rates of early prenatal care have improved, however, African American and women without a high school diploma are less likely to receive prenatal care. The Ohio rate for well-woman visit has improved since 2015 and is slightly above the national rate, but room for improvement exists. Ohio's teen birth rate has declined from 2014 to 2017 (25.2 to 20.8).

Mental health and addiction are serious issues facing Ohio's maternal population. More Ohio women (16.2%) experience postpartum depression in 2015 compared to the U.S. (12.8%) and an increase of more than 20% occurred in Ohio from 2012 to 2015. Unintentional drug overdose deaths for the overall Ohio population increased through 2017 but promising decreases were seen from 2017 to 2018. Ohio's rate of fetal alcohol exposure is nearly 20% lower than the U.S. rate. Ohio's rate of women who smoked cigarettes during pregnancy decreased by 15.3% between 2014 and 2017 but remained two times higher than the rate for the overall U.S., and women covered by Medicaid had nearly twice the rate of Ohio overall.

MCH programs serving women/maternal health population include the Reproductive Health and Wellness Program, FASD Program, Perinatal Smoking Cessation Program, Pregnancy-Associated Mortality Review, and Sexual Assault and Domestic Violence Prevention Program. Across all populations, the MCH Oral Health program supports access to dental care and MCH supports the Primary Care Office to identify and support medically underserved communities and the State Office of Rural Health in supporting access for rural populations in Ohio. While not MCH funded, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Home Visiting programs also serve Ohioans across the MCH populations.

Stakeholders identified the top five needs for women/maternal health across several categories:

- Health outcome needs: infant mortality and birth outcomes, mental health and suicide, drug use and dependency, unintended pregnancy and teen birth, and tobacco use.
- Social determinant of health needs: poverty, housing, transportation, employment and income, and Adverse Childhood Experiences (ACEs).
- Public health system, prevention, and health behavior needs: substance use/abuse, sexual and reproductive health, tobacco use, nutrition, and violence.
- Healthcare system and access needs: access to health care, access to mental health services, access to substance use/addiction treatment, insurance coverage and healthcare affordability, and home visiting and/or parent education.

The resulting MCH priorities: Decrease risk factors contributing to maternal morbidity; Increase mental health support for women of reproductive age; and Decrease risk factors associated with preterm births. To address the priority of maternal morbidity efforts must include improving the health outcomes for women before, during, and after pregnancy. The selected NPM 1 relates to leveraging women's well visits as key opportunities for health intervention and referrals. The need to address mental health for both women of reproductive and pregnant and postpartum women is reflected in the selection of outcome and performance measures (SPM unmet mental health need among women of reproductive age). The risk factors associated with preterm birth include and extend beyond interventions for pregnant women. The selection of the SPM for smoking among reproductive age women aligns with the need to address smoking before women become pregnant to complement the existing efforts to identify and support pregnant women in quitting during pregnancy.

Perinatal/Infant Health

Ohio's 2016 infant mortality rate was 1.25 times greater than the U.S. rate. While Ohio has seen a decrease of 18.4% in infant mortality due to preterm birth and low birthweight babies, Ohio has worse outcomes than the U.S. across multiple infant mortality measures, including neonatal, post-neonatal, sleep-related, and pre-term related mortality. Non-Hispanic Black infants in Ohio had the highest mortality rate in 2018 (14 per 1,000), 2.6 times as high as the non-Hispanic white rate (5.3 per 1,000).

Ohio's rate of infants born with neonatal abstinence syndrome (NAS) per 1,000 births was 76.5% higher than the U.S. rate and has increased in recent years. Further, Ohio infants covered by Medicaid experience NAS at nearly double the rate of Ohio overall.

Breastfeeding rates improved in Ohio between 2012 and 2015. The percent of infants ever breastfed increased by 13.9% (from 71.9% to 81.9%), and the percent of Ohio infants breastfed exclusively through six months increased by 63.4% (from 14.5% to 23.7%). Safe sleep rates also improved nearly 8% between 2012 and 2015, with the percent of infants places on their back to sleep increasing from 79.3% to 85.5%.

MCH programs serving the perinatal/infant health population include Title V Breastfeeding and Ohio First Steps for Healthy Babies, Infant Safe Sleep and Cribs for Kids©, Moms and Babies First, the Ohio Equity Institute, Newborn Screening for Critical Congenital Heart Disease, Comprehensive Genetics Services Program, Sickle Cell Services, Infant Hearing, Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Surveillance Program, Sudden Infant Death Syndrome Program, and Fetal Infant Mortality Review. While not MCH funded, the Women, Infants, and Children (WIC) and Home Visiting programs also serve Ohioans across the MCH populations.

Stakeholders identified the top five needs for perinatal/infant health across several categories:

- Health outcome needs: infant mortality and birth outcomes, drug use and dependency, mental health and suicide, unintended pregnancy and teen birth, and violence.
- Social determinant of health needs: poverty, housing, transportation, ACEs, and family and social support/family functioning.
- Public health system, prevention, and health behavior needs: breastfeeding, safe sleep, violence, nutrition, and parent/caregiver tobacco use.
- Healthcare system and access needs: access to health care, home visiting and/or parent education, insurance coverage and healthcare affordability, care coordination, and access to social services.

The resulting MCH priority: Support healthy pregnancies and improve birth and infant outcomes. Addressing the disparity in birth and infant outcomes will be measured through the SOM created for the Black infant mortality rate. Improvements in infant outcomes will be measured through NPM 4 breastfeeding and NPM 5 safe sleep.

Child Health

Ohio's children have similar overall health status when compared to the U.S., but a higher child mortality rate. In measures of access, Ohio children have a lower rate of uninsured, higher rate of medical home, and higher rate of receiving mental health treatment than the U.S. Ohio children also have a lower rate of tooth decay/cavities and decreasing rate of unmet dental care needs, but disparities for African American and Appalachian children persist. Ohio has similar rates for developmental screening but has not seen an improvement in this outcome. Compared to the U.S., Ohio has a lower rate of obesity among 2-4-year-olds, but a higher rate among ages 10-17, with lower income children experiencing disparities. Ohio performs similarly to the U.S. on several metrics related to nutrition and physical activity: fruit and vegetable consumption, access to exercise opportunities, and physical activity among children.

Ohio's overall child asthma prevalence is lower than the U.S. and has improved in recent years, but African American and Hispanic children are 1.5 times more likely to have asthma than white children in Ohio. In 2016-2017, nearly a quarter of Ohio children (23%) lived in a home where someone smokes, which is 1.5 times the percent among U.S. children.

MCH programs serving the child health population include Early Childhood Health, School Hearing and Vision, Ohio Healthy Homes and Lead Poisoning Prevention Program, School Nursing, and Child Fatality Review. While not MCH funded, the Women, Infants, and Children (WIC) and Home Visiting programs also serve Ohioans across the MCH populations.

Stakeholders identified the top five needs for child health across several categories:

- Health outcome needs: mental health and suicide, drug use and dependency, child maltreatment, healthy weight status/obesity, and violence.
- Social determinant of health needs: poverty, family and social support/family functioning, ACEs, housing, and education/school readiness.
- Public health system, prevention, and health behavior needs: nutrition, violence, substance use/abuse, physical activity, and health literacy.
- Healthcare system and access needs: access to health care, access to mental health services, insurance coverage and healthcare affordability, access to dental care, and access to substance use/addiction treatment.

The resulting MCH priority: Improve nutrition, physical activity, and overall wellness of children. To address the priority of improving overall child health efforts must address a broad range of issues impacting children. Pediatric primary care visits represent a key opportunity for monitoring and addressing the comprehensive needs of children's health. The selected NPM 6 relates to the critical role of developmental screening in monitoring and supporting child development.

Adolescent Health

Mental health and addiction issues are a challenge for Ohio. Adolescent and young adult suicide has increased by more than half from 2009 to 2018. The rate of adolescents with a major depressive episode in the past year has increased since 2011 and the percent of adolescents who bully others and who report being bullied is higher in Ohio than the U.S.

According to Ohio's Youth Tobacco Survey, e-cigarettes/vaping products were the most commonly used tobacco products by high school students in 2017 and U.S. data indicates that e-cigarette use among U.S. high school students increased from 11.7% in 2017 to 20.8% in 2018. The percent of adolescents, ages 12-17, perceiving great risk in consuming five or more drinks of an alcoholic beverage once or twice a week improved by 13.5%, increasing from 37% in 2013-2014 to 42% in 2016-2017. For young adults, ages 18-25, drug overdose deaths have more than doubled from 138 deaths in 2007 to 319 deaths in 2018. However, there was a promising decline of 28.8% in the overdose death rate for young adults between 2017 and 2018.

Ohio's rates of adolescent well-visits compare with the national rates, and improvements have been observed with nearly 80% of adolescents obtaining a well-visit, but disparities persist. While the overall rate by well-visits among Medicaid enrollees are lower, between July 2015 and June 2018, the rate improved 4% (42.6% to 44.3%).

MCH programs that serve the adolescent health population include Adolescent Health, School Nursing, Reproductive Health

and Wellness Program, Sexual Assault Domestic Violence Prevention Program, and Youth Risk Behavior Survey/Youth Tobacco Survey.

Stakeholders identified the top five needs for adolescent health across several categories:

- Health outcome needs: mental health and suicide, drug use and dependency, violence, healthy weight status/obesity, and tobacco use.
- Social determinant of health needs: poverty, ACEs, family and social support/family functioning, housing, and education.
- Public health system, prevention and health behavior: substance use/abuse, alcohol use, tobacco use, sexual and reproductive health, and nutrition.
- Healthcare system and access needs: access to mental health services, access to health care, access to substance use/addiction treatment, insurance coverage and healthcare affordability, and access to social services.

The resulting MCH priorities: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate; Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use. The selected NPM 10 aligns with the priorities as adolescent preventive medical visits provide key opportunities for screening, education, and referral on numerous topics including mental health and substance use.

Children with Special Health Care Needs

Overall Ohio has a higher proportion of children with special health care needs (CSHCN) compared to the U.S. (21.9 vs. 18.8). In Ohio, CSHCN have a similar rate of receiving care in a well-functioning system and a higher rate of receiving care in a medical home compared to the U.S. CSHCN have many of the same challenges faced by children without special healthcare needs in Ohio, including mental health and addiction. However, disparities exist. Children with special health care needs are 2.5 times more likely than children without special health care needs to be bullied. Challenges related to accessing healthcare also emerged from the data. For example, stakeholders highlighted the need for greater care coordination and increased access to services for children with autism, spectrum disorders, developmental disabilities, and learning disabilities. Adolescents, ages 12-17, with and without special health care needs, were also more than 17% less likely than U.S. peers to receive the services necessary to transition to the adult healthcare system in 2016-2017.

MCH programs serving the CSHCN population include the Children with Medical Handicaps Program (CMH) which includes the Title V supported Diagnostic Program, Treatment Program, Metabolic Formula, and Hearing Aid Assistance Claims Processing and programs with other state funds include Hospital-based Service Coordination, Adults Cystic Fibrosis, Adult Hemophilia Insurance Premium Payment, and Payor of Last Resort. The newborn screening and newborn screening follow-up programs listed in the perinatal/infant section and programs listed in the child section also serve CSHCN.

Members of the CMH Parent Advisory Committee (PAC) and Medical Advisory Council (MAC) were asked to reflect on strengths, challenges, and opportunities to improve health and health care outcomes for CSHCN and their families. The following opportunities and challenges were identified. Challenges: health systems discharge pediatric patients with medical complexity from the hospital to a home that is not equipped to address their needs; additional medical and emotional support services are needed for patients and caregivers; CSHCN and their families face barriers with primary payers who question and deny prescribed treatments/pharmaceuticals. Opportunities: Increase and improve services that promote and support transition to adulthood healthcare throughout adolescence; increase screenings for mental health needs of parents/caregivers of CSHCN and provide resources and connections to care; improve inclusion opportunities for CYSHCN within education and in settings that promote physical activity (e.g., state and local parks); increase and improve workforce development for those who provide physical and mental health services to CYSHCN to improve comprehensive and quality care; and educate primary payers on the rationale for why certain/unique services/goods need to be covered for this specialized population.

Stakeholders identified the top five needs for CSHCN health across several categories:

- Health outcome needs: mental health and suicide, child maltreatment, drug use and dependency, child maltreatment, infant mortality and birth outcomes, and violence.
- Social determinant of health needs: family and social support/family functioning, poverty, ACEs, housing, and transportation.
- Public health system, prevention and health behavior: health literacy, violence, substance use/abuse, nutrition, and tobacco use.
- Healthcare system and access needs: insurance coverage and healthcare affordability, access to health care, access to mental health services, care coordination, and services for children with autism, spectrum disorders, developmental disabilities and learning disabilities.

Resulting MCH priority: Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services. The selection of the NPM relates to the need to address transitions to adult care.

Cross-Cutting

An estimated 50% of modifiable factors that influence health are attributed to community conditions/social determinants of

health, or the factors within the social, economic, and physical environments in which families live. Community conditions, such as housing, transportation, education, and unemployment, lay the foundation for good health outcomes and are critical to ensure all mothers infants, children, and families in Ohio have the opportunity to lead healthy lives. Drivers in gaps in outcomes include poverty, racism, discrimination, trauma, violence, and toxic stress. Ohio has made some notable improvements in child poverty and unemployment; however, Ohio has many opportunities to improve outcomes across community conditions, particularly for exposure to violence and trauma, lead risk, and transportation.

The percent of Ohio fourth-graders proficient in reading is higher in Ohio than in the U.S., but disparities persist for children from low-income, Black, and Hispanic families. Ohio has experienced positive trends in recent years for income, employment, and poverty but performs worse than the U.S. for unemployment and median household income and in 2016 Black children were more than three times as likely to live in poverty than white children in Ohio. Ohio performs better than the U.S. on access to federal housing assistance and the number of people experiencing homelessness per capita. The percent of children in Ohio identified with elevated blood lead levels is below the U.S. rate, but lead exposure risk in many Ohio cities is extremely high.

Ohio performs similar to the U.S. for child abuse and neglect, incarceration, and intimate partner violence. Ohio had fewer violent crimes per capita than the U.S., but a higher incidence of children exposed to adverse childhood experiences (ACEs). Black, non-Hispanic children and children with low incomes were much more likely to be exposed to two or more ACEs as compared to peers.

Families in Ohio experience various transportation challenges with lower proportion of active commuting, lower transit accessibility in three cities, and more Black households without access to a vehicle than white households. The percent of households that are food insecure in Ohio decreased by 20% from 18% in 2011 to 15% in 2016 but remains above the U.S. rate of 13% in 2016. Food insecurity differed markedly by county, with a high of 20% in one Appalachian county.

Stakeholders noted the top social determinant of health needs across all populations as poverty, housing, adverse childhood experiences, employment and income, and transportation. When asked what needs to happen to achieve health equity, the most common response from stakeholders was coordination and collaboration among both state- and local-level partners. This was followed by improvements in educational attainment, employment opportunities, and healthcare provider access.

Resulting MCH priorities: Prevent and mitigate the effects of adverse childhood experiences; Improve healthy equity by addressing community and social conditions and reducing environmental hazards that impact infant and child health outcomes. These priorities will be addressed within each population domain and also from a systems-level.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

ODH is a cabinet-level agency that reports to the Governor's Office. As a cabinet-level agency, the ODH Interim Director Lance Himes reports to the Governor's Office. ODH is organized by Offices/Bureaus that ultimately report to the Chief of Staff. ODH is organized according to our core public health responsibilities:

- Eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, children, youth, and families in Ohio – Bureau of Maternal, Child, & Family Health
- Prevent and control the spread of infectious diseases – Bureau of Infectious Diseases
- Provide direction, support and coordination in preventing, preparing for and responding to events that threaten the public's health – Office of Health Preparedness
- Build strong communities to enable Ohioans of all ages and abilities live disease and injury-free – Bureau of Health Improvement and Wellness
- Address health inequities and disparities, and support access to comprehensive, integrated healthcare for all to achieve the best possible outcomes – Office of Performance and Innovation
- Assess and monitor environmental factors that potentially impact public health including air, water, soil, food, and physical and social features of our surroundings – Bureau of Environmental Health and Radiation Protection
- Assure quality in health care facilities, health care services, and environmental health through smart regulation to protect the health and safety of Ohioans – Office of Health Assurance and Licensing

Additionally, there are several Offices and Bureaus within the agency that assist with internal and external operations, including the Bureau of Vital Statistics, Bureau of Public Health Laboratory, Office of the Medical Director, Office of Management Information Systems, Office of Human Resources, Office of Financial Affairs, Office of Government Relations, Office of Communications, and the Office of General Counsel.

A total of 1,241 employees work for ODH. The majority of ODH employees work in the ODH central office located in Columbus, Ohio and approximately 200 work in the field at district or remote locations across Ohio. ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCH BG) in Ohio. The Bureau of

Maternal, Child, and Family Health (BMCFH) is responsible for MCH programs at the state/local level. The BMCFH is designed to improve the health status of women, infants, children, adolescents, and CSHCN in Ohio by identifying needs and implementing programs and services to address those identified needs. The BMCFH capacity to address the five population health domain needs is accomplished by engaging in a multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholders.

Programs administered and housed within the BMCFH supported by Title V funding include: Children with Medical Handicaps (CMH) Program, Title X Reproductive Health and Wellness, Gestational Diabetes Collaborative, Perinatal Quality Improvement programs, Infant Mortality, Ohio Equity in Birth Outcomes Institute (OEI), Group Prenatal Care Initiatives, Fetal Alcohol Spectrum Disorders Program, MCH smoking cessation, Infant Safe Sleep, MP Subsidy program (Adolescent Resiliency, Pregnancy and Postpartum Peer Behavioral Health, and Pre/Inter-conception care), Breastfeeding, Genetics Services and Sickle Cell Services related to newborn bloodspot screening for 36 metabolic, endocrine, and genetic conditions, Newborn Screening for Critical Congenital Heart Disease, Ohio's Birth Defects Surveillance System, the Universal Newborn Hearing Screening (UNHS), the Infant Hearing Program, Children's Hearing and Vision, Early Childhood Comprehensive Systems (ECCS) program, School Nursing, Adolescent Health, Oral Health, Help Me Grow (HMG) Home Visiting Moms and Babies First (MB) Ohio's Black Infant Vitality Program, and MCH data and surveillance including Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR), Ohio Study of Associated Risks of Stillbirth (SOARS), Ohio Pregnancy Assessment Survey (OPAS), Pregnancy Associated Mortality Review (PAMR), Sudden Infant Death Syndrome (SIDS) Program, and the Youth Risk Behavior Surveillance System (YRBS).

BMCFH also houses the Asthma, Save Our Sight (SOS) children's vision programs, non-Title V Home Visiting including Maternal Infant and Early Childhood Home Visiting (MIECHV), Infant Vitality Community Intensive, Sexual Risk Avoidance Education, Choose Life, and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and WIC Farmers' Market Nutrition (WIC FMNP) programs.

Programs with close working relationships and Title V funding outside of the BMCFH include Ohio Healthy Homes and Lead Poisoning Prevention Program, Primary Care Office, State Office of Rural Health, Violence and Injury Prevention, and Sexual Assault and Domestic Violence Prevention. The Title V program also has plans to strengthen programmatic relationships with the Tobacco Use Prevention and Cessation Program and Immunization Program.

III.C.2.b.ii.b. Agency Capacity

The BMCFH engaged in a process to map all programs within the bureau and program characteristics including MCH population(s) served, service level, funding sources, types of partner organizations, inclusion of health equity activities, and if the program is required by Ohio statute. Key partner programs receiving Title V funds outside of the bureau were also included to represent the full scope of the MCH BG funds. The program map details the number of programs serving each of the populations and the breadth of partnerships with external organizations. Additional information on partnerships is available in section b.iii. Title V Program Partnerships, Collaboration, and Coordination. The Program Map is available in section V. Supporting Documents. The program map is also an important planning tool to prioritize during COVID-19 operations including monitoring workforce capacity presented in the next section.

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

James Duffee, MD, MPH, FAAP, has spent his life advocating for the needs of Ohio's most disadvantaged children and serves as the chair of the CMH MAC. Dr. Duffee has also been contracted to act an as advisor during the COVID-19 response.

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

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

III.C.2.b.ii.c. MCH Workforce Capacity

The BMCFH has 221 positions in the ODH organizational chart and as of August 2020 employs 179 individuals. Many BMCFH staff are supported by multiple funding sources. Across all bureaus, currently 147 staff receive Title V funding for a total of 89.9 FTEs funded by the MCH BG. Across ODH, 249 staff are immediately eligible for retirement and an additional 158 are eligible within the next five years. Among the 179 BMCFH staff, 58 are eligible for retirement immediately and an additional 13 are eligible within the next five years. During the COVID-19 outbreak, nearly 50 BMCFH staff have contributed to the state's response. Specifically, BMCFH staff have been assigned full-time or volunteered part-time for Ohio's COVID-19 call centers, participated on state workgroups to develop guidance for sectors operating safely, participated in the Minority Health Strike Force, led the data team responsible for creating the Ohio Public Health Advisory System, and provided support for the state's population study of coronavirus infection. Staff not involved in the COVID-19 response have assumed additional duties to continue non-COVID-19 operations. In addition, as of March 2020, Governor DeWine ordered an immediate hiring freeze for all agencies, boards, and commissions under the control of the governor and a freeze on new contract services for the state of Ohio. With over forty vacant positions and the additional COVID-19 responsibilities, BMCFH leadership are utilizing the program map to ensure programs have adequate support to continue operations. ODH and BMCFH maintain resources for recruiting, training, and retaining a qualified workforce. Plans for addressing workforce capacity are in section III.E.2.b.i MCH Workforce Development.

Lance Himes serves as interim director of the agency. He has more than 15 years of public health experience and has previously served as director, interim director, chief of staff, and general counsel for ODH.

William McHugh serves as Assistant Director, over administrative support areas including fiscal, IT, and HR as well as the Bureaus of Vital Statistics and Public Health Laboratory. He has more than 20 years of previous experience at ODH.

Joanne Pearsol serves as the Deputy Director of the new Office of Performance and Innovation where she develops statewide policies and strategic plans to carry out the mission of public health in Ohio in coordination with local health departments, public health providers, as well as community action agencies. She oversees public health accreditation activities as well as leads the agency's quality improvement efforts.

Dyane Gogan Turner, MPH, RD/LD, IBLCLC, serves as the Title V Director and Chief of the Bureau of Maternal, Child, and Family Health. She has more than 24 years of public health experience working with the Supplemental Nutrition Program for Women, Infants, and Children (WIC), Child and Adult Food Care Program, and Title V Maternal and Child Health programs.

Anna Starr serves as the Assistant Chief for the Bureau of Maternal, Child, and Family Health and has previously served as Interim Chief as well as section administrator for Child and Specialty Health. Anna has over 34 years of experience in maternal and child health.

Patrick Londergan and is the Director of Children and Youth with Special Health Care Needs. Patrick has over 20 years of experience in the Children with Medical Handicaps Program, serving as the administrator of the program for 15 years.

Kirstan Duckett, MPH, CHES, serves as the Title V Maternal Child Health Block Grant Coordinator and previously served as the Birth Defects Surveillance System Coordinator within the BMCFH.

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

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

Two parent consultants joined the BMCFH in 2020 with the goal of improving integration of family perspective within programs. Kimberly Mathews is the parent of a child with special health care needs and has extensive background leading CYSHCN patient and family advisory boards and community organizations. Kimberly previously served as the chair for CMH Parent Advisory Committee. Melissa James is also the parent of a child with special health care needs and has extensive background in nonprofits and community organizations. Melissa leads the Pediatric Cancer Work Group for Ohio's Cancer Plan. Both consultants will work throughout the bureau programs and assist with engaging parent perspectives in our work, materials, and activities. In addition, they will lead specific projects around transition for CSHCN, working to improve diversity in the Parent Advisory Committee, and speaking directly with parents in Ohio to provide assistance and mentoring.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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

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

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

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

- The Governor's Early Childhood Advisory Council (ECAC) provides input and guidance to the Governor's Office of Children's Initiatives and early childhood programs. ECAC membership includes a diverse array of stakeholders from early childhood programs, schools, health, social services, unions, philanthropy, and other groups. Ohio's governance and administrative structures have the authority and responsibility to oversee, implement and coordinate state-funded or state-administered early childhood programs and services for children and their families. Title V staff also represent ODH on the Ohio Child Care Advisory Council responsible for advising and assisting JFS on the administration and development of statewide child care policies and procedures.
- ODH and ODM works together on the coordination of services by the Ohio Medicaid Managed Care Programs.
- At the state, regional, and local levels, the Ohio Medicaid Assessment Survey (OMAS) delivers health and healthcare data and gives insight into the health status of Ohio's Medicaid, Medicaid-eligible, and non-Medicaid populations. OMAS provides necessary data to measure the impact of healthcare reform over time, especially issues relevant to the efficient administration of the Ohio Medicaid program.
- DODD and ODH have an interagency agreement regarding the implementation of the Help Me Grow Early Intervention and Central Coordination services and sharing of data and referrals with other MCFH programs such as birth defects, infant hearing, and children with medical handicaps.
- The CMH program collaborates closely with Ohio Association of Children's Hospitals (OACH) as they are a key partner/advocate for health care issues for all children, especially CSHCN. OACH is a key member of the MAC Advisory Council. The Ohio Chapter of American Academy of Pediatrics (OH-AAP) co-chairs the Children with Disabilities Subcommittee with the CMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. OH-AAP also participates in many of the Title V Action Groups supporting the implementation of the 5-Year Strategic Plan.
- Title V staff co-lead the Infant Safe Sleep subcommittee of the Ohio Injury Prevention Partnership's Child Injury Action Group (OIPP, CIAG). The Office of Health Improvement and Wellness leads the OIPP, a statewide partnership that brings stakeholders and experts together to create and implement action plans to address injury priorities, promote policy and system's change, and improve statewide data collection.
- OhioMHAS, ODE, ODJFS, ODYS, DODD and ODH participate in an Interagency Council for Youth to support the unique needs of youth and young adults with co-occurring disorders. Policy and system improvements are made to the Deputy Directors of the Governor's Cabinet, when appropriate.
- Title V staff represent ODH on committees with ODE and ODM for school-based health concerns including the Whole Child and Student Wellness and Success committees, the Board of Directors for the Ohio Association of School Nurses, and OH-AAP's Home and School Health Committee.
- The Fetal Alcohol Spectrum Disorder (FASD) Steering Committee led by OhioMHAS and ODH coordinate efforts to

prevent FASD and improve screening and treatment.
- Title V staff also lead or represent ODH on a number of committees to prevent violence including Ohio Sexual Assault and Intimate Violence State Planning Group, Sexual Assault Advisory Board of Central Ohio, Ohio Injury Prevention Partnership, ODE's Anti-Harassment, Intimidation, and Bullying Committee, Interagency Victim Assistance Coordinating Council, and Family Violence Prevention Council.
- ODH staff participate in SNAP-ED, a statewide collaborative group made up of state agencies and USDA funded nutrition education programs serving similar populations with the goal of information and resource sharing.
- Title V staff participate in a statewide breastfeeding workgroup comprised of breastfeeding experts across the state. The group shares information and resources and identifies strategies and initiatives to improve breastfeeding initiation and duration rates, particularly among African American and Appalachian women.

Please see Section III.E.2.b.ii. Family Partnership for additional information on established family and consumer partnerships including: Ohio Family and Children First Councils, CMH Medical Advisory Council, CMH Parent Advisory Committee, Ohio Developmental Disabilities Council, Ohio's Interagency Workgroup on Autism, Early Childhood Advisory Council, Early Intervention Advisory Council, CMH Collaboration to Serve Ohio's Children with Special Health Care Needs, Family-to-Family Health Information Centers, Adolescent Health Partnership, and Ohio Collaborative to Prevent Infant Mortality.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Ohio's population health assessment and planning efforts were conducted through a joint process including the State Health Assessment (SHA), State Health Improvement Plan (SHIP), Title V MCH Needs Assessment, and MIECHV Needs Assessment. MCH priority needs were first identified by MCH/MCHIEV regional forum and online survey participants. These priorities were then revised and narrowed to a list of ten priority needs based on feedback from members of the MCH/MIECHV Steering Committee, feedback from BMCFH staff, and the results of the secondary data analysis. MCH/MIECHV Steering Committee members and BMCFH staff were asked to consider the following prioritization criteria when providing feedback on the MCH priority needs:

- Ability to track progress: measurable indicators are available to assess and report progress in a meaningful way on an annual basis at the state level
- Potential for impact: availability of evidence-based strategies, co-benefits, feasibility to address at the state level by ODH, and the ability to improve outcomes
- Nature of the problem: magnitude, severity, disparities, U.S. comparison, and trends (based on secondary data analysis)
- Alignment: with Ohio's 2020-2022 SHIP and other state agency plans and initiatives

From this process, the following 10 MCH priority needs were identified:

- Decrease risk factors contributing to maternal morbidity
- Increase mental health support for women of reproductive age
- Decrease risk factors associated with preterm births
- Support healthy pregnancies and improve birth and infant outcomes
- Improve nutrition, physical activity, and overall wellness of children
- Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
- Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use
- Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services
- Prevent and mitigate the effects of adverse childhood experiences
- Improve healthy equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

After identification of the MCH priority needs, a set of prioritization criteria was used by HPIO to propose national and state outcome and performance measures that aligned with the identified MCH priority needs and could be tracked in the State Action Plan.

- Health priority need alignments: measure aligns with a top MCH priority need
- SHIP alignment: measure aligns with a health outcome or health factor metric in the 2020-2022 SHIP
- NOM and NPM alignment: measure is identified as a NOM or NPM
- Evidence linkage: NPMs selected have an evidence linkage to a NOM
- Population domain alignment: minimum of five NPMs selected, one per MCH population domain

The BMCFH Title V program uses an Action Group structure to manage its MCH Priorities and implement strategies within the 5-Year Action Plan. Following completion of HPIO's final report with proposed outcome and performance measures, the Action Group teams began meeting in February 2020 on a bi-weekly to monthly basis through summer 2020. Stakeholders from BMCFH and programs and subject matter experts were invited to these meetings to utilize the results of the needs assessment to inform the development of Action Plan. In April 2020 the National MCH Workforce Development Center led

the Action Groups through remote training and planning workshops on Results Based Accountability (RBA). Action Groups completed a pre-workshop webinar on utilizing the RBA framework for advancing performance and measurement in addressing needs. During the workshops, tools including the Turn the Curve and Performance Quadrant report were used to help the teams identify data trends, identify root causes and partners, align performance measures, select evidence-based strategies, design evidence-based strategy measures, and identify the potential impact on the NOMs, NPMs, and SOMs. In June of 2020 Action Groups shared the Action Plan framework with sister state agencies in a meeting to ensure the measurements aligned with other state agencies' goals. Due to limited resources and staff capacity because of the state's response to the COVID-19 pandemic, the Action Groups plan to continue to expand stakeholder involvement in the groups and refinement in measures during the first year of 2021-2025 implementation. Additional discussion of the measures and alignment with the priorities are available by population domain within Section III.E.2.c. State Action Plan Narrative by Domain.

Since the conclusion of the needs assessment process an emerging issue has been the COVID-19 pandemic. While not on the list of priorities, responding to and protecting maternal, child, and family populations from the outbreak has been prioritized throughout ODH and other state agencies. As mentioned in the MCH workforce capacity section, BMCFH staff are active in the response and BMCFH leadership utilize the Program Map to plan and adjust to ensure all of the MCH priority needs are addressed.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$21,639,111	$20,208,893	$21,289,200	$20,208,893
State Funds	$34,129,391	$53,764,464	$57,518,051	$54,510,610
Local Funds	$0	$0	$0	$0
Other Funds	$44,956,530	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$100,725,032	$73,973,357	$78,807,251	$74,719,503
Other Federal Funds	$168,349,749	$240,674,314	$171,656,028	$237,055,972
Total	$269,074,781	$314,647,671	$250,463,279	$311,775,475

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$21,973,210	$21,012,697	$22,065,962	
State Funds	$55,838,575	$43,254,961	$67,346,423	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$77,811,785	$64,267,658	$89,412,385	
Other Federal Funds	$152,584,198	$196,641,329	$219,737,929	
Total	$230,395,983	$260,908,987	$309,150,314	

	2022	
	Budgeted	Expended
Federal Allocation	$22,331,382	
State Funds	$67,422,505	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$89,753,887	
Other Federal Funds	$209,018,526	
Total	$298,772,413	

Title V. Expenditures Narrative

A. Expenditures

Form 2

Title V FY20 expenditures totaled $20,012,697. FY20 expenditures for the Preventive and Primary Care for Children totaled $6,572,945 or 31.2% of total Title V expenditures. FY20 expenditures for Children with Special Health Care Needs totaled $8,143,943 or 38.7% of total Title V FY20 expenditures. FY20 expenditures for Title V Administrative cost totaled $1,045,076 or 5% of total FY20 Title V expenditures.

The state expenditures for FY20 totaled $43,254,961. This expenditure is 12,583,614 less than the original FY20 budget of 55,838,575 due to the agency re-organization of the Tobacco program which moved from the Bureau of Maternal, Child, and Family Health to the Bureau of Health Improvement and Wellness as well as the impact from the COVID-19 Pandemic.

Total FY20 expenditures for Federal-State Title V Block Grant Partnership is $64,267,658.

Form 3A

Title V FY20 expenditures totaled $19,967,621 excluding FY20 Administrative budget cost. FY20 expenditures for Pregnant Women totaled $ 3,327,883 and Infants <1 totaled $ 1,810,839. These expenditures for the pregnant women and Infant <1 include MCH services such as Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, and other Maternal and Child Health services that are dedicated to serving pregnant women and infants <1. FY20 expenditures for the Preventive and Primary Care for Children totaled $ 6,572,946. These expenditures for Primary Care for Children include MCH services such as School and Adolescent Health, Oral Health, and other Maternal and Child Health services that are dedicated to serving children from 1-22 years of age. FY20 expenditures for Children with Special Health Care Needs totaled $ 8,143,943. FY20 expenditures for All Others is $112,010.

State Funds FY20 expenditures totaled $43,254,959. FY20 State Funds expenditures for Pregnant Women totaled $2,095,992 and Infants <1 totaled $2,095,992. FY20 State Funds expenditures for the Preventive and Primary Care for Children totaled $6,032,902 FY20 State Funds expenditures for Children with Special Health Care Needs totaled $32,900,424. FY19 State Funds expenditures for All Others totaled $129,649.

Total expenditures for Federal-State Title V Block Grant Partnership was $63,222,580 excluding FY20 Title V Administrative cost.

Form 3B

Title V FY21 expenditures totaled $21,012,697 for MCH Services. Title V Direct Service FY20 expenditures totaled $ 3,972,000 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at $ 2,874,750. Preventive and Primary Care Services for Children at $541,478 and Children with Special Health Care Needs at $555,772. These expenditures are direct services related to Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, Oral Health, and services for children with special health care needs. Title V FY20 expenditures for Enabling Services was $8,165,549 and Public Health and Systems at $8,875,148. Historically, ODH MCH expenditures related to Direct Service included Case Management cost which ODH has now moved Case Management costs to Enabling Services along with Oral Health, Infant Hearing, MCH Genetics, and Vision program.

State expenditures for FY20 totals $ 43,254,961 for MCH Services. State Direct Service expenditures totaled $ 30,024,752 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at zero, Preventive and Primary Care Services for Children at $244,956, and Children with Special Health Care Needs at $29,779,796. Title V FY20 budget for Enabling Services was $10,595,989 and Public Health and Systems at $2,634,220.

FY20 COVID Efforts

In FY20, Title V expenditures toward COVID-19 Efforts was $772,214 and $503,263 in state funds. The COVID-19 Efforts consist of the utilization of the Ohio Department of Health's COVID-19 Call Center that provided public health information regarding COVID-19 to all Ohioans including the MCH population of Pregnant Women, Infants <1, Children 1-22, and Children with Special Health Care Needs. The FY20 total expenditure for both state and federal for COVID-19 Efforts is $1,275,477. The MCH 30/30/10 effort was not affected due to MCH staff providing assistance and public health information to the general public in their area of expertise related to MCH.

Title V. Budget Narrative

A. Budget

Form 2

Title V FY22 budget totals $22,331,382. FY22 budget for Services for Pregnant Women, Mothers, and Infants up to age one year is budgeted at $5,565,665. FY22 budget for Preventive and Primary Care for Children is budgeted at $8,255,443 or 34.9% of the FY22 Title V budget. FY22 budget for Children with Special Health Care Needs is $7,750,427 or 34.7% of FY22 Title V budget. FY22 Title V Administrative costs is budgeted at $651,538 or 3% of the FY22 Title V budget. Historically, ODH MCH budget has been highly focused on Children 1-22 years of age. The FY22 MCH budget is more well-rounded focusing on all MCH components which aligns with the MCH/CYSHCN priorities.

The State MCH Funds budget for FY21 is $67,422,505.

Total budget for Federal-State Title V Block Grant Partnership is $89,753,887.

Form 3A

Title V FY22 budget totals $21,679,844 excluding FY22 Administrative budget cost. Title V FY22 budget for Pregnant Women totals $3,340,613 and Infant <1 totals $2,225,052. The FY22 budget for Pregnant Women and Infant <1 consists of MCH services such as Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, and other Maternal and Child Health services that are dedicated to serving pregnant women and infants <1. Title V FY22 budget for Children 1 through 21 years of age is budgeted at $8,255,443. The FY22 budget for Primary Care for Children includes MCH services such as School and Adolescent Health, Oral Health, and other Maternal and Child Health services that are dedicated to serving children from 1-22 years of age. Title V FY22 budget for Children with Special Health Care Needs is budgeted at $7,750,427. Title V budget for All Others is $108,309.

State FY22 budget totals $67,422,509. Title V FY22 budget for Pregnant Women totals $5,886,587 and Infant <1 totals $5,886,587. Title V FY22 budget for Children 1 through 21 years of age is budgeted at $16,435,205. Title V FY22 budget for Children with Special Health Care Needs is $38,850,008. Title V budget for All Others is $364,119.

Total FY22 Budget for Federal State MCH Block Grant Partnership excluding Administration cost is $89,102,350

Form 3B

Title V FY22 budget totals $22,331,382 for MCH Services. Title V Direct Service budget $3,852,748 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at $ 2,993,834, Preventive and Primary Care Services for Children at $705,000, and Children with Special Health Care Needs at $153,914. The FY22 budget for direct services are related to Reproductive Health and Wellness, Ohio Infant Mortality Reduction Initiative, Oral Health, and services for children with special health care needs. Title V FY22 budget for Enabling Services is at $ 8,168,723 and consists of services related to Case Management, Oral Health, Infant Hearing, MCH Genetics, and Vision program. The FY22 budget for Public Health and Systems is at $ 10,309,911 which consists of MCH services related to Public Health Systems and policy.

State budget for FY22 totals $ 67,422,505 for MCH Services. Title V Direct Service expenditures total $ 40,318,136 which contains Preventive and Primary Care Services for Pregnant Women and Infant <1 at zero, Preventive and Primary Care Services for Children at $350,000, and Children with Special Health Care Needs at $39,968,136. Title V FY22 budget for Enabling Services is at $10,507,311 and Public Health and Systems at $16,597,058.

B. Summary and Budget Justification

Summary Budget Description for FY2022

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

Component A:	$ 5,565,665
Component B:	$ 8,255,443
Component C:	$ 7,750,427
Other:	$ 108,309

Subtotal: $ 21,679,844

Administrative Costs: $ 651,538

GRANT TOTAL: $ 22,331,382

Budget Justification

Maintenance of State Effort

In 1989, Ohio's MCH Block Grant award was $19,369,474 and the state provided $23,812,983 in support of the MCH activities. The fiscal year 2022 federal MCH award is $22,331,382 and the state will provide $67,422,509 to meet the maintenance of effort and state match requirements. State support is provided by appropriations from several state line items and one source of county funds which the Department is authorized to spend on behalf of children with special health care needs.

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

Administrative Costs

The administrative costs of Ohio's 2022 MCH Block Grant request are based on the budget and expenditures related to the MCH Bureau Chief Office.

FY21 Carry Over Funds

The amount of carryover funds is based on the projected total amount of funds to be available in FY22 minus the projected expenditures through September 30, 2021. As of August 2021, a total of $22,331,382 in MCH Block Grant funds was available to the State of Ohio. The projected FY21 MCH expenditures will total $10,520,821. When the total available funds are reduced by total projected expenditures the unencumbered balance will be $11,810,561.

The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 5 months' worth of expenditures in FY22.

III.E. Five-Year State Action Plan

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

State: Ohio

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The Ohio Department of Health (ODH) is the designated state agency responsible for Title V Maternal and Child Health (MCH) Program. Within ODH, the Bureau of Maternal, Child, and Family Health administers Title V programs to address preventive and primary care needs, which are family-centered, community-based, and culturally appropriate for MCH populations (https://odh.ohio.gov/wps/portal/gov/odh/about-us/offices-bureaus-and-departments/bmch). The overarching goal of MCH is to support and promote the development and coordination of systems of care for women of childbearing age, infants, children, including children with special health care needs (CSHCN), adolescents, and families in Ohio.

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

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

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

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

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

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

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

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

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

A new Statewide Competency was added for all state of Ohio Employees in August 2020, Embracing Diversity and Inclusion, to further promote and support equity in State government. To support employees in achieving this competency, a new training, Inclusive Listening: Pushing through Our Biases, is required for all state employees. Newly promoted or hired supervisors at ODH are required to complete the Windmills for Supervisors training. In addition to the mandatory and optional training opportunities provided by ODH, managers and employees are encouraged to seek other resources to enhance their professional development. The Office of Learning and Professional Development, within the Department of Administrative Services, offers a catalog of professional development courses that are available to all State of Ohio employees. ODH Workforce Development maintains a catalogue of trainings and also has an internal website that provides many valuable resources including external resources for additional training/education in public health. All State of Ohio employees have access to employee development funds, which are designed to provide tuition reimbursement assistance for professionals interested in completing a college degree or financial assistance for individuals doing short-term training or professional enhancement. Since the transition to remote learning and conferences due to COVID-19, many more staff have participated in trainings and conferences due to the elimination of travel costs.

The Bureau of Maternal, Child, and Family Health (BMCFH) has 179 staff members with various backgrounds including: medicine, public health, social work, epidemiology, social work, public policy, nutrition, health care administration, education, finance, and marketing. The diversity of education and qualification creates a workforce that is knowledgeable and skilled to meet the needs of the MCH population. The BMCFH hosts monthly learning sessions to provide opportunities for staff to learn about key topics and programs. All BMCFH staff have been added to the MS Team BMCFH Onboarding and Training. The Team includes an Onboarding Tool designed as a living library of resources to help orient staff new to the BMCFH and support all BMCFH staff with easy access to information. The bureau learning session recording are also archived in the Onboarding Tool. The Team also includes an outline for a newly proposed Training Hub, which will include a living library of recorded/on-demand trainings as well as a space for sharing upcoming live/interactive training opportunities with bureau colleagues.

In March 2020, Governor DeWine ordered an immediate hiring freeze for all agencies, boards, and commissions under the control of the governor and a freeze on new contract services for the state of Ohio. To address the vacancies during the hiring and contract freeze, positions were fully allocated to federal funding sources. In addition, BMCFH leadership used the program map created in 2020 (available in V. Supporting Documents) to demonstrate the impact of the BMCFH programs on populations to further advocate for positions. As of July 2021, most staff have returned from COVID-19 assignments and the BMCFH is working to fill vacancies. The BMCFH engages in ongoing planning to retain and recruit a diverse workforce. BMCFH has an engagement planning committee with representatives from programs across the bureau. The committee plans bureau meetings and has also planned activities for staff to stay connected during the extended telework period. Since starting full-time telework in March 2020, the BMCFH chief has sent weekly emails to the bureau that includes updates, get to know a program, and get to know staff sections. The bureau also hosts quarterly bureau meetings to share key information and support engagement. The bureau planning committee surveys staff regarding satisfaction with the bureau meetings and ideas for future topics to include. Staff are also encouraged to join bureau chats via Microsoft Teams Chat on non-work-related topics to maintain connectedness and morale.

BMCFH secured Mental Health First Aid training for a group of staff provided through a collaboration between Ohio Department of Mental Health and Addiction Services and Mental Health America. The training included recent updates with considerations for cultural competency. Nineteen BMCFH staff completed pre-work and engaged in a day long training in December 2020 to learn the skills to respond to the signs of mental illness and substance use. These important skills inform staff in their working relationships and in their program implementation. While the session was limited to only twenty staff, additional opportunities for BMCFH staff to participate individually in Mental Health First Aid trainings are shared with staff as they become available.

BMCFH formed the Health Equity Committee (HEC) in 2020 to develop a plan for addressing internal culture and staff cultural competency alongside a plan for improving health equity through our policies and programs (for details see III.E.2.c. Cross-Cutting Annual Report). The HEC has administered a staff competency survey and is using the results to plan training opportunities to be made available through individual recorded/on-demand sessions as well as bureau-level interactive/live opportunities. The HEC is committed to engaging staff in unique and fun opportunities and is leveraging a participation workgroup to determine ways to promote engagement while reducing burnout. In addition, a team from the HEC joined the National MCH Workforce Development Center November Skills Institute focused on operationalizing and implementing the newly developed state Action Plan. The team strategized using frameworks and best practices for application of the topics shared: newly revised 10 essential public health services, process flow diagramming, staying strategic in unique times, decision making during uncertainty, moving from plan to action in partnership, and lived experience and equity in planning. Building on the November 2020 skills institute, another workgroup from the HEC, focused on advancing equity through BMCFH subgrants, applied for and was accepted into the 7-month National MCH WFD Cohort to work on a transformational challenge specific to their state while increasing workforce skills and capacity.

In spring 2020, BMCFH engaged the National MCH Workforce Development Center to conduct a Results Based Accountability (RBA) training to learn the framework and apply the concepts and tools to the MCH BG planning process to ensure alignment of performance measures, selection of evidence-based strategies, and development of high value evidence-based strategy measures. The ODH SHIP also relies on the RBA framework and BMCFH staff were the first to have this type of training. Staff learned the RBA framework and applied the concepts and tools to the MCH BG planning process Because the training was offered digitally, more staff were able to engage with the pre-recorded webinar and staff were able to participate in multiple workshops for the population groups. In fall 2020, ODH began offering additional RBA and Clear Impact software trainings to further promote performance management in the agency. To date over 20 BMCFH staff have been trained in RBA and Clear Impact and programs are building Scorecards of contributing program performance measures for the infant mortality indicator in the SHIP.

Our Title V epidemiologist and one of our Parent Consultants participated in the 2020-2021 AMCHP Leadership Lab cohorts for MCH Epi Peer-to-Peer and Family Leaders, respectively. As staff new to Title V, the cohort experience built leadership capacity by providing foundational knowledge and skills for communication, collaboration, creating a vision for and measuring success, aligning activities, and authentically engaging stakeholders.

To ensure capacity for data and evaluation throughout BMCFH, the Data and Surveillance section continues to provide training opportunities to staff, as reported in III.E.2.b.iii. MCH Data Capacity.

BMCFH staff also participate in CoIINs (Collaborative Improvement and Innovation Networks) and other learning collaboratives, which in addition to driving improvements in program practices also improve staff capacity. More details on participation in CoIINs and learning collaborative are included throughout the population reports. Additional details on trainings and workforce development opportunities available to ODH staff and stakeholders throughout the year are provided below.

ODH Public Health Trainings

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

The Ohio State University Summer Program in Population Health

Each year, the OSU Summer Program brings leading experts in public health to Columbus, Ohio. The unique design of the program provides an opportunity for public health professionals to learn in an atmosphere of intense scholarship and collaboration. Courses educate and train practitioners, researchers, and students in population health methods and builds their capacity to address emerging health priorities. Courses are designed to appeal to a broad range of professionals interested in understanding and improving the health of communities. Skills learned in each of these courses support ODH,

BMCFH, and the Title V program.

ODH Workforce Development

ODH Workforce Development maintains a catalogue of required and optional training opportunities for ODH employees and supervisors. Courses include Managing and Adapting to change, Owning Your Morale, Bullet Journaling, Communication Curriculum, Get Organized Bootcamp, Position Pros: Mastering the Skills to Get the Job, Excel, Customer Service, and Meetings Master. Supervisors are also encouraged to schedule workshops for teams to participate including Customer Service: Team Edition, True Colors: Keys to Personal Success, Building Our Best Team, Working Through Changes, and Conflict Navigation.

ODH Required Professional Development Training

Required Training	Required Employees	Date Range of Training	Format	Duration
Windmills Training	All ODH Supervisors	As hires/promotions occur	Instructor Led	2 Hours
Ethics (*annual*)	All ODH Employees	2nd Quarter, 2021	Web Based	1 Hour
Securing Ohio (*annual*)	All ODH Employees	2nd Quarter, 2021	Web Based	3 Hours
Disability Etiquette and Awareness Training	All ODH Supervisors	3rd Quarter, 2021	Web Based	1 Hour
Responding to Domestic Violence in the Workplace	All ODH Employees	1st Quarter, 2022	Web Based	1.5 Hours
LEAD Ohio Leadership Development Program	All Newly Hired and Promoted Managers	As hires/promotions occur	Instructor Led	Varies
ODH Policy Acknowledgments	All OH Employees	As policies are implemented	Web Based	10 – 60 Minutes

ODH Optional Professional Development Training

Optional Trainings	Target Audience	Course Available	Format	Duration
Microsoft Teams	All ODH Employees	Available Now	Web-Based	2 Hours
Organizational Skills (Bullet Journaling)	All ODH Employees	SFY 2022	Instructor Led	2 Hours
Supervising Telework Employees	ODH Supervisors	Beginning 2nd Quarter, 2021	Instructor Led	1 Hour
Windows Essentials for Telework	All ODH Employees	Beginning 2nd Quarter, 2021	Web-Based	1 Hour
ODH-U Class of 2022	All ODH Employees, with selection	January, 2022	Blended Learning	Yearlong
Human Resources Skills for Supervisors	ODH Supervisors	Beginning 3rd Quarter, 2021	Web-Based	1 Hour

ODH-U

ODH-U is a supervisory preparatory education program conducted by ODH Human Resources. The goal of the program is to provide a roadmap for employees who are lacking supervisory experience to gain the essential knowledge, skills, and abilities in order to meet the minimum qualifications as related to supervisory experience. BMCFH has had several staff participate in the cohorts each year since the program's inception in 2017 with staff graduating in 2018, 2019, and 2020. The program was adapted during the 2020 cohort due to the pandemic. Due to ongoing pandemic responsibilities the beginning of the 2021 class has been delayed by ODH HR remains committed to the program. Staff complete various lead work

projects along with a year-long leadership development curriculum. Participation in this program builds long term internal leadership capacity in the BMCFH and throughout ODH and facilitates retention through career development and promotion opportunities.

Implicit Bias

The Ohio Department of Health (ODH) Bureau of Maternal, Child and Family Health (BMCFH) contracted with a vendor to deliver an implicit (or unconscious) bias training for BMCFH to educate staff and subgrantees and measure a change in knowledge based on the training provided. The vendor was tasked with developing a curriculum for an Ohio-specific implicit bias training which covered the following topics: 1. What is implicit bias; 2. Where and how does implicit bias function; 3. How implicit bias impact achieving established measures in maternal and infant health; 4. How to utilize learned implicit bias information in funding and program decisions; and 5. How to mitigate and dialogue about implicit bias. Staff are responsible for the development and implementation of programs and policies impacting Ohio's women, children and families. The training was provided to BMCFH staff in the fall of 2019. Regional trainings for BMCFH subgrantees and MCH professionals have been offered through several ODH programs.

Tableau Fundamentals

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

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

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

Within Title V programs, collaborative efforts by Ohio's state, local, and community-based service systems for individuals and families is vitally important. These systems work together on achieving shared policy and programmatic goals to ensure that all of Ohio's women, infants, children and youth with and without special health care needs, and families receive the services they need to promote their health and wellness. These partnerships are critical because no single system has the resources or capacity to meet this goal alone. Where applicable, the Title V program has established inter-agency agreements between ODH and its sister agencies to establish administrative and financial accountability for shared programs. In addition, there are data sharing and research project agreements between ODH and agencies with a mutual interest. These agreements foster the exchange of information for making data-driven decisions regarding MCH policies and practice. Where appropriate and when possible, Title V programs include families of CYSHCN and consumers of MCH services on its committees and councils. In addition to the partnerships listed below, the BMCFH hired two parent consultants in 2020 to better integrate the family perspective within programs. Both consultants work throughout the bureau programs and assist with engaging parent perspectives in our work, materials, and activities. In addition, they participate in councils and lead specific projects including supporting transition for CYSHCN, improving diversity in the Parent Advisory Committee, and speaking directly with parents in Ohio to provide mentoring and support. In addition, in 2021, our Adolescent Health Coordinator developed a working group to explore opportunities to further incorporate youth voice across MCH programs and services.

Ohio Family and Children First Councils (OFCF)
Established in 1993, OFCF is defined as the Governor's Children's Cabinet with the purpose of streamlining and coordinating government services for children and families. OFCF is a partnership of state and local government, communities, and families that enhances the well-being of Ohio's children and families by building community capacity, coordinating systems and services, and engaging families. OFCF's vision is for every child and family to thrive and succeed within healthy communities. The OFCF Cabinet Council is comprised of the following Ohio Departments: Aging, Developmental Disabilities, Education, Health, Job and Family Services, Medicaid, Mental Health and Addiction Services, Opportunities for Ohioans with Disabilities, Rehabilitation and Correction, Youth Services, and the Office of Budget and Management. Local county commissioners establish and maintain 88 county Family and Children First Councils (FCFC).

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

Universal Newborn Hearing Screening Subcommittee
The Universal Newborn Hearing Screening Subcommittee is a standing committee of the Children with Medical Handicaps Program (CMH) Medical Advisory Council (MAC). Committees of the MAC address specific issues, policies and procedures and standards of care relating to children with medically handicapping conditions such as Infant Hearing Screening and Assessment. This multi-faceted group was legislatively managed for the purpose of providing advice and recommendations to the Director of Health regarding program development and implementation of the statewide hearing screening, tracking, and early intervention program. Membership of the subcommittee is diverse, including representatives from otolaryngology, neonatology, nurses from a well-baby nursery, nurses from a special care neonatal nursery, pediatrics, neurology, hospital administration, audiologists experienced in infant hearing screening and evaluation, speech-language pathologists, parents of children who are deaf/hard of hearing, genetics, epidemiology, adults who are deaf/hard of hearing, representation from an organization representing deaf/hard of hearing, family advocacy, teacher of the deaf who works with infants and toddlers, the health insurance industry, the Ohio Department of Education, Children With Medical Handicaps, and the Ohio Department of Medicaid. Members have vast expertise, knowledge, and experience which have helped guide the care of infants in Ohio.

Parent Advisory Committee (PAC)
The CMH Parent Advisory Committee (PAC) is composed of a 15-member team of parents from around the state who meet regularly to advise CMH regarding care for children with special health care needs. The PAC mission is to assure family-centered care is an essential component in the development and delivery of programs and services for CYSHCN. The PAC members collaborate in three key areas: Outreach/Education, Awareness, and Parent to Parent Networking. Current PAC efforts involve expanding diversity of PAC both culturally and by medical condition and providing implicit bias training for PAC members. In the past year the Parent Consultants have continued efforts to diversify the PAC by increasing recruitment, revising the PAC application to increase accessibility, and updating the PAC By-Laws to reflect a stronger emphasis on health equity and diversity.

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

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

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

Ohio's Interagency Workgroup on Autism (IWGA)
Ohio has a rich and long-standing history of addressing autism spectrum disorders (ASD), driven by a strong network of individuals, families, and advocates. Informed by individuals, families, and stakeholders, IWGA meets monthly to review state policies, learn from current research and data, share learning, and identify opportunities to better communicate and coordinate autism policy. A hallmark of the IWGA's efforts is the creation of an innovative, free, online video training series, ASD Strategies in Action, now being used by more than 10,000 people across Ohio, giving them practical ways to care for and support loved ones with ASD, from early childhood through young adulthood.

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

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

CMH Collaboration to Serve Ohio's Children with Special Health Care Needs
The CMH program works with the aforementioned entities to address unique challenges faced by CYSHCN and their families. Program policy is informed by ongoing interactions with a broad representation of stakeholders, representing the many conditions that CYSHCN face. The CMH program facilitates quarterly regional meetings with community-based dietitians and with public health nurses from local health departments, as well as the MAC and PAC, to provide updates and receive feedback regarding CMH and Medicaid policy, and to review emerging trends effecting CYSHCN, families, and providers. In addition, a bi-weekly weekly case conference is conducted between clinical and policy teams from the CMH program and the ODM to ensure coordination of benefits across payer systems for CYSHCN enrolled in the CMH program. These case conferences are key to ensuring quality care, providing information to Medicaid managed care plans regarding unique needs for children with multi-disciplinary and complex medical needs, and for informing policy.

Newborn Screening Advisory Council

The Newborn Screening Advisory Council advises the director of health regarding the screening of newborn children for genetic, endocrine, and metabolic disorders. The council performs an ongoing review of the newborn screening requirements and provides recommendations to the director of health as the council considers necessary. Membership consists of fourteen members appointed by the director including individuals and representatives of entities with interest and expertise in newborn screening, including such individuals and entities as health care professionals, hospitals, children's hospitals, regional genetic centers, regional sickle cell centers, regional cystic fibrosis centers, newborn screening coordinators, and members of the public. The council holds three public meetings annually. BMCFH staff serve on this council.

Early Hearing Detection and Intervention Family Engagement
ODH's HRSA Early Hearing Detection and Intervention grant requires a contract with an external organization to engage families of infants/toddlers who are at risk for hearing loss following their newborn hearing screening. The contracted family organization works to enhance the EHDI system for better coordinated and comprehensive care by contacting families and encouraging diagnostic hearing evaluations and enrollment in Part C Early Intervention (EI) services. For families of infants/toddlers with hearing loss, the contracted family engagement organization provides family support in the form of coordinating Deaf Mentors, SnapShot Mentors, and statewide parent to parent event for families of children with hearing loss to build connections and share resources.

Ohio Adolescent Health Partnership (OAHP)
The OAHP is a diverse group of agencies, organizations, and individuals with expertise in adolescent health and wellness, and with common goals of supporting optimal health and development for all adolescents. OAHP's strategic plan focuses on the following topics: Behavioral Health, Injury and Violence Prevention, Reproductive Health, Nutrition/Physical Activity, Sleep, and Access to Care. Presentations during 2020 and 2021 included topics of youth tobacco use with a focus on EVALI, updates on adolescent risk behavior using the 2019 Ohio Youth Risk Behavior Survey results, and Coping with Covid-19. Youth voice is highly encouraged. Member organizations that host youth coalitions are utilized to solicit feedback on programmatic and system improvements.

Ohio Collaborative to Prevent Infant Mortality (OCPIM)
The Ohio Collaborative to Prevent Infant Mortality (OCPIM) is a statewide partnership that functions as a platform for community engagement, exchange of best practices, data management, and advocacy. OCPIM is comprised of a wide range of clinical and public health providers, business, government, associations, faith-based organizations, and advocacy groups from across the state. Success is defined by improving infant health outcomes and driving infant mortality reduction, including extreme preterm birth, sleep-related infant death, and congenital malformations. Members of OCPIM include stakeholder organizations across Ohio who desire to work together on behalf of a common goal to eliminate infant mortality through interventions based upon available evidence and informed by high-quality data.

Ohio Council to Advance Maternal Health (OH-CAMH)
The Ohio Council to Advance Maternal Health (OH-CAMH), established in spring 2020 as the state-focused maternal health task force, includes over 80 stakeholder organizations collaborating on the development and implementation of a statewide maternal health strategic plan. The stakeholders include women with lived experience (e.g., near misses for maternal mortality), clinical providers, local public health, local community services, state agencies, and advocacy organizations. The Pregnancy Associated Mortality Review program staff convene OH-CAMH.

Eliminating Disparities in Infant Mortality Task Force
Governor Mike DeWine established the Eliminating Disparities in Infant Mortality Task Force in December 2020 with the goal of developing a statewide shared vision and strategy for reducing infant mortality rates and eliminating racial disparities by 2030. The task force members include family representatives and individuals with lived experience, alongside state agencies, advocates, and community organizations. The members will work with local, state, and national leaders to create actionable recommendations for interventions, performance and quality improvement, data collection, and policies. The task force recognizes Ohio's Black and African American communities as the greatest resource for recommendation development and worked with community organizations to engage in listening sessions to drive efforts to make Ohio a better place for babies and families. ODH's Chief Health Opportunity Advisor co-chairs the task force and BMCFH members serve at as state support team members.

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

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

Ohio F2F is based within the University of Cincinnati University Center for Excellence in Developmental Disabilities (UC UCEDD). UC UCEDD believes that people with disabilities should and can be active, included, and fully participating members of their communities. UC UCEDD has four core functions: Community Services, Information Dissemination, Interdisciplinary Training, and Research. ODH Title V program is an active member of the Ohio F2F. The Ohio F2F contact also serves as a member on the CMH Parent Advisory Committee. In addition, ARC of Ohio, Ohio F2F, and ODH collaborated on a grant from Family Voices to better reach underserved populations. The team quickly leveraged the collaboration to provide language translation services for key COVID-19 documents.

Ohio Parent to Parent (P2P) Statewide Mentoring & Support Program
Ohio Parent to Parent (Ohio P2P), part of the Ohio F2F, is a statewide parent support program. It matches parents, siblings, self-advocates, foster parents, grandparents, etc. who have a family member, of any age, with a disability or special health care need, with an experienced, trained, volunteer support parent. The support parent provides support on needs and issues related to parenting and providing care to a loved one with a disability or special healthcare need. Support is provided via email, phone, virtual communication, and in-person. Ohio P2P is staffed by a family member of a person with disability or special health care need. Ohio P2P staff matches families who have diverse experiences, including but not limited to ethnicity, culture, race, language, socio-economic, disability, and other child/family related factors with other families for support. One of our parent consultants is a trained Parent Mentor.

Ohio F2F Family Caregiver Professional Advisory Council (FCPAC)
The Family Caregiver Professional Advisory Council (FCPAC) consists of professionals from Ohio F2F, DODD, ODM, and ODH, and parents/family members of CYSHCN. Our Parent Consultants serve along with up to 15 other diverse volunteer members representing family members and health care professionals. FCPAC members are expected to provide expertise, share needs from families, develop an annual work plan, advocate on behalf of families of CYSHCN, and connect Ohio F2F and share Ohio F2F resources with their networks.

Children's Behavioral Health Prevention Network Group
In 2020, Governor DeWine signed House Bill 12, which created the Children's Behavioral Health Prevention Network Group. Members have been tasked with coordinating and planning a comprehensive learning network that will support young children in their social, emotional, and behavioral development and reducing behavioral health disparities. Ohio's Title V MCH Director serves as a member alongside representative of state agencies, organizations, and a parent representative.

Ohio Partners for Cancer Control (OPCC)
Ohio Partners for Cancer Control (OPCC) is a statewide coalition dedicated to reducing the burden of cancer in Ohio. Our parent consultants are members of OPCC. For the first time, Ohio added pediatric cancer into the Ohio State Cancer Control Plan. Our parent consultant Melissa James is leading the work related to the Pediatric Cancer strategies within the Ohio Cancer Plan Objectives and Strategies 2021-2030. ODH is hosting the Ohio Children's Cancer Summit event to be held September 16 & 17, 2021 (virtual event).

Midwest Genetics Network (MGN) Patient and Family Council
The MGN Patient and Family Council is made up of two or more patients, parents, or family members from each of the seven states in the region (Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin). The council provides an opportunity to connect with other patients, parents, and family members. Patients and families share their experiences and provide input on network activities. Workgroups are made up of assorted stakeholders, including patients, parents and families, genetic service providers, healthcare providers, and public health professionals. Each workgroup focuses on an area of interest, including Long-Term Follow-up, Tele-genetics, Plain Communities (Amish), and Provider Education. The workgroups work on the priorities identified in MGN's workplan. Having input from a variety of individuals with genetic conditions, and their families, is crucial to ensuring that the network can meet their goal of improving services and increasing access to genetic services in a way that is meaningful and impactful. Kim Mathews, ODH Parent Consultant, and Michael Allen, Ohio Sickle Cell adult patient, are the co-chairs of this Council.

Home Visiting Advisory Council
In January 2019, Governor DeWine established the Home Visiting Advisory Council with the goal of developing

recommendations on how to enhance Ohio's home visiting system. BMCFH staff served with healthcare, governmental services, home visiting providers, community health organizations, and children and family representatives. The council developed a report of 20 recommendations in March 2019.

Lead Advisory Committee
Ohio Governor Mike DeWine created the Lead Advisory Committee which aims at preventing and treating lead poisoning and advising on the state's efforts to abate and remediate lead contamination. Members of the Lead Advisory Committee included the Director ODH designee, state agencies, clinical providers, and local organization, board, and commission representatives. The Lead Advisory Committee released their final report on January 31, 2021.

Charting the LifeCourse Ambassador Team – Community of Practice
Ohio was awarded the opportunity to participate in the National Community of Practice (CoP) for Supporting Families and will join other states in a multi-year effort to develop systems of support for families throughout the lifespan of their family member with intellectual and developmental disabilities (I/DD). This CoP is unique in Ohio because it focuses on all families with a member with a disability, not just those who receive formal supports. The Parent Consultants became Ohio CtLC Ambassadors in the fall of 2020. They have joined the Ohio Community of Practice team led by Tracey Manz, Family Resource Coordinator, at the Nisonger Center.

ECTA 2020 Inclusion Cohort: Intensive Technical Assistance to Improve High-Quality Inclusion - Ohio State Leadership Team
The ECTA 2020 Inclusion Cohort: Intensive Technical Assistance to Improve High-Quality Inclusion involves five selected states who are receiving technical assistance (TA) to build state capacity to assess, plan, and implement state-level strategies to increase and improve high-quality inclusion. The goal is to increase access to high quality programs that include and actively support the participation of children with disabilities. Team members include state agencies (ODE, DODD, JFS, OhioMHAS, ODM, and ODH) as well as partners from OCECD, Ohio Head Start, Disability Rights Ohio, OCALI, and a parent of a child with special health care needs, who is also a member of the Governor's Early Childhood Advisory Council. Our parent consultants represent ODH.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Data and Surveillance section of the Bureau of Maternal, Child, and Family Health (BMCFH) houses several surveillance, quality improvement, and other programs while also providing support to programs across the entire bureau (https://odh.ohio.gov/wps/portal/gov/odh/about-us/offices-bureaus-and-departments/bmch/data-and-surveillance-programs). The Data and Surveillance Administrator, Reena Oza-Frank, has a PhD in epidemiology and extensive training and expertise as a Maternal and Child Health epidemiologist. Dr. Oza-Frank leads the State System Development Initiative (SSDI) and other MCH data and surveillance efforts and leads a team of epidemiologists and research staff with experience analyzing data from relevant MCH sources using SAS and other software. Staff within Data and Surveillance are responsible for monitoring program and surveillance data, conducting data analyses, creating and disseminating data products, responding to public data inquiries, contributing to program evaluation, and assisting with the development and analysis of surveys. Staff also contribute to monitoring and tracking of MCH Block Grant performance measures.

Within the Data and Surveillance unit there are three units: Research and Evaluation; Pregnancy Associated Morbidity and Mortality; and Epidemiology. The Research and Evaluation unit of the Data and Surveillance section houses four Researchers who are at least Master's prepared and primarily work with program data. This requires a deep understanding of program goals, policies, and procedures. The Epidemiology section is managed by a master's prepared epidemiologist with nearly two decades of public health experience. The Epidemiology unit includes 5 Epidemiologists who have either an MPH in Epidemiology or a Masters in Biostatistics. Some of the epidemiologists are funded by specific programs (e.g., WIC, Asthma Prevention, SSDI) while others are funded primarily by the Title V Block Grant and support programs throughout the Bureau, as well as work on projects that advance our knowledge base of maternal and child health in Ohio. The Epidemiology unit also includes a master's prepared Health Services Policy Analyst who works specifically with our Infant Vitality Program. As of March 2020, a statewide hiring freeze and reassignments of BMCFH epidemiologists due to COVID-19 activities limited our Section's ability to perform at capacity. Additionally, our CDC Senior MCH Assignee, who was with our Bureau for 14 years, left the agency for a different position. We are in the process of trying to replace that position.

To ensure capacity for data and evaluation throughout BMCFH, the Data and Surveillance section continues to provide training opportunities to staff. As an unexpected outcome of COVID-19, many conferences and training courses were offered online and therefore, did not require travel. Many of our staff took advantage of these opportunities using SSDI funds to pay for registration costs. Staff attended the Association of Maternal and Child Health Programs (AMCHP) 2020 Annual Conference and the 2020 CityMatCH Leadership and MCH Epidemiology Conference. Additionally, many staff members took virtual courses offered by The Evaluators' Institute (TEI) at Claremont Graduate University in Summer 2020. SSDI funding also paid for the development of Quality Improvement training, with participation of all Data and Surveillance staff. In 2021, staff have also completed online SAS and Tableau training.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Ohio State Systems Development Initiative (SSDI) is managed by the Data and Surveillance team in the Bureau of Maternal, Child and Family Health (BMCFH) at the Ohio Department of Health (ODH). The purpose of the Ohio State Systems Development Initiative (SSDI) is to expand and enhance current state and jurisdictional MCH data capacity and to develop new, more timely data systems and infrastructure that will support MCH program objectives in alignment with the Title V Block Grant. Both grants are held by the BMCFH. The Data and Surveillance section within BMCFH is comprised of epidemiologists, researchers, and policy analysts. This group provides scientific support and guidance to facilitate data-driven decision-making needed to inform, implement, and evaluate Title V Maternal and Child Health programs as well as other BMCFH programs.

The goals and objectives of Ohio's SSDI are:

Goal 1: Build and expand Ohio Maternal and Child Health (MCH) data capacity to support Title V Program efforts and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation.

Objective 1.1: Provide ongoing assessment of chosen Title V Block Grant structural, process, and outcome measures to assist in planning, implementation, and evaluation of Title V programs. *Ongoing*

Objective 1.2: Review annual objectives at least annually and advise priority workgroups to revise as needed. *Ongoing*

Objective 1.3: Conduct data analyses and provide additional data summaries (trends, risk factors, and disease outcomes by subgroups) as needed for use in the prioritization process for ongoing needs assessment and the next Title V five-year needs assessment. *Ongoing*

Objective 1.4: Advise Title V priority work group members on evidence base, relevance, and data availability for proposed structural/process measures. *Ongoing*

Objective 1.5: Increase the number of sampled addresses for the National Survey of Children's Health (NSCH). *Ohio has contracted with the US Census Bureau for an oversample of the 2021 NSCH*

Objective 1.6: Develop data products from analysis of the Ohio Pregnancy Assessment Survey (OPAS), a PRAMS-like survey. *Ongoing*

Goal 2: Advance the development and utilization of linked information systems between key MCH datasets in Ohio

Objective 2.1: Add two new variables to the birth and infant mortality datasets in the Ohio Public Health Data Warehouse (OPHDW), Medicaid status and managed care plan, in order to calculate infant mortality rates and other perinatal health indicators for the Medicaid population. *Completed October 2018*

Objective 2.2: Development of a Birth and Death Certificate Data Extract to Upload to Maternal Mortality Review Information App (MMRIA). *Completed August 2019*

Objective 2.3: Link COVID-19 case data with birth and fetal death records in order to monitor COVID-19 related pregnancy and birth outcomes. *Ongoing*

Objective 2.4: Link WIC participant data with birth records. *Ongoing*

Goal 3: Support program evaluation activities around the NPMs that contribute to building the evidence base for the Title V MCH Block Grant Program and provide data support to IM CoIIN project(s) as needed.

Objective 3.1: Evaluate effectiveness of Ohio's First Steps for Healthy Babies program on increasing rates of breastfeeding at time of discharge. *Completed June 2020*

Objective 3.2: Provide data support for HRSA IM CoIIN project(s). *Completed April 2020*

During the SSDI budget period December 1, 2019, through November 30, 2020, the Ohio SSDI project has accomplished many tasks related to their goals and objectives. We completed the evaluation of the First Steps for Healthy Babies (First Steps) program outcomes. First Steps is a joint project of ODH and the Ohio Hospital Association (OHA) aimed at encouraging hospitals to promote and support breastfeeding. Program Steps are based on a 10-step list adopted for the

World Health Organization and Baby-Friendly USA's Ten Steps to Successful Breastfeeding. Initial results of the evaluation were presented at the American Academy of Pediatrics (AAP) National Conference & Exhibition on November 4, 2018. The final results were published in *the Ohio Journal of Public Health (Ohio First Steps for Healthy Babies: A Program Supporting Breastfeeding Practices in Ohio Birthing Hospitals)*.

SSDI funds a full-time epidemiologist at 80%. This epidemiologist is responsible for supporting the Title V Block grant as detailed above in Goal 1. She advises program staff on setting annual objectives and selection of indicators, monitor performance and outcome measures and annual objectives, assist with identification of data sources, perform analysis as needed, and interpret data. The epidemiologist is also responsible for completing data forms for the annual report. The epidemiologist will continue to work with the MCH Block Grant Coordinator and priority group leads to identify additional data needs and perform analysis as needed. She has developed a data resource document for staff that outlines Ohio's Title V Block Grant measures including definitions, trends, annual objectives, and data sources. During FY 20, she produced several data products including a data brief looking at the association of interpregnancy interval and poor birth outcomes. Additionally, she is finalizing a brief on racial disparities in infant mortality utilizing data from OPAS and submitted an abstract on post-partum contraceptive use to the 2021 MCH Epidemiology Conference.

There are a couple of data linkage projects that are not funded by SSDI, but are being carried out by staff in the Data and Surveillance section which manages the SSDI grant. This includes linking WIC and Vital Statistics data in order to assess and compare birth outcomes between WIC participants and women who were WIC eligible but did not participate.

BMCFH is also conducting surveillance on woman who were infected with coronavirus disease 2019 (COVID-19) during pregnancy. The aim of these activities is to assess health-related outcomes of mothers and infants among COVID-19 affected pregnancies. Cases of COVID-19 are reported to ODH by local health departments who enter the case information into the Ohio Disease Reporting System (ODRS). Cases of COVID-19 during pregnancy are identified by performing probabilistic matching of confirmed cases of COVID-19 to birth and fetal deaths records using "event date" to determine if the infection took place during pregnancy. Event date is the earliest date associated with the case and pulls from onset date, diagnosis date, lab test date, date reported to the local health department, and date reported to ODH. Birth certificates of identified cases are shared with the National Vital Statistics System.

The Pregnancy and Neonate modules developed by the CDC were added to ODRS. Vital statistics data obtained from the linkage is entered into these modules in ODRS, BMCFH has completed a preliminary analysis using this data for pregnancy related infections that occurred in 2020. We have developed a sampling plan to perform medical record abstractions on all cases where there may have been perinatal infection (in the infant during delivery hospitalization) and a 3% random sample of the remaining pregnancies. Data from these medical record abstractions will also be entered into ODRS. We are in the process of developing the infrastructure to share this data with CDC's Surveillance for Emerging Threats to Mothers and Babies (SET-NET).

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

BMCFH Data and Surveillance provide critical data for Title V program activities, including the needs assessment, performance measure reporting/monitoring, and program evaluation for data-driven programming. In addition to providing research and epidemiologic expertise to programs across the BMCFH, data capacity efforts include MCH surveillance, surveys, and other data initiatives.

MCH Surveillance

The Pregnancy Associated Mortality Review (PAMR) program reviews all pregnancy associated deaths in Ohio. Once maternal deaths have been identified by the Bureau of Vital Statistics, PAMR nurse abstractors request relevant medical, law enforcement and social service records to compile case summaries. These summaries are reviewed by a multidisciplinary committee who completes a "Committee Decision Forms" which reflects the consensus opinion related to preventability, contributing factors and recommendations to prevent future deaths. Data are entered into a Centers for Disease Control and Prevention (CDC) centrally hosted database (MMRIA). ODH has a Data Sharing Agreement in place with CDC which allows Ohio data to be combined with other states to provide a more comprehensive view of maternal mortality in the United States.

Fetal Infant Mortality Review (FIMR) is conducted in nine Ohio Equity Institute counties across the state. These urban counties have the highest Black infant mortality rates in Ohio. ODH provides funding to assist these counties to identify fetal deaths and conduct maternal interviews and case reviews by a Case Review Team (CRT). The CRT develops recommendations which are presented to the Case Action Team (CAT) who will work to implement prevention initiatives in their community.

Child Fatality Review (CFR) is required by statute to be conducted by each of Ohio's 88 counties. All deaths to children under the age of 18 are reviewed by a multidisciplinary team of local experts and prevention initiatives are recommended. Case data are entered into a database hosted by the National Center for Fatality Review and Prevention. Annually, ODH downloads Ohio data and prepares a comprehensive report that is disseminated to the Governor, legislators and other interested parties and is posted on the ODH web site.

As existing surveillance systems are not designed to monitor opiate abuse and the health outcome for women, children, and young families, Ohio is currently developing a new perinatal substance use surveillance system in Ohio by using multiple existing data sources. In addition, in response to the COVID-19 pandemic, data collection has been expanded for maternal populations through additional questions on SOARS and OPAS and linking of birth certificate data to the Ohio Disease Reporting System. This data will be used to understand the impact of the pandemic on Ohio's MCH population.

Surveys

The Ohio Pregnancy Assessment Survey (OPAS) is Ohio's PRAMS-like survey. OPAS began in 2016 after Ohio had participated in PRAMS from 1999-2015. By implementing our own survey, and leveraging MEDTAPP funding, OPAS provided county-level estimates for Ohio's 3 largest counties for the first time, a feature unavailable through PRAMS. Furthermore, OPAS sample sizes have continued to increase to around 4,000-5,000 respondents, compared with around 600 respondents in PRAMS. Ongoing implementation of OPAS through State Fiscal Year 2021 (SFY 21) continues as a collaboration funded by ODH and ODM and administered by The Ohio State University Government Resource Center (GRC). In SFY 2020, Ohio, along with 32 PRAMS states and one additional non-PRAMS state (California), was selected to receive supplemental funds from CDC to implement an opioid supplement. This supplement utilizes existing methodology and maternal and child health surveillance infrastructure within states that are not currently funded for the Pregnancy Risk Assessment Monitoring System (PRAMS) to implement rapid surveillance of maternal behaviors and experiences related to use of prescription pain relievers and other opioids among women who deliver a live-born infant. Preliminary data from this effort was published by CDC in July 2020. The final data will inform state health departments, clinical providers, CDC, and other federal agencies on programs and policies to mitigate the risk of opioid exposure during pregnancy.

As a separate, but related surveillance activity, ODH initiated implementation of a stillbirth survey in SFY19. The methodology is identical to the Ohio Pregnant Assessment Survey, but the target population will be fetal death certificates rather than live birth certificates. Survey planning continued throughout the grant year and the survey is expected to be in the filed in the spring of 2020. The Ohio Study of Associated Risks of Stillbirth (Ohio SOARS) survey will provide ODH with critical, timely, and relevant population-based data to better understand maternal experiences and behaviors prior to, during, and immediately following pregnancy among women who have recently experienced a stillbirth to inform targeted interventions to prevent stillbirth.

Based on feedback from ODH youth survey forums and experience during the 2015 and 2017 Youth Risk Behavior Survey (YRBS) cycles, ODH combined YRBS and the Youth Tobacco Survey (YTS) for the Fall 2019 administration cycle. Combining the YRBS and YTS allowed the bureau and the ODH Tobacco program to leverage resources and utilize a team

approach to plan and conduct the survey, instead of separately administering two surveys to twice as many schools. This partnership allowed ODH to garner more support externally which ultimately led to greater participation from schools and resulting in 2019 weighted data for both the high school and middle school populations, and allowed for middle school data to be collected for the first time for YRBS.

The National Survey for Children's Health (NSCH) provides data on multiple, intersecting aspects of children's lives– including physical and mental health, access to quality health care, and the child's family, neighborhood, school, and social context. A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, and 2019. Among other changes, the 2016 National Survey of Children's Health started integrating two surveys: the previous NSCH and the National Survey of Children with Special Health Care Needs (NS-CSHCN). The NSCH provides data for many Title V National Performance Measures (NPM) and National Outcome Measures (NOM). ODH has contracted with the US Census Bureau to sample an additional 5,205 addresses in Ohio for the 2021 NSCH. This oversample will allow ODH to have more precise estimates on key indicators monitored by the Title V grant as well as allow for getting estimates for certain sub-populations. Specifically, the additional samples are designed to increase the number of Black and Hispanic households that are surveyed to get better estimates for those populations. Additionally, the larger sample may allow us to get estimates stratified by income, education, disability status, etc. Accurate data on vulnerable populations is vital to our efforts at improving health equity.

Other Data Initiatives

The InnovateOhio Platform (IOP) is an initiative lead by Ohio's Lieutenant Governor to provide integrated and scalable capabilities that enable state agencies to become more customer-centric and data-driven. Through collaboration and innovation, the InnovateOhio Platform creates an integrated customer experience that brings higher-quality services to the public – ultimately making Ohio a better place to live, work, and do business. The Ohio Department of Health was one of the first state agencies to post data on the IOP. The Bureau of Maternal, Child, and Family Health currently has 69 data sets available for public consumption through the IOP. Forty-six (46) of those data sets had never been publicly available before. Additionally, 43 data sets include data visualization, i.e., charts and graphs to help illustrate the data.

Beginning in 2020 WIC has expanded collaboration with Ohio Department of Medicaid and Job and Family Services to increase referrals, data and information sharing, and operational efficiencies related to the WIC program and its eligible population. The WIC, Medicaid, SNAP, and TANF cross-enrollment project uses the InnovateOhio Platform to provide local WIC agencies contacts for potential WIC enrollment. WIC has also initiated a pilot program with a county WIC program for local staff to access SNAP/TANF/Medicaid income data to determine adjunctive eligibility to streamline the certification process for staff and families.

The Infant Mortality Research Partnership (IMRP), a collaboration between state agencies, researchers, and subject matter experts, uses big data to gain a better understanding of how to lower infant mortality in Ohio. The IMRP team includes the ODH, ODM, Ohio Department of Higher Education, and university researchers across multiple disciplines such as biostatistics, pediatrics, and geography. ODH continues to be an active partner in IMRP. The current phase of this work 1) expands upon the spatiotemporal analysis to develop a mapping tool to longitudinally assess changes in preterm birth, low birthweight, and infant mortality over time by census tract; 2) developed a health opportunity index by census tract to align health opportunity with birth outcomes; and 3) used the results of the data analytics to develop a risk calculator to predict one-day mortality, very preterm birth (<32 weeks), or preterm birth (<37 weeks) using clinical data. The results will improve upon and expand the previously developed models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. Future plans include field testing the risk calculator within a Maternal-Fetal Medicine clinic to inform edits/refinements of the calculator and incorporation of the calculator into one hospital system electronic health record.

The Statewide Student Identifier (SSID) began as an identifier within the Ohio Department of Education for school-aged children. Since the implementation of SSID, additional state agencies have adopted use of SSID, including adding for children as young as newborns, to facilitate easier data linkage across state agency programs. Within BMCFH, several projects and programs have explored use of such a shared identifier, and the home visiting program will be implementing SSID within the OCHIDS data system.

The Ohio Department of Medicaid provides data to ODH from the Pregnancy Risk Assessment Form (PRAF), which is completed by OB providers, and serves as a significant source of referrals to the ODH home visiting program.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The welfare and safety of Ohio citizens is severely threatened during disasters. The goal of emergency management is to ensure that in disaster response, mitigation, preparedness, and recovery actions the State effectively functions so that public welfare and safety is preserved and restored. The Ohio Emergency Operations Plan (Ohio EOP) is an integral element of the State's emergency management response effort. State agencies in Ohio cooperate with the Ohio Department of Public Safety, through the Ohio Emergency Management Agency (Ohio EMA), in an ongoing planning process for the Ohio EOP.

The Ohio EOP establishes a comprehensive framework through which State of Ohio Agencies and other designated non-state agencies assist local jurisdictions to respond to and recover from disasters that affect the health, safety, and welfare of the citizens of Ohio. The Ohio EOP follows the Emergency Support Function structure as outlined in the U.S. Department of Homeland Security's National Response Framework, and incorporates the National Incident Management System. The Ohio EOP is available electronically at the Ohio EMA website at https://ema.ohio.gov/EOP_Overview.aspx. Ohio's EOP is reviewed and updated on a four-year schedule with 25% updated each year due to the large number of documents that comprise the entire state EOP. The Ohio Department of Health, including the Title V MCH program, supports the update and development of tabs within the Ohio EOP.

In addition, Ohio Department of Health's (ODH) Bureau of Health Preparedness (BHP) provides direction, support, and coordination in preventing, preparing for and responding to events that threaten the public's health. ODH takes a whole community approach to preparedness and response. Whole-community planning and response means considering the whole community as our baseline to ensure that everyone is being effectively served. A plan/response is effective when it serves the most vulnerable members of the community. ODH engages representatives of populations with access and functional needs, including subject matter experts within the MCH program. "Access and Functional Needs" replaces the old terminology of "special needs," to better operationalize the myriad needs individuals may have during emergencies. Access and functional needs include anything that may make it more difficult– or even impossible– to access, without accommodations, the resources, support, and interventions available during an emergency.

ODH utilizes the CMIST framework to address access and functional needs in emergency plans and responses. The CMIST framework defines the components of access and functional needs:

- Communication – Refers to limitations in both receiving and providing information (e.g., only speaking a language other than English, not being able to read or write well, or being unable to speak).
- Maintaining Health – Refers to needs associated with managing health conditions that require observation or ongoing treatment (e.g., requiring dialysis or administered oxygen, needing IV therapy or tube feeding, relying on power-dependent equipment to sustain life, or needing medication to maintain optimal levels of health).
- Independence – Maintaining independence is the goal of CMIST.
- Safety and Support – Addresses individuals who may have lost the support of assistants, attendants, family, or friends; or may be unable to cope in new or strange environments (e.g., people with Alzheimer's or individuals who experience stressors beyond their ability to cope, people who function adequately in a familiar environment but become disoriented in an unfamiliar environment, children who are unaccompanied, or people who are incarcerated).
- Transportation – Refers to needs related to travel (e.g., not having a vehicle or driver's license, needing specialized transportation, or being unable to navigate existing transportation options).

In addition, ODH has championed person-first language and appropriate terminology to engage individuals with access and functional needs. This initiative was rolled out statewide, and all Local Health Departments (LHDs) have adopted the use of appropriate, person-first language.

Emergency planning and preparedness intersects Incident Engagements, Planning Support, and Preparedness Training.

Incident Engagement
The MCH program has a key role in incident response. MCH has provided subject matter experts (SMEs) and supported outreach to impacted populations over a variety of incidents, including, COVID-19, Zika, Ebola, water shortages, and power outages. MCH leadership and other MCH staff are incorporated in ODH's Incident Management Structure in Planning and Operations sections depending on the event's needs. During the Zika response, MCH championed a number of interventions to engage pregnant women, women intending to be pregnant, and their partners. Outreach was conducted through a variety of avenues, including WIC and STD clinics. MCH also supported the pregnancy registry, follow-up with impacted families, and ongoing surveillance of birth defects potentially related to Zika. Engaging male partners was an often-overlooked aspect of this response, and highlighting this would be important to demonstrate the community-wide perspective that protecting unborn children involves both men and women, not just expectant mothers.

Throughout the COVID-19 pandemic MCH has been integral to ODH's response. During the COVID-19 outbreak, nearly 50 BMCFH staff have contributed to the state's response. Specifically, BMCFH staff have been assigned full-time or volunteered part-time for Ohio's COVID-19 call centers, participated on state workgroups to develop guidance for sectors operating safely, participated in the Minority Health Strike Force, led the data team responsible for creating the Ohio Public Health Advisory System, and provided support for the state's population study of coronavirus infection. Staff not involved in the COVID-19 response have assumed additional duties to continue non-COVID-19 operations. Early during the COVID-19 pandemic, MCH developed a survey of local partners regarding needed supports for continued operations, including supports for alternate services to accommodate suspension of face-to-face services. MCH routinely developed and updated guidance for locals to ensure safety during COVID-19. In addition, as discussed in other sections of the application, multiple MCH data and surveillance activities have also been modified or expanded to collect data to understand the impacts of COVID-19 and inform planning and response.

Other incidents MCH prepares to engage for include water shortages and power outages. Due to aging infrastructure and environmental hazards, Ohio experiences a number of water shortages. During these shortages, the MCH program identifies the number of impacted WIC recipients and supports messaging through the local health department. This engagement ensures vulnerable families can access supplemental water resources. Accessing water resources could take a number of forms: ensuring responders serve vulnerable populations, especially women and children who cannot afford to purchase bottle water or who cannot travel to where water is being distributed; making populations aware of the impacts to the water system and available support; and communicating guidance about formula and cooking for families with children.

Ohio also experiences a number of power outages that can have cascading impacts on private water systems and population health, especially during extreme heat or cold. As with water shortages, MCH supports outreach and guidance to ensure impacted families can navigate resources and impacts. Support could include: sharing guidance on food safety in home, especially after extended power outages, sharing guidance on generator safety in the home, and support replacement of food for WIC participants.

Planning Support
The MCH program has critical roles in plan development. The MCH program supports updates and development of: the Ohio EOP, ODH response plans, and ODH emergency response procedures.

The Ohio EOP is reviewed and updated on a four-year schedule with 25% updated each year due to the large number of documents that comprise the entire state EOP. The Ohio EMA manages the Ohio EOP and coordinates the review and update process. When a section of the Ohio EOP is scheduled for review, the Ohio EMA sends ODH BHP the related documents and the BHP emergency response unit coordinates review within ODH. The review process within ODH includes sharing of the documents with all points of contact and a meeting to discuss proposed revisions. Ohio EMA collates all revisions from the primary and support agencies in the EOP and sends a finalized draft to all state agencies involved for executive signature. The MCH program is included in this process to support the updates of existing and development of new tabs within the Ohio EOP. Review of state EOP documents was suspended in early 2020 due to the COVID-19 response. In spring of 2021 Ohio EMA reached out to ODH BHP to discuss resumption of the review process. Because many staff are still involved in the COVID-19 response, the timeline for revision and completion of review is still being determined. At this time anticipated sections that might be reviewed in 2021 include: ESF #8 Public Health and Medical Services base plan, ESF 8 Tab F Medical Surge Plan, ESF #8 Mass Fatality Incident Response Plan, and ESF #13 Tab B Ohio Medical Countermeasures Security Plan.

MCH also advocates for the needs of women and children in ODH response plans, including the ODH Emergency Response Plan (ERP)- Basic Plan, ODH Pandemic Influenza Response Annex, and ODH Continuity of Operations (COOP) Plan. The ODH ERP is reviewed annually but changes can be made at any time if information from either exercise or real-world event After Action Reports/ Improvement Plans show a need.

Within ODH response plans, MCH supports the refinement and execution of the following response procedures:

- Incident Size-up: defines the process for determining activation of the response plan, setting objectives and identifying key partners to engage.
- CMIST Size-up: identifies the access and functional needs in the impacted area and strategies to serving the whole community
- CMIST Profile: Defines the key CMIST demographic info for the State of Ohio; each county in the state has their own CMIST profile
- Internal SME Contact List: Defines the key personnel who would be called on to support response efforts, based on incident needs.
- Communicating with and about: Describes person-first language and identifies appropriate terminology for various types of access and functional needs

- Water Shortage: defines the response steps taken by ODH to support local response to water shortages

Specific MCH considerations in the ODH Pandemic Influenza Response Annex include: leveraging the school nurse program during pandemics, including the school nurse reporting database for absences and closures due to illness; supporting outreach strategies to vaccinate women and children during a pandemic; pregnant women, infants and children with related medical needs are in Tier 1 of vaccination priorities; and supporting the provision of guidance through established channels programmatically and with LHDs.

Within the ODH COOP, MCH has two essential functions identified to ensures that these functions will continue without interruption, even during the direst circumstances. The two identified essential functions are Bicillin provision for Syphilis treatment and the Metabolic Formula program within the Children with Medical Handicaps program.

Since fall 2020, MCH and BHP have jointly participated in AMCHP's Action Learning Collaborative (ALC) to better integrate considerations of the MCH population into ODH's planning and response functions. The ALC has provided a structured process to identify areas for improvement while balancing the ease of implementing improvement strategies and the anticipated impact of the improvement strategies. To improve collaboration, BMCFH and BHP leadership have begun meeting quarterly to discuss shared issues. BMCFH has shared information about Title V, bureau programs, and MCH population considerations to educate BHP staff. BHP will present on public health emergency preparedness during Preparedness Month (September) at the BMCFH Learning Session to educate BMCFH staff. BMCFH staff have also been working with BHP to update the COOP, and are planning for a comprehensive review of the EOP to recommend areas where considerations for the MCH population could be added. During the COVID-19 response, BMCFH leadership received the daily Situation Report, call center script updates, and an invitation to a daily department leadership briefing call. BMCFH was invited to participate in an interview that will contribute to the ODH COVID-19 After Action Report. One gap that has been identified is that while MCH staff are often pulled to serve in Incident Command roles there is not a designated MCH role in ICS. This means that while MCH is technically represented, often times MCH perspectives are not requested, and so MCH population needs may not be fully assessed and addressed. BHP and BMCFH are committed to continuing to enhance our partnership to better serve MCH populations.

Preparedness Training
ODH facilitates trainings to support health preparedness. Trainings are made available through webinars and/or integrated into grant requirements (* = Previous PHEP grant requirement and ongoing recommended training; ** = Identified in PHEP grant as a recommended training):

- 20 Things Every School Nurse Should Know about Preparedness
- CMIST Introduction Webinar*
- Disability Training for Emergency Planners: Serving People with Disabilities* (available on Ohio Train)
- Emergency Response for People Who Have Access and Functional Needs. (http://terrorism.spcollege.edu/SPAWARAFN/guide.html)**
- IS-368: Including People with Disabilities & Others with Access & Functional Needs in Disaster Operations**
- L197: Integrating Access and Functional Needs into Emergency Planning**

During the COVID-19 pandemic additional trainings were provided across numerous topics and through numerous programs to support MCH populations and professionals serving these populations.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Medicaid is Ohio's largest health payer. Over 90,000 providers deliver services for individuals insured by Medicaid. As of March 2021, an estimated 3.18 million Ohioans, including more than 1.28 million children, receive coverage for healthcare services through Medicaid.[i] This is an increase from the June 2020 enrollment of 2,984,644.

Most beneficiaries now receive Medicaid health care benefits through one of five private managed care plans (MCPs). As of March 2021, 88% of beneficiaries receive care through MCPs, 7.4% receive care through fee for service (FFS), and 4.4% have limited coverage. Ohio Department of Medicaid (ODM) pays the MCPs monthly, per person, using capitation rates. In 2017, Ohio extended managed care enrollment to additional populations that had previously been excluded from care coordination, including children in Ohio's foster care, children in custody system, individuals enrolled in the Ohio Department of Health (ODH) Children with Medical Handicaps (CMH) Program and Breast and Cervical Cancer Program, and optional managed care for individuals with developmental disabilities enrolled on a HCBS Waiver administered by the Ohio Department of Developmental Disabilities (DODD).

The 2022-2023 biennial budget (HB 110) made investments in the next generation of Medicaid Managed Care, which focuses on the individual and will streamline administrative processes to increase transparency and improve access and care coordination. The Next Generation strategic initiatives include: enhanced managed care procurement process to renegotiate contacts between MCOs and ODM; selection of a fiscal intermediary as single point of entry for providers; Single Pharmacy Benefit Manager to manage contracts and pharmacy benefits; OhioRISE coordination for children with behavioral health needs; and centralized credentialing via ODM.

The state's 2022-2023 biennial budget extended postpartum Medicaid coverage for women from 60 days to 12 months, as permitted under the American Rescue Plan Act (ARPA), to begin in April 2022. The budget also maintains initiatives enacted during the previous biennial budget (HB 166) but paused due to COVID-19, which aim to reverse Ohio's infant mortality rate and provide newborns and mothers care during stages of critical development. Stakeholder engagement sessions for the Maternal and Infant Support Program (MISP) are underway (see ODM website).

The OhioRISE program (Ohio Resilience Through Integrated Systems and Excellence) is implementing a new approach to care coordination for children and youth enrolled in Medicaid with serious behavioral health needs. Enhancements include expanded treatment options and support services spanning the behavioral health, child protection, juvenile justice, health, developmental disabilities, and education systems for an estimated 55,000 children and youth.

In the 2018-19 biennial budget, Ohio implemented a rule that the state should seek federal approval for a work requirement that would apply to the Medicaid expansion population. This requirement would not apply to enrollees age 50 or older, children, pregnant women, caretakers caring for minor children or a disabled person, people receiving unemployment or Supplemental Security Income, people in drug or alcohol treatment programs, or anyone deemed physically or mentally unable to work. Of the more than 700,000 people enrolled in Medicaid expansion, it is estimated that 36,000 will need to start working or enroll in job training, education, or certain volunteer activities, for at least 20 hours per week, in order to avoid being disenrolled. The rest of the Medicaid expansion population is either already working or would be exempt from the work requirement. The Centers for Medicare and Medicaid Services granted approval for the work requirement waiver and intended to implement the requirements in January 2021; however, implementation has been delayed due to the Maintenance of Eligibility requirement associated with the COVID-19 pandemic Public Health Emergency, which is expected to be renewed for the duration of 2021.

During the past five years, ODH and ODM have transformed their relationship towards joint decision-making. In strategic planning to improve health outcomes for Ohio's most vulnerable populations, the agencies have developed and defined common metrics, created dual data reports, and developed processes for bi-directional data exchange. To stay abreast of needs and coordination, the agencies meet bi-weekly to support data sharing and advise policy implementation and planning processes. ODH and ODM engage in numerous joint initiatives to ensure effectiveness in the state's health care delivery system to meet the needs of women and children, as discussed throughout this application.

The Ohio Medicaid Technical Assistance and Policy Program (MEDTAPP) enables the use of federal Medicaid administrative funds to identify barriers and improvements in accessing healthcare services and improving the healthcare workforce in high need areas. MEDTAPP is a partnership combining nonfederal and federal funds to support the efficient and effective administration of the Medicaid program. This formal state-university partnership is driven by a multi-agency agreement (available in section V. Supporting Documents) between GRC and ODM, ODH, DODD, Department of Mental Health and Addiction Services, Department of Higher Education, Department of Aging, and the Department of Education. Projects include workforce development; maternal and infant health; health services research and data, including the Ohio Medicaid Assessment Survey (OMAS); and integrated physical & behavioral health. MEDTAPP MCH projects are

implemented by the Ohio State University Government Resource Center and include:

- Past projects:
  - The Ohio Progesterone Promotion Project, in collaboration with the Ohio Perinatal Quality Collaborative (OPQC), engaged maternity care providers to increase screening for the need for progesterone and utilization of progesterone when indicated.
  - The Ohio Type 2 Diabetes Learning Collaborative worked with obstetric, primary care, family medicine, and ODH Home Visiting providers to increase postpartum visit and glucose screening rates among women at high risk for developing Type 2 Diabetes.
  - The Pregnancy Risk Assessment Form (PRAF), a collaboration with OPQC, started as a paper form completed by Medicaid obstetric providers at the first prenatal care visit to identify risks for intervention/referral needed to improve birth outcomes. The PRAF 2.0, or ePRAF, is an electronic version of the same form, and projects focus on improved use of the ePRAF to facilitate communication among pregnant women and their care providers and facilitate referrals to ODH evidence-based home visiting.
- Ongoing projects:
  - Smoke Free Families quality improvement projects, in collaboration with the Ohio Chapter of the American Academy of Pediatrics, implement the 5As of smoking cessation in pediatric practices to improve caregiver screening and referral for smoking cessation services. Extensive resources for supporting families and providers were developed.
  - The Ohio Pregnancy Assessment Survey (OPAS) is Ohio's PRAMS-like survey. OPAS began in 2016 after Ohio had participated in PRAMS from 1999-2015. By implementing our own survey leveraging MEDTAPP funds, OPAS provides county-level estimates for Ohio's 3 largest counties and larger sample sizes. In addition to the statewide OPAS questionnaire, Ohio implemented an opioid supplement starting in 2019 and COVID-19 supplement in 2020. Preliminary data from the opioid supplement effort was published by CDC in July 2020.
  - ODH initiated a stillbirth survey in 2019 with methodology identical to OPAS, but the target population drawn from fetal death certificates rather than live birth certificates. The Ohio Study of Associated Risks of Stillbirth (Ohio SOARS) survey will provide ODH with timely population-based data to better understand maternal experiences and behaviors prior to, during, and immediately following pregnancy among women who have recently experienced a stillbirth to inform targeted interventions.
  - OPAS for Dads will collect data on new and expectant fathers' behaviors and attitudes towards pregnancy, and the health of men during their reproductive years. The data will provide insight into gaps and disparities in male health care services and use, ultimately supporting men and improving the family's health outcomes.
  - The Ohio Women's Behavioral Health Support Learning Collaborative aims to implement best practices to improve depression/anxiety screening, diagnosing, and providing education and follow-up for women of childbearing age with special focuses on health equity and the Medicaid population in primary care.

[i] https://www.healthpolicyohio.org/wp-content/uploads/2021/06/OhioMedicaidBasics2021.pdf

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Interagency Agreement (IAA) between the Ohio Department of Health (ODH), which includes Title V MCH, and the Ohio Department of Medicaid (ODM), Title XIX, is updated biannually. The cooperative agreement between ODH and ODM codifies the relationship of shared responsibilities in regard to:

1) Coordination of health services, conducting outreach, program eligibility, and payment for services for Ohio citizens;
2) Performing environmental lead risk assessments for Medicaid-eligible children identified as having elevated blood lead levels;
3) Performing lead hazard abatement activities in the homes of low-income children and pregnant women;
4) Reimbursement of ODH bureaus and/or local public health departments for Medicaid administrative activities provided by them;
5) Maintaining and enhancing the statewide automated Immunization Information System (Impact/SIIS) including the Vaccines For Children Program (VFC) through a collaborative exchange of electronic data from ODM to ODH;
6) Reimbursing ODH the cost of operating the Ohio Tobacco Quit Line to the extent it complies with the State Medicaid Letter (SMDL #11-007) dated June 24, 2011; and
7) Defining the relationships and responsibilities between the parties for the conduct of desk reviews, interim settlements, field audits, and final settlements for ODH's for Children with Medical Handicaps Program (CMH).

As of application submission, the 2021-2023 IAA is in the official authorization and signature process with ODH and ODM leadership and includes the same attachments for key topics as the included 2019-2021 IAA:

- A- Maternal and Child Health (p9)
- B- Lead (p13)
- C- Medicaid Administrative Claiming (MAC) (p19)
- D- Immunizations (p89)
- E- Smoking Cessation (p93)
- F- Children with Medical Handicaps (p97)
- G- Definitions (p101)
- H- Metabolic Formula (p107)
- I- ODH and ODM System Access (ODM QDSS and ODH Warehouse) (p109)
- J- WIC (p111)

The Title V program facilitates enrollment in Medicaid through a number of programs. Per the ODH IAA with Medicaid, programs, such as WIC, are required to make families aware of Medicaid. Reproductive Health and Wellness Program sites are required to ensure that a Certified Application Counselor (CAC) or Navigator is available to assist Title X clients with Marketplace enrollment as well as ensuring eligible Title X clients are assisted with enrollment into Medicaid. Both ODH and ODM also invest in community workers who are able to facilitate outreach and identification of women and families and support them in connecting to and completing the process for coverage. Funded models of community workers include Community Health Workers, home visitors, and *Ohio Equity Institute: Working to Achieve Equity in Birth Outcomes* Neighborhood Navigators.

ODH conducts a bi-weekly case conference with the Ohio Department of Medicaid (ODM) to review individual cases where families are experiencing challenges with coverages through MCPs. This process has proven beneficial not only in remediating challenges for individual families, but also in driving policy change and clarification between ODM and the plans. ODH participated in the development of the solicitation for the renegotiation of contracts with the MCPs. ODH will continue to conduct case conference and will assist with orienting new managed care organizations (if any) about the specialized needs of Ohio's CYSHCN population.

ODM and ODH continue to partner on coordination of infant vitality efforts. Starting in FY 2018, ODM required managed care agencies to provide enhanced prenatal and maternal care through infant vitality efforts. In determining and informing implementation of the strategies for ODM's infant vitality funding, ODH was an equal partner in identifying evidence-based strategies, scoring and common metrics. Since establishment and investment in these efforts, ODH and ODM continue to work to more effectively align investments through evaluation of these efforts. ODH has also allowed and encouraged the epidemiologists funded through the *Ohio Equity Institute: Working to Achieve Equity in Birth Outcomes* program to support ODM-funded entities in effective data analysis of local birth outcomes data. ODH participates in bi-weekly meetings with ODM and its infant vitality funded organizations to ensure immediate access to relevant state infant vitality information for funded entities. This collaboration continues to be an important way for ODH and ODM to coordinate infant vitality efforts at the local level.

The Infant Mortality Research Partnership (IMRP), a collaboration between state agencies, researchers, and subject matter experts, uses big data to gain a better understanding of how to lower infant mortality in Ohio. The IMRP team includes the

ODH, ODM, Ohio Department of Higher Education, and university researchers across multiple disciplines such as biostatistics, pediatrics, and geography. The current phase of this work 1) expands upon the spatiotemporal analysis to develop a mapping tool to longitudinally assess changes in preterm birth, low birthweight, and infant mortality over time by census tract; 2) developed a health opportunity index by census tract to align health opportunity with birth outcomes; and 3) used the results of the data analytics to develop a risk calculator to predict one-day mortality, very preterm birth (<32 weeks), or preterm birth (<37 weeks) using clinical data. The results will improve upon and expand the previously developed models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. Future plans include field testing the risk calculator within a Maternal-Fetal Medicine clinic to inform any edits/refinements of the calculator and incorporation of the calculator into one hospital system electronic health record.

ODH WIC is working closely with the InnovateOhio Platform (IOP) staff on a Medicaid/SNAP/TANF cross-enrollment project. The IOP is an initiative lead by Ohio's Lieutenant Governor to provide integrated and scalable capabilities that enable state agencies to become more customer-centric and data-driven.

In January 2020, ODM was awarded the Integrated Care for Kids Model (INK) grant through the Centers for Medicare & Medicaid Services' Center. Ohio's Title V program is on the partnership council for the project which plans to address behavioral and medical needs of children and improve coordinated care in rural communities. In 2021, Nationwide Children's Hospital (NCH) assumed responsibilities for the seven-year cooperative agreement with continued partnership from ODM and the partnership council. The planning period began in January 2020 and will continue through December 2021, with the council planning interventions and designs to improve care coordination for kids. Implementation will take place in years three through seven (2022-2026) for the planned interventions, and the council will track progress toward meeting program goals.

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

State Action Plan Introduction

The 2021-2025 Ohio Action Plan drives the development and implementation of strategies and activities aligning the state MCH priorities, objectives, performance measures, outcomes measures, and evidence-based strategy measures. The MCH priorities and Action Plan resulted from the comprehensive five-year needs assessment process, which included extensive use of data and stakeholder input (see section III.C. Five-Year Needs Assessment Summary). The state Action Plan is organized around the MCH priorities grouped by population domain:

Women
- Decrease risk factors contributing to maternal morbidity
- Increase mental health support for women of reproductive age
- Decrease risk factors associated with preterm births

Infant
- Support healthy pregnancies and improve birth and infant outcomes

Child
- Improve nutrition, physical activity, and overall wellness of children

Adolescent
- Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
- Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

Children and Youth with Special Health Care Needs
- Increase prevalence of children with special health care needs receiving integrated, physical, behavioral, developmental, and mental health services

Cross-Cutting/Systems Building
- Improve health equity by improving community and social conditions and reduce environmental hazards that impact infant and child health outcomes
- Prevent and mitigate the effects of adverse childhood experiences

The Ohio MCH program uses an Action Group structure to manage its MCH priorities and implement strategies within the Action Plan. Each priority Action Group is comprised of staff, stakeholders, and consumers including representatives from state agencies, local health departments, health care organizations, managed care organizations, insurance, consumers, parent and family groups representing CYSHCNs, universities, and community agencies. When developing their population Action Plan following the 2020 needs assessment, each group was also asked to consider the Cross-Cutting priorities during their population planning. The goal of this process was to ensure integration throughout each of the population domains in addition to the system's level Action Plan for the Cross-Cutting priorities.

The Action Groups use the logic model version of the Action Plan, available in section V. Supporting Document (Ohio Title V MCH BG Priority Action Plan FY 21-25). Each year the action groups update the five-year Action Plan and throughout each year assess performance measure outcomes, implement and monitor strategies to impact the performance and outcome measures, and create or identify an evaluation plan to assess whether or not the interventions have been successful. In addition to the Action Groups, MCH program administrators utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes.

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

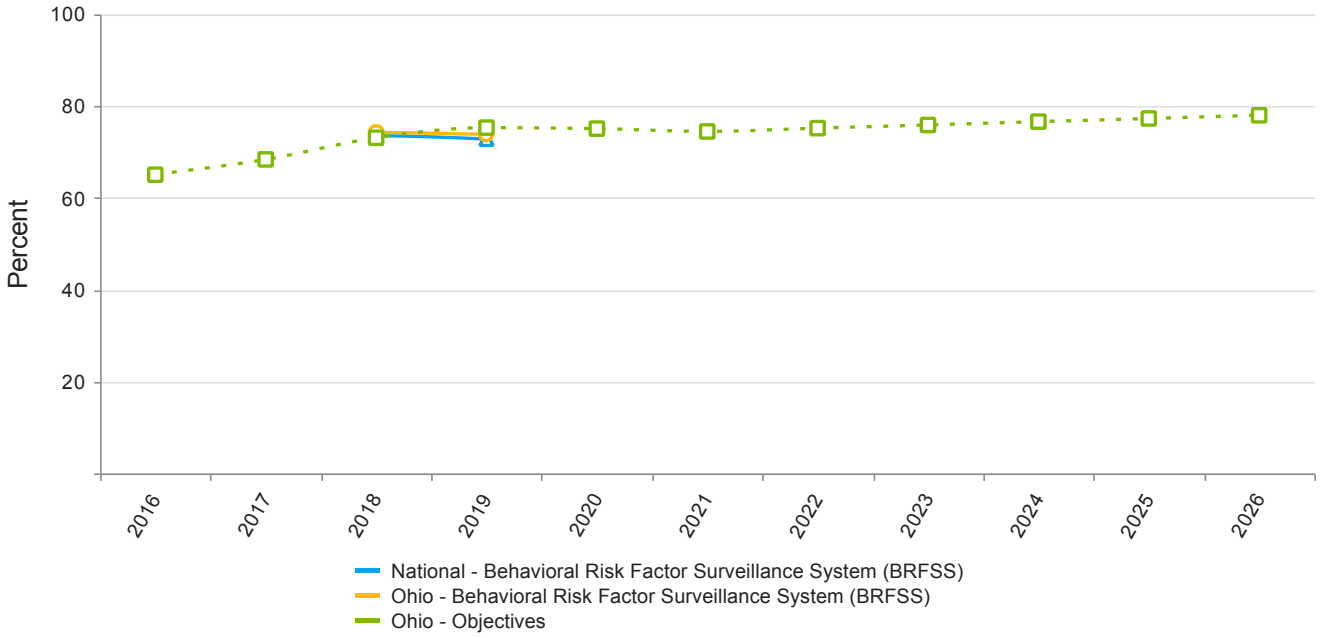
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	77.8	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	19.7	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.6 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.5 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	26.9 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	7.0	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.7	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.3	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	234.6	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	119.1	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2015	6.4 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	11.7	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.5 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	18.8	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	16.2 %	NPM 1

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					75
Annual Indicator				74.3	73.7
Numerator				1,442,216	1,438,131
Denominator				1,941,208	1,951,578
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	74.4	75.1	75.8	76.5	77.2	77.9

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		0
Numerator		0
Denominator		102
Data Source		Program data
Data Source Year		FY 2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	40.0	80.0	100.0	100.0

State Performance Measures

SPM 1 - Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	9.4	15.5
Numerator	173,603	290,381
Denominator	1,846,840	1,873,426
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.2	15.0	14.7	14.5	14.2	14.0

SPM 2 - Percent of women ages 18-44 who smoke

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	22.2	22.1
Numerator	426,982	414,681
Denominator	1,922,700	1,879,577
Data Source	Behavioral Health Risk Factor Surveillance System	Behavioral Health Risk Factor Surveillance System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	21.2	20.1	19.7	19.4	19.0	18.6

State Outcome Measures

SOM 1 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	118.6	123.9
Numerator	266	276
Denominator	22,422	22,271
Data Source	HCUP-SID	HCUP-SID
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	121.4	118.9	116.5	114.0	111.5	109.0

SOM 2 - Percent of women ages 19-44 with 14 or more mentally distressed days in past month

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8	11
Numerator	149,350	209,312
Denominator	1,866,875	1,902,836
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.8	10.6	10.5	10.3	10.1	9.9

State Action Plan Table

State Action Plan Table (Ohio) - Women/Maternal Health - Entry 1	
Priority Need	
Decrease risk factors contributing to maternal morbidity	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By 2025, increase percent of women with a preventative medical visit by 5%.	
Strategies	
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)	
ESMs	**Status**
ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - 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

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

Priority Need

Decrease risk factors contributing to maternal morbidity

NPM

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

Objectives

By 2025, develop expanded maternal health surveillance to allow for adequate monitoring and tracking to inform programmatic interventions.

Strategies

Expand data collections for COVID-19 for maternal population (SOARS, OPAS, ODRS linking to birth certificate)
Enhance surveillance for maternal morbidity through PAMR program
Develop maternal substance use surveillance system and provide epidemiological support for implementation of associated activities (CSTE fellowship)
Develop protocols for systemic data into action

ESMs	Status
ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - 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

State Action Plan Table (Ohio) - Women/Maternal Health - Entry 3

Priority Need

Increase mental health support for women of reproductive age

SPM

SPM 1 - Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year

Objectives

Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44.

Strategies

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)

State Action Plan Table (Ohio) - Women/Maternal Health - Entry 4

Priority Need

Decrease risk factors associated with preterm births

SPM

SPM 2 - Percent of women ages 18-44 who smoke

Objectives

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.

Strategies

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)

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

State Action Plan Table (Ohio) - Women/Maternal Health - Entry 5

Priority Need

Decrease risk factors contributing to maternal morbidity

SOM

SOM 1 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women

Objectives

By 2025, reduce the rate of severe maternal morbidity by 12%.

Strategies

Increase use of AIM safety bundles in healthcare systems for at-risk pregnant women.

Develop a statewide strategic maternal health plan through the Ohio Coalition to Address 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

Continue Gestational Diabetes QI projects to improve postpartum visit and testing rates (completed in FY 21)

Train emergency department providers to recognize, triage, and treat obstetric emergencies

Train maternal health care providers on how to conduct effective telehealth encounters

Increase women's health screenings during pediatric well visits

State Action Plan Table (Ohio) - Women/Maternal Health - Entry 6

Priority Need

Increase mental health support for women of reproductive age

SOM

SOM 2 - Percent of women ages 19-44 with 14 or more mentally distressed days in past month

Objectives

By 2022, develop plan to increase coordination, referral, and uptake of mental health services for women 18-44.

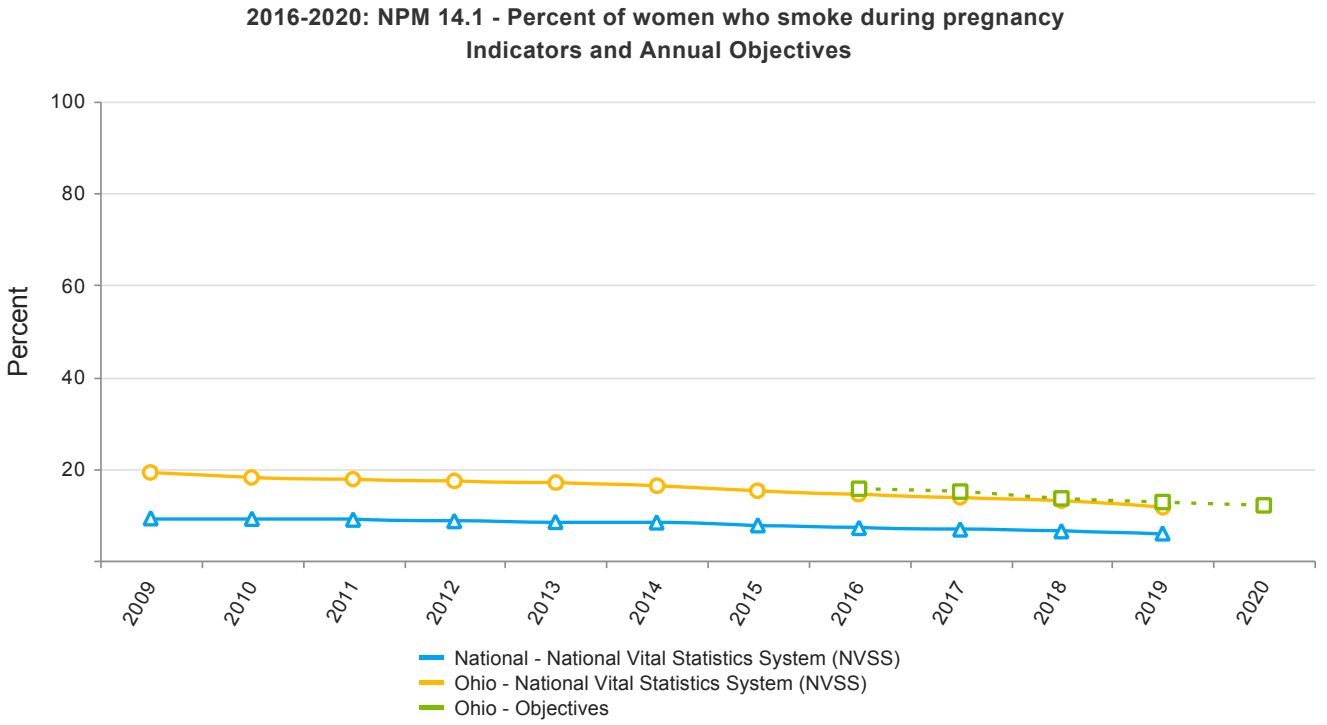
Strategies

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

2016-2020: National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15.7	15.1	13.6	12.8	12.1
Annual Indicator	15.2	14.4	13.8	13.2	11.8
Numerator	21,150	19,764	18,917	17,760	15,906
Denominator	138,801	137,722	136,641	134,979	134,293
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 14.1.2 - Number of pediatric and obstetric practices participating in the Smoke Free Family quality improvement project

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			15	15
Annual Indicator			16	18
Numerator				
Denominator				
Data Source			Project data	Project data
Data Source Year			FY 2019	FY 2020
Provisional or Final ?			Final	Final

Women/Maternal Health, Annual Report FY 2020

The annual report is organized by the two priorities for Women/Maternal health: Increase the prevalence of women receiving preconception care and Reduce the rate of smoking and substance abuse by pregnant women.

Priority: **Increase the prevalence of women receiving preconception care**

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

- According to the HRSA Federally Available Data (FAD), in 2018, 74.3% of women 18-44 years old in Ohio received a past year preventive visit. This is an increase from 68.4% in 2017 and 72% in 2016. Between 2009 and 2016, there was a significant increase of about 1.3% per year. Women who are insured are more likely to have had a preventive visit than those who are not (73.5% versus 46.0%). Women with a household income of less than <$15k are more likely to have had a past year preventive visit than those with a household income of $15k-$24K and $25k-$49K. Although there may be many reasons for this, one explanation is that being covered by Medicaid increases the likelihood that a woman will receive preventive care. We hope to see this continue to increase with our efforts to assist women with obtaining primary health care coverage. However, these efforts may be hampered by policy changes and budget cuts at the federal and state level.

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

- According to the FAD, in 2018, the percent of women in Ohio who received prenatal care beginning in the first trimester was 76.6%, up from 75.4% in 2016 and 75.6% in 2017. Since 2009, there has been a significant increase of about 0.6% per year.

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

- For those served by the Ohio Department of Health Reproductive Health and Wellness Program (RHWP) in FY 20 61% of females, ages 18 through 44, unduplicated clients had public or private insurance. This is an increase from 56% in FY 19. All clients are offered assistance with enrollment, however some decline to enroll. Overall, this is an increase since the same time in FY 12 when only 44.2% of women had primary care coverage.

Priority 1 Objectives identified in the FY 16-20 five-year action plan continued to include: A. Strengthen comprehensive preconception health care services that are provided to clients of child bearing age. B. Increase the utilization of reproductive life plans (RLP) for clients of childbearing age. C. Increase provider utilization of evidenced based, culturally competent, preconception care. D. Partner with stakeholders and relevant health care providers to increase the prevalence of women receiving preconception care. E. Utilize social media to promote preconception care and targeted health messages. F. Develop documentation on solutions to overcoming barriers in conducting a comprehensive visit including financial compensation and increasing allowable visits. G. Improve the socio-emotional health and addiction needs of reproductive age women. H. Support trauma informed practices and programming for women before, during, and after pregnancy.

RHWP

FY 20 was a year of increased funding, expansion of services, implementation of new opportunities for service delivery, and the development of new initiatives for Ohio's Title X program.

In 4/1/19, funding for Ohio's Title X program increased by $4 million dollars enabling the Ohio Department of Health's Reproductive Health and Wellness Program (RHWP) to increase services to more counties across the state. The funds also allowed for the piloting new program initiatives focused on delivery of services to special populations and faith-based organizations. The pilot has resulted in clinics statewide developing partnerships with nontraditional community agencies that effectively extended the reach of clinic services to a more vulnerable population that would not typically seek services from community clinic sites. However, the onset of COVID-19 impacted clinic operations as most of Ohio's subrecipients were drafted to assist with COVID-19 response activities as well as limiting in person services. Most clinics made a quick transition to telehealth services and were able to keep a skeleton crew available to see patients as needed. The challenges faced by RHWP can be seen by the decrease in visits despite the expansion of sites with the additional funding.

In FY 20, the RHWP Advisory Group held two biannual meetings. The group is comprised of MCH-funded programs that serve the women and maternal health population. The goals and objectives for this committee are to meet biannually to promote the program's activities, assist with the program's evaluation, build stronger partnerships with strategic partners, and collaborate to reach vulnerable Ohioans in need of our services. The workgroup includes representatives from a wide variety of ODH programs serving women of reproductive age including Adolescent Health, Birth Defects, Maternal and Child Health, Pregnancy Associated Mortality Review, Reproductive Health and Wellness, Sexual Assault and Domestic Violence Prevention, and Data and Surveillance. Stakeholders from outside ODH include representatives from Medicaid, Mental Health and Addiction Services, local Federally Qualified Health Centers (FQHCs) and Medicaid Managed Care Plans. The group keeps updated on data and services related to women's/ maternal health, reviews the literature for evidenced-based

best practices, and discusses challenges and barriers regarding Ohio's data and current practices. Recently, this committee has been focused on offering program improvement strategies to reach special populations and faith-based organizations which were new initiatives developed in FY 20.

The RHWP continues to offer professional development through the Clinical Training Center which was launched in April 2019. The training center is managed by a Women's Health Nurse Practitioner with twenty years of experience. Services provided by the training center include but are not limited to: Clinician training on Long Acting Reversible Contraception (insertion, removal, education, etc.), Reproductive Life Planning, Client-Centered Contraceptive Counseling, Clinic Flow, and Billing and Coding. The training center provides the required educational requirements of the Title X grant. Title V funds complement Title X funds to support the RHWP. In FY 20, many of these webinars have been recorded and are available through Ohio Train where they have been turned into Independent Learning with Continuing Nurse Education Credits per webinar. Additional topics that were added this year include: LGBTQ Inclusive Care, LARC Preceptorships and Evidence-Based Contraception, Moving RHWP to Telehealth, Implementing Community Based Models: A Blueprint for Success, Adolescent Education & Counseling, and Comprehensive Coding for Providers *with Consult 2 Code.*

1. In FY 20 (4/1/19 -3/31/20), Ohio's Title X program received an additional $4 million dollars to serve more of Ohio's communities. The additional funds enabled Ohio to expand services to recruit 9 more sub recipients, provide services to 10 more counties adding 20 additional service sites across the state. From October 1, 2019-September 30, 2020, ODH RHWP sites provided 57,374 visits to 34,755 unduplicated clients in 80 sites in 58 counties. These sites include local health departments, community action organizations, and non-profit agencies providing family planning direct care. Of these, 22,025 women, ages 18 through 44, were provided a reproductive health visit. This is a slight decrease from 23,042 women for the same time frame in FY 19. The decrease can be attributed to the COVID-19 pandemic, which caused many of our clinic sites to close down for a couple of months and staff shortages within the clinic. All of our sites have been able to implement operational delivery models and telehealth to continue safely seeing clients. Due to the increase in access from additional sites, a statewide media campaign was conducted in September to promote and increase awareness of clinic services and locations. Additional information was provided about telehealth services during COVID-19. From April 2020-September 2020, 3,444 telehealth visits have been conducted.
2. In FY 20 (October 1, 2019-September 30, 2020), 20,428 unduplicated Reproductive Life Plans were provided for all clients age 15-44 compared to 18,480 in FY 19. That is an almost 10% increase. Of these, 3,692 were provided to clients ages 15 through 19. The RHWP requires that all clinics implement a RLP with every client and it is updated/reviewed at least annually, or as needed, with any change in their health status. The RHWP Clinical Training Center prepared a Webinar, Reproductive Life Planning – Made Easy, which was delivered to all RHWP subrecipients in January 2020.
3. ODH monitors 43 subrecipients using nationally recognized Contraceptive Care Performance Measures. All subrecipients are required to offer at least on type of Long Acting Reversible Contraceptive and training is offered through our RHWP Clinical Training Center. The ODH RHWP staff compiles LARC and Most-moderately Effective Reports to monitor the percent of women at RHWP clinics utilizing these contraceptive methods on a quarterly basis. Overall, our rates have remained consistent from FY 19 to FY 20. In FY 20, 17.5% reported using LARC compared to 17.6% in FY 19. While, 22.4% reporting using Depo Provera in FY 20 compared to 22.5% in FY 19. Analysis is comprised of women ages 15-44, and does not include women who reported using abstinence or had no method because they were pregnant or seeking pregnancy.
4. Client insurance data was reviewed and discussed with RHWP subrecipients during site visits. In FY 20 (October 1, 2019-September 30, 2020), 13,672 of 34,755 unduplicated clients in RHWP clinic sites were covered by public insurance, 13,447 were uninsured, and 7,150 had private health insurance. RHWP sites are required to ensure that a Certified Application Counselor (CAC) or Navigator was available to assist Title X clients with Marketplace enrollment as well as ensuring eligible Title X clients are assisted with enrollment into Medicaid. For those served by the Ohio Department of Health RHWP, in FY 20, 61% of females, ages 18 through 44, unduplicated clients were covered by public or private insurance. This is a 5% increase from 56% in FY 19.

Maternal and Child Health Program (MP Subsidy)

Ohio's priority for the Women/Maternal population emphasizes preventive services that address a women's health and healthcare needs before, during, and after pregnancy. The Maternal and Child Health Program, or MP Subsidy, funds initiatives to support this priority including one initiative focused on preconception health which supports strategies to promote the health and well-being of women before pregnancy. Started in FY 19 and continued in FY 20, ODH implemented a new strategy to support the health of women in the workplace through the MP subsidy, which is fully funded through Title V funds. This strategy was designed to act as both enabling services to increase access to primary care services, screening for chronic illnesses, and health education and strengthen public health systems by providing businesses with support to institutionalize health promotion programming and policies to improve the health of female employees. As a part of the funding deliverables, health departments, businesses, and employees were required to work collaboratively to identify health needs and design uniquely targeted policies, programs, and services.

According to the American Community Survey, as of 2019, women (aged 16 and older) made up 59% of Ohio's workforce. As of 2020, the gender pay gap for women compared to men is 79% (America's Health Rankings). Additionally, female headed households make up 40% of the poverty rate in Ohio (Ohio Poverty Report, 2020). Although most women in Ohio are insured through public or private insurance (93% for ages 19-64), disparities in health status and health outcomes persist (Kaiser Family Foundation, 2018). In Ohio, 14.7% of women suffer from more than three chronic health conditions, higher than the national average of 11.7.% (America's Health Rankings, 2020). The percentage of women ages 18-44 in Ohio who smoke is higher the national average, 22.3% vs 15%. Racial disparities in infant mortality and maternal mortality continue to persist among Black families in Ohio as well. In 2019, the infant mortality rate in Ohio for Black babies was 14.3, almost three times higher than the national average of 5.7. Black women in Ohio are two and a half times more likely to die from pregnancy related conditions (PAMR, 2018). Black women also suffer from higher rates of chronic illnesses such as diabetes and hypertension which can lead to poor health outcomes before pregnancy. The workplace serves as a great opportunity to address health disparities, quality healthcare services, and build the capacity of businesses interested in investing in women's health.

In FY 20 $790,400 was awarded to 19 counties to address women's preconception health in the workplace. Populations served by this grant represented urban, rural, Appalachian, low-income, and minority population groups. Funded entities were tasked with: 1) identifying five employers with less than 50 employees to implement women's health program and policy change/implementation to support women's health initiatives; 2) host at least two women's health program initiatives (with pre- and post-surveys including health screenings with opportunity for referrals to preventative care services in the community; 3) determine health program plan and policy/implementation changes specific for women's health initiatives in the workplace; and 4) appropriate educational and health promotion materials related to preconception, inter-conception, preventative health, prenatal care, and other women's health topics.

4. Preconception health: Support access to health and wellness, prenatal care, preventive medical visits information, and referrals and workplace policy development and implementation that can support women's health initiatives for businesses with less than 50 employees.
    - During FY 20, funded entities engaged 79 businesses, and 89% of business remained engaged during most of the program. Workplaces enacted 58 policies related to mental health, stress management, physical activity, healthy eating and employee wellness days. Policies were enacted at 68% of engaged businesses. In addition, 68% of businesses screened women for reproductive health, mental health, and other chronic diseases and 47% of businesses made referrals for mental health services, chronic disease management, reproductive health, and primary care.
    - A total of 415 women were reached through screenings, and 175 referrals were made during screenings in FY 20. This is a decrease from 533 screening participants in FY 19, but an increase in referrals from 40 referrals in FY 19. In addition, 21 education sessions were held in FY 20, compared with 41 in FY 19. During the implementation of screenings, education sessions, and policy changes at most businesses, COVID-19 had devastating effects on this strategy. Some of the businesses were not able to engage with the local health departments long term. All 19 counties that participated also had staff in their health departments that were reassigned to COVID 19 emergency relief efforts.

7. Behavioral Health: The MP behavioral health strategy (G1 Work with MCH sub-grantees to implement the MCH behavioral health strategy related to mental health and addiction) funding was re-allocated to the women's workplace project above and other MP activities (Ohio Healthy Program in Child annual report and Adolescent Resiliency in Adolescent annual report). Additional activities related to maternal substance use are reported under Priority 2. In FY 21, the MP subsidy will fund sites to assess peer support systems and physical and behavioral health screening tools available within the target area to support pregnant and/or post-partum women within one year of pregnancy. In subsequent years the MP subsidy will provide support to these sites to implement a plan to provide peer support person-centered wellness through staff training, behavioral health screenings, and referrals to support services.

Sexual Assault and Domestic Violence Prevention Program

The Adverse Childhood Experiences (ACEs) Study found that individuals with four or more of the ten adverse life experiences (including child abuse and/or neglect, domestic violence, parental loss, and parental substance abuse) are more likely to smoke cigarettes, engage in drug abuse, suffer from chronic alcoholism, have attempted suicide, have double the risk of obesity, and to have health problems (diabetes, heart disease, cancer, and compromised immune systems) that put them at risk of early death. Women are 50% more likely than men to have an ACE score of 5 or more. Over half (54%) of depression in women can be attributed to childhood abuse. Women with an ACE score of 4 or more are almost nine times more likely to become victims of rape and five times more likely to become victims of domestic violence than women with a score of zero. Two-thirds of all suicide attempts are attributable to ACEs; women are three times more likely to attempt suicide than men across the lifespan.[1]

Evidence shows that the three priority topics of the State Health Improvement Plan (Mental Health and Addiction, Chronic Disease, and Maternal and Infant Health) all are improved through a trauma informed approach to care. Without a trauma approach, other efforts to reduce negative health outcomes in these areas are less effective. ODH programming seeks to support a trauma approach in the provision of health services in order to assist public health providers to: understand the impact of trauma, learn how to adapt their programs to meet the needs of the people they serve who have experienced trauma, and strengthen connections between public health and the mental health trauma care system to ensure effective recognition, response, and referral for clients who have experienced trauma.

FY 20 updates on activities related to our strategies include the following:

8. Trauma informed strategies: provide training to health care providers on trauma informed care for adult survivors of abuse and violence including training on sexual and domestic violence, human trafficking, and adult survivors of child abuse. Support programming in local communities for professionals and community members on preventing violence and on identifying and responding to victims of violence.
    - Trauma Informed Care for public health care providers – Staff partnered with the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to provide opportunities for training. Staff co-presented a "train the trainers" program for staff at the Hamilton County Department of Health, with ten (10) participants. Kim Kehl from OhioMHAS provided a training to fifteen (15) ODH staff on ways that other state agencies have integrated a trauma informed response in their work and workplaces. Staff supported the statewide Trauma Informed Care conference, organized by OhioMHAS. Initial plans were in place to host a pre-conference day of learning on being trauma informed for health departments, but this had to be cancelled due to the impact of the pandemic. Additional planned work for both ODH and local programs is postponed due to on-going pandemic needs.
    - Domestic Violence- Staff funded by the Title V MCH BG provided leadership for the Barbara Warner Workplace Domestic Violence Committee and Ohio Department of Administrative Services to train state of Ohio employees to respond appropriately when state employees are experiencing or causing harm in their relationships. These efforts included online training, with separate trainings for managers and other employees. During this reporting period these trainings reached over 5,000 state managers and over 25,000 other employees. Staff also provided four sections of a three-hour virtual training for the human resources points of contact in state agencies, providing them with guidance and information on how to respond when managers come to them for support in responding when employees they supervise are affected by domestic violence. Sixty-eight (68) human resources staff attended these trainings.
    - Ohio Men's Action Network (OHMAN)- Through both MCH BG and other ODH programs, ODH staff supported efforts of OHMAN. OHMAN is a network of men and women, as individuals and as representatives of local and state organizations, working to engage men and boys in efforts to prevent sexual violence; sexual exploitation; domestic, intimate partner, family and relationship violence; and to promote equitable, nonviolent relationships and a culture free of oppression. OHMAN seeks to create and support communities where all people can live free of violence within their relationships, and share in their commitment to respect, safety, and equality. During this time period OHMAN created a statewide marketing plan and established regional leadership teams.
    - Human Trafficking Intervention and Prevention- ODH staff participated in both the Ohio Attorney General's Human Trafficking Commission and in work led by the Governor's task force on human trafficking. Activities included attendance at subcommittee meetings of the Attorney General's Commission on public awareness, demand reduction, and healthcare, and presenting (virtually) to new school nurses (121 in attendance) on considerations for school policy work related to human trafficking and bullying prevention.
    - Anti-Harassment, Intimidation and Bullying Work Group- Staff participate in the anti-harassment, intimidation, and bullying work group led by the Ohio Department of Education (ODE) seeking to implement related Ohio legislation requiring school to have policy, staff training, and student training. The legislation originally focused on harassment, intimidation, and bullying but added topics including teen dating violence, suicide, cyber-bullying, and human trafficking.
    - Sexual Violence Prevention- Primarily through the CDC Rape Prevention Education grant funds, ODH partnered with the Ohio Alliance to End Sexual Violence (OAESV) to work on statewide sexual violence prevention initiatives and funded eleven local programs to do similar work in local communities.
    - Sexual Assault Crisis Services- Staff supported sexual assault crisis services including maintaining and updating the Ohio Protocol for Forensic and Medical Evidence Collection which is used when survivors of sexual assault go to the emergency department, and funding local programs to do crisis services with a focus on culturally specific community organizations.

PAMR

Maternal death marks a tragedy for families and communities and is associated with poor outcomes for infants and children,

including a higher risk of infant mortality. While maternal deaths in the United States plummeted during the twentieth century, they began to rise again in the late 1990s. In response, ODH established a maternal mortality review committee called the Ohio Pregnancy-Associated Mortality Review (PAMR) in 2010. PAMR exists to comprehensively assess the causes and factors that contribute to maternal deaths so that recommendations can be made to prevent future deaths. Title V funds are used to support staff positions to conduct surveillance activities and to conduct training and program development.

The goal of the Ohio PAMR is to identify and review all pregnancy-associated deaths in Ohio to implement data-driven recommendations to improve quality of care among Ohio's mothers as well as address social determinants of health to reduce health inequities. The PAMR process has three main steps. First, the ODH Bureau of Vital Statistics identifies deaths to Ohio women that occurred either during pregnancy or within a year of the end of a pregnancy (collectively known as *pregnancy-associated* deaths). Second, ODH PAMR staff seek clinical and social service records from various entities and create a de-identified case summary. Finally, the PAMR multidisciplinary committee of experts meets to review the deaths and determines whether the deaths were pregnancy-related (if pregnancy contributed to her death), if there was some chance to alter the outcome (if the death was preventable), contributing factors (steps along the way that, if altered, may have prevented her death), and opportunities and recommendations for preventing future deaths. These determinations highlight the unique and critical role of PAMR: preventability, contributing factors, and recommendations for improvement. The committee has over 35 members; meets three to four times per year; and reviews all pregnancy-associated cases. Because PAMR uses a state-wide systems approach to prevent future maternal deaths, there is potential to serve 100% of the population of women of reproductive age.

All case reviews are complete for 2008 through 2016. There were 610 pregnancy-associated deaths in Ohio during this time frame; 31% were pregnancy-related resulting in a pregnancy-related mortality ratio of 14.7 deaths per 100,000 live births. Among pregnancy-related deaths, the mortality ratio among non-Hispanic black women was 29.5, two and half times higher than the ratio among non-Hispanic white women (11.5). Fifty-seven percent of deaths were determined to be preventable (among deaths occurring from 2012 to 2016) and 65% of pregnancy-related deaths occurred in the postpartum period, up to one year after pregnancy, with 46% of those occurring within six weeks of pregnancy. The full, comprehensive report on pregnancy-associated deaths in Ohio 2008-2016 was released in November 2019.

In May 2019, PAMR submitted an application in response to Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees, also known as CDC-RFA-DP19-1908. In July 2019, PAMR applied in response to the HRSA State Maternal Health Innovation Program (HRSA-19-107). Ohio was selected for both funding opportunities. The CDC grant will provide $450,000 annually for five years; the HRSA grant will provide $10,423,277 total over five years. Through these grant funds, the following activities ramped up during FY 20:

- Ohio Council to Advance Maternal Health (OH-CAMH) is the newly formed statewide maternal health task force. This group will use data from PAMR, Title V, State Health Improvement Plan, and other resources from OH-CAMH membership to develop and implement a statewide, maternal health strategic plan. With 80 participating organizations, this group will focus on implementation and on broadly addressing maternal health in Ohio. OH-CAMH held a kick-off meeting in FY 20 with over 100 attendees. Attendees learned about the background of PAMR and current ODH PAMR grant initiatives. Attendees also participated in a virtual engagement activity using Mural, an interactive web-platform, aligning their current work and activities with the PAMR recommendations. Members also completed a member survey and one-on-one stakeholder interviews, which lead to the development of the OH-CAMH Needs Assessment a collection of over 300 maternal health activities and initiatives across Ohio, which will serve as the foundation as we begin next steps to draft a statewide maternal health strategic plan.
- Ohio will be part of the Alliance for Innovation on Maternal Health (AIM) cohort beginning in October. The first bundle for statewide implementation will be Hypertension, funded using HRSA funds. The next bundle for implementation will be Hemorrhage (likely to be implemented in 2022-2024), also using HRSA funds. The Racial Disparities bundle content will be incorporated into the Hypertension and Hemorrhage bundle implementation. The AIM Hypertension Bundle will include participation from 34 delivery hospitals from across the state in the first wave of implementation. During FY 20 recruitment for the first wave began with implementation to begin in FY 21. Hospitals included in the first wave represent various geographies, Levels I/II/III, and diversity of births. The goal is to implement the bundle in all 102 delivery hospitals in subsequent waves of the project.
- Implicit Bias Training for Women's Health Providers- The first round of implicit bias trainings funded by ODH began with Bureau of Maternal, Child and Family Health (BMCFH) staff on September 2019 followed by five subsequent trainings that were hosted in the five Ohio regions for BMCFH grantees and ended in January 2020. The trainings served 193 participants total. A second round of implicit bias trainings will be hosted by the ODH PAMR program including 26 trainings held between May 2020 and June 2022, providing continuing education credit for women's health providers. Six trainings have been completed with 208 attendees; six trainings have been scheduled through February 2021. The remaining trainings will be scheduled after that. These trainings will be offered to all the providers affiliated with the delivery hospitals participating in the AIM Hypertension Bundle.

- The Urgent Maternal Warning Signs (UMWS) is a quality improvement activity focused on teaching moms' severe symptoms that can occur during pregnancy or in the postpartum period that should never be ignored. Although the nature of the severe symptoms is clinical, many moms may engage in non-clinical services where this messaging could effectively be provided such as in WIC clinics and through Home Visiting providers. Starting to educate moms on the warning signs prenatally as well as postpartum could provide life-saving education. The education is based on the campaign recently released by the Council for Patient Safety, which is part of the national American College of Obstetricians and Gynecologists (ACOG). (https://safehealthcareforeverywoman.org/urgentmaternalwarningsigns/), and the CDC HEAR HER campaign (https://www.cdc.gov/hearher/index.html). ODH has had multiple conversations with national ACOG and CDC about our plans and ensuring alignment. In FY 20, ODH selected a vendor to implement the UMWS Quality Improvement Project (QIP). The majority of activities in FY 20 included the development of a planning committee, inclusive of clinical experts and ODH WIC, to develop the data collection tool, clinical change package, key driver diagram and SMART AIMS, in addition to planning for recruitment and engagement of individual WIC sites. Recruitment is scheduled to begin in FY 21.
- Emergency Obstetric Simulation for Emergency Medicine Providers- For educating providers and patients on obstetric complications, we developed a series of trainings for emergency medicine providers to increase their knowledge and preparedness related to obstetric emergencies. A total of three trainings were conducted in SFY 20. Learners included emergency department nurses, physicians, advanced practice practitioners, and EMS. Participants learned how to identify signs and symptoms of obstetric emergencies, such as deliveries with postpartum hemorrhage, hypertensive emergency, and peripartum cardiomyopathy. They also learned about appropriate interventions for obstetric emergencies and how to manage them with supplies available in the emergency department. Evaluations will be formally analyzed in SFY 21.
- Telehealth Delivery Training for Women's Health Providers- The purpose of this training is to train women's health providers to provide sensitive and culturally competent care in a telehealth encounter and increase access to specialty care, with the long-term goal of improving patient access to care. A total of three trainings were conducted in SFY 20. Learners included but was not limited to professionals from the following specialties: primary care, OB/GYN, and maternal-fetal medicine. Participants practiced simulated telehealth encounters to identify, assess, and manage various maternal health conditions, such as hypertension in a postpartum patient, gestational diabetes, hemorrhage, maternal mental health, and mastitis. Participants were instructed how to communicate with patients effectively and efficiently via telehealth during these trainings. Evaluations will be formally analyzed in SFY 21.
- IMPLICIT Network- Maternal health in between pregnancies is a key factor in having a future, positive pregnancy outcome. IMPLICIT Network (Interventions to Minimize Preterm and Low birth weight Infants using Continuous quality Improvement Techniques) is a framework that focuses on maternal health screenings (https://www.fmec.net/implicit). Specifically, this quality improvement project will ensure moms receive screenings for smoking/tobacco use, multivitamin use, family planning and depression during their child's pediatric well-visits. Progress during FY 20 included establishing a clinical team in collaboration with the Ohio Chapter of the American Academy of Pediatrics and completing project timeline and budget, and drafts of project SMART AIMS, Key Driver Diagram, data collection form, clinical change package and recruitment plan. Recruitment is scheduled to begin in FY 21.

Priority: **Reduce the rate of smoking and substance abuse by pregnant women**

NPM 14.1- Percent of women who smoke during pregnancy

- The rate of smoking during pregnancy continued to decrease in Ohio from 13.8% in 2017 to 13.2% in 2018. Disparities persist by educational attainment, race/ethnicity, health insurance status, and WIC participation.

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

- The rate of severe maternal morbidity per 10,000 delivery hospitalizations continued to decrease in Ohio from 74.6 in 2016 to 70.2 in 2017.

ESM 14.1.2- Number of pediatric and obstetric practices participating in the Smoke Free Family quality improvement project

- In FY 20 there were 18 pediatric sites participating, exceeding both the target of 15 sites and the previous FY 19 with 16 sites and FY 18 with 14 sites.

Priority 2 Objectives continued to include: A. Increase the number of pregnant and post-partum women completing of smoking cessation programs in collaboration with Ohio Partners for Smoke Free Families, B. Build local infrastructure to implement grant programs to reduce maternal smoking and second-hand smoke exposure, C. Reduce the number of alcohol exposed pregnancies, D. Reduce opiate exposed pregnancies.

Smoking during pregnancy remains one of the most common preventable causes of infant mortality. According to America's

Health Rankings, 16.3% of mothers in Ohio used tobacco during pregnancy in 2016 and 15.2% of mothers in Ohio used tobacco during pregnancy in both 2017 and 2018. Among women giving birth in Ohio, 17% smoke during the 3rd trimester of pregnancy, a rate that is double that of the nation. Rates are highest among low-income mothers, mothers with partners who smoke, mothers of multiple children, mothers with a strong addiction to tobacco, mothers ages 20-24, and mothers insured under Medicaid. Smoking cigarettes during pregnancy has been identified as one of the most significant factors contributing to poor pregnancy outcomes including preterm birth, low birth weight, birth defects of the mouth and lip, abnormal bleeding during pregnancy and delivery, miscarriage, ectopic pregnancy, damage to a baby's developing lung and brain, and increased risk of sudden unexpected infant death. Women who quit before or during pregnancy can reduce or eliminate these risks. Pregnant women who quit smoking during the first trimester deliver infants that are of comparable weight and height to those of non-smoking women.

Infants are uniquely vulnerable to the hazards of smoke exposure. Compared to older children and adults, very young children are smaller in size, resulting in greater exposure; more likely to be in close proximity to a smoking parent; more likely to ingest dust and smoke particles when crawling or putting objects in their mouths; and at risk for experiencing long-term damage to developing systems from smoke exposure. The Surgeon General reported in 2014 that in the past 50 years, more than 100,000 infants in the US have died as a result of SIDS, complications of low birth weight or prematurity, or other pregnancy problems resulting from parental smoking.

Ohio Partners for Smoke Free Families (OPSFF)
The Ohio Partners for Smoke Free Families was developed by ODH in collaboration with the Smoke Free Families National Dissemination Office in Chapel Hill, North Carolina. OPSFF was developed as collaboration of programs from across ODH plus external partners with the goal of reducing smoking among women before, during, and after pregnancy and to reducing exposure to second-hand smoke by increasing the adoption, reach, and impact of evidence-based behavioral cessation programs. OPSFF promotes and facilitates implementation of evidence-based smoking cessation models by providing training and resources. The program was integrated into different health care settings including the Supplemental Nutrition Program for Woman, Infants, and Children (WIC), Maternal and Child Health (MCH), Help Me Grow (HMG), Moms and Babies First, RHWP, and Federally Qualifies Health Centers (FQHCs).

In SFY18, ODH and ODM contracted with the Ohio Colleges of Medicine Government Resource Center (GRC) to engage pediatric and OB/GYN providers in the implementation of the 5A's brief tobacco intervention. GRC worked with the Ohio Chapter American Academy of Pediatrics (Ohio AAP) to reduce the use of tobacco among Medicaid women postpartum and the exposure to second-hand smoke of their infants and other family members using evidence-based practices in a pediatric center. ODH continues to fund the Smoke Free Families pediatric project and ODM funds the OB/GYN project. In FY 20, 18 sites participated in the pediatric project. As a result of FY 19 work, enrolled pediatric practices improved tobacco screening of caregivers during well-child visits to > 90%. Of caregivers who received smoking counseling and then had a follow-up visit (n=95), the mean number of cigarettes smoked daily decreased significantly from 10.5 to 4.8 (p=0.03). Additionally, 34.9% of caregivers reported that they quit smoking at their second visit. Safe sleep practices were also assessed, and 27% of infants screened positive for inappropriate sleep position or environment at their initial visit. Of infants that screened at risk for unsafe sleep, 50% of caregivers that received counseling practiced safer behaviors at follow-up.

Baby and Me Tobacco Free Program
The Mom's Quit for Two subsidy program is administered through the Maternal and Infant Wellness Program's Perinatal Smoking Cessation program (MIWP). The goal of the ODH Perinatal Smoking Cessation program is to reduce smoking among Ohio women before, during, and after pregnancy and to reduce exposure to second-hand smoke. The Perinatal Smoking Cessation program has worked to increase the adoption, reach, and impact of evidence-based behavioral cessation programs. The program has experienced success supporting the implementation of Baby & Me, Tobacco Free model, and other evidence-based interventions in Ohio.

In 2008, the United States Public Health Service released clinical practice guidelines for treating tobacco use. The guidelines identify effective, evidence-based tobacco cessation programs. Studies suggest that pregnancy is a good time to intervene and that a brief intervention with self-help materials can increase cessation rates by 30-70% compared with only advice to quit. The Baby & Me Tobacco Free Program is a model developed to increase smoking cessation among pregnant and postpartum women. The model uses a unique approach, combining cessation support specific to pregnant women, offering practical incentives and monitoring success (http://babyandmetobaccofree.org).

The participating agency completes a one-day training session required to certify the agency to administer the Baby & Me, Tobacco Free program. Additional materials to implement the program include carbon monoxide (CO) monitors and testing supplies; diaper vouchers including shipping and handling; handouts, flyers, and brochures; and technical assistance, as needed. Women enter the program during pregnancy. Their partners, who are smokers and live in the home, are eligible to participate in the program.

The participating agency conducts four individual prenatal smoking cessation sessions (10 minutes each) and tests each participant using carbon monoxide (CO) testing at each smoking cessation session to ensure client smoke free status. Participants may receive up to two supplemental visits per participant/partner as needed. Participants are eligible to receive one diaper voucher if tobacco free and at the completion of the third and fourth prenatal counseling session. After the baby is born, the participant receives twelve individual monthly smoking cessation sessions (10 minutes each) with CO monitoring. If the participant/partner remains tobacco free, the participant/partner receives a $25 diaper voucher each month up to twelve months postpartum. The program implements the clinical practice guidelines of providing brief interventions for smoking cessation including the 5A's and motivational interviewing. These services are enabling services that improves access to care and improves health outcomes, as well as public health services that provide program implementation and quality improvement surrounding perinatal smoking cessation.

The perinatal smoking cessation program offers the Mom's Quit for Two subsidy to the highest need counties; however, the perinatal smoking cessation program is a statewide project that provides information through media campaigns, technical assistance, and resources. The program partners with programs such as the tobacco program, infant safe sleep, Ohio Equity Institute, Community Intensive, and WIC. The stakeholders incorporate their voice through the quarterly conference calls and directly to the program through phone and email. In 2016-2018, the stakeholders' voice was incorporated in an evaluation of the program provided through a vendor that worked directly with the funded projects.

The process measures for the project are related to the number of women served and retention of women throughout the necessary sessions. The FY 20 project served 836 that were successfully selected to participate in the Mom's Quit for Two subsidy. The projects are provided specific technical assistance (with the goal) to improve the retention rate from 21% to 45% for FY 20, 70% in FY 21 and 94% in FY 22. It should be noted that the COVID-19 pandemic had affected the recruitment of new clients. This was in part because ODH had issued advice to limit face-to-face contact. Unfortunately, COVID-19 could continue to affect the recruitment and retention of clients in coming fiscal years.

The subsidy has been provided in a competitive bid process each year, which typically gains new projects each FY. As of FY 21, a continuation grant has been provided to have the same projects to extend the duration. A new goal now is proposed to increase the grant to at least three or more years this would assist on consistency and performance improvement.

The outcome measures are to have 100% of the births of the participants to be:

- greater than or equal to 5.5 pounds
- greater than or equal to 37 weeks gestational age
- greater than or equal to 5.5 pounds AND 37 weeks gestational age
- The participants should have a decrease in CO level by sessions and at less than 6.0 in the final session.

Funded projects submit data to the BMTFP from their participants. Data consist of participant demographics including race, sex, ethnicity, age, and insurance provider, as well as the number of sessions and CO levels of the participants. In addition to providing data to BMTFP, grantees submit monthly reports to ODH regarding number of sessions completed, number of participants, and training attended. The MIWP provides monthly outputs of these reports to the grantees for the purpose of discussion, technical assistance, and performance improvement. The grantees attend quarterly conference calls hosted by the MIWP and BMTFP to discuss barriers, successes, and new ideas and information.

The FY 20, total woman served was 836 (July1, 2019 to June 30, 2020) and out of those the projects served 60 have completed the program,317 are still active 495 are not active, these either dropped out or have not attended a session in 6 months. The retention rate taking active plus completed is 45%. The retention rate has been challenging. As stated above, the COVID-19 pandemic has affected the projects recruitment and retention, due in part of a no face-to-face contact imposed. As well, the subsidy has been provided in a competitive bid process each year, which typically presents new projects each year. Having the same projects for a longer duration such as three or more years would assist on consistency and performance improvement.

The outcome measures of the births of the participants:

- 87% of births were greater than or equal to 5.5 pounds
- 85% of births were greater than or equal to 37 weeks gestational age
- Births greater than or equal to 5.5 pounds and 37 weeks gestational age; 314 births showed both 5,5 or greater and 37 or greater gestation. Please note, there were several blank fields, or incompletes in the Tableau, when completed by various projects.
- The ability to provide consistent CO monitoring levels have been affected by COVID-19. This based upon the no contact rule and the inability to obtain a CO reading. At this time during virtual sessions, facilitators (counselors) are having to take the word of the client and partner have decreased or ceased smoking tobacco products.

Tobacco Use Prevention and Cessation Program (TUPCP)

Ohioans of all ages are eligible for free tobacco cessation services through the *Ohio Tobacco Quit Line*. After several years of limited eligibility, Ohio made changes to eligibility in July 2019 that open participation for ALL Ohioans regardless of insurance status or income. Eight weeks of nicotine replacement therapy (NRT) is available; one two-week dose is shipped after each call (up to four times). Participants have their choice of patches, gum, or lozenges (NRT is not provided to participants under 18). Consumers of any tobacco or nicotine products may enroll. There were 8,935 intakes for enrollment in FY 19 an increase of 83.9% since 2015. There were 7,864 intakes for enrollment in FY 2020, which represents a 12% decrease from FY 19. This was a nationwide trend and likely the result of the COVID-19 pandemic.

TUPCP has been engaged in the fight to address the causal association of maternal smoking to infant mortality for many years. A specialized Pregnancy Protocol through the Ohio Tobacco Quit Line is promoted throughout the state. The program is offered by coaches trained to work with pregnant woman through the post-partum period. TUPCP is funded through a CDC grant and also works with other partners addressing maternal smoking, such as the Baby and Me Tobacco Free Program. Program grantees are required to work with healthcare providers to ensure pregnant women are being screened and referred to available services. Mass media campaigns, specifically targeting pregnant women and their close contacts, are also part of regular program activities.

FY 2020 updates on activities related to our strategies include the following:

1. Since the Pregnancy Protocol was implemented in 2012, 2,126 women have enrolled. Between 7/1/19 and 6/30/20, there were 133 enrollments. While utilization of the program is low, quit rates are encouraging, with the validated quit rate in 2020 being 51.4%, much higher than the general population's quit rate (35.8%) for the same time period.

Alcohol

Fetal Alcohol Spectrum Disorders (FASD) is a term that describes a range of birth outcomes and potentially lifelong effects that can result if a mother drank alcohol during her pregnancy. The effects include physical, mental, behavioral, and/or learning disabilities. Per the CDC, up to 16 out of 1,000 children are estimated to be affected by FASD. FASD Steering Committee efforts are led by the Ohio Department of Mental Health and Addiction Services and Title V funded staff at the Ohio Department of Health. In addition, all WIC projects implement the Alcohol Screening and Brief Intervention (ASBI) within their clinics.

1. The strategic plan has been updated yearly and trainings on FASD prevention, screening for FASD, and treatment are being conducted throughout the state. In FY 20, trainings were held. The 4th Annual Forum was held with Susan Ellsworth being the keynote speaker. Information has been disseminated though conferences and hosting vendor tables. Radio and video messages were created to spread the prevention messaging regarding alcohol in the preconception and pregnancy stages. FASD Signage Bill (SB 340) has been formally introduced. In FY 20, a Needs Assessment was conducted focused on parent's needs and an FASD Screener was developed to be used in various settings. Ohio FASD Steering Committee has recruited Law Enforcement and a Parent of and individual(s) with FASD to the Ohio FASD State Champion Team. The next five-year strategic plan is in the draft phase and will be implemented for FY 22-FY 27. Feedback was solicited from community members and other stakeholders. The new plan will also add older adult education as they care for kin, and integrate trauma informed and health equity strategies.

Opiates

As part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Statewide Needs Assessment, ODH contracted with HPIO to prepare a report with a needs assessment update to identify the state's capacity for providing substance use disorder (SUD) counseling and treatment services to pregnant women and families with young children. The joint Title V MCH/MIECHV Steering Committee reviewed the results of this assessment and developed recommendations to serve as the first steps in developing a more coordinated comprehensive plan to address Ohio's unmet SUD capacity needs.

In FY 19 and FY 20, Ohio participated in the ASTHO Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI). OMNI is a learning community funded through CDC's Division of Reproductive Health (DRH) and the National Center for Birth Defects and Developmental Disabilities (NCBDDD). The purpose of the learning community is to disseminate strategies and best practices supporting program and policy implementation related to substance use disorder (SUD) among pregnant and postpartum women and infants diagnosed with neonatal abstinence syndrome (NAS). In year one of the learning community, ASTHO engaged 13 states (Cohort 1) selected for their work in advancing policy in these areas. Those states included: Washington, Nevada, Alaska, Illinois, Kentucky, Tennessee, West Virginia, Pennsylvania, Maryland, Florida, Vermont, Rhode Island, and Ohio. Five additional states were added to the OMNI cohort in 2019: Wyoming, New Mexico, Indiana, New York, and Maine. To inform content for learning community activities, ASTHO and CDC identified technical assistance needs and promising practices in several key areas including Provider Awareness and Training; Reimbursement and Financial Sustainability; Ethical and Legal Considerations; Logistics; Consumer Awareness; Data, Monitoring, and Evaluation. Additionally, ASTHO and CDC provided Ohio with enhanced level of capacity building and expertise through both targeted community support and providing Ohio with a placement of a field

assignee.

Ohio's OMNI vision statement was "Enhance collaboration between state, policy, community, and clinical partners to ensure appropriate care for reproductive aged women with substance use disorder and impacted families." Ohio OMNI Goals were:

- By June 30, 2020, convene a statewide governing body to identify measurable strategies and opportunities for improving quality and coordination of care to optimize health outcomes for women with SUD and their children across their life course.
- Increase awareness and knowledge about plans of safe care by leveraging the work of the Ohio Department of Job and Family Services.
- Implement at least 2 best practices to improve care coordination and transition care before and following delivery of the child and through the life course.

The OMNI Core Committee selected 4 contiguous counties to focus efforts on opioid use disorder, maternal outcomes, and neonatal abstinence syndrome: Athens, Gallia, Ross, and Scioto. These specific counties were selected based on collected data that includes: number of hospitalizations related to neonatal abstinence syndrome, risk of maternal opioid use, counties with high number of births outside of the state to assess transfer of care between states, inclusion of states both with and without OB delivery hospitals, and evaluation of other available programs and resources within the community. Journeying sessions were completed in Athens, Gallia, Ross, & Scioto counties. The purpose of these sessions was to engage and educate participants (those who have interaction and provide care to mothers and families with SUD/OUD) about Comprehensive Addiction and Recovery Act (CARA), Child Abuse Prevention and Treatment Act (CAPTA), and PoSC, share best practices occurring in another Ohio counties and identify strengths and gaps related to PoSC and care collaboration. After these journeying sessions, follow up sessions were held in each county to discuss a Strengths, Opportunities, Aspirations, Results (SOAR) analysis for each county and to share next steps for improvement.

The three Ohio workplan goals were met. A statewide governing body continued to provide direction to improve quality and coordination for the care of women with substance use disorder/opioid use disorder (SUD/OUD). The OMNI Learning Community identified and began implementation of method to improve utilization of Plans of Safe Care (PoSC). This included developing county-level templates, improving care collaboration by increasing inter-departmental and cross agency networking. During the journeying sessions, educational needs were identified. Trainings have been organized to meet those needs, including trainings related to stigma, implicit bias, and best practices for medical management of newborns with neonatal abstinence syndrome (NAS).

COVID-19 prevented travel to the counties to meet in-person with key participants. It also affected the workplan by preventing any in-person meetings that were essential to build a strong network and improve collaborative efforts. Due to the inability to travel, all meetings were moved to the virtual environment. The networking component of the journeying sessions would have been stronger had the sessions been in-person. Despite COVID-19, the results of the journeying sessions were positive, and momentum was built towards the improvement of the utilization of PoSC, development of a standardized template, and care collaboration.

OMNI ended in FY 20. For Ohio, the work continues as part of the 2020 Practice and Policy (P&P) Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families, and Caregivers supported by SAMHSA and being led by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). The goal of this initiative is to continue the efforts started in OMNI to standardize implementation of and data collection related to PoSC throughout Ohio. The state team convened for OMNI overlaps with the team composition of P&P, including ODH BMCFH involvement.

[1] http://www.acestudy.org/

Women/Maternal Health, Application Year FY 2022

Within the women and maternal population domain key issues emerged from the 2020 needs assessment process and informed the selection of priorities to address maternal morbidity, mental health, and risk factors for preterm birth.

Maternal Morbidity

Severe maternal morbidity is more than 100 times as common as pregnancy-related mortality—affecting about 52,000 women annually—and it is estimated to have increased by 75 percent over the past decade. Rises in chronic conditions, including obesity, diabetes, hypertension, and cardiovascular disease, are likely to have contributed to this increase. Minority women and particularly non-Hispanic Black women have higher rates of severe maternal morbidity. Non-Hispanic Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women had 2.1, 1.3, 1.2, and 1.7 times, respectively, higher rates of severe morbidity compared with non-Hispanic white women (Federally Available Data Resource Document, 2019).

Preconception and Maternal Mental Health

Postpartum depression is common, affecting as many as 1 in 7 mothers. It occurs when brief “baby blue” symptoms of crying, sadness, and irritability become severe and result in depressed mood and loss of interest in activities for more than two weeks. Postpartum depression is associated with poor maternal-infant bonding and may negatively influence child development. Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force (Federally Available Data Resource Document, 2019).

Preterm Birth

Ohio continues to have high rates of infant mortality, with prematurity as the leading cause of infant death in Ohio. Maternal smoking is implicated in preterm birth and in 2017 Ohio’s rate of women who smoked cigarettes during pregnancy was two times higher than the U.S. rate. Moreover, 25.5% of pregnant women covered by Ohio Medicaid smoked during pregnancy in 2017, nearly twice the rate for Ohio overall. Smoking cessation before and during pregnancy improves infant outcomes.

Emerging Issues

Since the completion of the 2020 needs assessment, the COVID-19 pandemic has underscored the importance of the focus on mental health supports for women of reproductive age, as well as addressing the disparities in maternal morbidity and mortality.

Priority: Decrease risk factors contributing to maternal morbidity

Measures

- NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- SOM: Disparity- Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NPM 1: Percent of women (18-44) with a preventive medical visit in past year
- ESM: Percent of birthing hospitals that have implemented the AIM hypertension bundle.

To address the priority of maternal morbidity efforts must include improving the health outcomes for women before, during, and after pregnancy. The selected NPM relates to leveraging women’s well visits as key opportunities for health intervention and referrals. The SOM was established to measure the disparity in maternal morbidity outcomes. The ESM relates to the priority and efforts to improve safety related to maternal morbidity by standardizing assessment and responses for hypertension, which will contribute to addressing disparate outcomes.

Objective 1: By 2025, increase percent of women with a preventative medical visit by 5%.

Strategies:

1. Provide well-woman visits within Title X clinics following ACOG guidelines.
2. Community needs assessment on barriers to pre- and inter-conception care through MP subgrant.
3. Implement culturally relevant community, clinical, or community-based services to address unique pre- and inter-conception issues for women 18-44 through Maternal and Child Health Program (MP) subgrant.
4. Implement education and awareness for pre-conception and reproductive health targeting high-risk women through MP subgrant.
5. Find and review data on quality and comprehensiveness of preventive medical visits as well as feasibility and evidence-based practices for promoting standards (include mental health, health behaviors, dental, social determinants, referrals).
6. Work with partners to develop plan to increase coordination, referral, access, and uptake of high-quality services for at-risk women 18-44.

7. Distribute guidelines on managing oral health care during pregnancy to perinatal and dental care providers.
8. 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).

The ODH Reproductive Health and Wellness Program (RHWP) will continue to promote the use of ACOG guidelines for well-women visits in Title X clinics over the next year. To date, the RHWP has included information on ACOG's well-woman recommendations and articles for providers regarding action steps to help reduce fetal alcohol spectrum disorder in program newsletters, as well as updating and publishing the RHWP/Title X Clinical Services and Protocol manual. Additionally, the MCH Bureau Medical Consultant will deliver a presentation on the ACOG well-woman and postpartum exam recommendations, Fourth Trimester Project, and data from Pregnancy-Associated Mortality Review during the July 2021 planning call with the Title X clinics. RHWP will continue to track the number of well-woman visits following ACOG guidelines provided at Title X clinics over the year and identify additional strategies to increase uptake.

The Maternal and Child Health Program (MP) subgrantees are in the process of completing a community health needs assessment on pre- and inter-conception care. There are 19 subgrantees completing community health needs assessment in their respective counties. Findings from these needs assessments will be used to address strategies C-F (Implement culturally relevant community-based or clinical services to address unique pre- and inter-conception issues for women 18-44; Implement education and awareness for pre-conception and reproductive health targeting high-risk women; Find and review data on quality and comprehensiveness of preventative medical visits as well as feasibility and evidence-based practices for promoting standards; Work with partners to develop plan to increase coordination, referral, access, and uptake of high-quality services for at-risk women 18-44 by SFY 2023).

Guidelines for prenatal and dental care providers on managing oral health care during pregnancy have been integrated into the ODH Prenatal Care grant. The impact of the integration of these guidelines will be monitored by tracking the number of prenatal care providers who complete training on oral health and pregnancy, number of pregnant women with dental needs who are referred to dental care and the number of women who complete dental care. Additionally, funds have been awarded to 3 agencies/health care systems to provide oral health services to uninsured MCH population from low-income families, which will help to impact this strategy. A continuing education module for nurses and nutritionists is in the process of being developed on oral health and pregnancy and will be available to MCH programs, such as WIC and Home Visiting.

Objective 2: By 2025, reduce the rate of severe maternal morbidity by 12%.
Strategies:
1. Increase use of AIM safety bundles in healthcare systems for at-risk pregnant women.
2. Increase women's health screenings during pediatric well visits.
3. Develop a statewide strategic maternal health plan through the Ohio Coalition to Address Maternal Health (OH-CAMH).
4. Increase the percent of pregnant and postpartum women who receive urgent maternal warning signs education in WIC, Home Visiting, and Healthy Start programs.
5. Continue Gestational Diabetes QI projects to improve postpartum visit and testing rates.
6. Train emergency department providers to recognize, triage, and treat obstetric emergencies.
7. Train maternal health care providers on how to conduct effective telehealth encounters.

The ODH Pregnancy-Associated Mortality Review (PAMR) program has implemented the AIM Hypertension patient safety bundle in 30 participating Wave 1 birthing hospitals sites to date. This patient safety bundle is being implemented by the Government Resource Center (GRC) using quality improvement science. Over 1,400 data submissions of patient encounters with women who have or are at risk for hypertension have been submitted to date and a health equity survey with over 350 hospital staff participating in Wave 1 has been completed. This patient safety bundle will be implemented in all birthing hospitals throughout the state by SFY 24. Additionally, the PAMR program with GRC is in the process of planning implementation of the AIM Hemorrhage patient safety bundle.

The PAMR program subcontracted with GRC to implement the IMPLICIT Network inter-conception care model implementing maternal health screenings for depression/anxiety, folic acid use, smoking/tobacco, and family planning during the pediatric well-visit through quality improvement science methodology. There are currently 9 pediatric sites and family practices enrolled in Wave 1 implementation. Additional pediatric and family practices will be onboarded in future waves of this initiative which will continue through SFY 24.

The Ohio Council to Advance Maternal Health (OH-CAMH) is the newly formed statewide maternal health task force. This group will use data from PAMR to develop and implement a statewide, maternal health strategic plan. OH-CAMH consists of over 80 external organizations and the purpose of OH-CAMH is to:
- Identify and fill gaps in addressing maternal health, both statewide and in local communities.
- Facilitate conversations among various stakeholders across the field, both in clinical and public health settings.

- Build on work already being done in Ohio.
- Collaborate to identify new areas to implement strategies and activities for addressing maternal health needs in Ohio.

To create the strategic plan, ODH PAMR staff spent over 55 hours talking with OH-CAMH members from across the state between June and August of 2020 to listen to the OH-CAMH members about what type of work they were currently involved with, what type of changes in maternal health they wanted to see in Ohio, and perceived challenges to maternal health. These one-on-one discussions were coded and analyzed to identify common themes.

A smaller subgroup of OH-CAMH members was convened in February 2021 to develop the first draft of OH-CAMH Strategic Plan. This group is referred to as the Strategic Plan Workgroup. The first draft of the statewide strategic maternal health plan will be completed and shared back to general OH-CAMH membership in June 2021. This strategic plan will be refined over the next SFY, and implementation teams will be formed to begin taking action to achieve the objectives set forth in this plan.

The ODH PAMR program subcontracted with GRC to implement urgent maternal warning signs education in public health settings. Over the past year, 27 WIC clinics across four counties in Ohio have been onboarded to this quality improvement initiative. Additional WIC sites across Ohio will be recruited and onboarded over the coming year. This program will continue implementation through SFY 24.

The first 5 waves of the Gestational Diabetes quality improvement project were focused on working with Primary Care, OB/GYN, and Family Medicine providers to improve postpartum follow-up and postpartum and long-term screening of Type 2 diabetes among women with Type 2 diabetes. The most recent wave of the project was implemented in 11 ODH Home Visiting sites. This wave resulted in more participants getting a postpartum visit, but not a postpartum glucose screen compared with a comparison group. The data collection for this wave will inform efforts to enhance the Home Visiting data system with GDM specific fields in future waves of implementation. The Gestational Diabetes QI project implementation will come to an end between Q2 and Q3 of SFY 22. A new QI project titled, “Women’s Behavioral Health Learning Collaborative” will use lessons learned from the Gestational Diabetes project will be initiated in SFY 22 and will be a new strategy ODH will utilize to, “Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44" (Objective 2 under Increase mental health support for women of reproductive age Priority).

A needs assessment survey of delivery hospitals in Ohio revealed that though 98% of hospitals reported conducting simulation drills to prepare for obstetric emergencies, 100% involve labor and delivery or postpartum nursing staff, 80% involve physicians, but only 30% involved emergency department staff. Additionally, between 2008-2016 23% of pregnancy-related deaths in Ohio occurred in an outpatient or emergency department setting. The PAMR program has contracted with the Clinical Skills Education and Assessment Center at The Ohio State University to develop and deliver Obstetric Emergency Simulation Training for Emergency Medicine Provides. The goal of these trainings is to reduce preventable maternal morbidity & mortality in EDs and during maternal transports. Six trainings have been conducted to date with very positive feedback from participants and statistically significant improvement of pre- to post-test knowledge of recognizing, treating, and managing various obstetric emergencies. There is great demand of these trainings and every training to date has had a waitlist of registrants. There are 22 more trainings planned to occur between now and SFY 24.

The PAMR program has contracted with the Clinical Skills Education and Assessment Center at The Ohio State University to develop and deliver Telehealth Delivery Training for Women’s Health providers. The goal of the telehealth trainings is to train women’s health providers to provide sensitive and culturally competent care in a telehealth encounter and increase access to specialty care. These trainings have been offered to any type of care provider who reaches women at any point before, during, and after pregnancy (WIC providers, OBGYNs, residents, family med physicians, NPs, Providers, etc.). Five trainings have been conducted to date with positive participant reviews. Target populations most recently served include WIC health professionals, family medicine residency programs, and OB/GYN residency programs. Approximately 25 additionally trainings will take place between now and SFY 24.

<u>Objective 3: By 2025, develop expanded maternal health surveillance to allow for adequate monitoring and tracking to inform programmatic interventions.</u>
Strategies:

1. Expand data collections for COVID-19 for maternal population (SOARS, OPAS, ODRS linking to birth certificate).
2. Enhance surveillance for maternal morbidity through PAMR program.
3. Develop maternal substance use surveillance system and provide epidemiologic support for implementation of associated activities (CSTE fellowship).
4. Develop protocols for systemic data into action.

In FY 20, to leverage current BMCFH related surveillance activities to collect additional data on how COVID-19 is impacting

Ohio's MCH population, Ohio amended the 2020 Ohio Pregnancy Assessment Survey (OPAS; Ohio's PRAMS-like survey) and the 2020 Ohio Study of Associated Risks of Stillbirth (SOARS) questionnaires to add supplemental questions related to COVID-19. By adding questions about diagnosis and impact of COVID-19 on pregnant women, additional analyses will be conducted on the prevalence of pandemic-induced financial difficulty, healthcare access issues, social issues, anxiety or depression, etc. among mothers who either recently delivered a live birth or experienced a stillbirth.

Additionally, the Data and Surveillance section initiated two additional projects regarding COVID-19 in pregnancy in FY 20. First, enhanced surveillance of pregnancies with SARS-CoV-2 infection was initiated. In April 2020, the CDC released a pregnancy module to the COVID-19 case report form (CRF) that is comprised of a Pregnant Case Form and a Neonate Form. The module includes surveillance questions for the mother on the clinical course of disease including severity of disease, treatments, mortality, timing of SARS-CoV-2 infection, presence of symptoms, and underlying risk factors; for delivery on adverse fetal and birth outcomes of infants born to mothers with SARS-CoV-2 infection; and for the neonate on frequency and risk factors for neonates testing positive for SARS-CoV-2 infection. ODH modified the Ohio Disease Reporting System (ODRS) for COVID-19 to capture all fields within the pregnancy module and create files for export to CDC's Data Collation and Integration for Public Health Event Response (DCIPHER) platform. Data collection includes identification of pregnant COVID-19 cases within the existing surveillance system, following case-patients until due dates, identifying birth or fetal death certificates within the states vital records system, contacting clinicians for additional information, and abstracting relevant information. Both projects will continue through SFY 22.

BMCFH epidemiology staff are performing a retrospective data linkage using the Ohio Disease Reporting System (ODRS) and Vital Statistics (VS) data, including birth and death certificates. There are 2 objectives of this data linkage: First, to evaluate the quality of the pregnancy variable documented in the case report form mentioned in the first project (Enhanced Surveillance collaboration with the ODH Bureau of Infectious Diseases). Preliminary data show that the pregnancy variable is missing a value about 40% of the time. Thus, to confirm pregnancy status and improve surveillance accuracy, the gold standard for pregnancy status will be a live birth or fetal death documented within Ohio's vital statistics. Through this linkage, BMCFH Epi staff can quantify the missingness, and accuracy (sensitivity, (predictive value positive and predictive value negative) of the pregnancy variable. Confirmation of pregnancy among confirmed COVID-19 cases will also allow for erroneous data to be corrected in ODRS and for identification of additional cases for which the pregnancy module could be completed. Second, using the linked ODRS and VS data, BMCFH Epidemiology staff will examine outcomes of pregnancies with confirmed SARS-CoV-2 infection. In addition to the ODRS data on infection, the birth and fetal death certificate data provide information such as birth weight, gestational age, abnormal conditions of the newborn, and characteristics of labor and delivery. BMCFH Epi staff will calculate frequency of adverse outcomes among women with confirmed or probable COVID-19 infection and will stratify analyses by race. Both projects will continue through SFY 22.

The Ohio Hospital Association (OHA) is the agency that collects maternal morbidity data from Ohio hospitals. ODH PAMR requests this data from OHA for analysis and has already created a data brief with this data. This data brief is currently being approved by ODH Communications and will be published for public viewing at some point in SFY 22.

ODH Data and Surveillance matched for a CSTE Applied Epidemiology Fellow for 2020 – 2022. Because current existing surveillance systems concerned with maternal and infant health are not designed to monitor opiate abuse or its health outcomes on women, children and young families, the fellow led 2 projects:

- The development of a new perinatal substance use surveillance system in Ohio that will take advantage of multiple existing data sources.
- Neonatal Abstinence Syndrome (NAS) Surveillance Evaluation - This evaluation will look at the data collected from The Ohio Connections for Children with Special Needs (OCCSN), Ohio's birth defects surveillance system and compare it with the data from the Ohio Hospital Association, the 2 main data sources for NAS data in Ohio. The goal of this evaluation is to make sure that OCCSN is accurately capturing cases of NAS and referring those cases to the proper healthcare providers.

The CSTE Fellow accepted a full-time employment opportunity at the end of SFY 21. These two projects will be continued by other staff within the Data and Surveillance section throughout SFY 22.

Stakeholders across the Maternal, Child, and Family Health Bureau at ODH will develop a plan/process to routinely review program data within the Bureau and disseminate it internally at ODH to inform programming by the end of SFY 22. Key objectives of this process will be to set up an internal process to map the end results of surveys and to streamline data sharing and dissemination internally and externally. Implementation of this plan will occur in by SFY 25.

Priority: Increase mental health support for women of reproductive age

Measures

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

- SOM: Percent of women (18-44) with 14 or more mentally distressed days in past month (OMAS)
- SPM: Percent of women (18-44) with unmet mental health care or counseling services need in past year (OMAS)
- ESM: None developed at this time.

The need to address mental health for women of reproductive age, pregnant and postpartum is reflected in the selection of outcome and performance measures for both subsets of the population of women.

Objective 1: By 2022, develop plan to increase coordination, referral, and uptake of mental health services for women 18-44.
Strategies:

1. Develop plan in coordination with other state agencies to increase coordination, referral, and uptake of mental health services for women of reproductive age.
2. Continue to build trauma informed care into interventions in community-based settings for mental health.
3. Continue screenings for mental health/ substance abuse and provide referrals through Title X program.

There are currently several programs within ODH and outside of ODH already working toward improving coordination, referral, and uptake of mental health services for women of reproductive age but there is not a centralized place for this information to be stored or tracked. By the end of SFY 22, a small sub-committee from the larger the Women and Maternal Health Committee within the BMCFH will convene to inventory existing initiatives within ODH. This workgroup will review findings/data from ODH programs that are currently offering screening, referral, and coordination related to mental health services (e.g., MP Preconception Health, MP Peer Support, Reproductive Health, IMPLICIT project). After this comprehensive review is complete, a subcommittee of members will engage existing relationships with Ohio Mental Health and Addiction Services (OhioMHAS), Ohio Department of Medicaid (ODM), and others to look at existing work outside of ODH. Once a comprehensive overview of initiatives is developed, the workgroup will work with necessary stakeholders to develop a plan in coordination with other state agencies to increase coordination, referral, and uptake of mental health services for women of reproductive age.

The ODH Sexual Assault and Domestic Violence Prevention (SADVP) program is in the process of coordinating key stakeholders (e.g., Ohio Domestic Violence Network, Ohio Association of Community Health Centers) throughout the state to provide trainings for community health centers, on trauma-informed care, intimate partner violence and human trafficking. These trainings will continue to occur throughout SFY 22. To monitor progress toward this strategy, the SADVP program will monitor the number of trainings and number of people trained.

The ODH RHWP continues to implement best practices regarding screening for mental health and/or addiction issues (e.g., Edinburgh Screening tool, ASBI). Every client has a Reproductive Life Plan (RLP) and is screened for mental health needs. If needed, clients are referred for appropriate care. A process and outcomes tracking system has been developed to document and ensure monitoring and oversight of screening and referrals to providers. Over the coming year, Title X clinics will increase care coordination and quality assurance of linkages of women to care by developing a network of providers that will accept referrals for un/under-insured clients and tracking those referrals. Title X clinics will track progress toward this objective by continuing to track the number of clients screened and number of clients referred receiving treatment.

Objective 2: Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44.
Strategies:

1. Implement culturally relevant peer support behavioral health services for high risk pregnant and postpartum women through MP subgrant.
2. Implement programs and strategies to decrease alcohol use during pregnancy.
3. Continue Practice and Policy Academy participation to inform implementations of plans of safe care.
4. Increase women's postpartum depression/anxiety screening during pediatric well visits.

Six subgrantees of the MP grant are in the process of developing comprehensive plans to implement culturally relevant peer support behavioral health services for high risk pregnant and postpartum women. Grantees that receive a second year of funding from the MP grant will implement their approved plans starting in October of 2021 through September 2022. The purpose of these plans will be to:

- Increase the number of peer support personnel working with pregnant and postpartum women to improve their mental wellness.
- Increase the number of screenings for behavioral health to pregnant and postpartum women.
- Increase the number of referrals for pregnant and postpartum women to behavioral health services.
- Increase the behavioral health knowledge of personnel who work with pregnant and postpartum women by attending educational and training events.

The ODH Fetal Alcohol Spectrum Disorders (FASD) program will implement a multi-media campaign to increase

awareness of the impact of alcohol-exposed pregnancies, collaborate with agencies to establish resources, coordinate interventions, and diagnostic services for families affected by FASD. The program plans to work to evaluate the impact of other relevant strategies identified in the FASD strategic plan for implementation in coming years.

There are currently two ODH staff participating in the Practice and Policy Academy that serve as liaisons and communicate information from the Academy to the ODH Home Visiting team and ODH Ohio Connections for Children with Special Needs (OCCSN, Birth Defects Surveillance program). In April 2021, ODH hosted a joint meeting with the Ohio Departments of Job and Family Services and Development Disabilities to train staff from each of our respective agencies. During this meeting, information on the Plans of Safe Care was provided.

All of our Home Visiting programs can serve families that have a Plan of Safe Care, there are no exclusions with any of our four models. The Plans of Safe Care work is currently being piloted in several communities throughout Ohio and they are being supported directly by the Practice and Policy Academy. This support includes technical assistance and information sharing about all of the different partners that may be involved with families in a community. Home Visiting could be one of those partners, depending on the needs of the families. There is no end date for implementation, the Plans of Safe Care work with be ongoing.

ODH PAMR program is working with GRC and the Ohio chapter of the American Academy of Pediatrics (AAP) to implement a statewide initiative based on a program developed by the Family Medicine Education Consortium IMPLICIT Network (Interventions to Minimize Preterm and Low birth weight Infants using Continuous quality Improvement Techniques). IMPLICIT Network is a framework that focuses on maternal health screenings at well-child visits. This is the first pediatric focused QI program to implement a nationally tested interconception care model in well-child visits for birth – 18 months. To date, 11 pediatric practices have confirmed participation in Wave 1 of implementation. Educational materials have been translated in 3 languages (Spanish, Arabic and Somali). Recruitment of wave 2 sites will continue over SFY 22 to increase the reach of women's postpartum depression/anxiety screening during pediatric well visits.

Priority: Decrease risk factors associated with preterm birth

Measures

- NOM 5: Percent of preterm births (<37 weeks)
- SPM: Percent of women (18-44) smoking in reproductive age
- ESM: Percent increase in enrollment of high-risk populations in evidence-based home visiting programs

The risk factors associated with preterm birth include and extend beyond interventions for pregnant women. The selection of the SPM for smoking among reproductive age women aligns with the need to address smoking before women become pregnant to complement the existing efforts to identify and support pregnant women in quitting during pregnancy. Home visiting services targeted at high-risk pregnant women can improve birth outcomes and the ESM will measure efforts contributing to addressing the priority.

Objective 1: By 2025, reduce the proportion of women of reproductive age smoking by 15%.
Strategies:

1. 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).
2. Improve cross-referrals among programs addressing tobacco use (e.g., Quit Line refer to Baby and Me Tobacco Free).
3. Identify and leverage cross promotional/marketing opportunities (media, partner, collaborations.
4. Continue to provide supports for pregnant women to quit smoking through Moms Quit for Two program.

The following programs will work together over SFY 22 to develop a plan to streamline strategies for addressing smoking among women of reproductive age and identify and leverage cross promotional/marketing opportunities:

- Asthma Program
- Home Visiting Program
- Oral Health
- Mom's Quit for Two
- RHWP
- FASD
- MP
- Tobacco
- WIC
- Safe Sleep/Cribs for Kids

By the end of SFY 22, a smaller working group of the BMCFH Women and Maternal Health will convene to explore how cross-referrals among programs to address tobacco use currently occurs and how this process may be enhanced. Once this plan is developed, it will be implemented by SFY 25.

The ODH Perinatal Smoking Cessation program is a statewide project that provides information through media campaigns, technical assistance, and resources. The program also funds implementation of the evidence-based model Baby & Me Tobacco Free through the Moms Quit for Two subgrant. The subgrant currently funds 19 entities throughout Ohio to provide support and resources for pregnant women to quit smoking. This grant program will continue throughout SFY 22 with the goal of providing specific technical assistance to improve the retention rate of program participants from 70% in FY 21 to 94% in FY 22. ODH Perinatal Smoking Cessation partners with programs such as Tobacco Use and Cessation, infant safe sleep, Ohio Equity Institute, Infant Vitality Community Intensive Pilot Projects, and WIC.

Objective 2: By 2025, increase enrollment of high-risk populations in evidence-based home visiting programs by 10% each year.
Strategies:

1. Implement home visiting services for at risk pregnant and post-partum women.

The four Home Visiting models, Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents as Teachers (PAT), and Moms & Babies First (MBF), all serve at-risk pregnant and post-partum women. In FY 21 ODH Home Visiting expanded into all 88 counties and continued to reach more women and families than in previous years.

We have engaged home visiting providers across the state in conversations around expanding to meet the needs in their communities, focusing attention where we know there are waitlists and/or many unserved, eligible women/infants. A number of specific efforts are underway that will result in further expansion of home visiting services for at risk pregnant and post-partum women in FY 22:

1. Revision of OAC Home Visiting rule that will expand eligibility and allow more women and families to be served.
2. Strengthened, streamlined referral process from Child Protective Services to HMG Home Visiting, allowing more high-risk families to be referred.
3. Nurse Family Partnership expanded eligibility in some programs to allow multiparous (more than one pregnancy) women, and women beyond the 28th week of pregnancy to enroll (traditional NFP enrolls first time pregnant women up through the 28th week).
4. Parents as Teachers expansion in Ohio to meet the need for increased home visiting capacity.

Other Efforts Supported by Title V MCH
The majority of MCH programs are represented within the application narrative above. Several program summaries are included below to highlight additional relevant programs and a complete list of programs serving the Women population is available in the Program Map (section V. Supporting Documents).

Ohio Equity Institute (OEI)
The Ohio Equity Institute: Working to Achieve Equity in Birth Outcomes is a grant-funded collaboration between the Ohio Department of Health and local partners in nine counties to address the racial inequities in birth outcomes. OEI addresses disparities in prenatal, infant, and maternal health through downstream (neighborhood navigators identify and connect priority prenatal population to clinical and social services) and upstream (facilitate development, adoption, or improvement of policies and practices that impact social determinants of health related to pre-term birth and low birth weight, including reducing barriers to accessing clinical social services by improving quality, availability, and cultural competence of service delivery, and working with local leadership who can adopt policies) strategies. The nine counties implementing OEI include: Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit. Goals of this project include the reduction of low birth weight, very low birth weight, preterm birth and very preterm birth among Black women served in OEI counties.

Ohio Connections for Children with Special Needs (OCCSN)
Ohio Connections for Children with Special Needs (OCCSN) is Ohio's statewide population-based birth defects surveillance program. The Ohio Revised Code 3705.30 authorizes the state director of health to require hospitals, physicians, and freestanding birthing centers to report children from birth to 5 years of age with certain reportable birth defects to the Ohio Department of Health (ODH). Collection of birth defect data is important for public health action, including facilitating referrals to services such as early intervention and targeting prevention strategies. The OCCSN program includes activities in four major areas: surveillance of birth defects, analysis of surveillance data, referrals to early intervention services, and awareness and prevention activities.

Comprehensive Genetics Services Program

The Genetics Services Program funds a network of eight genetic centers that provide comprehensive care and services to people affected with, or at risk for genetic disorders. The purpose of the program is to ensure availability of quality, comprehensive genetic services in Ohio. Genetic services include, but are not limited to genetic counseling, education, diagnosis and treatment for genetic conditions and congenital abnormalities. Persons in Ohio who would like genetic counseling, or other genetic treatment services, may contact one of the Comprehensive Genetic Centers (CGC), or may be referred by their primary care physician. The goals of the Comprehensive Genetic Centers (CGCs) are to ensure that children and adults with, or at risk for birth defects or genetic disorders and their families receive quality, comprehensive genetic services that are available, accessible, and culturally sensitive; and providers, the general public and policy makers are aware and knowledgeable about birth defects, genetic conditions, genetic disease related services in Ohio.

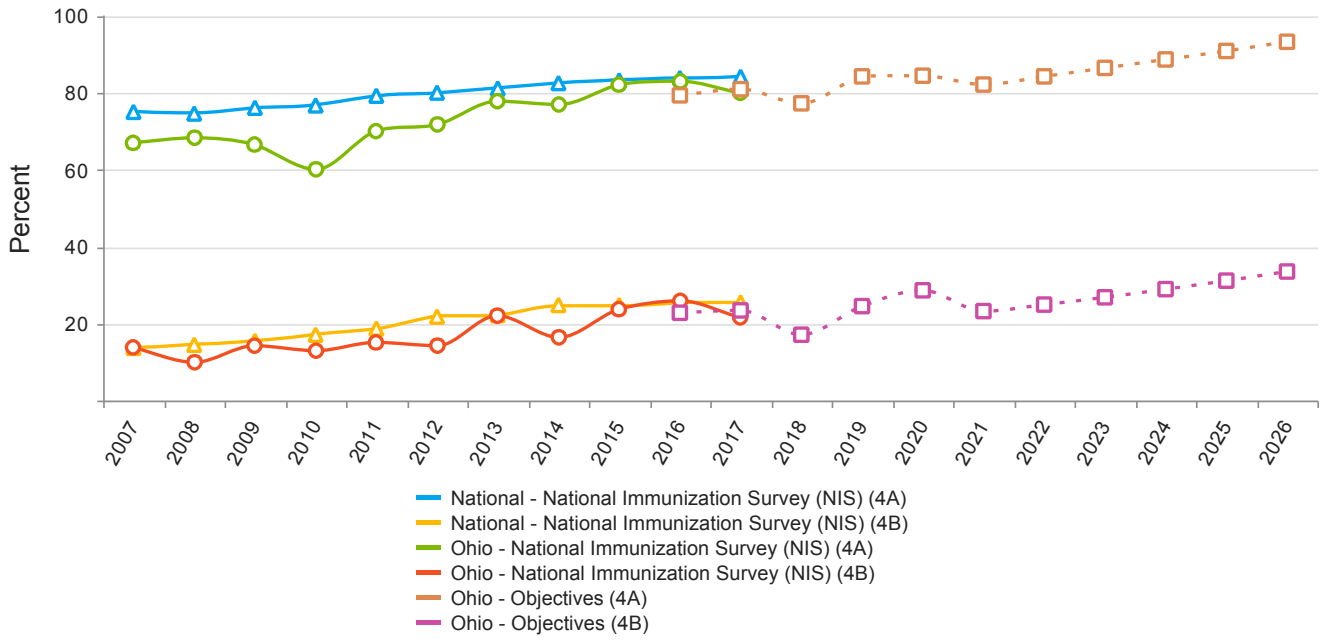
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.3	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	119.1	NPM 4 NPM 5

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79.3	80.9	77.2	84.2	84.4
Annual Indicator	77.7	76.8	81.9	82.8	80.1
Numerator	101,883	101,413	106,884	110,538	101,710
Denominator	131,148	132,017	130,510	133,422	127,037
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.1	84.2	86.4	88.6	90.8	93.2

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	22.9	23.5	17.2	24.6	28.7
Annual Indicator	22.3	16.7	23.7	26.0	21.6
Numerator	27,862	21,279	30,504	33,213	26,964
Denominator	125,021	127,543	128,458	127,978	124,604
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.3	25.0	26.9	29.0	31.2	33.6

Evidence-Based or –Informed Strategy Measures

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

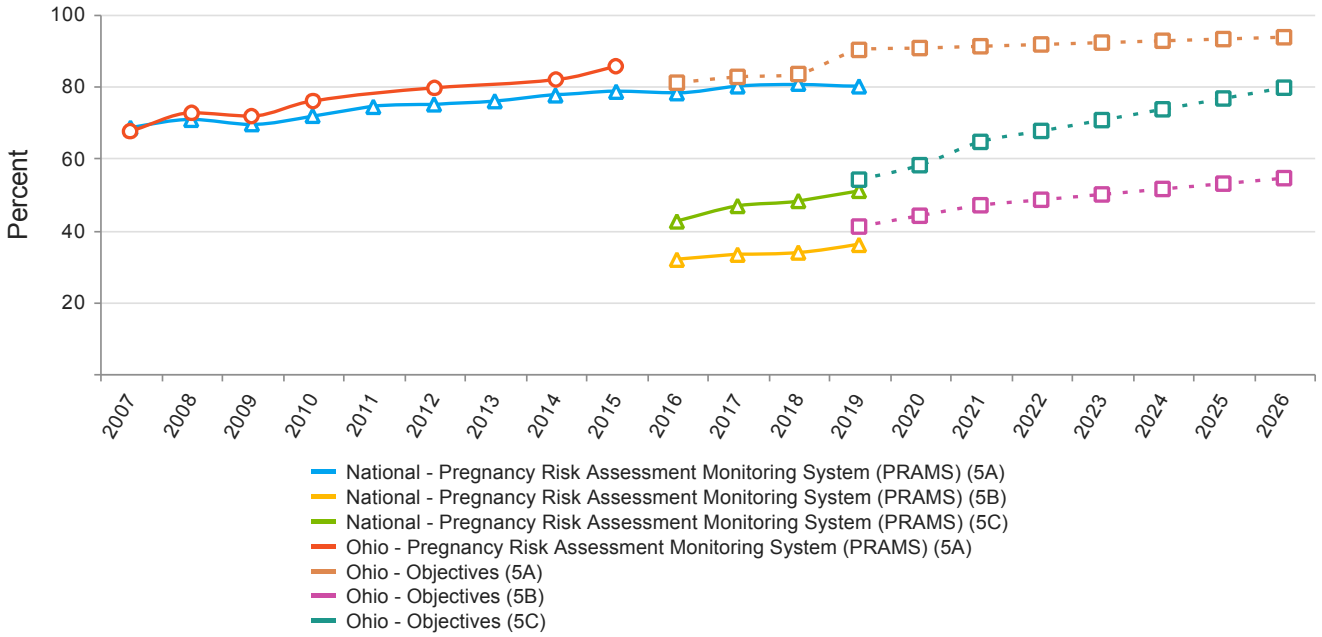
Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		66	72.6	82.7	84.5
Annual Indicator	49.1	67.9	77.9	82.5	86.1
Numerator	52	72	81	85	87
Denominator	106	106	104	103	101
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.4	88.3	90.3	92.2	94.2	96.2

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

Indicators and Annual Objectives



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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	80.9	82.5	83.3	90	90.5
Annual Indicator	79.3	85.5	85.5	85.5	85.5
Numerator	100,183	111,358	111,358	111,358	111,358
Denominator	126,366	130,239	130,239	130,239	130,239
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2012	2015	2015	2015	2015

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	80.9	82.5	83.3	90	90.5
Annual Indicator		82.7	85.5	86.6	87.6
Numerator					
Denominator					
Data Source		OPAS	OPAS	OPAS	OPAS
Data Source Year		2016	2017	2018	2019
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	91.0	91.5	92.0	92.5	93.0	93.5

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			41	44
Annual Indicator	39	40.4	42.3	45.4
Numerator				
Denominator				
Data Source	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.9	48.4	49.9	51.4	52.9	54.4

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			54	58
Annual Indicator	40.9	51.9	57.7	61.5
Numerator				
Denominator				
Data Source	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.5	67.5	70.5	73.5	76.5	79.5

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of families provided with a crib and safe sleep education through Cribs for Kids

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			5,500	5,500
Annual Indicator			5,961	6,019
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			FY 2019	FY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5,750.0	6,000.0	6,000.0	6,000.0	6,000.0	6,000.0

State Outcome Measures

SOM 7 - Black Infant Mortality Rate (per 1,000 live births)

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			15.5	12.9
Annual Indicator	15.2	15.6	13.9	14.3
Numerator	369	384	339	356
Denominator	24,316	24,542	24,359	24,971
Data Source	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.6	11.0	9.3	7.7	6.0	4.3

State Action Plan Table

State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 1	
Priority Need	
Support healthy pregnancies and improve birth and infant outcomes	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
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%.	
Strategies	
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	
ESMs	**Status**
ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

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

Priority Need

Support healthy pregnancies and improve birth and infant outcomes

NPM

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

Objectives

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%.

Strategies

Continue implementation of the Cribs for Kids Program to provide safe sleep education and safety-approved cribs to families

Support local collaborative efforts to plan and implement safe sleep strategies through the Cribs for Kids Program

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 (anticipated in 2021)

ESMs	Status
ESM 5.1 - Number of families provided with a crib and safe sleep education through Cribs for Kids	Active

NOMs

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

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

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

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

Priority Need

Support healthy pregnancies and improve birth and infant outcomes

SOM

SOM 7 - Black Infant Mortality Rate (per 1,000 live births)

Objectives

By 2025, reduce Black infant mortality rate to 6.0 per 1,000 live births.

Strategies

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

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

Priority Need

Support healthy pregnancies and improve birth and infant outcomes

Objectives

By 2022, develop plan for enhancing coordination of pregnancy and post-partum supports and messaging.

Strategies

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

State Action Plan Table (Ohio) - Perinatal/Infant Health - Entry 5

Priority Need

Support healthy pregnancies and improve birth and infant outcomes

Objectives

By 2022, assess need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-baby visit.

Strategies

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

Perinatal/Infant Health, Annual Report FY 2020

The annual report is organized by the three priorities for Infant health: reduce the rate of infant mortality and disparities statewide, increase comprehensive newborn screens and improve Ohio's newborn screening system, and increase access to early infant care and wellness.

Priority: Reduce the rate of infant mortality and disparities statewide

SOM 1: Black Infant Mortality Rate

- In 2019, 929 Ohio infants died before their first birthday. The number of white infants who died was 518, the lowest number in the past 10 years. There were 356 Black infant deaths in 2019, an increase of 17 from 2018. However, this is still lower than 2015, 2016, and 2017. Ohio infant mortality across all races was 6.9 per 1,000 live births in 2019, the same as it was in 2018. The Black infant mortality rate was 14.3 in 2019, up from 13.9 in 2018. Black infants were more than 2.8 times more likely to die than white infants.

NPM 5: Safe Sleep

- A: Percent of infants placed to sleep on their backs was 87.6% (2019 OPAS). This represents an increase from the previous year, at 86.6%.
- B: Percent of infants placed to sleep on a separate approved sleep surface was 45.4% (2019 OPAS). This represents an increase from the previous year, at 42.4%.
- C: Percent of infants placed to sleep without soft objects or loose bedding was 61.5% (2019 OPAS). This represents an increase from the previous year, at 57.7%.

ESM 5.2:

- The number of families provided with a crib and safe sleep education through Cribs for Kids® programs during FY 20 was over 6,400, which exceeds the annual objective for FY 20 of 5,500.

Ohio's Overall Infant Mortality Rate (IMR) remained 6.9 per 1,000 live births in 2019, the same as in 2018. From 2009 through 2019, Ohio's infant mortality rate decreased at an average of 1.2 percent per year. The white IMR was 5.1 in 2018, down from the 2018 IMR of 5.4. The number of white infants that died in 2019 was 518, the lowest number in the past 10 years. The Black infant mortality rate was 14.3 in 2019, up from 13.9 in 2018. There were 356 Black infant deaths in 2019, an increase of 17 from 2018. This is still lower than 2015, 2016, and 2017. Racial disparities gap continues to widen; Black infants are 2.8 times more likely to die than white infants. These disparity gaps are amplified due to decreases in white infant mortality without significant change in Black infant mortality.

Since 2010, Ohio has seen small, but significant decreases in the overall and white infant mortality rates. From 2010 through 2019, the overall infant mortality rate decreased at an average of 1.2% per year, while the white infant mortality rate decreased an average of 2.6% per year. The Black and Hispanic infant mortality rates have not experienced a significant change during the past 10 years. Ohio's State Health Improvement Plan (SHIP) has set a 2028 target of 6.0 for Ohio's overall infant mortality rate. This includes all priority populations identified in the SHIP.

The leading causes of infant deaths in Ohio in 2019 were: prematurity-related conditions including pre-term birth, respiratory distress, and low birth weight (29%); congenital anomalies (19%); external injury (12%); and sudden infant death syndrome (6%). There were more Black neonatal deaths (occur during the first 27 days of life) and an increase in the number of Black births <28 weeks. There were 22 more Black neonatal deaths between 2018 and 2019 (whereas there were 70 fewer Black neonatal deaths between 2017 and 2018). From a number's perspective, this is one of the main reasons for the increase in Black IMR. The number of deaths in the Black population increased between 2018 and 2019 by 17. Specifically, there were 22 more Black neonatal deaths and 5 fewer postneonatal deaths. This is likely due to an increase in premature births, especially those born prior to 23 weeks gestation. Births <28 Weeks: There were more Black births at <23 weeks (15 more from 2018 to 2019) and 23-27 weeks (31 from 2018 to 2019). These additional extreme preterm births likely led to the small increase in the Black infant and neonatal mortality rates. Although infants born less than 24 weeks accounted for 0.3% of total infants born, they accounted for over one-third of all infant deaths. Despite the same proportion of babies born at full term (37 or more weeks gestation) in 2019 and 2018 (90%), the proportion of term babies dying was 35% in 2019 compared with 30% in 2018.

The Ohio Department of Health and stakeholders have worked to establish a comprehensive statewide strategy to address that state's infant mortality and persistent disparities. The statewide strategy includes: data collection, surveillance and analysis, identification of the highest priority populations, addressing known causes of infant death and poor birth outcomes, continuous quality improvement efforts, newborn screenings, breastfeeding, and safe sleep efforts. Programs include the Ohio Equity Institute, Infant Vitality Community Intensive Pilot Project, Fetal Infant Mortality Review, Sexual Risk Avoidance Program, Title V Breastfeeding and Ohio First Steps for Healthy Babies, and Infant Safe Sleep and Cribs for Kids©.

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

As a result of findings identified in earlier years of the project, communication barriers were identified as a key issue preventing women from being identified as needing progesterone and receiving progesterone. The Pregnancy Risk Assessment Form (PRAF) 2.0 was established in response to these concerns. In its new iteration, the PRAF 2.0 serves as a universal communication form that automatically notifies the county, managed care plan and home health provider of the pregnancy and the need for progesterone "in real time." Continuation of this project seeks to assist maternity care providers in implementing the electronic PRAF 2.0 for all pregnant women insured by Medicaid. This form facilitates communication among pregnant women, their care providers, Medicaid Managed Care Plans, pharmacies, home health services and the Ohio Department of Job and Family Services. Title V funds were used to fund ODH's contract with OPQC in additional to State General Revenue Funds.

The ePRAF form is used by the Ohio Department of Medicaid to facilitate referrals to ODH-funded evidence-based home visiting. Ohio's Central Intake and Referral partner, Bright Beginnings, processes the referrals, contacts families to share the benefits of home visiting, determines eligibility and assigns the family to a local home visiting program, based on the family's needs. In FY 20, 18,399 families were referred to home visiting through use of the ePRAF, accounting for 42.9% of all home visiting referrals.

Objective D: Increase identification of at-risk women and connect them to services
In Ohio, Black babies are 2.8 times more likely to die than white babies before their first birthdays. In 2019, nine metropolitan areas accounted for 61% of all infant deaths, and 87% of Black infant deaths. Ohio's disparity gap in birth outcomes between Black and white infants continues to grow. We understand that even the best evidence-based interventions won't "move the needle" if they don't reach the most at-risk women or those women identified to carry the greatest burden of poor birth outcomes.

From October 1, 2019-September 30, 2020 the Ohio Equity Institute (OEI) screened and connected 3,502 pregnant women to needed clinical and social services. OEI strives for 80% of pregnant women served through neighborhood navigation to be Black/African American, as defined by self-identification. Of the women served through neighborhood navigation, 71.6% were Black/African American and 25.8% were White/Caucasian women. Most program participants also self-identified as non-Hispanic (96.1%). Based on program eligibility criteria, OEI teams collectively served 74% of eligible, pregnant women across the nine OEI counties (3,502/4,713). During year one, the OEI Teams reached only 33% of the total women served goal (1,522 of 4,660). During year two, OEI achieved 74% of the total women served goal (3,501 of 4,713); a 224% increase.

During year one of OEI 2.0 much of the first quarter (October 2018 -December 2018) was spent building capacity and conducting community outreach in order to find eligible women for OEI services. However, in year two, OEI teams and their strategies were already established. Teams were able to increase the number of women served each month from October through March. In April, COVID-19 shutdowns and statewide mandates were in place, which most likely contributed to the decline in the number of women served April through June. Teams re-strategized during this time, state restrictions were loosened, and teams began reaching women through safe and socially distanced avenues. Despite COVID-19, teams were more successful in July at serving women than any other month (n=426) and surpassed the monthly goal of serving 393 women.

In addition to the downstream Neighborhood Navigation program component, OEI plays an intentional role in developing upstream strategies to address the key drivers of inequities in birth outcomes. Each OEI develops and/or participates in a local social determinant of health (SDOH) team whose responsibility is to facilitate the development, adoption, or improvement of policies and/or practices which impact the SDOH related to preterm birth, low birth weight, and infant mortality in each county. The upstream policy and practice change efforts are designed and intended to impact the physical and/or social environment of the community in which Black pregnant women live, work, and play. Improving the physical and social environments of communities will improve and reduce inequities in birth outcomes. During each grant year, SDOH teams are responsible for adopting some form of policy or practice change within their communities. In the subsequent years, the teams are responsible for implementing and sustaining the adopted policy or practice changes.

In FY 20, most teams focused their policy and practice change efforts on the following SDOH domains: Racial/Cultural

Equity, Housing, Transportation, and Practice/Protocol Changes. The following policy adoptions have been made by local SDOH teams with the leadership and/or support of the OEI-funded entities:

Racial/Cultural Equity

- Resolutions were passed by Cincinnati City Council acknowledging and expressing commitment to address racism as a public health crisis. The SDOH Team advocated for infant mortality to be one of the issues prioritized as it relates to racial justice. The OEI Project Coordinator was confirmed as a member of the city's Racial Equity Task Force.

Housing

- Leveraged resources from the ODH-funded *Targeted Services for Homeless Pregnant Youths* grant to continue Columbus' Healthy Beginnings At Home program. The OEI Neighborhood Navigators will assist in recruiting women for this housing support program. Priority outreach will occur for pregnant youth and dual enrollment in the Pathways Community HUB program will provide long-term wraparound support for participants.
- The YWCA Mahoning Valley will provide access to at least four permanent supportive housing units and one transitional unit for pregnant and new moms experiencing homelessness.
- The City of Canton Department of Development approved financial assistance for tenant-based rental assistance on January 1, 2020.
- Summit County Public Health and the Full Term First Birthday Greater Akron Collaborative (FTFB) will be teaming with the Akron Metropolitan Housing Authority to implement a pilot program. The pilot program will allow for two preference points for applicants to prioritize pregnant women who are in imminent risk of homelessness, as well as provide wraparound services through designated FTFB services and programming.

Transportation

- Creation of a transportation resource pamphlet for pregnant women and mothers in Butler County outlining transportation options for distribution to community health workers, home visiting programs, hospitals and prenatal offices. The SDOH Team will also be advocating for bus stops and routes that support easier access to hospitals and prenatal offices for pregnant women.
- Using OEI data, the Cuyahoga SDOH team partnered with their regional transit authority to develop a grant proposal to address transportation barriers in three zip codes in Cuyahoga County: 44108, 44110, and 44112. The zip codes were chosen based on percentage of families without a vehicle and infant mortality rates. The funded proposal includes:
    - Funding to improve infrastructure at waiting areas (seating, lighting, coverings, etc.);
    - Bus tickets to meet medical, social and personal needs for any family that includes a pregnant woman; and
    - Access to private van service for medical, social, and personal needs.

Practice/Protocol Changes

- Expanded grocery delivery options for low-income pregnant women in Montgomery County by subsidizing delivery fees, expanding non-traditional ordering options and providing additional purchasing options. Through this project, in partnership with Produce Perks Midwest, pregnant women will be able to receive produce boxes or vouchers, informational handouts and literature, participate in cooking classes and receive meal kits.
- Commitment from a large hospital system in Lucas County to support the OEI team in addressing racism and improve health equity for pregnant women by screening pregnant women at risk of high lead levels.
- An assessment of community health worker's knowledge of family planning, birth control options, and sexually transmitted infections (STIs) will be conducted to develop a training to improve knowledge and ability of Stark County THRIVE Pathways HUB community health workers to educate clients.

In addition to adopting new policy and/or practice changes as described above, OEI teams were also tasked with implementing the policies and practice changes adopted during the last grant year. See the OE19 annual report for a refresher of previously adopted policy and/or practice changes for implementation in the OE20 grant year.

From October 1, 2019-September 30, 2020 the Community Intensive Pilot Project's three agencies served 300 pregnant and postpartum women by providing social and clinical referrals, education, and addressing social determinants of health. A portion of the women reside in four rural counties that have high rates of social determinant and health risk factors. Women served in these areas earn less than 200% of the Federal Poverty Level and are Medicaid-eligible. Another portion reside in two Cincinnati census tracts. While the two areas are demographically different in terms of race, poverty level, and median age, both areas have experienced persistently poor birth outcomes. The final portion of women reside in eleven census tracts in Toledo. The census tracts have high rates of social vulnerability, socioeconomic concerns, and poor birth outcomes. African American women and children carry the greatest burden of poor birth outcomes.

The Community Intensive Pilot Projects (CIPP) are focused on priority communities, defined by the community's infant mortality rate, preterm birth rate, low birth weight rate, and disparity rate between Black and white infant deaths. In April 2018, three agencies, in various parts of the state, implemented community intensive pilot projects, or place-based

initiatives. CIPP are designed as a multi-pronged population health approach with goals to produce direct, measurable improvements in birth outcomes, reduce disparities in birth outcomes, and reduce the impacts of social determinants on pregnant women and infants. The projects promote a healthy environment and educate the communities on healthy practices. In addition, the projects encourage and communicate the importance of addressing individual needs and the support for individuals to make choices in their own best interest. Each project is implementing a community-driven approach to address infant mortality rates by reducing maternal behavioral and medical risk factors, thereby improving healthy birth outcomes for women and infants.

All services provided through the project are enabling, providing non-clinical services that enable individuals to access health care and improve health outcomes. Agencies also engage in various public health services and system activities, such as policy development, needs assessment, program planning, implementation, evaluation, and quality improvement. Partners and collaborators include local health departments, government agencies, children's and maternity hospitals, universities, medical providers, local businesses, and social service, community action, home visiting, and housing agencies. Roles of partners and collaborators include receiving and providing referrals, providing services to priority population, hosting outreach, conducting evaluation, and partnering to work towards policy change. Consumers and stakeholders are involved at the local level, collaborating with outreach, education, community engagement, and policy change.

ODH is the collaborator in implementing the strategies of the Community Intensive Pilot Project. The services are not provided through ODH, but rather through the funded agencies. The agencies also proposed their own methodologies with a goal to improve birth outcomes, reduce disparities in birth outcomes, and reduce the impacts of the social determinants of health on pregnant women and infants.

There have been many accomplishments through the work of CIPP. Accomplishments include serving 300 pregnant and postpartum women 10/1/19-9/30/20, and providing those women over 100 cribs, 40 housing referrals, 35 employment referrals, 24 mental health referrals, 22 Baby and Me Tobacco Free referrals, and referring 3 infants to a neonatal abstinence syndrome clinic, in addition to many more referrals. Through some of the work, women in services were also provided education regarding a variety of pre- and postnatal topics. Agencies also hosted and attended several community outreach and education events throughout the year.

While there have been many accomplishments, there have also been several challenges. A challenge for implementation has been navigating the different infrastructures and services and providing appropriate technical assistance in weaker areas as the agencies proposed their own methodologies. Another challenge is the short-term nature of the grant, the potential lack of sustainability, and the extended length of time to demonstrate improved birth outcomes.

Agencies will use what they learned during the first year to continue implementation. Technical assistance will continue in order to learn more about the work, and to provide guidance. Title V funds have been used to support partial program administration and implementation, coupled with state General Revenue Funds. Funds have supported state-level program staff to design, monitor and evaluate local programs, as well as support the direct implementation of programs locally through subgrants.

Objective C: Decrease the birth rate among 13-19-year-olds

ODH utilizes a multi-pronged approach to reduce the birth rate among 13-19-year-olds. Resources are provided to support teenagers and their families in making healthy and informed choices about their reproductive health. While not funded by Title V, the below program provides resources to support the objective.

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

The Sexual Risk Avoidance Program currently funds organizations who oversee and facilitate Sexual Risk Avoidance Education programming across four geographical regions. The Ridge Project is Ohio's sub recipient in Region 1, which covers northwest Ohio cities and communities. Relationships Under Construction is Ohio's second sub recipient and they reach Regions 2, 3 and 4, which covers the remainder of the state. Currently, each region is awarded $561,054 through the Sexual Risk Avoidance Program. Subgrantees partner with local school districts to provide Sexual Risk Avoidance curriculum through health classes and afterschool programs. Some sub grantees offer Summer camps and Spring Break camps with an emphasis on Risk Avoidance programming. The subrecipients operate by contracting with local agencies to build upon the strategy of local control, community collaboration, and evidence supported program design. Each agency will focus on specific priority counties with high rates of teen pregnancy or birth rates. In addition, the program targets youth ages 11-14 to promote good decision making and positive healthy behaviors through prevention and positive youth

development messages.

In FY 20, Ohio's SRA Program served 51,083 students, 73% of those were middle school aged children, the focus audience, an increase from 71% in FY19. Although the program strives for 80% of programs occurring in middle school, some local school districts desire SRA Education to occur in ninth grade. Subgrantees attempt to accommodate parent and school administration requests as much as possible. Although there was a decline in general numbers last year because of COVID, the subrecipients were creative in their attempts to continue class instruction and developed online and distance learning modules to modify their current curricula that allowed them to continue programing.

Objective E: Increase the number of at-risk women and infants that receive a comprehensive assessment of risk factors & evidence-based/best practice interventions to address them.
Ohio launched the Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS) in July 2018. Throughout FY 20, continued enhancements were made to OCHIDS, allowing ODH to better track data surrounding the use of a comprehensive assessment tool to identify risk factors. The comprehensive assessment is used to identify needs of the family and gain an understanding of the psychosocial and social determinants of health affecting the family such as housing, mental health concerns, food insecurity, economic needs, and prior health concerns such as prematurity and entry into prenatal care. The home visitor develops interventions to address the needs identified in the comprehensive assessment with the family to help mitigate the risk factors associated with poor birth outcomes and disparities. The data from the assessment and home visits is entered into OCHIDS and is used to monitor progress and ongoing resolution of the risks identified in the comprehensive assessment and ongoing home visits.

During FY 20, ODH Home Visiting programs completed at least one comprehensive assessment for 8,971 (73.8%) of the 12,158 enrolled families. This is a 3% increase over the number of families with a completed assessment completed in FY 19.

Other efforts to address the priority:
Data and Surveillance
Fetal Infant Mortality Review (FIMR) is a multi-disciplinary, multi-agency, community-based program that reviews fetal and infant deaths and utilizes a community action team to develop recommendations and initiatives to reduce infant deaths. The nine OEI counties receive funding to conduct FIMR as part of a community-wide effort to decrease fetal and infant deaths in these high priority counties. Information submitted by the counties in monthly and quarterly reports has been used to inform ODH program efforts. In July 2019, legislation passed in the Ohio Revised Code Sections 3707.701, allowing any board of health to establish and operate a FIMR review board, and providing protections to current FIMR teams to gain access to medical records in order to complete reviews. From October 2019-September 2020, FY 20, 103 fetal death reviews were completed. Additionally, maternal interviews are completed as a key part of the FIMR processes, allowing mothers to provide insight and information about health equity and disparities among populations in the community. In FY 20, fewer maternal interviews were entered into the case reporting system than FY 19. In FY19, 51 maternal interviews were completed and entered into the case reporting system as compared with 8 entered into the system in FY 20. This outcome could be due to a number of variables including but not limited to turnover and additional challenges with staff capacity and data entry brought on since the onset of the COVID-19 pandemic. In addition, the inability to schedule in-person interviews has significantly affected the process. In an effort to address this matter, we are working with our local FIMR Coordinators and board members to provide TA on conducting successful maternal interviews amidst the restrictions presented by the pandemic, the importance of immediate recording into the case reporting system, and the most efficient ways to complete this task.

An investment to support Ohio's stillbirth prevention education campaign Count the Kicks continued. Access to free brochures, app reminder cards and posters for providers to share with pregnant moms, along with use of the Count the Kicks phone app remain available for Ohio providers and families. During 10/1/19-9/30/20, there were over 100 material orders of nearly 40,000 materials from providers and maternal health workers across the state, contributing to more than 1,800 expectant parents downloading the Count the Kicks app. This campaign is supported through the use of state general revenue funds and Title V funds support staff who manage implementation.

As a separate, but related surveillance activity, ODH initiated implementation of a stillbirth survey. The methodology is identical to the Ohio Pregnant Assessment Survey (OPAS; Ohio's PRAMS-like survey), but the target population will be fetal death certificates rather than live birth certificates. Survey planning continued throughout the grant year and the survey started fielding in April 2020. The Ohio Study of Associated Risks of Stillbirth (Ohio SOARS) survey will provide ODH with critical, timely, and relevant population-based data to better understand maternal experiences and behaviors prior to, during, and immediately following pregnancy among women who have recently experienced a stillbirth to inform targeted interventions to prevent stillbirth. The questionnaire collects data not available in medical records or on fetal death certificates topics such as life experiences before and during pregnancy, social support and stress, services and medical tests offered in hospitals after a stillborn delivery, substance use, and grief and bereavement support. Women are contacted to complete the survey approximately 2-3 months after a reported loss and can participate by completing a paper survey

delivered via mail, online survey, or telephone survey. The 2020 SOARS data will be available in early Fall 2021.

Ongoing implementation of OPAS through SFY 21 continues as a collaboration funded by ODH and ODM and administered by the Ohio Colleges of Medicine Government Resource Center (GRC). In addition to the statewide OPAS questionnaire, in SFY19 and SFY 20, new data collection will commence. Along with 32 PRAMS states, and one additional non-PRAMS state (CA), Ohio was selected to receive supplemental funds from CDC to implement an opioid supplement to use the existing methodology and maternal and child health surveillance infrastructure within states that are not currently funded for the Pregnancy Risk Assessment Monitoring System (PRAMS) to implement rapid surveillance of maternal behaviors and experiences related to use of prescription pain relievers and other opioids among women who deliver a live-born infant. Data from this effort will inform state health departments, clinical providers, CDC, and other federal agencies on programs and policies to mitigate the risk of opioid exposure during pregnancy. CDC published a multi-state report, including Ohio data, using data from the opioid supplement (Ko JY, D'Angelo DV, Haight SC, et al. *Vital Signs:* Prescription Opioid Pain Reliever Use During Pregnancy — 34 U.S. Jurisdictions, 2019. MMWR Morb Mortal Wkly Rep 2020;69:897–903).

In FY 20, in an effort to leverage current BMCFH related surveillance activities to collect additional data on how COVID-19 is impacting Ohio's MCH population, Ohio amended the 2020 OPAS and SOARS questionnaires to add supplemental questions related to COVID-19. By adding questions about diagnosis and impact of COVID-19 on pregnant women, additional analyses will be conducted on the prevalence of pandemic-induced financial difficulty, healthcare access issues, social issues, anxiety or depression, etc. among mothers who either recently delivered a live birth or experienced a stillbirth.

Further, Data and Surveillance initiated two additional projects regarding COVID-19 in pregnancy in FY 20. First, enhanced surveillance of pregnancies with SARS-CoV-2 infection was initiated. In April 2020, the CDC released a pregnancy module to the COVID-19 case report form (CRF) that is comprised of a Pregnant Case Form and a Neonate Form. The module includes surveillance questions for the mother on the clinical course of disease including severity of disease, treatments, mortality, timing of SARS-CoV-2 infection, presence of symptoms, and underlying risk factors; for delivery on adverse fetal and birth outcomes of infants born to mothers with SARS-CoV-2 infection; and for the neonate on frequency and risk factors for neonates testing positive for SARS-CoV-2 infection. ODH modified the Ohio Disease Reporting System (ODRS) for COVID-19 to capture all fields within the pregnancy module and create files for export to CDC's Data Collation and Integration for Public Health Event Response (DCIPHER) platform. Data collection includes identification of pregnant COVID-19 cases within the existing surveillance system, following case-patients until due dates, identifying birth or fetal death certificates within the states vital records system, contacting clinicians for additional information, and abstracting relevant information.

The second project involves linking ODRS data to Vital Statistics data. BMCFH epidemiology staff are performing a retrospective data linkage using the Ohio Disease Reporting System (ODRS) and Vital Statistics (VS) data, including birth and death certificates. There are 2 objectives of this data linkage: First, to evaluate the quality of the pregnancy variable documented in the case report form mentioned in the first project (Enhanced Surveillance collaboration with BID). Preliminary data show that the pregnancy variable is missing a value about 40% of the time. Thus, to confirm pregnancy status and improve surveillance accuracy, the gold standard for pregnancy status will be a live birth or fetal death documented within Ohio's vital statistics. Through this linkage, BMCFH Epi staff can quantify the missingness, and accuracy (sensitivity, (predictive value positive and predictive value negative) of the pregnancy variable. Confirmation of pregnancy among confirmed COVID-19 cases will also allow for erroneous data to be corrected in ODRS and for identification of additional cases for which the pregnancy module could be completed. Second, using the linked ODRS and VS data, BMCFH Epidemiology staff will examine outcomes of pregnancies with confirmed SARS-CoV-2 infection. In addition to the ODRS data on infection, the birth and fetal death certificate data provide information such as birth weight, gestational age, abnormal conditions of the newborn, and characteristics of labor and delivery. BMCFH Epi staff will calculate frequency of adverse outcomes among women with confirmed or probable COVID-19 infection, and will stratify analyses by race.

The Infant Mortality Research Partnership (IMRP), a collaboration between the ODH, ODM, and GRC, continued to use data analytics to better understand how we can lower infant mortality in Ohio. The current phase of this work 1) expands upon the spatiotemporal analysis to develop a mapping tool to longitudinally assess changes in preterm birth, low birthweight, and infant mortality over time by census tract; 2) developed a health opportunity index by census tract to align health opportunity with birth outcomes; and 3) used the results of the data analytics to develop a risk calculator to predict one-day mortality, very preterm birth (<32 weeks), or preterm birth (<37 weeks) using clinical data. The results will improve upon and expand the previously developed models that focus on factors that increase risk, such as those related to social and behavioral health or structural and institutional factors. Future plans include field testing the risk calculator within a Maternal-Fetal Medicine clinic to inform any edits/refinements of the calculator and incorporation of the calculator into one hospital system electronic health record.

Ohio CoIIN Social Determinants of Health

The Ohio CoIIN Social Determinants of Health team accomplished its identified aims 1) By Spring 2020 through defining the Ohio Equity Institute's role in addressing the social determinants of health, each OEI will implement at least one policy and/or practice at the local level which will directly impact the determinants of health impacting birth outcomes. Implementation of previously adopted policy/practice by local OEI teams will take place during the second year of the OEI 2.0 grant beginning October 1, 2019; and 2) Development and implementation of a prescription produce pilot program for Ohio's material population in two identified counties. In response to insufficient resources available to adequately address hunger for Ohio's women and families, funds have been secured and a contract is in place to begin implementation of the prescription produce pilot program for pregnant women in Hamilton, Montgomery, and Franklin Counties in December 2019. This work will happen in alignment with the prescription produce program for Ohioans experiencing prediabetes and diabetes as supported by ODH's Creating Healthy Communities. The vendor supporting all prescription produce programs is also the Produce Perks provider for SNAP benefits; this program automatically doubles Ohio SNAP/EBT for fruit and vegetable purchases at all participating locations.

Year one of the project resulted in:

- 145 patients enrolled
- 32 patients completing the program, 86 women rolling into the next year for completion
- 547 household members served
- 15 redemption sites established
- Produce prescriptions redeemed:
    - CSA shares: $20,220.35
    - PRx Vouchers: $4,656.77

Implicit Bias

The first round of implicit bias trainings funded by ODH began with Bureau of Maternal, Child and Family Health (BMCFH) staff on September 2019 followed by five subsequent trainings that were hosted in the five Ohio regions for BMCFH grantees and ended in January 2020. The trainings served 193 participants total.

A second round of implicit bias trainings will be hosted by the ODH PAMR program including 26 trainings held between May 2020 and June 2022, providing continuing education credit for an estimated 1,000 women's health providers. Six trainings have been completed with 208 attendees; six trainings have been scheduled through February 2021. The remaining trainings will be scheduled after that. These trainings will be offered to all the providers affiliated with the delivery hospitals participating in the AIM Hypertension Bundle. Additional details are provided in the Women Annual Report.

Home Visiting

The Department and state partners continue to work together to enhance Ohio's evidence-based and promising-practice models to address the needs of high-risk women and children. In March 2019, the Governor's Advisory Committee on Home Visitation released 20 recommendations aimed at improving the delivery of Ohio's home visiting services. As a result of those recommendations, the Department has taken the following actions:

- Reviewed current home visiting rules to allow for streamline and expand eligibility to serve additional high-risk families.
- Reviewed current home visiting rules to align home visitor education requirements to model standard requirements.
- Increased reimbursement rates for home visits and related activities.
- During SFY 19 and SFY 20, Ohio expanded home visiting services in five additional counties, bringing the total to 86 counties with funded services.

ODH supported home visiting providers in transitioning to virtual services in response to COVID-19. Family retention funding was made available to support the implementation of virtual visits and assure the health and safety of families and home visitors. As a result of this support, Ohio saw a decrease in the number of families who exited the program in FY 20 as compared to the number in FY 19. Families exiting the program in SFY 20 were enrolled for 28 days longer and received 3 additional home visits.

<u>Objective B: Increase Safe Sleep Initiatives</u>

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

B1) Implement strategies to reduce sleep-related deaths.

B2) Increasing the number of families provided with a crib and safe sleep education through the ODH-funded Cribs for Kids® (CFK) program as reported in the CFK program reporting requirements.

B3) Increase the percent of families screened for a safe sleep space as required by Ohio Revised Code 3701.67 safe sleep screening mandate.

B4) Increasing the number of impressions achieved though ODH safe sleep media campaign as provided by ODH Communications.

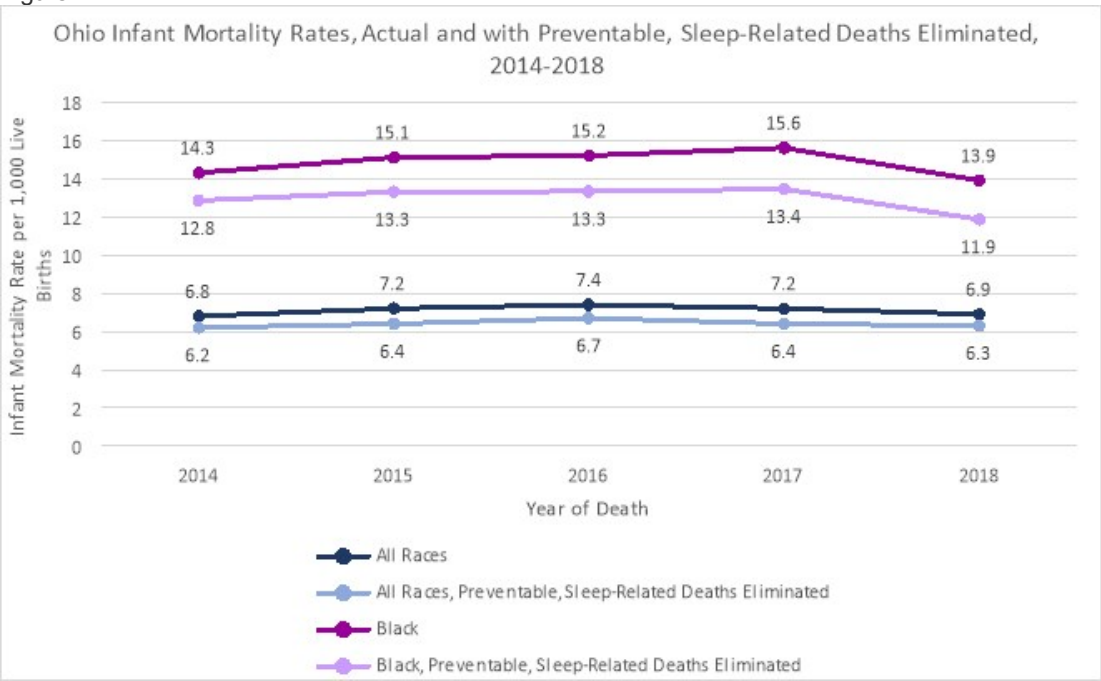
In Ohio from 2014 to 2018, there were 693 infant death reviews related to sleeping or the sleeping environment, based on the Ohio Child Fatality Review (CFR) 19th Annual Report.[i] This represents over 27 Kindergarten classrooms full of children at the minimum ratio of one full time equivalent teacher per 25 students.[ii] The death of each infant represents a tragic loss for the family and the greater community. ODH is committed to working with partners around the state to reduce the number of sleep-related deaths.

The 693 infant death reviews related to sleeping or the sleeping environment represent 16 percent of the 4,440 infant death reviews. Sleep-related deaths become less common as infants age but still occur up to one year. Fifty-three percent of the sleep-related deaths from 2014 to 2018 involved infants between one month and three months of age. Bed-sharing was reported at the time of death in 54 percent (371) of the reviews. Sleep-related deaths are among the most preventable of infant deaths. Of the 693 sleep-related deaths from 2014 to 2018, 72 percent were found to be preventable.

Of the 693 infant, sleep-related death reviews from 2014-2018, the infant's sleep location (e.g., crib, adult bed, couch), presence of items in the crib, and put to sleep position (i.e., on back, on stomach, on side) was known and reported in 535 cases. Among the 535 reviews, 363 (68%) were deemed probably preventable. Importantly, of these preventable sleep-related deaths, only 2 (1%) indicated the baby was Alone, on the Back, and in an empty Crib/bassinet, following the ABCs of Safe Sleep. The ABCs are based on the evidence-based guidelines from the American Academy of Pediatrics (AAP)[iii] and form the basis of various infant safe sleep education efforts promoted by ODH and numerous partners statewide.

There is also a significant racial disparity in sleep-related infant deaths, with Black infants disproportionately affected. Of the 693 infant sleep-related death reviews from 2014-2018, 45.9% (318) were for Black infants, while Black infants comprise only 18.2% of all resident live births.[iv] If all preventable, sleep-related deaths were eliminated, the Ohio infant mortality rate for 2018 would have been reduced by 0.6, from 6.9 to 6.3 deaths per 1,000 live births. If the preventable, sleep-related deaths of Black infants were eliminated, the Black infant mortality rate for 2018 would have been reduced by 2.0, from 13.9 to 11.9 deaths per 1,000 live births (Figure 1 below).[v]

Figure 1



Source: Ohio Child Fatality Review and Ohio Department of Health Bureau of Vital Statistics

In comparison to sleep-related deaths data, which are determined through thorough case reviews conducted by local CFR boards, Sleep-related Sudden Unexpected Infant Death (SUID) is based on the death certificate. The Ohio SUID rate is higher than the rate nationwide. For 2014-2018, the Ohio SUID rate was 106.1 per 100,000 live births, in comparison to the U.S. average of 91.2 per 100,000 live births. For 2019, Ohio's SUID rate was 109.2 per 100,000 live births (corresponds to NOM 9.5).

Given the preventability of many sleep-related infant deaths, Ohio has undertaken several initiatives focused on prevention and education, following the AAP guidelines. The ODH Maternal and Infant Wellness Program implements multiple overarching strategies to reduce sleep-related deaths under Objective B. Increase Safe Sleep Initiatives. Initiatives with Title V MCH Block Grant funding have been noted.

Linking Families in Need with Free Cribs and Education
One of these strategies is supporting a network of Cribs for Kids® (CFK) program partners to provide safe sleep environments and education to eligible families (Strategy B2), including 28 grantees partially funded by the Title V MCH Block Grant for FY 20. This strategy was designed as an enabling service that integrates health education for individuals. In FY 20, ODH awarded a total of $1.5 million to CFK program grantees. ODH also provided additional cribs to 14 CFK partners serving families in infant mortality hotspots. In order to receive a crib, eligible families must receive education provided by their local CFK partner. In this session, the parent/caregiver(s) receives information on infant safe sleep practices according to the AAP recommendations. Eligible families include pregnant women in the third trimester and families with infants under the age of one. Eligible families must also meet income guidelines set by local programs. During FY 20, CFK partners served over 50 Ohio counties. Corresponding to ESM 5.2, over 6,000 families were provided with a crib and safe sleep education through this network of CFK partners for FY 20, which exceeds the annual objective set for 2020 of 5,500. This also represents a small increase from the number distributed during FY18, at over 5,900. The vast majority of grantees (over 85%) met their deliverable-based goal for the number of families served.

Although a figure for WIC income eligible families corresponding to the CFK program target population could not be located, the number of deliveries covered by Medicaid is known and incorporates similar income requirements. CFK programs typically utilize WIC guidelines for income eligibility at 185% federal poverty, and pregnant women in Ohio are eligible for Medicaid benefits up to 200% federal poverty. In Ohio during 2019, a total of 54,955 resident births were paid for by Medicaid. Using this number as the best-known estimate for the overall target population statewide, roughly 10% of this total number could have received a free crib and safe sleep education through the network of CFK partners. Although only estimated, this suggests a significant reach statewide among the target population.

During FY 21, ODH continues to provide funding for programs providing safe sleep environments and safe sleep education to eligible Ohio families, with the service area for funded programs totaling at least 54 Ohio counties. As part of these

efforts, ODH provides CFK funded programs and other facilities with safe sleep resources and updates through an ongoing partnership with the Child Injury Action Group (CIAG) Safe Sleep Subcommittee. CIAG is an action group of the Ohio Injury Prevention Partnership (OIPP), which is funded by the Centers for Disease Control and Prevention (CDC) Core Violence and Injury Prevention Grant. CIAG consists of representatives from the state and local levels, including local health departments, state agencies, hospitals, professional associations and universities. Members are organized into subcommittees by child injury priority area, with members of each subcommittee working together to achieve joint measures and activities. The Safe Sleep Coordinator, whose position is partially funded by the Title V MCH Block Grant, works on the various safe sleep activities outlined in this Title V MCH Block Grant objective and serves as the ODH liaison to the safe sleep subcommittee and as a member of the OIPP and CIAG leadership teams. The safe sleep subcommittee includes members representing at least 44 Ohio counties and meets via conference call, with FY 20 meeting attendance averaging around 40 people. The Safe Sleep Subcommittee also serves an advisory role, with subcommittee members sharing information and providing feedback to help inform the development and continuous improvement of ODH initiatives, such as the annual infant safe sleep training, which will be discussed in more detail later in this section.

Infant Safe Sleep Screenings

An additional strategy for reducing sleep-related deaths centers around ensuring newborns have a safe sleeping environment at home prior to hospital discharge, with an associated measure for increasing the percent of families screened for a safe sleep space (Strategy B3). The Ohio Infant Safe Sleep Law (Ohio Revised Code 3701.67) enacted by Amended Substitute Senate Bill 276 of the 130th Ohio General Assembly in May 2015 requires birthing centers and hospitals to screen new parents and caregivers prior to discharge to determine if the infant has a safe sleeping environment at their residence. The enactment of this law represents a population-based public health services strategy. If the infant is determined not to have a safe sleeping environment per this screening, the facility, excluding critical access hospitals, must assist the family in obtaining a safe crib at no charge. Hospital staff are also required to provide the parent or caregiver with safe sleep education prior to discharge, representing an enabling service.

ODH developed a model screening form for facilities to use to identify parents and caregivers who do not have a safe sleep environment for their infants. Beginning January 1, 2017, a new tab was added within the state's Integrated Perinatal Health Information System (IPHIS) to capture infant safe sleep environment screening data. In 2016, ODH conducted regional trainings on the topic of infant safe sleep and how to enter safe sleep environment screening data into the new IPHIS tab. Facilities with IPHIS access report safe sleep environment screening data into the system. These data, along with demographic data, are extracted to monitor the need for safe sleep environments and appropriate action taken by facilities to connect families in need with a safe crib for an annual report developed by ODH.

Based on the most recent report, 126 facilities provided ODH with safe sleep screening data for 2018. The results indicated that 129,999 caregivers of newborns were screened; of them, 129,380 (99.5%) reported having safe sleeping cribs for their infants at home, and 619(0.5 percent) reported not having safe sleeping cribs for their infants at home. This is similar to the previous year, when 632 parents/caregivers reported not having safe sleeping cribs for their infants at home (0.5%) and a slight decrease from 2017, when 815 parents/caregivers (0.6%) reported not having a safe sleeping crib for their infant at home.

The 0.5% of parents/caregivers who reported not having a safe crib at home were provided a crib by the hospital/birthing center or referred to a resource where they could get one, such as an ODH funded CFK program. (Twenty-two were reported as not providing a response.) While the direct impact is not known, the only 0.5% reporting not having a safe crib in 2019 could be significantly higher without the CFK network of partners serving eligible families that include expectant mothers and providing thousands of cribs annually.

Based on IPHIS reporting facility data for 2019, 97.6% of caregivers statewide were screened for a safe sleep environment. This is a slight increase from 2018, at 97.4%. Among caregivers screened for a safe sleep environment, infants whose mothers identified as a minority race, Hispanic, or resided in large metropolitan counties were disproportionately reported as needing safe cribs compared to all caregivers screened for a safe sleep environment by IPHIS reporting facilities. As a result, ODH plans to continue addressing the disproportionate need for more access to safe sleep environments in metropolitan counties and among minority women. Ohio's birthing centers/hospitals are critical partners for providing high quality, consistent education to parents/caregivers during their maternity stays. ODH will continue to build strong networks of supports and partnerships at the local level to reduce barriers that families may face in obtaining safe sleep environments.

Additional Health Promotion Efforts

The final strategy (Strategy B4) focuses on enabling and population-based health services for health promotion and education efforts, including implementation of a safe sleep media campaign, free annual safe sleep training classes, and free safe sleep educational materials available to local organizations for distribution to individuals statewide. These efforts focus on educating Ohioans on the AAP safe sleep recommendations in order to improve awareness, increase knowledge,

and ultimately change behavior.

Data available from the Ohio Pregnancy Assessment Survey (OPAS), which is representative of women who gave birth in Ohio and examines maternal behaviors and experiences, show key areas for continued focus and improvement. The associated measures for NPM 5A - 5C describe specific safe sleep behaviors corresponding to the AAP recommendations and associated ABCs of Safe Sleep. The NPM 5A measure for the percent of infants placed to sleep on their backs in Ohio for 2020 is 87.6% (2019 OPAS). This number has been trending upward and represents an increase from the previous year, at 86.6%, although it falls short of the 2020 Title V MCH Block Grant objective of 90.5%. The NPM 5B measure for percent of infants placed to sleep on a separate approved sleep surface is 45.4% (2019 OPAS). This number has also been trending upward, with an increase from the previous year at 42.4%. Additionally, this 5B measure for 2020 exceeds the 2020 Title V MCH Block Grant objective of 44%. However, it represents considerable room for improvement, given less than half of Ohio mothers report placing their infant to sleep on a separate approved sleep surface. The NPM 5C measure of percent of infants placed to sleep without soft objects or loose bedding is 61.5% (2019 OPAS), which represents a significant increase from the previous year, at 57.7%, and exceeds the 2020 Title V MCH Block Grant objective of 61%. While trending in the right direction, this measure also represents significant room for improvement, with nearly 40% of Ohio mothers not placing their infant to sleep without soft objects or loose bedding.

ODH continues work to improve these measures by promoting the AAP safe sleep recommendations through population-based health promotion efforts. One such efforts is the ODH safe sleep media campaign conducted annually. During FY 20, ODH continued the safe sleep media campaign targeting mothers and fathers ages 16 to 45 and grandparents in high-risk Ohio counties with infant safe sleep messages focused on ABCs of Safe Sleep and smoke-free environment messages, given smoke exposure represents a significant risk factor for sleep-related death statewide. Under Strategy B4, ODH aimed to increase the number of impressions achieved through the media campaign, as well as making additional refinements. The FY 20 campaign goal was to educate the target population (mothers 16-45, fathers, and grandparents in high infant mortality areas of Ohio) on the important of following the correct way to put infants to bed in safe, smoke-free environments. During FY 20, the campaign delivered over 57 million impressions via various media channels including television, radio, digital radio, website/digital advertising (digital display, YouTube), Hulu, Facebook, and Instagram. This represents an increase from the 29 million impressions delivered in FY 19. The FY 20 campaign ran during April to July of the COVID-19 pandemic and focused more heavily on mediums experiencing increased viewership, such as Broadcast TV, cable and streaming services. In addition, ODH continues to offer free infant safe sleep educational materials that can be shipped directly to organizations statewide, including hospitals and health departments, for local distribution to families. These materials focus on providing information on the ABCs of Safe Sleep and other AAP recommendations for safe sleep.

Further, Substitute Senate Bill 332 of the 131st Ohio General Assembly requires ODH to provide annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in the infant mortality hot spots. Working in partnership with the OIPP CIAG Safe Sleep Subcommittee, ODH developed an online safe sleep training and made it available during FY 18. The training is posted on the ODH website and Ohio TRAIN. This online training is updated annually with assistance from Safe Sleep Subcommittee members. The updated training includes the latest data and is organized into three modules focusing on an introduction to the terminology and data for infant mortality and sleep-related deaths, the AAP safe sleep recommendations, and tips for working with families and overcoming barriers.

During the upcoming year under Strategy B4, the ODH Safe Sleep Program intends to continue targeting mothers, fathers and grandparents in high risk Ohio counties and demographic groups for the safe sleep campaign. In addition, ODH intends to continue including smoke-free environment messages in the media campaign. Further, ODH plans to explore additional improvements of safe sleep education and materials, working with the CIAG Safe Sleep Subcommittee and other partners.

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

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

- Ohio met 6 of the 7 benchmarks. The final benchmark was not met due to the inability to identify a successful vendor to implement an integrated newborn screening system.

Benchmarks with Status as of Year 4 (FY 20) of 5-Year Grant Period:

1. Report of refusals across the 3 screenings completed and disseminated – COMPLETED
2. Development of a combined NBS brochure – COMPLETED
3. Hiring/onboarding contractor to conduct review of systems and provide review of solutions – COMPLETED
4. Consolidating reports of newborn screening results to providers – no progress, waiting on integrated system
5. Final report from contractor received with analysis of potential solutions – COMPLETED
6. Develop technical specifications and system requirements for integrated NBS system with DAS – COMPLETED
7. Implement solution – INCOMPLETE. Ohio executed two rounds of competitive RFPs to identify a successful vendor

to implement this solution. Unfortunately, a successful vendor was not identified.

The Ohio Department of Health utilizes 5 separate systems for collecting, managing, and reporting of newborn screening information. Each newborn screening program collects data their own way: the ODH Newborn Screening Lab collects data in Life Cycle for bloodspot screening; the Genetics Program, which conducts much of the short-term follow-up and long-term management of individuals with these disorders, collects data in the MCHIDS system; the Sickle Cell Program conducts the follow-up for babies with abnormal hemoglobinopathy screening results through an annual spreadsheet of aggregate data; the Infant Hearing Program collects screening information as part of the electronic birth certificate (IPHIS) and management and referrals to EI is done through Hi Track; and the newborn screening data for critical congenital heart disease is also collected as a separate tab in the electronic birth certificate (IPHIS). None of these systems can interact with each other and the newborn bloodspot system is not connected with Vital Statistics birth records to enable accurate population-based reporting. ODH has embarked on a multiple year project to explore IT solutions for integrated newborn screening systems that meet the needs of each of the newborn screening programs and their stakeholders.

During FY 20, ODH staff continued to work with DAS to refine a new solicitation to be posted during the first 6 months of calendar year 2020. To assist with supporting the costs of development of a new system, a capital budget request was submitting to the Ohio Office of Budget and Management. There were no successful applicants identified during this process. Due to COVID-19, this initiative was placed on hold in order to revisit the system requirements and revise as necessary in order to be more successful in the bidding process.

While the work on the integrated NBS system was ongoing, staff from each newborn screening program continued to monitor the number of babies screened, diagnosed, and referred for treatment, as well as those lost to follow-up. In addition, an enhancement to the MCHIDS data system was completed to collect Sickle Cell education event data. Providing education is an integral component of Ohio's Sickle Cell Program and required in state statute. This enhancement was completed in June 2020.

Annually, the Genetics Program Coordinator conducts an analysis of abnormal newborn bloodspot screening results pulled from the NBS Lab system and cross references them with follow up data in the MCHIDS system. This analysis is done annually and reported back to the ODH NBS Lab and the Genetic Centers.

The Infant Hearing Program continues to use quality improvement methods to ensure primary care providers (PCPs) are knowledgeable about the importance of newborn hearing screening and promote the follow-up from referred hearing screening results to their patients parents/caregivers. The ODH Infant Hearing Program monitors letters sent to PCPs regarding patients needing follow up and the results received.

Priority: Increase Access to Early Infant Care and Wellness

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

- According the National Immunization Survey (NIS), 80.1% of Ohio infants born in 2017 were ever breastfed and 21.6% were exclusively breastfed for six months.

ESM 4.1 Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies

- As of the end of FY 20, 87 (86.1%) hospitals had received recognition from Ohio First Steps for Healthy Babies. This exceeds our 2020 objective of 77.3%.

Priority Objectives identified in the five-year action plan continued to include: A. Increase the number of birthing hospitals meeting all or part of the Ten Steps to Successful Breastfeeding through the First Steps for Healthy Babies Initiative, B. Adapt culturally appropriate trainings to increase breastfeeding rates among Black and Appalachian mothers and babies, C. Increase access to breastfeeding friendly environments, D. Increase community awareness to promote and support breastfeeding, E. Establish a breastfeeding designation program for child care providers.

Breastfeeding

According the National Immunization Survey (NIS), 80.1% of Ohio infants born in 2017 were ever breastfed and 21.6% were exclusively breastfed for six months. We have seen an average annual percent increase of 2.6% ($p<0.05$) since 2007 in the percent of infants ever breastfed. The percent of infants who were exclusively breastfed has also increased an average of 7.6% ($p<0.05$) since 2007. Breastfeeding rates for infants born in 2017 in Ohio were lower than the previous cohort of births, these decreases were not statistically significant. Data for the subsequent year will be helpful in determining if this apparent decline is an aberration or reflective of a true change in breastfeeding rates. Although the overall rate of breastfeeding has been steadily increasing, there are racial and income disparities.

The Ohio Pregnancy Assessment Survey (OPAS) provides additional data related to breastfeeding. According to the 2019 OPAS, the percent of women who ever breastfed their infant was very similar among racial groups: 84.4% among non-

Hispanic Black women, compared to 85.3% among non-Hispanic white women, 81.7% among Hispanic women, and 90.0% among non-Hispanic women of all other races. These rates have remained fairly consistent since 2016, the first year that OPAS was administered.

However, a racial disparity appears in breastfeeding over time: at 8 weeks postpartum, 52.7% of non-Hispanic Black women reported breastfeeding, compared to 65.4% of non-Hispanic white women, 56.8% of Hispanic women, and 67.8% of non-Hispanic women of all other races. It should be noted that non-Hispanic Black women were slightly more likely to report certain barriers to breastfeeding, including too many other duties, feeling like it was the right time to stop, medical reasons, and returning to work.

An increase in household income appears to be associated with an increase in breastfeeding. According to OPAS data, in 2019, 92.1% (95% CI: 90.4-93.8) of women with a household income of greater than $57,000 ever breastfed compared to 77.6% (95% CI: 74.3-80.9) of woman with a household income of $32,000 or less. This is very similar to the rates observed in 2018, when 93.5% (95% CI: 92.1-94.9) of women with a household income of greater than $57,000 ever breastfed compared to 77.5% (95% CI: 74.7-80.3) of woman with a household income of $32,000 or less.

ODH implements public health strategies that align with *The Surgeon General's Call to Action to Support Breastfeeding* and *The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies.* These include increasing breastfeeding support across hospital, childcare, worksite, and community settings through policy, system, and environment changes. Overall, these initiatives aim to reduce breastfeeding disparities and ultimately decrease infant mortality.

Objective 1: Increase the number of birthing hospitals meeting all or part of the Ten Steps to Successful Breastfeeding through the First Steps for Healthy Babies initiative.

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

The core team for *First Steps* is made up of eight individuals representing ODH, OHA, Ohio Chapter of American Academy of Pediatrics (Ohio AAP), Ohio Breastfeeding Alliance (OBA), Ohio Lactation Consultant Association (OLCA), and Baby-Friendly USA designated hospitals. The team develops materials, provides technical assistance to hospital staff, and reviews hospital breastfeeding policies and *First Steps* applications in addition to providing ideas and guidance on statewide breastfeeding initiatives.

The initiative launched in March 2015, with the first round of applications accepted in July 2015. Throughout FY 20, there were four rounds of applications. In total, there have been 21 rounds of applications at the end of FY 20 and 86.1% (87 of 101) hospitals were recognized. This is an increase of two hospitals from FY 19 and exceeds our FY 20 objective of 77.3%. Hospitals continue to apply as they achieve more steps.

As part of the ongoing education and support for birthing hospitals, the *First Steps for Healthy Babies* team provides a free, online, self-paced two-part training for hospital maternity staff. In FY 20, 1,401 health professionals completed Part 1 of the training. In November 2019, ODH launched Part 2 of the training. In FY 20, 403 health professionals completed Part 2 of the training. Upon completion of the both trainings, staff received 15 nursing continuing education contact hours (8 hours for Part 1; 7 hours for Part 2) that can be applied towards staff education requirements for Step 2 of the *Ten Steps to Successful Breastfeeding* and *First Steps* designation.

Additionally, the First Steps Review Committee made modifications to the application to be in alignment with the *Interim Guidelines and Evaluation Criteria* released by Baby-Friendly USA. The First Steps team compiled a PowerPoint presentation on Step 2 education for non-maternity unit staff that hospitals can modify and adapt for their needs.

The First Steps team had a research article published in the June 2020 issue of the *Ohio Journal of Public Health*: Ohio First Steps for Healthy Babies: A Program Supporting Breastfeeding Practices in Ohio Birthing Hospitals.

The *Ohio First Steps for Healthy Babies*, in partnership with OBA and OLCA, accepted applications and presented awards for the "Maternity Care Best Practice Award 2019" bag-free recognition in March 2020. This award recognizes hospitals for removal of free infant formula samples and formula company branded diaper bags and goods. This supports hospitals in progress towards practices that align with Baby-Friendly USA certification requirements, as well as the overall goal of reducing infant mortality in Ohio. Eighty-two (of 101) received recognition for 2019. Since 2016, more hospitals have received recognition each year: 80 hospitals in 2018, 73 hospitals in 2017, and 59 hospitals in 2016.

The Ohio Birth Certificate collects data on exclusive breastfeeding at discharge. In 2019, 51.2% of women who gave birth in Ohio hospitals exclusively breastfed at discharge. Rates were 51.6% in 2018, 51% in 2017, 52.3% in 2016, and 52.8% in 2015. This field was newly added to the birth certificate in 2014 and the first full year of collection was 2015. Earlier years of data were less complete and may have issues with quality. It was missing on 11.7% of birth certificates in 2015, on 5.0% of birth certificates in 2016, 3.8% in 2017, 3.6% in 2018, and 3.7% in 2019.

Objective 2: Adapt culturally appropriate trainings and tools to increase breastfeeding rates among Black and Appalachian mothers and babies.
ODH partnered with the Michigan Breastfeeding Network to offer free continuing education webinars to health professionals in Ohio. Many of the webinars are focused on breastfeeding inequities and strategies to bridge the gap.

ODH received funding from the Association of State and Territorial Health Officials (ASTHO) to advance breastfeeding and health equity. ODH partnered with Professional Data Analysts (PDA) to conduct focus groups with African American and Appalachian women (two groups with the highest breastfeeding disparities) with the goal is to identify strategies that state and local partners can implement to improve breastfeeding rates, particularly breastfeeding duration. This work will conclude in FY 21.

In March 2020, ODH launched a 24/7 statewide breastfeeding hotline. The Appalachian Breastfeeding Network (ABN) operates the toll-free 24/7 hotline with live, trained lactation professionals. Services are available free of charge to all callers, including mothers, their families and partners, expectant parents, and health care providers. Hotline operators are located across the state and encompass different cultures and regions for statewide representation. The hotline averaged 12 calls/day in its 6.5 months of operation in FY 20. Hotline usage continues to increase.

Objective 3: Increase access to breastfeeding friendly environments.
With funding from the CDC State Physical Activity and Nutrition (SPAN) grant, ODH contracted with Every Mother, Inc., a national breastfeeding expert, to provide training and tools on the federal lactation accommodation law. The nine counties participating in the Ohio Institute for Equity in Birth Outcomes (OEI) received training and participated in the project. The counties worked with employers in their community to improve lactation accommodations and policies in the workplace in FY 20. A total of eight policies were implemented.

ODH also launched a toolkit, *Ohio Workplace PLUS (Providing Lactation Upgrades and Support)*, for employers and employees. This toolkit targets the special needs of Ohio businesses and even features some Ohio businesses and how they were able to make their lactation accommodations work. The nine counties provided the toolkit as part of the education to the worksites. Given the challenges of COVID-19, ODH and Every Mother, Inc., created “Considerations for Safe Worksite Lactation Spaces,” a document based on the CDC guidance for work spaces but adapted to milk expression areas since guidance specific to worksite lactation support areas was nonexistent. The initiative continued for the nine counties and also expanded to eight additional counties for FY 21.

Objective 4: Increase community awareness to promote and support breastfeeding.
WIC partnered with Coffective to focus on state and local coordination and collaboration to help improve breastfeeding rates and access to support for moms. State and local partners came together to develop sustainable partnerships that work toward bridging gaps in services/care and decrease health disparities in local communities, with the goal of improving coordination of maternal and child health partners with a specific focus on building and strengthening relationships at the local level.

State WIC met with a variety of state partners including Ohio Chapter of American Academy of Pediatrics, ODJFS and Commission on Fatherhood, Ohio Lactation Consultant Association, Appalachian Breastfeeding Network, as well as leaders of Title V. State leaders were brought together and were tasked in identifying ways their state programs could align goals and coordinate efforts to positively impact local community coordination. State leaders engaged in the project played a key role in one or more of the following ways:

- Shared program information, resources, and communication opportunities with their local networks
- Engaged and encouraged local networks to participate in the project
- Disseminated surveys, reports, resources, and lessons learned

At the community level, 15 WIC Projects participated in coaching with the Coffective. Community Coordination Coaching provides organizations the opportunity to take their partnerships to the next level. Coaching includes one-on-one guidance for local organizations to enhance their ability to collaborate more efficiently and sustainably. It provides guidance and support around:

- Identify partners and common interests to work towards aligning shared priorities.
- Learn to develop key partnerships to build capacity and strengthen relationships.
- Create multi-stakeholder community coordination
- Incorporate community voice in program development and processes.

As a result, communities are moving closer to consistent messaging, continuity of care, increased referrals to WIC, and increased capacity through collaboration of services.

WIC projects also have access to a Community Match Platform to help them connect with community partners and community members. Local community organizations have a strong interest in coordinating, but often face barriers in doing so effectively. They may not know the potential partners exist or understand the services they offer. Sometimes they lack contact information, or specific strategies for coordinating once they have made the right connections. In the communities where progress toward coordination has been made, the lessons have not always been shared with other communities. Data collected from surveys was utilized to populate Community Match, a tool to assist and decrease barriers to community coordination. Community Match is an online platform that helps organizations identify, learn about, and connect with other organizations. It is intended to connect key community partners and help them move closer to true community coordination.

Objective 5: Establish a breastfeeding designation program for child care providers.
Also, in collaboration with the CDC SPAN grant, ODH launched a breastfeeding friendly child care designation program. A statewide network of breastfeeding experts, child care experts and other stakeholders met monthly to plan and design the program that launched in January 2020. The initiative consists of a model policy, training, application and award. Four child care providers (three family providers and one center) earned Gold status designation. Over 1,000 child care professionals completed the free, two-hour online training course, *Supporting Breastfeeding in the ECE Setting,* in FY 20.

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[i] Ohio Department of Health, Ohio Child Fatality Review (CFR) 19th Annual Report 2014-2018 – *report not yet released as of date of writing*
[ii] Ohio Department of Education, Kindergarten page, under Teacher-to-Student Ratio "The ratio of teachers to students in kindergarten through fourth grade on a school districtwide basis shall be at least one full-time equivalent classroom teacher per 25 students in the regular student population. Said ratio shall be calculated in accordance with sections 3317.02 and 3317.023 of the Revised Code (ORC 3301-35-05)," http://education.ohio.gov/Topics/Early-Learning/Kindergarten, accessed 1/14/2020
[iii] Ohio Department of Health, based on 2014-2018 Child Fatality Review (CFR) data – *report not yet released as of date of writing*
[iv] Ohio Departmnent of Health, based on 2014-2018 Child Fatality Review (CFR) data

[v] Ohio Child Fatality Review and Ohio Department of Health, Bureau of Vital Statistics

Perinatal/Infant Health, Application Year FY 2022

The 2020 needs assessment process resulted in a strong and leading identification of infant mortality and birth outcomes as a priority health need. The number of Ohio infants who died before their first birthdays dropped to 929 in 2019 from 938 in 2018, marking a third straight year of decline (2019 is Ohio's most recent infant mortality data released in December 2020). Nine more families were able to celebrate their babies' first birthdays than in the previous year. Ohio's infant mortality rate remains at 6.9 per 1,000 live births, consistent with the 2018 rate. Unfortunately, the racial disparities gap continues to widen. Black infants are 2.8 times more likely to die than white infants. There were 356 Black infant deaths in 2019, an increase of 17 from 2018; while we recorded the lowest number of white infant deaths (518) during the past 10 years. The needs assessment process identified poverty, housing, transportation, employment, income, and family and social support as leading social determinants of health needs associated with poor birth outcomes. The Action Group continues to prioritize care coordination and access to health care and social services as opportunities within existing health care and social service systems to improve birth outcomes. Opportunities identified for changes at the systems level included: improve collaboration and coordination among community programs and among state agencies; identify women and families most in need; and improve data sharing and outcome tracking.

Emerging Issues

Calendar year 2020 and the first half of 2021 have highlighted a myriad of challenges for Ohio's mothers, fathers, infants, children, and families related to the global COVID-19 pandemic. These challenges further validate the importance and urgency of systems-level change. The COVID-19 pandemic exposed and amplified the health disparities and inequities facing Ohioans of color. At the same time, Ohio, and the rest of the nation are grappling with instances of unjust use of violence and the lives of people of color taken too soon. This led to widespread recognition that racism must be addressed in our state and communities. The events of recent months present a unique opportunity to shine the spotlight on the challenges faced by Ohioans of color and propel policy action toward change. Ohio can combat this crisis by taking a comprehensive and systemic approach.

Priority: Support healthy pregnancies and improve birth and infant outcomes

Measures

- NOM: Infant mortality rate per 1,000 live births
- NOM 9.2: Neonatal mortality rate per 1,000 live births
- SOM: Black infant mortality rate per 1,000 live births
- NPM 4: Percent of infants ever breastfed, and percent breastfed exclusively through 6 months.
- NPM 5: Percent of infants placed to sleep on their back, alone on separate approved sleep surface, without soft objects or loose bedding
- ESM: Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies
- ESM: Number of families provided with a crib and safe sleep education through Cribs for Kids

Addressing the disparity in birth and infant outcomes will be measured through the SOM. Both NPMs improve infant outcomes and the ESMs will measure progress in improving both.

Objective: 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%.

Strategies:

1. Continue implementation and expand promotion of the statewide 24/7 breastfeeding hotline and virtual lactation consultants.
2. Continue to build upon breastfeeding initiatives in hospitals, worksites, and childcare facilities.
3. Improve breastfeeding continuity of care with statewide partners.

In March 2021, Professional Data Analysts, Inc. (PDA) created two reports, *Breastfeeding Experiences of Black or African American Women in Ohio* and *Breastfeeding Experiences of Appalachian Women in Ohio,* based on quantitative and qualitative data from focus groups. PDA also identified future collaborations, topics for discussion, and strategies to implement to improve breastfeeding initiation and duration, particularly focusing on African American and Appalachian women. ODH will engage partners to identify new strategies and activities as well as improve and enhance current activities.

ODH extended the contract with Appalachian Breastfeeding Network to continue 24/7 breastfeeding support throughout FY 22. Data will continue to be collected and reported monthly.

The Ohio First Steps for Healthy Babies hospital initiative will include an optional Father/Partner engagement award. Hospitals that apply will be recognized for their inclusion of fathers and partners as they implement the *Ten Steps to Successful Breastfeeding.* First Steps will continue with quarterly applications and recognition. Continuing education webinars will also be planned.

ODH will enter Year 4 of the CDC State Physical Activity and Nutrition (SPAN) Cooperative Agreement. Activities planned include developing and implementing a Breastfeeding Worksite Award. The 17 counties receiving funding to educate local businesses and assist with development of lactation policies and accommodations in FY 21 will continue their work and expand to new worksites.

The ECE Breastfeeding Friendly Child Care Award remains available for ECE providers who completed a required training and application depicting their implementation of breastfeeding-friendly practices. Outreach to all licensed childcare centers and family providers will continue. Recognized providers will also be eligible for the up-and-coming Breastfeeding Worksite Award.

ODH will continue to improve breastfeeding continuity of care by reaching out to new statewide partners as well as enhancing collaboration with current partners. The Coffective initiative, with the WIC program, will continue to link local WIC projects with hospitals and community organizations.

Objective: 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%.

Strategies:

1. Continue implementation of the Cribs for Kids Program to provide safe sleep education and safety-approved cribs to families; including improved data collection by race.
2. Continue implementation of the annual safe sleep campaign to provide consistent messaging on safe sleep practices to families.
3. Partner with local infant mortality collaboratives to tailor statewide safe sleep messaging to better reflect experiences of communities of color.

Ohio is participating in the HRSA-funded CityMatCH Alignment for Action Cohort (AAC) with a local government partner on safe sleep messaging for Black women and families. Information was collected through focus groups for Black women about their sources of safe sleep information, sleeping behaviors, and how mothers think and communicate about safe sleep. This information will serve as the foundation of activity design between the local partner and State Title V during FY 22.

Objective: By 2022, develop plan for enhancing coordination of pregnancy and post-partum supports and messaging.

Strategies:

1. Enhance partnerships with state agencies, local organizations, and stakeholders to improve coordination of pregnancy and post-partum services.
2. Enhance partnerships with state agencies to improve coordination of state funding for local MCH activities.
3. Explore coordination of safe sleep, breastfeeding, and smoking cessation messaging.

The Ohio Council to Advance Maternal Health (OH-CAMH) is coordinating with 79 member organizations to develop a statewide strategic plan. Partner organizations include local organizations, state organizations, national organizations, Title V staff, and patients/families. The Council will work to refine and prioritize strategies and identify or develop evaluation metrics for each strategy through the development of a strategic plan. Multidisciplinary collaboration, racial/ethnic diversity, and inclusion of those with lived experience in decision making processes are some of the core values and expectations that OH-CAMH indicated were important in the OH-CAMH Charter. Assessing the diversity of the workgroup membership list will occur before starting the strategic planning process.

A cohort of seven Ohio communities represented by seven of the nine Ohio Equity Institute counties (more information in the next objective) will join for technical assistance and training around the Queens Village model developed by Cradle Cincinnati. Queens Village is a supportive community of powerful Black women who come together to relax, repower, and take care of themselves and each other. Queens Village is an initiative of Cradle Cincinnati, a collective impact organization that fights high rates of infant mortality that disproportionately affect Black women in Cincinnati and beyond. They center Black women’s voices on changing not just racial disparities in birth outcomes but also the conditions that drive inequity in maternal and infant health. The cohort will seek to train community-based organizations to provide a safe space for Black mothers to support and be supported by their peers, to connect, to relieve stress, to process trauma, and to build a better world together for themselves and their children.

The Ohio Department of Health will leverage Governor Mike DeWine's Cross-Agency Leadership Team as a planning resource to better coordinate state funding for MCH activities. As well as continue strategic planning for infant mortality investments with partners at the Ohio Department of Medicaid through managed care plan community dollars prioritizing the needs of Black pregnant women.

The Title V team will conduct an environmental scan of other states' safe sleep, breastfeeding, and smoking cessation messaging. We will explore the use of existing infant mortality collaboratives throughout the state to develop a collective, statewide strategy for messaging.

Objective: By 2025, reduce Black infant mortality rate to 6.0 per 1,000 live births.

Strategies:

1. Increase access to clinical and social services through outreach and identification of Black pregnant women.
2. Increase use of social support services among high-risk Black pregnant women to address social determinants of health.
3. Support local community-driven policy and practice change addressing social determinants of health that impact poor birth outcomes.
4. Improve access to basic needs resources for pregnant and postpartum women (e.g., Cribs for Kids).
5. Data to examine variations in cause of infant death by race and ethnicity to inform data to action.

Last year, Healthy People 2030 developed new goals for our country's infant mortality rates. While Ohio has long achieved the Healthy People goal for white infants, we have not reached the same goal for Black infants. Ohio Governor Mike DeWine has tasked the Eliminating Racial Disparities in Infant Mortality Task Force with developing recommendations to achieve this goal for all infants by 2030. The Task Force's recommendation must acknowledge the events that unfolded in 2020 and also create a bold roadmap for change in actionable, practical, but ambitious recommendations that accelerate the rate of change we need to overcome decades of disparities in birth outcomes. Recommendations will be founded on the experiences and recommendations of Ohio's Black families.

The Ohio Equity Institute (OEI) will serve as an implementation mechanism for recommendations designed by the Eliminating Racial Disparities in Infant Mortality Task Force. The Ohio Equity Institute (OEI): Working to Achieve Equity in Birth Outcomes is a grant-funded collaboration between the Ohio Department of Health and local partners created in 2012 to address the racial inequities in birth outcomes. Each OEI community will also receive technical assistance through a cohort-model to develop and implement Black women-led community engagement. This equity and community strategy will center Black women's voices on changing not just racial disparities in birth outcomes but also the conditions that drive inequity in maternal and infant health.

Four subgrantees supported through the Disparities in Maternal Health Community Grant Program will design innovative and culturally humble initiatives to address racial/ethnic and/or geographic health disparities related to maternal health in Ohio. Projects will uplift the voices of the communities most likely to experience disparities in maternal mortality/morbidity and support existing and/or new interventions in these communities; as well as fund solutions identified by communities to address unmet needs through a disparity-focused, equity lens.

The Action Group will define "basic needs resources" and the scope of this strategy as well as expand the prescription produce program for pregnant and postpartum women in five priority counties.

Perinatal Periods of Risk (PPOR) Phases 1 and 2 will be completed. Results of this analysis will inform the design of activities aligned with workplan strategies. A brief focused on racial disparities in infant mortality and maternal experiences before, during, and after pregnancy is under development and will be disseminated to key partners to inform strategy development.

Contributing program scorecards for infant mortality will be created in Clear Impact. ODH has adopted the Results Based Accountability (RBA) framework for performance management and invested in the Clear Impact platform as the data collection system to manage performance objectives and track progress over time. ODH has started implementation of RBA and use of Clear Impact with the State Health Improvement Plan (SHIP) indicators, which include infant mortality. Each program in the Bureau of Maternal Child and Family Health (BMCFH) that contributes to addressing infant mortality is creating a program scorecard to track key performance measures, share data with program partners and the public, and have conversations that drive change and improve outcomes. To ensure the scorecards are useful as we strive to eliminate the Black infant mortality disparity, programs are including disaggregated measures.

Objective: By 2022, assess need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-baby visit.

Strategies:

1. 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.)
2. Explore cross-program support opportunities through partnership with ODH Immunizations program.

The Title V team will continue to engage partners and collaborate on identifying gaps in screening and education. As we continue to plan, we are revisiting the intended goal of this objective. Our Epidemiologist is currently working on PPOR Phase 2 data. This data will allow us to investigate the opportunity gaps to discover which risk and preventive factors are likely to have the largest effect on improving our state's infant mortality rate and also provide additional information to better direct intervention prevention planning. As we gain more insight from this process, we plan to align and refine our strategies and activities.

Other Efforts Supported by Title V MCH

The majority of MCH programs serving the Infant population are represented within the above application narrative. Several program summaries are included below to highlight additional relevant programs and a complete list of programs serving the Infant population is available in the Program Map (section V. Supporting Documents).

Ohio Connection for Children with Special Needs – Birth Defects Surveillance Program

Ohio Connections for Children with Special Needs (OCCSN) is Ohio's statewide population-based birth defects surveillance program. The Ohio Revised Code 3705.30 authorizes the state director of health to require hospitals, physicians, and freestanding birthing centers to report children from birth to 5 years of age with certain reportable birth defects to the Ohio Department of Health (ODH). Collection of birth defect data is important for public health action, including facilitating referrals to services such as early intervention and targeting prevention strategies. The Birth Defects program's mission is to improve the lives of children through birth defects surveillance, referral to services, research, and prevention. The program uses cross-agency collaboration to elevate maternal and infant health and to better serve Ohio families.

OCCSN began surveillance of Neonatal Abstinence Syndrome (NAS) in January 2020. Suspected cases are reported through the OCCSN data system from hospitals and provides passive surveillance of cases reported. Comprehensive genetic centers conduct case review for suspected birth defect cases seen at their facilities. For cases with confirmed NAS, referrals are sent to Part C Early Intervention for services and are automatically eligible for enrollment. OCCSN is also involved in the Pathways to Community Plans of Safe Care initiative that is focused on cross-agency collaboration to elevate maternal and infant health and to better serve Ohio families through building infrastructure to provide plans of safe care for infants who have been exposed to NAS.

Comprehensive Genetics Services Program

The Genetics Services Program funds a network of eight genetic centers that provide comprehensive care and services to people affected with, or at risk for genetic disorders. The purpose of the program is to ensure availability of quality, comprehensive genetic services in Ohio. Genetic services include, but are not limited to genetic counseling, education, diagnosis, and treatment for genetic conditions and congenital abnormalities. Persons in Ohio who would like genetic counseling, or other genetic treatment services, may contact one of the Comprehensive Genetic Centers (CGC), or may be referred by their primary care physician. The goals of the Comprehensive Genetic Centers (CGCs) are to ensure that children and adults with, or at risk for birth defects or genetic disorders and their families receive quality, comprehensive genetic services that are available, accessible and culturally sensitive; and providers, the general public and policy makers are aware and knowledgeable about birth defects, genetic conditions, and genetic disease related services in Ohio.

Infant Hearing Program

The Ohio Department of Health Infant Hearing Program (IHP) is the state of Ohio's Early Hearing Detection and Intervention (EHDI) Program. The national EHDI principles under the Joint Committee on Infant Hearing (JCIH) include screen for risk of hearing loss by 1 month of age; diagnose a suspected hearing loss by 3 months of age; and begin provision of early intervention by 6 months of age. National averages indicate that about three infants per 1,000 births are identified with a hearing loss. The IHP has several goals that align with the national EHDI principles. These include ensuring that all infants who do not pass their hospital hearing screening receive no more than two screenings prior to hospital discharge. The IHP also provides follow-up coordination for tracking and monitoring of infants who need diagnostic hearing evaluations after non-pass hospital hearing screening results. In addition, the IHP refers families for home-based, early intervention services to help with the development of communication and language in infants and toddlers with hearing loss in order to help them build the best possible skills during the developmental stages for communications skills.

Newborn Screening for Critical Congenital Heart Disease

In 2014, the Ohio General Assembly enacted legislation requiring Critical Congenital Heart Disease (CCHD) screening, and the Ohio Department of Health (ODH) in partnership with hospitals and birthing centers developed standard screening

guidelines and began to systematically collect CCHD screening results. ODH continues to monitor hospital reporting and offers guidance to newly appointed hospital screening coordinators. Pulse oximetry, the measure of the oxygenation levels in the blood, is used to screen and identify infants that may have CCHD. Low pulse oximetry readings may be used as a reliable indicator for the seven specific CCHDs targeted for identification in Ohio. These include hypoplastic left heart syndrome, pulmonary atresia, Tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus. Birth facilities and hospitals with access to vital statistics electronic birth records enter the CCHD screening results directly into the Integrated Perinatal Health Information System (IPHIS). Children's hospitals without access to IPHIS, or other facilities where an infant may be transferred, provide ODH with paper reports of CCHD screening results upon discharge of the infants from their facilities.

Sickle Cell Services Program

The Ohio Department of Health (ODH) funds two grant initiatives under Sickle Cell Services Program related to sickle cell disease, sickle cell trait, and other hemoglobinopathies. These initiatives are the Sickle Cell Initiative and the Statewide Family Support Initiative. As a public health program, the Sickle Cell Services Program works to ensure and enhance the availability and accessibility of quality, comprehensive sickle cell services and care for newborns, children and adults; promote public, patient, consumer, family, and professional education to increase awareness and knowledge about sickle cell disease, sickle cell trait, and other hemoglobinopathies; and, increase strategies to maximize collaboration, coordination, and utilization of all sickle cell-related services and resources in Ohio.

Child Fatality Review

Child deaths are often regarded as indicators of the health of a community. While mortality data provide us with an overall picture of child deaths by number and cause, it is from a careful study of each child's death that we can learn how best to respond to a death and how best to prevent future deaths. Recognizing the need to better understand why children die, Governor Bob Taft signed a bill in July 2000 mandating child fatality review (CFR) boards in each of Ohio's counties to review the deaths of children under 18 years of age. For the complete law and administrative rules pertaining to CFR, refer to the Ohio Department of Health website at odh.ohio.gov/wps/portal/gov/odh/health-rules-laws-and-forms.

To accomplish this, it is expected that local review teams will: Promote cooperation, collaboration, and communication among all groups that serve families and children; maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths; and recommend and develop plans for implementing local service and program changes and advise ODH of data, trends, and patterns found in child deaths.

CFR boards must meet at least once a year to review all deaths of child residents of that county. The basic review process includes: The presentation of relevant information; the identification of contributing factors; and the development of data-driven recommendations. At the state level, we are re-establishing the CFR Advisory Board. The purpose of this advisory board is to review Ohio's child mortality and CFR data to identify trends in child deaths, identify system responses to child deaths in Ohio, to make recommendations in law, policy, and practice to prevent future child deaths in Ohio, and to review and provide input for the annual CFR report.

Fetal/Infant Mortality Review

Fetal Infant Mortality Review (FIMR) is a multi-disciplinary, multi-agency, community-based program that identifies local infant mortality issues through the review of fetal and infant deaths and develops recommendations and initiatives to reduce infant deaths. Currently, there are active FIMR programs in all Ohio Equity Institute (OEI) counties.

The FIMR process includes:

- Identification of cases based on the infant mortality issues of the community.
- Collection of appropriate records from medical, social service, and other providers.
- Maternal interview.
- Abstraction of available records to produce a de-identified case summary.
- Presentation of de-identified case summary to review team.
- Development of data-driven recommendations.
- Implementation of recommendations to prevent future deaths.
- Case Review Team reviews case summaries and develops recommendation.
- Case Action Team reviews recommendations and develops a plan to implement interventions.

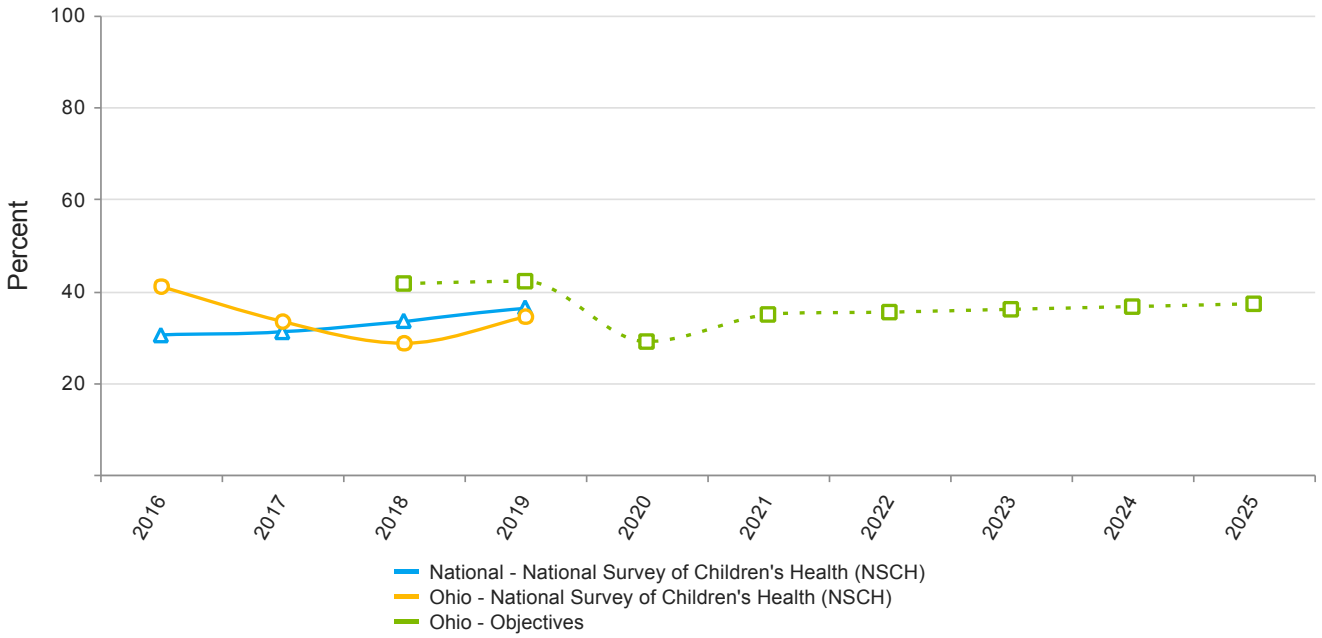
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.5 %	NPM 6

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			41.6	42.1	29
Annual Indicator		41.1	33.3	28.5	34.3
Numerator		114,362	95,915	73,603	105,296
Denominator		278,232	287,752	258,257	306,997
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	34.9	35.4	36.0	36.6	37.2	37.7

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			50	70
Annual Indicator			70	65.4
Numerator			5,879	5,251
Denominator			8,394	8,027
Data Source			OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	74.0	76.0	78.0	80.0	82.0

State Outcome Measures

SOM 3 - Percent of children ages 0-5 with confirmed elevated blood lead levels

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2.3	2.1
Numerator	3,856	3,533
Denominator	168,352	165,832
Data Source	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.8	1.5	1.3	1.2	1.0	0.9

State Action Plan Table

State Action Plan Table (Ohio) - Child Health - Entry 1	
Priority Need	
Improve nutrition, physical activity, and overall wellness of children	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By 2025, increase the percent of children, ages 9-35 months, that receive developmental screens via home visiting programs by 10%	
Strategies	
Support MIECHV and other home visiting programs to provide developmental screening using Ages and States Developmental Screening tool	
Implement Medicaid/CHIP reimbursement claim code for developmental screening activities at provider level	
Educate parents about developmental screening tools	
ESMs	**Status**
ESM 6.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Ohio) - Child Health - Entry 2

Priority Need

Improve nutrition, physical activity, and overall wellness of children

SOM

SOM 3 - Percent of children ages 0-5 with confirmed elevated blood lead levels

Objectives

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.

Strategies

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)

Child Health, Annual Report FY 2020

The annual report is organized by the two priorities for Child health: Increase the prevalence of children receiving integrated physical, behavioral, mental and developmental health services and Reduce the rate of childhood obesity.

Priority: Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services

NPM 6: Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool in the past year.

- According to 2018-2019 NSCH data, 34.3% of Ohio children ages 9-35 months received a developmental screening in the past year. This compares with 36.4% of children nationwide in 2018-2019. Previous Ohio rates were 28.5% in 2017-2018 and 33.3% in 2016-2017.

ESM 6.1: Percent of children, ages 9 through 35 months, receiving home visiting services who have received a developmental screening.

- Developmental screenings are required to be completed during the identified intervals within the Ohio Home Visiting Program. Screening data is recorded for each child enrolled within the data system and referral and follow-up is monitored by the home visitors. In FY 19, 70% of children who were enrolled received the developmental screening with the ASQ3 or ASQE2. While this represented an increase from 59% in FY 18, we were cautious in interpreting the difference due to the change in data system and potential differences in measure criteria. Children were included in the FY 19 denominator if the family had at least 1 home visit during the time period (making them “enrolled”) and if they were 30 days or older during the time period (making them “due” for a screen). Children meeting those criteria were also included in the numerator if they had 1 or more developmental screens during the time period (ASQ3 or ASQE2). In FY 20, 65% of enrolled children received a developmental screen. We expected the number of completed screens to be lower this year due to COVID-19. ODH advised home visiting providers to use only telehealth visit options (phone, video, text message, and drop off materials) since mid-March 2020; providers have indicated it is challenging to complete required screening and assessments due to technological issues and distractions during telehealth visits.

During FY 20, the Maternal and Child Health Block Grant (MCH BG) Child Health Priority work group continued its collaboration and partnerships with various stakeholder groups who represented public health programs, medical professionals, family organizations, and non-profit organizations to impact the priority to increase the prevalence of children receiving integrated physical, behavioral, and mental health services.

According to the 2011-2012 National Survey of Children’s Health, 93.9% of Ohio children aged 0-5 received one or more preventive medical care visit. Eighty-six percent of Ohio children aged 6-11 received one or more preventive medical care visit. According to the 2016-2017 National Survey of Children’s Health, 92.4% of Ohio children aged 0-5 received one or more preventive medical care visit. Eighty percent of Ohio children aged 6-11 received one or more preventive medical care visit. Percentages of children in the identified age ranges have each declined for the 2016-2017 National Survey of Children’s Health when compared to the 2011-2012 National Survey of Children’s Health results. Due to changes in item(s) between survey years the 2017-2018 preventive medical visit data could not be combined; however, 2018 NSCH data indicates continued decreases in preventive medical visits across age groups with 75.2% 0-5, 74.2% 6-11, and 70.9% 12-17. These compare with 2018 nationwide results of 78.8% 0-5, 69.0% 6-11, and 64.8% 12-17.

According to 2018-2019 NSCH data, 34.3% of Ohio parents indicated their children ages 9-35 months received a developmental screening using a parent-completed screening tool. Previous Ohio rates were 28.5% in 2017-2018 and 33.3% in 2016-2017. Due to the substantial reported decrease in 2017-2018 the targets were adjusted, and as such the 2018-2019 rate exceeds the FY 20 29.0% target but is still lower than the national rate of 36.4% in 2018-2019.

Trainings continued for healthcare providers prior to the pandemic. These in person trainings incorporated best practice/evidenced-based approaches for separate components of the comprehensive well-child visit and were conducted during the reporting period. Trainings included the provision of educational and follow-up resources for providers and families. Following the beginning of the pandemic, trainings for healthcare providers shifted from the in-person platform to a live virtual platform. Although trainings and provision of resources were provided during the reporting period, these continue to be disjointed. Overarching updates for the objectives are reported below, followed by more detailed updates provided for each program.

Objective: Increase the number of providers conducing quality comprehensive well-child visit in accordance with best-practice standards and guidelines that include developmental screenings

Programs continued to provide their trainings to healthcare providers to promote best practices and monitored their own screening rates and reported on these to determine changes and needs. Due to the pandemic, the number of healthcare

providers who participated in trainings decreased during Ohio's stay home stay safe orders.

Objective: Work with diverse stakeholders to explore the implementation of comprehensive well-child visits best-practice standards and guidelines that include developmental screenings
Programs continue to collaborate with diverse stakeholder groups to promote well care. Programs continued to promote and provide parent materials that could be used to educate families on the next steps for positive screenings (e.g., lead, hearing, vision, dental, ASQ). Programs who had evidenced-based trainings continued to spread these trainings to providers to help increase screening. Programs were asked to review their own data and determine areas of need.

Due to the COVID-19 pandemic, physician offices postponed well child visits due to the Ohio's stay home stay safe orders. The number of children receiving child well visits with their primary care providers dramatically decreased, whether because of practitioner closures or restrictions or fear on the part of families. Noting these challenges, the ODH Early Childhood Health program contract with the Ohio Chapter American Academy of Pediatrics was updated effective July 1, 2020 to include development of resources and professional development for pediatricians and their office staff to address best practices for offices to provide care for young children and allay the fears of the families during the pandemic The contract also continues to provides professional development, continuing education credits, and resources to pediatricians and their office staff in support of obesity prevention messaging, BMI screening, and motivational interviewing through the Parenting at Mealtime and Playtime (PMP) program.

Objective: Explore a shared data system to track and share information on screening referral and follow-up services
This objective was removed after year 3 due to inability to collect/link screening data in OCHIDS, the new Home Visiting database.

Objective: Explore reimbursement models and standard reporting options
Both the Lead and Vision programs have accomplished this objective. Lead implemented a revised State Plan Amendment (SPA) with Medicaid for lead testing. Vision was granted a new CPT code outside of the bundled well-child visit to bill Medicaid for vision screenings. A MEDTAPP project with Vision on the implementation of the new code was completed in FY 20. The results of this project will spread the use of the new CPT code to bill for vision screenings for the Medicaid population. Standard reporting options across all programs continue to be limited by the inability to implement a comprehensive data system.

Early Childhood Health and Safety
Between the years 2013-2017, two of the top four Serious- and Moderate-Risk Noncompliance Violation citations by the Ohio Department of Job and Family Services (ODJFS) in licensed childcare programs in Ohio were related to health. The two most commonly cited violations were care of children with health conditions and administration of medication. In Ohio Department of Education (ODE) licensed programs, between 2015-2017 one of the top three violations was also health related (child medical statement).

The impact of pandemic restrictions can be seen in children care program data. During State Fiscal Year (SFY) 2020, Child Care Aware reports Ohio had 5,055 licensed childcare programs, down from 6,426 the year before. This included 2,819 childcare centers and 2,236 family childcare programs (https://info.childcareaware.org/hubfs/2020%20State%20Fact%20Sheets/Ohio-2020StateFactSheet.pdf?utm_campaign=Picking%20Up%20The%20Pieces&utm_source=Ohio%20). While there were 555,567 childcare spaces in Ohio in 2019, there were only 137,352 spaces in July 2020. This fact sheet shows that there are more than 827,626 Ohio children in the 0-5 age ranges, with 370,875 of them living in poverty. They estimate that 555,147 Ohio children under the age of 6 years have all parents in the workforce and need childcare.

Objective: Create and Deliver health and safety trainings for early childhood programs
The ODH Early Childhood Health (ECH) and Safety program was created in 2018 to provide training, technical assistance, and develop resources for staff in these systems specifically related to the health and safety of the children in their care. This program joined the ODH Early Childhood Obesity Prevention Program (ECOPP) to improve the childcare and preschool environments for Ohio children. The goal of this program is to improve the safety of early childhood environments in Ohio by providing high quality professional development/workforce development, technical assistance, and resources to ECE professionals with the goal of
reducing the number of health-related Serious- and Moderate-Risk Noncompliance Violations by ODJFS and ODE.

The content of these courses support ECE professionals as they work with families to increase the prevalence of integrated services, improve access to health services, and support access to PCMH for CYSHCN. In addition to online trainings, the ECH program planned to host a half day regional Early Childhood Health and Safety Conference in Spring 2020 in conjunction with each of the three ODH Regional School Nurse Conferences at venues around the state. While the first conference was held on February 27th to address the topics of oral health and health equity, the remaining two conference

dates were cancelled due to pandemic restrictions.

This Public Health Services and System (PHS) strategy seeks to provide professional/workforce development to the licensed child care workers in Ohio. The strategy is being implemented on a statewide level, with collaboration with other state agencies including Ohio Departments of Education, Developmental Disabilities, Jobs and Family Services, as well as with the Ohio Child Care Resource and Referral Agency and the Ohio Center for Autism and Low Incidence. These partners serve on a Steering Committee to review content, provide recommendations and to promote the trainings to their constituents. As mentioned previously, a focus group of ECE providers is convened annually (virtually in summer 2020) to identify training topics and delivery methods.

During FY 20, ECH offered each online course every two weeks. These courses all offer “Ohio Approved” hours needed for professional development. There was a surge in requests for courses in May and June as childcare professionals were seeking continuing education credits to maintain their accreditation, so additional classes were offered during that time. During this year, “How to Care for CSHCN” (offered 30 times) was completed by 2,772 people; “How to Survive Cold and Flu Season” (offered 30 times) was completed by 3,131; “How to Manage Asthma” (offered 27 times) was completed by 1,968; “How to Manage Allergies” (offered 27 times) was completed by 2,207; “How to Accommodate Children with Disabilities” (offered 16 times) was completed by 1,129 participants; “Oral Health’ was completed by 359 (offered 8 times); and “Health Equity” (offered 7 times) was completed by 515 participants, for a total of 12,081 completions of online courses for the year.

During FY 20, the ECH program participated in two Healthy Kids Healthy Future Technical Assistance Programs (HKHF TAP) funded by the Centers for Disease Control and Prevention (CDC) and implemented by Nemours Children’s Health System (Nemours). One of these opportunities provide ODH ECH staff with an Outdoor Learning Environment course from North Carolina State University, while the other afforded the opportunity to invite 20 partners to participate in the Ohio Equity Workshop presented by IPHI. Program was able to use the information acquired in these trainings to create professional development for ECE professionals.

Title V was vital to the implementation of this strategy. Title V funding provided for the staff (.5 FTE) to take the lead to conduct the assessment, course development, and content delivery. In addition, Title V funds were used to contract with the three venues used for the face-to-face conferences (no outlay of funds was incurred for the cancelled events). With Title V support, development of professional/workforce development opportunities for ECE professionals has continued and expanded. Courses were launched throughout the year with large enrollment numbers and strong evaluations. While attendance at the face-to-face conferences were limited due to the pandemic, the online independent studies were well received. Anticipated next steps include development of more training opportunities for this target population, as well as further evaluation of outcomes.

Hearing and Vision
The Children's Hearing and Vision program is a program of early detection, diagnosis, and treatment of children with hearing and vision problems by setting the screening guidelines and requirements and providing training to screeners. Title V funding supports the Children’s Hearing and Vision program.

Trainings for healthcare providers incorporate best practice/evidenced-based approaches for the separate hearing and vision components of the comprehensive well-child visit. The trainings for healthcare providers were revised to include directions for the correct billing of the new vision screening CPT code that was established in FY 20.

Although trainings include the provision of educational and follow up resources for providers and families, these resources continue to be disjointed and cause barriers for follow-up care. New resources were developed for primary care providers to assist in the referral to appropriate eye care providers and audiologists following non-pass hearing and vision screenings. The web-based pediatric diagnostic audiology provider and pediatric vision provider directories assist in the primary care referral and follow-up process by listing contact information, acceptable insurance coverage, ages served, and services provided at each facility listed within the directories. Upcoming revisions to the eye care directory include a separate directory for low vision. Education and outreach were conducted with various screening stakeholders and families to raise awareness and promote the use and availability of these new resources.

In response to the pandemic, the Children’s Hearing Program and the Children’s Vision Program developed COVID-19 guidance documents for schools to conduct hearing and vision screenings safely. A total of 812 schools reported they who were unable to complete hearing and/or vision screenings due to the pandemic. In addition, data from the current year is not available for hearing and vision screenings in Ohio due to the reassignment of researcher staff for the pandemic.

Ohio Healthy Homes and Lead Poisoning Prevention Program

There is no safe level of lead in the body. The primary source of lead exposure in children with elevated lead levels is deteriorated lead-based paint (dust). Other potential lead exposure sources include soil, water, and consumer products. ODH has administered a comprehensive statewide lead poisoning prevention program since 1991. The Ohio Lead Advisory Council (OLAC) provides the Director of Health with advice regarding the policies the childhood lead poisoning prevention program should emphasize, preferred methods of financing the program, and any other matter relevant to the program's operation. ODH's lead program provides guidelines on lead testing and medical management, educates healthcare providers, conducts surveillance and case management, conducts public health lead investigations (either directly or through local delegated boards of health), licenses the professional workforce, approves lead laboratories, and provides compliance assistance and monitoring. In addition to Title V funds, the ODH receives funding for lead poisoning prevention from the U.S. Centers for Disease Control and Prevention, U.S. Department of Housing and Urban Development, U.S. Environmental Protection Agency, Ohio Development Services Agency, Ohio Housing Finance Agency, and General Revenue Funds.

When a child under six years of age is identified with an elevated blood lead level (lead poisoning), ODH or its delegated authority conducts a public health lead investigation to determine the probable source of lead exposure. If an investigation identifies an existing lead hazard, a Lead Hazard Control Order is issued ordering the property owner to control the lead hazard. If a property owner refuses to control an identified lead hazard, an order to vacate the property is issued, declaring it unsafe for human occupation, especially for children younger than 6 years of age and pregnant women. The ODH Director of Health can delegate the authority to conduct public health lead investigations to local health jurisdictions in accordance with Ohio Revised Code 3472.34.

In 2019 (the most recent finalized data available), 165,832 Ohio children under age 6 received a blood lead screening test, compared to the 168,352 children tested in 2018. The Census estimates Ohio population of children under age six is 810,728 (2019 ACS 5-Year Estimates, United States Census Bureau), which equates to 20.5% of children under age six were tested for lead exposure in 2019. The distribution of tests by blood lead level is depicted in Table 1.

Table 1: Blood Lead Testing of Ohio Children less than 72 Months of Age in 2019

Result	**Number of Children**
Not elevated	161,288
Confirmed Elevated Total	3,33
5-9	2,555
10-44	956
≥45 µg/dL	22
Unconfirmed Elevated	969
Total Tested	165,832

Source: Ohio Public Health Data Warehouse

Ohio's definition of an elevated blood lead level was updated in November 2014 from 10 micrograms per deciliter (µg/dL) to 5 µg/dL based on new guidance from the Centers for Disease Control and Prevention Advisory Council on Lead Poisoning Prevention. All blood lead levels at or above this threshold are now considered to be elevated blood lead levels. In 2019, there were 978 Ohio children with confirmed blood lead levels of 10 µg/dL or greater (0.59% of the total tested population) and 3,533 children with confirmed blood lead levels of 5 µg/dL or greater (2.13% of the total tested population). The 2019 data represent a decrease in the number of children with confirmed elevated blood lead levels compared to 2018 data. There was also a significant decrease in the number of children with unconfirmed elevated blood lead levels, from 1,343 in 2018 to 969 in 2019. This indicates that more children received appropriate follow-up lead testing in 2019, which enabled more children to receive appropriate case management services.

Ohio law requires primary care providers to order a blood lead screening test for any child under six years old who is determined to be at risk of lead exposure based on their zip code. High-risk zip codes were determined through modeling of lead testing, housing, and socioeconomic data. The law also requires that a blood lead screening test be performed on all Medicaid-enrolled children at ages 1 and 2, and up to age 6 if a child is found not to have received a previous test.

The Ohio Healthy Homes and Lead Poisoning Prevention Program is working with the Ohio Chapter of the American Academy of Pediatrics to improve blood lead testing rates. The responsibility of testing children for lead is on primary care providers, but it is well understood that about 40% or more of children that should be tested for lead never receive a lead test. This project will focus on developing a training plan and new training materials. The training will incorporate quality improvement initiatives so that blood lead testing rates improve in the practices touched by this training.

Children with confirmed elevated blood lead levels are now automatically eligible for Early Intervention services from DODD. Early Intervention, known as EI, provides coordinated services to parents of eligible children under the age of 3 with

developmental delays or disabilities. A child's team works with the family in their home or other places they spend time in order to develop a coordinated plan called an Individualized Family Service Plan. The team will work through the plan building upon existing supports and resources while discovering ways to enhance the child's learning and development.

An expansion of the Ohio Lead Advisory Council membership through the biennium budget allowed for 4 new appointees: Nicholas Newman, a physician knowledgeable in the field of lead poisoning prevention; Jamie McMillen, a representative from Ohio Realtors; Kelan Craig, a representative of the Ohio Housing Finance Agency; and a representative of the public, who is soon to be appointed. The Ohio Lead Advisory Council (OLAC) was established within the Ohio Revised Code Chapter 3742.32. OLAC is tasked with providing the Director of Health with advice regarding the policies the childhood lead poisoning prevention program should emphasize, preferred methods of financing the program, and any other matter relevant to the program's operation.

Healthy Homes Awareness Month (HHAM) activities were conducted across the state in April 2019. The purpose of HHAM is to provide local health jurisdictions the opportunity to educate and raise awareness in their communities about the benefits of having a lead safe and healthy home. During HHAM 2019, ODH awarded 15 local health jurisdictions up to $10,000 each to increase public awareness about lead poisoning prevention and the tenants of a healthy home (Keep It: Dry, Clean, Safe, Well Ventilated, Pest Free, Contaminant Free and Well Maintained). The majority of HHAM activities focused on public outreach through billboards, banners, radio, television, digital advertising, social media, and local public transportation advertising to disseminate educational messages about lead poisoning prevention and healthy homes. Several local health jurisdictions also pursued in-person outreach, which included attending health fairs, hosting trainings, hosting community meetings, and providing materials to daycare centers and WIC clinics. In addition, some local health jurisdictions visited physicians' offices and provided staff with materials focused on increasing awareness and knowledge about childhood lead poisoning and increasing blood lead testing of at-risk children.

Title V Maternal Child Health Block Grant (MCH BG) funds are vital to the Ohio Healthy Homes and Lead Poisoning Prevention Program. The over 1.3 million dollars of MCH BG funds are used to leverage a 12-million-dollar lead poisoning prevention program. Most of these funds are utilized to pay the salaries of the lead staff who perform the state mandated surveillance activities, implement lead hazard control home repair programs, and provide hundreds of public health lead investigations for affected families each year.

Oral Health

The work of the Oral Health Program supports children receiving integrated services. The Oral Health Program is supported by Title V funding. In FY 20, the OHP supported 14 local agencies operating school-based dental sealant programs (SBSPs) in qualified schools with 40 percent or more of the students enrolled in the free and reduced-price meal program. These 14 programs applied dental sealants in qualified schools in 51 of the 88 counties in Ohio.

The COVID-19 pandemic resulted in SBSPs stopping sealant placement for 8 months. During this time, the Oral Health Program developed guidelines for SBSPs to start back into schools and operate safely, including using a different sealant material that can be applied without creating aerosols. Funded programs must follow the new sealant placement procedures set forth in the guidelines until further notice. Despite the shutdown from March-November 2020, 12,326 Ohio schoolchildren received dental sealants during the reporting period. This is a decrease of more than 6,000 students from previous years. We expect the number of students receiving sealants to continue to be lower than usual for the remainder of FY 21, but will slowly pick up as the operation of SBSPs resumes.

The Oral Health Safety Net Dental Program provides funding for safety net dental clinics in the state to provide comprehensive oral health services to lower income, uninsured persons. In FY 20, funding was provided to four safety net dental clinics to support services provided to the MCH population. Clinics were reimbursed at a rate of $100 per visit for services provided to the uninsured maternal and child health population. ODH reimbursed funded clinics for 2,003 visits between January 1 and September 30, 2020. COVID-19 significantly impacted the number of clients and visits in 2020 since clinics were offering emergency dental care only from mid-March until the beginning of June. While productivity has steadily increased since June, ODH-funded safety net dental clinics have sustained an overall reduction in productivity of approximately 35%. We have seen safety net dental clinics slowly increase their capacity, and we expect that the numbers of patients served will continue to rise through the remainder of FY 21.

In FY 20, work began to create an online, interactive oral health curriculum for early childhood education (ECE) providers. The topics for the curriculum were selected based on a needs assessment of providers and include topics such as the prevention of tooth decay, recognizing signs and symptoms or oral diseases, oral injury prevention and first aid, signs and symptoms of child abuse and neglect in the mouth, and assisting families in getting dental care for their child. The curriculum will be available in FY 21 for continuing education credits to home- and center-based ECE providers, including Head Start providers. In addition, the curriculum will be revised for use by staff in WIC clinics.

The Oral Health Program also works to integrate oral health into the training provided to other health professionals. For example, in FY 20, OHP staff conducted in-person training at two Early Childhood Health conferences.

In FY 20, 61 schools and 11,763 students participated in the school-based Fluoride Mouthrinse Program (FMRP). Unfortunately, after more than 36 years, the FMRP ended in May 2020. The only manufacturer in the U.S. of the sodium fluoride packets used to mix the mouthrinse stopped manufacturing them. Schools were notified that the program would be discontinued at the close of the 2019-20 school year. Unused sodium fluoride packets were returned from participating schools to the ODH warehouse for disposal. The Oral Health Program provided a letter for schools to send home to parents that encouraged them to notify their child's dentist that their child was no longer going to participate in the rinse program at school so other sources of fluoride could be considered. The letter also contained a list of resources for parents on oral health.

Ohio Act Early Team

In FY 20, Ohio Title V joined a state team in applying for the Association of University Centers on Disabilities grant opportunity Support for Early Childhood State Systems Through the Act Early Network. The proposal for the grant was led by the current Act Early Ambassador to Ohio who works at Cincinnati's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program and University of Cincinnati Center for Excellence in Developmental Disabilities (UCCEDD). The grant project goals are to increase awareness about the importance of developmental screening in early childhood and tracking of developmental milestones with the support of the evidence-based Learn the Signs Act Early materials developed by the CDC. Title V staff joined others on the state team including the Part C/Early Intervention, WIC, Ohio AAP, Ohio F2F, Head Start/Early Start. UCCEDD was successfully awarded the funds in September 2020, and Title V will collaborate on and support implementation of the project activities: development of the Act Early Ohio state team, completion of needs assessment, and development of implementation plan including ECHO, outreach and education to Latinx families via community health worker, engagement with social media influencers, and development and launch of a physicians toolkit.

Priority: Reduce the rate of childhood obesity

SPM 6: Percent of 2-5-year-old children consuming 1 or more sugar sweetened beverage per day.

- According to the 2019 Ohio Medicaid Assessment Survey (OMAS), 16.9% of children 2 through 5 years old consumed 1 or more sugar sweetened beverages (SSB) a day. This is a decrease from 19.2% in 2017 and meets the target of 17.2%. Disparities in this SPM are decreasing but persist. Black children are more likely than white children to drink SSBs (24.2% versus 15.2% in 2019), but the rate has decreased since 2017 (30.3% versus 17.1%). Additionally, children in families with an income less than 207% FPL are more likely to drink SSB than those with greater than or equal to 207% FPL (21.8% vs. 10.9%) but the disparity has decreased since 2017 (26.3% versus 10.9%).

ESM: Percent of children in child care attending an Ohio Healthy Program (OHP) designated child care site. (Note: There is not a Form 10 for this since it is attached to an SPM, not NPM. However, we address it in the narrative.)

- At the end of FY 20, a total of 3,172 children attended one of 329 OHP designated licensed childcare centers in the state. This number is drastically reduced from FY 19 due to the pandemic (16,035 vs. 3,172). With 5,055 licensed childcare programs in the state, this shows that 6.5% of programs are OHP designated.

The Ohio ECH program was approached by the CDC via Westat to participate in the Childcare Survey of Activity and Wellness (C-SAW) Pilot Study. The goal of this project is to better understand ECE center practices related to nutrition, physical activity, and wellness to effectively inform state and national programs. The pilot survey will be used to inform the development of a potential national surveillance system enabling states and CDC to track changes over time and obtain data to guide the planning, implementation, and evaluation of national and state obesity prevention efforts. The questionnaire will collect information on the ECE centers' practices and policies across seven topic areas: (1) Nutrition (including information about meals/snacks served and a limited number of questions on food security, food brought from home, farm to ECE activities, and breastfeeding support practices); (2) Physical activity; (3) Screen time; (4) Staff training on related topics; (5) activities (including curriculum) used by the ECE center to improve their nutrition and physical activity offerings; (6) other wellness topics; and (7) the role of the person (administrative, teaching or both) who completed the questionnaire. ECH staff worked closely with Westat to collect permission and provide childcare and public preschool databases for sampling, with the goal of being in the field in March 2020. The pandemic postponed that project for a year, with it now planned for March 2021.

Early Childhood Obesity Prevention Program

Like much of the nation, obesity has reached epidemic levels among 2 to 5-year-olds in Ohio. Ohio's Pediatric Nutrition Surveillance System (PeDNSS) data collected in 2018 (Ohio 2018 Pediatric Nutrition Surveillance Growth Indicators by Race/Ethnicity or Age) indicate that among children ages 2-5 years, 15.4% are overweight and 12.1% are obese.

Based on current statistics researchers have developed the following predictions for adult weight based on childhood weight:

- More than half of current children in the U.S. are going to be obese by 35.
- An obese 2-year-old has only a one in four chance of *not* being obese at age 35.
- If that 2-year-old is severely obese, the chance of being at a healthy weight at 35 is only one in five.
- By the time that severely obese child is 5, they have only a one in 10 chance of not being obese at 35.

The Early Childhood Obesity Prevention Program (ECOPP) began in 2013 and includes several initiatives to address this epidemic including Parenting at Mealtime and Playtime (PMP) and the Ohio Healthy Program (OHP). The overall goal of ECOPP is to deliver consistent messaging to adults who care for children age 0-5 years to prevent obesity in early childhood and reduce risk of physical and mental health outcomes in childhood and adulthood. This is done through modifying three behaviors: healthy eating, physical activity, and screen time.

ECOPP leverages funding from Title V, Preventive Health and Human Services Block Grant (PHHSBG), and the State Physical Activity and Nutrition (SPAN) grant to implement PMP and OHP.

ODH partners with the Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) to implement to PMP in the clinical setting with healthcare practitioners and in the home environment with community health workers (CHW) and home visitors. The goal is to train and support healthcare professionals to assess obesity and risk factors and counsel parents/guardians.

In collaboration with the Ohio Child Care Resource and Referral Agency (OCCRRA), Columbus Public Health, Children's Hunger Alliance (CHA), and the ODH Maternal and Child Health (MP) grant and Creating Healthy Communities grant, OHP reaches early childcare and education (ECE) professionals in public preschools, licensed child care centers, and family child care homes. OHP includes training and technical assistance to ECE providers around healthy foods, active play, and parent engagement with the goal of achieving policy, system, and environment changes in the ECE setting. Providers who attend trainings, create healthy menus, and engage families are eligible to apply for OHP designation.

OHP is a statewide recognition and innovation program, an identified strategy within the CDC's Spectrum of Opportunities Framework for State-Level Obesity Prevention Efforts Targeting the Early Care and Education Setting.

The specific objectives integrated within the Title V Action Plan include:

- Increase the number of at-risk children birth to 5 years receiving interventions to prevent and manage obesity through health practitioners.
- Increase the number of licensed ECE providers that have adopted healthy eating/active living (HEAL) policies.

Objective: Increase the number of at-risk children birth – 5 years receiving interventions to prevent and manage obesity through health practitioners.
Efforts focused on 1) launching an online physician learning collaborative on obesity risk assessment and counseling, 2) planning, marketing, and organizing regional obesity prevention trainings for community health workers, home visitors, and other practitioners, and 3) building and leveraging partnerships with other programs and agencies to expand obesity prevention education among professionals who work with families and young children who may be at risk.

PMP Wave 7 began October 2019, using the online Quality Improvement Data Aggregator (QIDA). Over the seven waves, PMP has reached 5.4% of pediatricians in Ohio and 0.2% of family practitioners. Of the providers participating in the program, 71% were located in metropolitan counties, 14% in suburban counties, 10% in rural non-Appalachian counties, and 6% in rural Appalachian counties. Participants served 24% of Ohio counties with ≥30% childhood obesity, 55% of counties with >20% African American children, and 12% of counties with >10% Hispanic/Latinx children. All waves showed an observed increase in documentation of three desired outcomes (review of intake/physical activity form, discussion of age appropriate nutrition/physical activity behaviors, provided family a PMP handout) and stabilization of documentation at the post evaluation.

Throughout its history, PMP has updated fifteen Pound of Cure handouts for family/caregiver; created sixteen family caregiver PMP handouts, including ten available in Spanish and Somali; six family/caregiver portion advice handouts (four in Spanish); six provider handouts; six provider training videos; a primary care pocket guide for providers; and a mobile app for parents and providers.

To expand obesity prevention assessment and counseling into Ohio's primary care systems, ODH has built partnerships across the Ohio AAP, ODH WIC and Help Me Grow programs, several local health departments and non-profit agencies that employ home visitors, and CHWs. Professional Data Analysts (PDA) is a key partner who assists with evaluation on the all the interventions. ODH continues to make progress with PMP implementation, however, challenges arise in provider recruitment and participation, especially among physicians.

For the updated contract that started July 1, Ohio AAP is transitioning PMP away from a QI activity. They are creating an electronic PMP Toolkit which will be available on their website for use by practices implementing PMP for the first time or for those desiring a refresher. They are also creating a PMP Journal Club with monthly articles and activities promoting healthy eating and active living among their patients and families. These resources will also be available for home visitors, community health workers, and other health professionals.

Objective: Increase the number of licensed ECE providers that have adopted healthy eating/active living (HEAL) policies.
In order to expand reach across the state, two OHP train-the-trainer trainings occurred during FY 20. Children's Hunger Alliance (CHA) provided training and on-site technical assistance to 86 family child care providers. ODH created and conducted an in-person physical activity training at the Ohio Afterschool Network Conference in February. The training supplements OHP and provides in-depth activities for ECEs to implement.

In a contract with Columbus Public Health, the curriculum and resources used in OHP, including the electronic trainings, were revised and updated. They were also all translated to Spanish. All of the new resources went live October 1, 2020. During FY 20, 3,863 participants completed online courses offered by ODH. In addition, ODH continues to provide a monthly Social Media Toolkit based on the OHP 13 Key Messages to the >1,300 ECE professionals enrolled in the ODH Early Childhood Health Bulletin Board.

The Early Childhood Health Bulletin Board is a one-way means of communication from ODH to early childhood professionals. There are 1,350 users. In 2020, a total of 27 messages were sent to only the Early Childhood Health Bulletin Board contacts, with an average open rate of 43.9% and average click rate of 10%. A monthly social media toolkit based on the Ohio Healthy Programs 13 Key Messages has an average open rate of 42.9%. In addition, 53 messages were sent to both the Early Childhood Health and School Nurses bulletin Boards with a 49% open rate, which is 31% above the industry average. There were 66 pandemic related messages sent, 46.8% of the total messages.

In FY 19, an analysis of OHP designated sites revealed that they implemented 1,185 HEAL policies and 285 menu improvements. ODH continues to increase OHP participation and designation, with specific focus on ECE providers in areas of need. ODH faces challenges recruiting and engaging providers, particularly in communities disproportionately affected by poor health outcomes. As a result, OHP created a funding opportunity for sub grantees in four regions of the state identified as high need. The subrecipients started October 1, 2020 to provide technical assistance to childcare centers seeking designation or redesignation.

Funding through the MP subgrant program supports the designation and re-designation of OHP childcare providers to improve the overall health and nutrition of children. To date subgrantees have achieved train-the-trainer (14), childcare center staff trained (603), technical assistance provided (217), policy changes (151), menu changes (347), family engagement activities (1,068), OHP designation (31), and OHP re-designation (82).

Objective: Collaborate with the Oral Health Program to conduct a BMI surveillance within child care centers in Ohio public and private preschools.
The School and Adolescent Health Program, in collaboration with the Oral Health Program, conducted Body Mass Index (BMI) surveillance data collection. The statewide BMI survey of preschool children was completed in May 2017. Of the 82 sites surveyed (18 public preschool programs and 64 Early Childhood Education Centers), 3,098 children ages 2-5 were measured for height and weight for BMI assessment. Results show that 14.1% of low-income preschool-aged (2-5 years) children are overweight, and 11.6% are obese. The data also showed that children that receive financial help for child care have a significantly higher rate of overweight/obesity (36.4%) than children that do not (21.4%). Planning commenced for the next round of statewide preschool BMI data surveillance but has been temporarily put on hold due to pandemic restrictions.

Evaluation
PDA serves as an external evaluator for ECOPP. Their work over FY 20 included an ECOPP Annual Program Report for both OHP and PMP, an ECOPP roadmap, reach maps for both OHP and PMP. They worked closely with ODH to create and pilot the Ohio ECE Nutrition and Physical Activity Assessment Tool that will be used by ECE providers to identify current nutrition and physical activity practices and areas for improvement, and will be required for submission for OHP designation. The soft launch for the instrument was October 1, 2020. ODH will use the results for future OHP programming, and ECE program can use the results to select goals for the upcoming year and then evaluate their progress in reaching those goals. Moving forward, PDA will be working with ODH to develop a measurable definition of equity for the program.

Below are FY 20 success stories from OHP designated providers:

- "I have a 4yr old child in my care that Mom claims is a very picky eater. She caters to him at home and serves the same few foods over and over. Chicken tenders, macaroni and cheese, corn, apples, etc. Not a wide variety and doesn't offer anything new because child throws a fit and refuses to eat. I decided that they needed an introduction to

the wider variety of foods available. So, I made it fun, educational and yummy! First, I showed the child all the different vegetation that animals eat, they showed them things such as many foods come in many varieties. For instance, over 400 kinds of apples. I then allowed them to go to the grocery store with me and gave them the very important job of picking out something new for the group to try. They also got to present it to the group and tell them all about it. We then have a taste testing party and discuss what we liked (or maybe didn't like so much) about the item. I also use our curriculum about other cultures to introduce new foods to the children. We make crafts, dress up, find the area on a map and many other things to learn about new places. All this has been working great. Mom showed up during snack one day and couldn't believe her eyes when her child was munching away on pepper strips and hummus dip! Now we no longer have a picky eater, but one that is super excited to discover new things. Granted not everything we try is going to be liked by everyone, even adults have food preferences, but I am no longer having the struggles with meal times. The kids all look forward to the adventures now."

- "Staff have become educated further about "fried and processed" foods. It was not considered in the past that "flash-fried" foods then frozen was unhealthy foods. Since being trained in Ohio Healthy Programs training our cooks and menu planner are now more aware of unhealthy foods and taking into consideration how foods are prepared. Cooks are now preparing more foods from scratch and using less frozen, processed foods."

Association of State Public Health Nutritionist (ASPHN) Obesity Mini CoIIN
Ohio is one of 5 states involved in the ASPHN Obesity Mini CoIIN project. The purpose of the project is to support and enhance state level farm to early care and education (ECE) initiatives to increase the quality of ECE nutrition and physical activity environment for young children by July 2020. This project provides technical guidance and support for state teams utilizing a quality improvement process to increase the number of ECEs conducting sustainable, comprehensive farm to ECE. In 2019, a statewide needs assessment was completed by 1,680 ECE educators in Ohio, indicated that 861 are participating in F2ECE, 194 had not heard of F2ECE before taking the survey, 375 plan to start F2ECE activities and 261 do not plan to start. The cost of local items and funding for supplies is the largest barrier and perceived barrier to starting and seasonality of local items was a close second. A lot of interest was expressed in the Ohio Healthy Program and online, self-paced F2ECE modules. All responses present opportunities for action.

Asthma Program
While not funded by Title V, the Asthma program works within the BMCFH to improve outcomes related to asthma and improve health equity and has relationships with Title V funded programs. In Ohio children, African Americans and low-income families experience significant disparities related to asthma prevalence and hospital utilization. State data show that asthma-related visits to hospital emergency departments are 4 times higher and asthma-related hospital admissions are 5 times higher among Black children than white children (OHA, 2012-2016). To address these disparities, the ODH Asthma Program (ODH AP) has a significant focus on equity and addressing systemic factors that contribute to poor health outcomes for children with asthma. The ODH AP mission is to is to engage individuals and entities intentionally and consistently across sectors and disciplines to build capacity and promote health equity to eliminate disparities, improve quality of life, and achieve optimal health outcomes for people with asthma in Ohio.

ODH AP strategies focus on: promoting inter- and intra-agency collaboration and strategic partnerships to address factors associated with asthma-related disparities; fostering opportunities for healthcare providers and stakeholders to learn about health equity, cultural competence, implicit bias, and structural racialization; and enabling stakeholder engagement to promote community-level approaches to reducing asthma disparities.

ODH AP has engaged in a number of activities during FY 20 to address these strategies. Funded local projects that not only work in geographic areas of high burden of our target population, but that also utilize specific health equity strategies to reduce disparities and hospital utilization and improve adherence and quality of life for children with asthma. Developed a health literacy toolkit to inform providers and professionals who work with people with or develop materials for people with asthma to increase understanding of how health literacy affects health outcomes as well as provide actionable strategies to improve communication between physicians and patients.

ODH AP is developing an Asthma Health Equity Action Plan to assure the integration of methods and strategies to address disparities into all aspects of asthma care in Ohio. ODH AP conducted formative evaluations such as the Health Equity Affinity Focus Group and key stakeholder interviews, both with African American professionals who work in health equity or with primarily African American populations. The goal of these evaluations was to inform ODH AP regarding the perception of the nature of health equity as identified by African Americans as well as identify strategies to address asthma disparities. These evaluation findings helped inform the Health Equity Action Plan.

ODH AP has developed and widely promoted five online courses on topics related to health equity including: Implicit Bias, Community Health Workers, Social Determinants of Health, Asthma and CLAS standards, and Health Literacy and Asthma. ODH AP has conducted several in person trainings of healthcare professionals, nursing students, and early childcare staff.

Additionally, the Asthma Program Supervisor holds a master's degree in Racial Identity and Health Equity in Healthcare Delivery and serves as subject matter expert on health equity. Her work serves as a model for other ODH programs. She also shares her time between the Asthma Program and the ODH Office of Performance and Innovation to inform health equity strategies for the State Health Improvement Plan and agency-wide initiatives. In this role, she also consults with programs such as the Infant Vitality Program, the Early Childhood Program, and the School Nursing Program to identify strategies and activities appropriate for their target population and program objectives to reduce health inequities.

Child Health, Application Year FY 2022

The 2020 needs assessment process identified the priority for the child population: improve nutrition, physical activity, and overall wellness of children. Ohio has a lower rate of obesity among 2-4-years-olds than the U.S., but a higher rate among ages 10-17. Children in Ohio are also more likely to experience adverse childhood experiences. While more children in Ohio receive developmental screenings compared to the U.S., this only represents one-third of children and early data indicates that the COVID-19 pandemic has decreased screening due to the suspension of face-to-face visits in health and home settings.

Emerging Issues

Since the completion of the needs assessment, the COVID-19 pandemic has reduced the number of children with documented developmental screenings performed by Home Visiting due to visits being transitioned to virtual and the temporary suspension of face-to-face visits.

Because of the temporary closure of facilities and discontinued face-to-face trainings, there was an increase in online offerings for ECE trainings for professionals around nutrition and health along with other COVID-19 related topics. There was also an increase in telehealth visits, which created a need to share more information virtually for parents and caregivers around nutrition, physical activity, and overall health issues.

The COVID-19 pandemic also highlighted the importance of the Cross-Cutting equity and ACEs priorities. In FY 22 the Child Action Group will continue to explore the integration of these priorities within the Child Action Plan.

Priority: Improve nutrition, physical activity, and overall wellness of children

Measures:

- NOM 19: Percent of children (0-17) in excellent or very good health
- NOM 20: Percent of children (2-4) and adolescents (10-17) are obese
- NOM 25: Percent of children (0-17) who were not able to obtain needed health care in the last year
- SOM: Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) (confirmed only)
- NOM 14: Percent of children (1-17) who have decayed teeth or cavities in the past year
- 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: Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening

To address the priority of improving overall child health efforts must address a broad range of issues impacting children. Pediatric primary care visits represent a key opportunity for monitoring and addressing the comprehensive needs of children's health. The selected NPM relates to the critical role of developmental screening in monitoring and supporting child development. The SOM was established to measure the efforts to address child lead exposure in Ohio, which also relates to the Cross-Cutting domain and is aligned with the measure in the State Health Improvement Plan. Home visiting services also play an important role in monitoring and supporting child development. The ESM will measure the impact of efforts to improve rates of developmental screening for the child population served by Home Visiting.

Objective 1: By 2022, coordinate across programs to implement a plan to increase rates of primary care providers conducting quality comprehensive well child visits that include developmental and other screenings.

Strategies:

1. 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).
2. Partnership between programs that can mutually promote comprehensive well visit (e.g., state immunization)
3. Explore opportunities to support/implement evidence-based models for pediatric primary care
4. Increase the awareness of the need for developmental screenings and other screenings amongst parents and caregivers.
5. 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).

Ohio collected public comments on the objectives and strategies for the child population and this will serve as a guide for FY 22 and beyond. We will move from creating a plan to implementing the plan through ODH programs and with state partners. Over the next year, ODH will partner with Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) to develop and provide trainings and resources to medical and allied professionals around key topics appropriate for children and their

caregivers. The Ohio AAP trainings will also help to lay the groundwork for Quality Improvement projects during FY 23. During FY 22, ODH will also explore partnerships to promote comprehensive well visits along with vaccination education and increase developmental screenings by reaching out to other populations such as public health nurses and the foster care community. The ODH Lead program is also working on creating a targeted testing model in high-risk areas by zip codes and working on billing coding for professionals around assessments.

Objective 2: By 2025, increase the percent of children, ages 9-35 months, that receive developmental screens via home visiting programs.
Strategies:

1. Support MIECHV and other home visiting programs to provide developmental screening using Ages and States Developmental Screening tool.
2. Implement Medicaid/CHIP reimbursement claim code for developmental screening activities at provider level.
3. Educate parents about developmental screening tools.

The Home Visiting program saw a decrease in developmental screenings in 2020 because of the COVID-19 pandemic and the suspension of face-to-face visits. ODH advised home visiting providers in mid-March 2020 to use only telehealth visit options (phone, video, text message, and drop off materials) and providers have indicated it is challenging to complete required screenings and assessments due to technological issues and distractions during telehealth visits. With the upcoming return of face-to-face visits in 2021 and 2022, ODH anticipates an increase in screenings and education provided to caregivers. In addition, Home Visiting protocols require completion of an ACEs screening tool and additional required screenings which cover some of the social determinants of health (housing employment, insurance, food insecurity, etc.). A tools completion report is under development to allow providers and ODH to track screening completion rates more easily to better address gaps and missing data. Finally, Home Visiting will continue to explore ways to implement Medicaid/CHIP reimbursement claim codes at the provider level.

Other Efforts Supported by Title V MCH
Many of the programs presented in the Perinatal/Infant Application section also serve children and adolescents. Several program summaries are included below to highlight additional relevant programs. Please see the Program Map (section V. Supporting Documents) for the full list of programs.

School Hearing and Vision Programs
The Ohio Department of Health (ODH) Children's Hearing and Vision Programs set the screening requirements and guidelines for school-based preschool and K-12 schools. ODH is given the authority by the Ohio Revised Code (ORC) to set the hearing screening requirements for school-aged children and to track the data (ORC Sections 3313.50 and 3313.69). ODH works in partnership with ad hoc committees to develop the requirements. These requirements determine the grade levels routinely screened each year, approved hearing screening tests and equipment and referral criteria. In addition to establishing school screening requirements, the program conducts a biennial statewide survey of school hearing screening programs.

Early Childhood Health and Safety, Ohio Healthy Program (OHP), Early Childhood Obesity Prevention Program (ECOPP)
The Early Childhood Health and Safety program works collaboratively with other state agencies to identify learning needs of the early childhood educators in diverse setting such as public preschools, childcare centers, and family child care. Based on the assessments, the professional development program for health and safety designs and implements quality, relevant, accessible, cost-effective opportunities for professional development related to provision of safe and healthy environments for children in their care. Such topics include, responding to allergies, asthma, cold and flu season and other pertinent health topics.
The OHP provides technical assistance for Family Care, Child Care Centers, and Public Preschools by providing the training they need to make policy and environmental changes that will lead to OHP designation through Step Up to Quality and that ultimately will improve the health and wellbeing of children and families they serve. The OHP is part of a larger effort within the Early Childhood Obesity Prevention Program (ECOPP), which is a coordinated and comprehensive approach involving families, early childhood education professionals, health professionals, and community organizations working together with consistent messaging and strategies to ensure a sound foundation for health in the future.

Parenting at Mealtime and Playtime (PMP)
Parenting at Mealtime and Playtime (PMP) is a professional development initiative for a variety of health care providers to optimize obesity risk assessment, prevention counseling, and family support for children 0-5 years of age and their families. PMP curriculum offers providers developmentally appropriate guidelines on nutrition, healthy activity, and sleep to share with families within the context of building resilient family-child interactions that support healthy habits.

ODH's Early Childhood Obesity Prevention Program (ECOPP) partners with the Ohio Chapter, American Academy of Pediatrics (Ohio AAP), to deliver PMP physician training that grants Maintenance of Certification (MOC) Part-IV professional

development credit. Visit Ohio AAP's PMP site for more information and to sign up for the PMP Resource Toolkit.
PMP training and resources are also available for healthcare providers such as home visitors, community health workers, and WIC professionals. These include a series of one-hour independent study courses for health care providers working with families in the early childhood population. In these courses, local experts address the latest information about PMP to prevent obesity and improve the health of children 0-5 years of age. The purpose of the trainings is to increase understanding of developmentally appropriate guidelines on nutrition, healthy activity, and sleep, all within the context of building resilient family-child interactions that support healthy habits.

Farm to ECE Implementation Grant (FIG)
Farm to early care and education (farm to ECE) offers increased access to the three core elements of local food sourcing, school gardens and food and agriculture education to enhance the quality of the educational experience in all types of ECE settings (e.g., preschools, child care centers, family child care homes, Head Start/Early Head Start, programs in K – 12 school districts). Farm to ECE offers benefits that parallel the goals and priorities of the early care and education community including emphasis on experiential learning opportunities, parent and community engagement and life-long health and wellness for children, families and caregivers.

School Nursing
The ODH School Nursing program provides school nurses, schools, and school communities with resources to support the health and academic achievement of students. The program provides technical assistance, creates resources, manages the School Nurse Bulletin Board communication system, collects data regarding school health needs and services, and provides extensive professional development for licensed nurses working in the school setting.

The professional development offered by the School Nursing program includes a library of more than 40 online independent study courses house in OhioTRAIN. Program typically hosts three live, in-person Regional School Nurse Conferences, one summer conference, and one three-day New School Nurse Orientation each year. With the onset of COVID-19, the program has pivoted to offer these as live, virtual events. Continuing Nursing Education contact hours are offered for all courses. Program also develops and disseminates resources, such as handouts and resources for school nurses to use to teach school staff how to administer medications to students. These resources are heavily used by school nurses, with more than 700 nurses attending the live conferences and more than 1,000 participating in the online independent study courses annually.

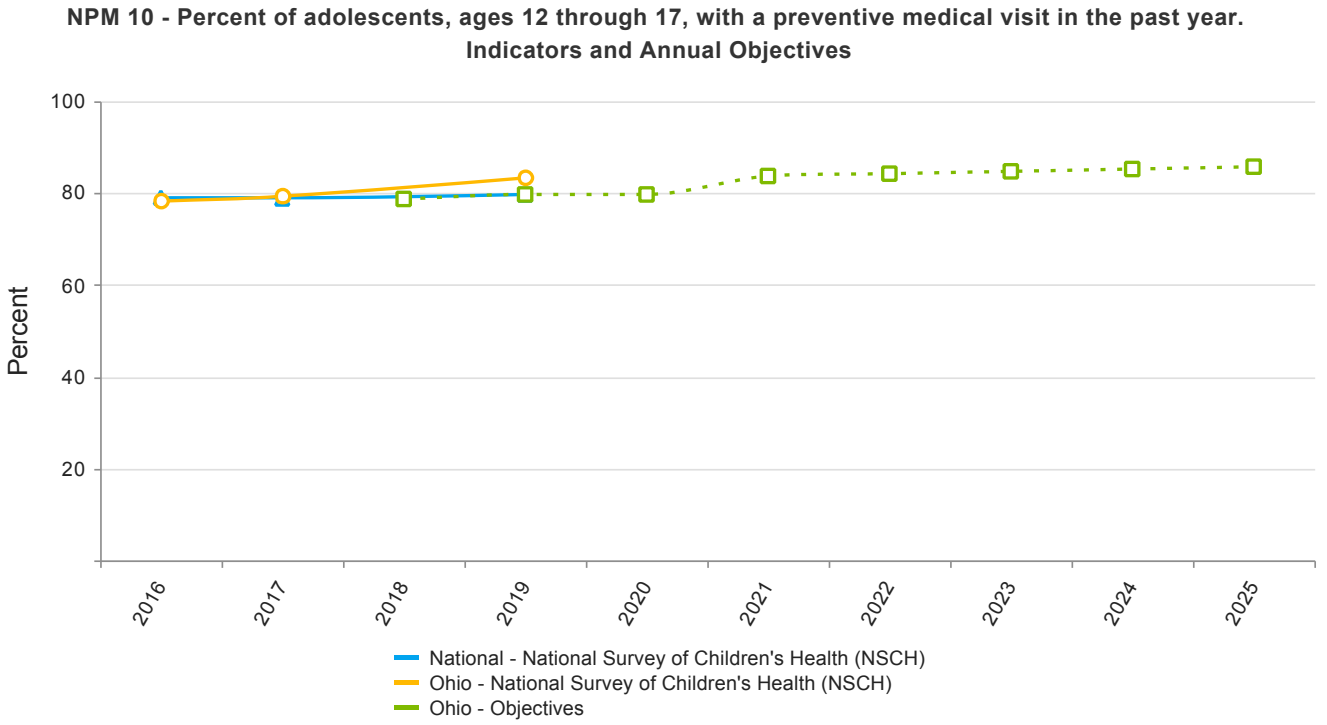
Ohio Healthy Homes and Lead Poisoning Prevention Program
Lead can damage nearly every system in the human body and has harmful effects on both adults and children. It is a serious environmental public health threat to children in Ohio. The Ohio Healthy Homes and Lead Poisoning Prevention Program (OHHLPPP) addresses the needs of lead-poisoned children from birth through 5 years (up to 72 months) of age. The program assists family members, medical care providers, and other community members to reduce and prevent lead poisoning. OHHLPPP recognizes that children under the age of 3 years (36 months) are at greatest risk for lead poisoning. The program receives funding from the Centers for Disease Control and Prevention (CDC), Maternal and Child Health Block Grant, and the Ohio Department of Medicaid (ODM) for childhood lead poisoning prevention efforts in Ohio. OHHLPPP receives all blood lead testing results on Ohio resident children and performs inspections of homes, childcare facilities, and schools to determine the source of a child's elevated blood lead level. The program coordinates funding to complete lead hazard abatement for qualified families.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	35.0	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	11.5	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.6	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.2 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	15.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	12.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	16.8 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	59.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	69.7 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	94.2 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	91.9 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	18.8	NPM 10

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78.6	79.6	79.6
Annual Indicator		78.1	79.1	79.1	83.1
Numerator		694,854	708,785	708,785	747,153
Denominator		889,704	895,626	895,626	899,030
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			78.6	79.6	79.6
Annual Indicator	42.6	43.9	44.3		
Numerator	137,032	144,230	140,942		
Denominator	321,606	328,769	318,477		
Data Source	Ohio Mediciad	Ohio Medicaid	Ohio Medicaid		
Data Source Year	SFY 16	SFY 17	SFY 18		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	83.6	84.1	84.6	85.1	85.6	86.1

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	48	44.4
Numerator	149,363	139,489
Denominator	311,048	313,853
Data Source	Ohio Department of Medicaid	Ohio Department of Medicaid
Data Source Year	SFY 2019	SFY 2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.3	46.2	47.1	48.1	49.0	50.0

State Performance Measures

SPM 3 - Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	489.2	465.9
Numerator	3,727	3,521
Denominator	761,856	755,742
Data Source	Ohio Hospital Association	Ohio Hospital Association
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	453.7	441.5	429.3	417.1	404.9	392.7

State Outcome Measures

SOM 4 - Percent of high school students who have used alcohol within the past 30 days

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	25.9	25.9
Numerator	104,317	104,317
Denominator	402,688	402,688
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.9	24.4	23.9	23.4	22.9	22.4

SOM 5 - Percent of high school students who have used marijuana within the past 30 days

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	15.8	15.8
Numerator	65,023	65,023
Denominator	410,565	410,565
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.8	14.3	13.8	13.3	12.8	12.3

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	36.7	36.7
Numerator	155,186	155,186
Denominator	422,534	422,534
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.5	34.0	33.4	32.9	32.3	31.8

State Action Plan Table

State Action Plan Table (Ohio) - Adolescent Health - Entry 1	
Priority Need	
Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
By 2025, increase percent of adolescent with a preventive medical visit in past year by 3%.	
Strategies	
Continue collaborative efforts to convert sports physicals to comprehensive well-visits	
Partner with payors to incentivize the well-visit	
Partner with Medicaid and Education to support School Based Health Care initiatives	
ESMs	**Status**
ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit	Active

NOMs

NOM 16.1 - Adolescent mortality 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 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 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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Ohio) - Adolescent Health - Entry 2

Priority Need

Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate

SPM

SPM 3 - Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000

Objectives

By 2025, reduce risk and increase protective factors for adolescents.

Strategies

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

State Action Plan Table (Ohio) - Adolescent Health - Entry 3

Priority Need

Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate

SPM

SPM 3 - Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000

Objectives

By 2022, develop a plan for MCH to support implementation of Ohio Suicide Prevention Plan among targeted youth population

Strategies

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

State Action Plan Table (Ohio) - Adolescent Health - Entry 4

Priority Need

Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

SOM

SOM 4 - Percent of high school students who have used alcohol within the past 30 days

Objectives

By 2022, develop plan for promoting comprehensive adolescent well-visit that includes:

Strategies

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

State Action Plan Table (Ohio) - Adolescent Health - Entry 5

Priority Need

Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

SOM

SOM 5 - Percent of high school students who have used marijuana within the past 30 days

Objectives

By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use

Strategies

- 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)

State Action Plan Table (Ohio) - Adolescent Health - Entry 6

Priority Need

Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

SOM

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

Objectives

By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use

Strategies

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)

Adolescent Health - Annual Report

Adolescent Health, Annual Report FY 2020

Priority: **Reduce barriers, improve access, and increase the availability of health services for all populations**

NPM 10: Percent of Adolescents, ages 12 through 17 with a preventive medical visit in the past year.

- According to the National Survey of Children's Health, Ohio increased from 78.1% in 2016 to 79.1% in 2017. In State Fiscal Year (SFY) 2019, 48% of Ohio's eligible Medicaid youth, ages 12-17, received a well-care visit. This figure was 44.4% in SFY 2020.

ESM 10.1: Number of clinical providers in Ohio trained on Bright Futures clinical recommendations.

- From FY 16-18, 267 providers were trained through webinars and trainings, including those provided through contact with Ohio American Academy of Pediatrics (Ohio AAP). In FY 19, ODH did not renew the contract with Ohio AAP and instead collaborated with Ohio AAP on webinars and a statewide conference to train 100 clinical providers on Bright Futures clinical recommendations, and in FY 20 an additional 80 clinical providers were trained.

Adolescence is a unique developmental time that is characterized by distinct and dramatic developmental, physical, social, emotional, and intellectual changes. Many lifestyle behaviors that contribute to or reduce risk for chronic disease and disability in adulthood are developed in adolescence. Adolescence is defined as ages 10-24, including young adults due to the finalization of frontal lobe development that impact decision-making skills. This transition into young adulthood is important to recognize as youth shift from child serving agencies into adult focused systems. Development within this age range varies by the individual and is much more complex than chronical age. Certain subgroups of adolescents may experience development tasks of adolescents in different ways, such as those with special health care needs, chronic physical or mental health conditions, or disabilities. Adverse childhood and adolescent experiences may also impact or delay development and maturity. Other subgroups of adolescents may be more vulnerable to risk factors and poor health outcomes such as those living in poverty, foster care, juvenile justice, homelessness, racial or ethnic minority youth, and youth identifying with sexual or gender minority.

Health outcomes among adolescents reflect the disparities in the larger population. Lack of access to health care, safe housing, transportation, and lower educational attainment disproportionally impact minority adolescents and young adults, which impact overall health outcomes. In Ohio, approximately 20% of the population is between the ages of 10 and 24 (U.S. Census Bureau, population Division).

Ohio Title V recognizes the need to improve areas of preconception health and understanding of health literacy and engagement with the medical field during adolescence for improved maternal and infant health outcomes. Particular areas of concern are Ohio's adolescent overweight, obesity, vaping prevalence, and lack of physical activity. Ohio is the only state in the country without Health Education Standards which prevents the assessment and improvement of quality health education skills development.

Despite the deficits, Ohio Title V staff have strong partnerships with entities that aim to improve adolescent health outcomes. The following will describe some the partnerships and strategies implemented during FY 20. It should be noted that Ohio's Adolescent Health Coordinator position was vacant for a majority of FY 20.

In the last Needs Assessment process, Ohio selected National Performance Measure (NPM) 10, Percent of adolescents, 12-17 years, with a preventive medical visit in the past year. According to the National Survey of Children's Health, Ohio increased from 78.1% in 2016 to 79.1% in 2017. In SFY 2020, 44.4% of Ohio's eligible Medicaid youth, ages 12-17, received a well-care visit. This figure had continued to improve each year from 2016 to 2019, but showed an expected drop during 2020 due to COVID-19 (SFY 2016 42.6%, SFY 2017 43.9%, SFY 2018 44.3%, SFY19 48.0%). Despite the challenges of COVID-19 the 2020 rate was still higher than in the rates seen 2016-2018.

Over the past five years of the Title V adolescent health action plan, Ohio has developed an advisory committee, assessed the status of well visits, conducted assessments regarding needs for improvement from a parent, practitioner, public health, and insurance perspective. Ohio has continued to provide professional development to practitioners serving adolescents on strategies to increase and improve adolescent well visits and Bright Futures recommendations and health topics. Education and support were provided through webinars and quality improvement practices. Within the assessments and feedback from QI, adolescents, and families, recommendations for Ohio to improve policy, process, and practices have become evident such as providing improvement strategies for the following:

- Quality measures and improvement activities related to:
    - Improving access to care
    - Issues related to claims data
    - Issues related to performance metrics and incentives

    - Considerations for confidentiality, privacy, EMR and patient portal access
- Screening and referral needs and issues for relevant adolescent health issues addressed in well-care visit
- Transition strategies for healthy health care consumerism as adolescents mature
- Conversion of sports physicals to comprehensive well visits
- Adolescent and family voice

In FY 19, Ohio released a Request for Proposal (RFP) asking for a vendor to create a recommendation brief on policies and strategies to increase well visits, including the above topics. The brief would include the status of well visits including national and state-specific data, recommended best practice strategies, current activities, barriers and successes, and proposed policy improvements impacting practice and reimbursement. In addition, the brief would include needs of adolescents, parents, and practitioners to increase and improve visit outcomes. Ohio did not receive a valid response for either of two RFP rounds.

After the solicitation timeframes, attempts were made to receive feedback from perspective vendors as to why they did not respond. Timing and partnership needs were the two largest barriers. It was noted that the experts in adolescent well visits and health outcomes are not the policy and brief development experts. Therefore, more relationship building is necessary to bring together the two types of expertise to successfully implement the deliverables.

Since the fall of 2018, the Title V program has been in conversations with the Ohio Department of Education (ODE) and Nationwide Children's Hospital (NCH) regarding the topics from the proposed brief and leveraging school-based health care (SBHC) in providing services to adolescents. Over the past few years, ODE has increased their level of technical assistance and guidance to school districts in developing SBHC, including publishing a toolkit and providing webinars. The ODH Title V Director participated in development of the toolkit. NCH is a provider of SBHC to districts in Central Ohio; has an adolescent medicine department consisting of board-certified Adolescent Medicine physicians, advanced practice nurses, social workers, and nutritionists; and has developed a state-of-the-art behavioral health center. Both ODE and NCH, are interested in creating systemic changes to improve practices related to sport physicals that would provide opportunities to more comprehensively assess adolescent's health.

ODE and NCH are also lead entities in a school-based health center COIIN that has worked to develop PDSA opportunities for SBHC's that are associated with NCH. The COIIN plans to explore opportunities to expand the initiative to a more statewide approach. Due to ODH staff vacancies, there was not ODH representation on the COINN in FY 20, but ODH continues to get updated on the work and plans to continue SBHC collaborative work with state and local partners. In addition, the ODH School Nursing program is a participant in Ohio's team in the National Center for School Mental Health (NCSMH) 12-month Collaborative Improvement and Innovation Network to focus on making measurable improvements in students'' mental health (including social, emotional, behavioral health, and substance use). Ohio is one of five states participating.

During FY 19, Ohio Title V and ODE became involved in the Midwest Adolescent Health Project, which is a HRSA funded project to build capacity for adolescent centered care in rural and underserved communities in Region V. Two Ohio-based entities were selected to participate in activities during FY 20: Cleveland Clinic Children's Hospital and Rock Hill Family Medical Center. Both provide school-based health services and adolescent well visits. Due to the COVID-19 pandemic, the timeline for the round 1 sites was adjusted, with the kick-off occurring in September 2020, instead of March 2020 as previously planned. During FY 20, an RFP was distributed to recruit sites to participate in round 2 of the project. One entity was selected from Ohio to participate: Lower Lights Christian Health Centers. The kick-off for round 2 will occur in March 2021, with further updates on both rounds to be provided in the FY 21 report.

The ODE also released $675 million, through HB 166 released in July 2019, to Ohio school districts to support student's academic achievement through mental health counseling, wrap around services, mentoring, and after-school programs. School districts are to work with local organizations, such as local health departments and mental health agencies, to determine community needs and resources. Title V staff are on a committee to assist ODE with these student wellness initiatives, as well as on a Prevention and Harm Reduction team. Districts are required to partner with local organizations such as local health departments and local mental health agencies. In late 2019, ODE released a survey asking districts about their current level of collaboration with community agencies and needed support. The data collection from this survey was extended, and results are expected to be available in early 2021. ODH Title V staff will provide assistance, as needed, based upon results.

Further connection to Title V within ODE is the Anti-Intimidation Harassment and Bullying (Anti-HIB) Initiative that focuses on bullying reduction through Positive Behavior Intervention Supports (PBIS) and local district policy, training, and curriculum support. ODH staff funded through Title V and CDC participate in the work group led by ODE. Risk topics include harassment, intimidation, bullying, teen dating violence, suicide, cyber-bullying, and human trafficking. During FY 20, the group spent time compiling a suite of Anti-HIB resources. In addition, considering the swift transition to remote learning

across the state during the COVID-19 pandemic, the group focused on creating a cyberbullying prevention toolkit. The toolkit was created to provide resources to support staff, students and families identify, respond and report cyber bullying.
In addition, School Nursing program staff participate in the ODE Trauma Informed Schools Committee which, among other activities, hosted a virtual Trauma Conference with over 3,000 attendees.

Also supporting behavioral health, Title V adolescent health has served on the Ohio Interagency Council for Youth (OICY) which supports the creation and maintenance of a comprehensive continuum of care to facilitate timely access to appropriate services among youth with behavioral health needs. OYIC's purpose is to make recommendations to state and local entities to increase access to behavioral services for children and youth and to reduce behavioral health disparities. Committees focus on trauma-informed care, state and local policies and regulations, funding and resources, workforce development, and youth and family engagement. Youth and family with lived experience are present and involved at each meeting. OYIC was created by the OhioMHAS through funding from SAMSHA. Current initiatives align goals from multiple grants across cabinet-level agencies, including ODE, OhioMHAS, Ohio Medicaid, Ohio Department of Job and Family Services, ODH (Title V and Health Care Shortage funding goals), Ohio Department of Youth Services, and Ohio Department of Developmental Disabilities. The ODE's Office of Workforce Transformation recently accepted the group's application for a new industry credential for a Mental Health Technician. Youth will be able to enroll in courses beginning in the 2021 school year and graduate from high school with this credential. The process has strengthened the relationship across all state agencies in better understanding workforce development needs and how to develop successful applications that can impact multiple medical and public health employment services.

Title V has supported the Ohio Adolescent Health Partnership through leadership and facilitation. Over 100 agencies with expertise in adolescent health and wellness are members. The group provides professional development and networking, focusing on the needs of the whole adolescent. The aim is to reduce silos and build the capacity of agencies to more effectively and positively serve adolescents. Topic addressed during FY 20 meetings (prior to COVID-19) focused on adolescent vaping and EVALI and results from the 2019 Ohio Youth Risk Behavior Survey. During the COVID-19 pandemic, meetings were transitioned to a virtual platform. Much of the meeting content after March focused on resources available during COVID-19 and impact the pandemic had on the work of the member agencies.

In FY 20 a research article was published in the journal *Health and Social Care in the Community* on the infant mortality and positive youth development project funded by Title V in 2018 (https://doi.org/10.1111/hsc.13158). The research project was designed to identify the root causes, structural and individual factors associated with the health and well-being of adolescent girls within the communities with the highest infant mortality rates. Guided by the SWOT framework findings were organized by strengths, opportunities, weaknesses, and threats to explore links between access to positive youth development programming, community supports, and maternal, adolescent and infant health outcomes. The results have implications for community-based efforts that can leverage positive youth development contexts (e.g., school, afterschool, youth sports) to improve maternal health, prevent infant mortality and
promote positive health and well-being for adolescent girls.

The above initiatives and partnerships support National Outcome Measures (NOMs) associated with tooth decay, child and adolescent mortality, adolescent suicide, needs of students with special health care needs, mental health treatment, obesity, vaccination, teen births, and, ultimately infant mortality. And, NPMs related to physical activity, bullying, well visits, transition, medical home, and oral health may also be impacted.

Maternal and Child Health Program- Adolescent Resiliency (MP Subsidy)
The Maternal and Child Health Program (MP Subsidy), fully funded by Title V, administers funds to counties across the state to improve MCH outcomes and started a new component for FY 19-21 related to adolescents. The Adolescent Health Evidence-Based Resiliency component was designed to support the identification and implementation of evidence-based projects related to physical activity, prevention activities (vaping, tobacco, illicit drugs, mental health, and/or healthy eating), or staff capacity training for community based organizations (trauma informed, implicit bias, suicide prevention, drug abuse prevention, effective communication with English language learners, ACES, violence prevention/Safe Space, nutrition, and/or physical activity).

The MP Subsidy engaged 20 subgrantees in FY 19 to complete an assessment on the engagement of adolescents using community resources to inform future adolescent resiliency efforts. Subgrantees submitted final assessment reports with needs including transportation, expanding programs, parent partnership, youth voice in programming, among others. Subsequent MP Subsidy funding years include a strategy to create an implementation plan that addresses the needs and recommendations from the FY 19 assessment report.

In FY 20 MP Subsidy engaged 19 subgrantees to support the development of an Implementation Plan that will improve physical activity of adolescents (ages 11-14) to at least 60 minutes per day, decrease the prevalence of overweight and obese adolescents, and/or improve the overall health of adolescents to good or excellent health. Activities that were

proposed for implementation included: Community gardens, life skills, cooking matters, physical activity, violence prevention, trauma informed and ACES programming, library connections, family engagement, transportation support, mindfulness skill building, mental health education, and resiliency programming. The subgrantees will use FY 21 funds to implement the Adolescent Resiliency programs.

School Nursing

The Ohio Department of Health School Nursing program provides support for a number of MCH priorities, including:

- Increase prevalence of children receiving integrated physical, behavioral, mental, and developmental services
- Reduce the rate of childhood obesity
- Reduce barriers, improve access, and increase the availability of health services for all populations
- Increase access to care via Patient Centered Medical Home (PCMH) for children and youth with special healthcare needs (CYSHCN)

Ohio has almost 1.7 million preschool-12th grade public school students. Fifty percent of these students are classified as economically disadvantaged, while 15% are students with disabilities (http://www.ohiobythenumbers.com/). In addition, almost 22 % of Ohio children have special health care needs (https://www.childhealthdata.org/browse/survey) such as asthma, allergies, seizure disorders, and diabetes. Most of these children spend their days in the school setting. Schools rank the following chronic health conditions as most difficult to manage: diabetes, mental health issues, allergies, and asthma (https://odh.ohio.gov/wps/wcm/connect/gov/bf86c00c-1003-4c77-85fc-fbefc48500d9/2017+ODH+Health+Services+Survey+webFINAL.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-bf86c00c-1003-4c77-85fc-fbefc48500d9-mMqOoKq). A large number of medications are administered in Ohio schools on a daily and as needed basis. While the person most likely to administer the medication is an RN, more than 40% of medications are administered by unlicensed school staff such as secretaries and school administrators; these unlicensed staff must all be trained for this task by a licensed health professional. Many of these data are from the ODH Survey of Health Services in Ohio Schools. The next iteration of that survey was planned to be in the field in spring 2020 but had to be postponed because of pandemic restrictions.

While the descriptions of activities are those that typically occur in school, the pandemic created dramatic change in the schools. In March 2020 schools were closed and had to transition to a remote learning environment within a matter of days. With so little known or understood about COVID-19 at that time, there were widespread fears about handling student papers completed at home and submitted to the school. There were disruptions in services provided to CYSHCN, food meal services, and other activities typically held at school. During the summer both ODH (https://coronavirus.ohio.gov/wps/portal/gov/covid-19/responsible-restart-ohio/Sector-Specific-Operating-Requirements--see Schools) and ODE (http://education.ohio.gov/Topics/Reset-and-Restart) provided guidance to schools for the 2020-21 school year, but there has continued to be wide variation of school services (see map at ODE link above).

Despite the challenges of the pandemic, school nurses continue providing care to children with special healthcare needs, conduct COVID-safe health screenings, health education, in-service education to other school staff, and acute injury and illness care for all students. As needed, they refer children and families to medical homes or other community resources (including Medicaid if appropriate) for healthcare services. These school nurse activities address these four MCH priorities.

The ODH School Nursing program activities include professional/workforce development, provision of technical assistance, resource development, and data collection. Professional development is provided in both face-to-face conferences as well as online independent study opportunities. Topics for professional development are determined by requests of school nurses on conference evaluations, trending topics in technical assistance requests, and emerging issues. Annually, program convenes a focus group of practicing school nurses to identify the topics for the upcoming year and which should be shared as conferences or online independent studies. These Public Health Strategies (PHS) are designed to support school nurses in providing direct (D) and enabling (E) services to students and school communities. Title V funds, with a smaller amount of GRF dollars, pays for the School Nursing program staff, venues, and speakers for conferences if needed.

Professional/Workforce Development

In a typical year, the School Nursing program hosts a three-day in person orientation for new school nurses, three regional school nurse conferences on a variety of topics, and a summer conference where an entire day is devoted to a specific topic. Continuing nursing education (CNE) contact hours are provided for all professional development.

Due to the pandemic, only one of the regular Regional School Nurse Conferences was held in the spring, providing 6.25

CNEs for topics including Leadership, Self-Harm/Cutting, Tick- and Mosquito-Borne Diseases, Psychogenic Seizures, and Social Media to 185 nurses. One was completely cancelled, and one was transitioned to a virtual conference within the week for 130 nurses. All of these topics support MCH goals of integrative services, reducing barriers/improving access, and care of CYSHCN. Summative evaluations for the conference were excellent.

The conference in the summer of 2020 addressed homeless and was also transitioned to a virtual platform; 60 nurses attended, earning 5.25 CNEs. Summative evaluations for the conference were excellent.

For the new school nurse orientation in August, the conference was transitioned to three successive Friday virtual conference days, rather than three successive face to face conference days. Registration for this virtual format was higher than previous years with 141 nurses.
earning 17.8 CNEs. While all of the topics support the health of children in the school setting, the agenda specifically included presentations on BMI-for-Age screening (obesity prevention); MSP and MAC (Medicaid reimbursement for CYSHCN, medical home, reducing barriers/improving access); chronic disease management, autism, special education services, vision and hearing screening, management of food allergies, and more topics (CYSHCN, integrated services). Summative evaluations for the conference were excellent.

As previously mentioned, professional development is also offered through online independent study opportunities. The School Nursing program has developed a library of more than 40 online independent study courses. A minimum of four new courses are added each year. Courses are revised and updated or discontinued as necessary to ensure continuing relevance. Depending on the topic, trainings range from one-hour trainings on a single topic to Blended Learning Series that provide more than five hours of CNEs. In the past year, 1,651 nurses took courses from the library and earned up to 20.7 CNEs. A wide variety of topics are included in the library, including many that specifically address MCH goals. These include allergies, anxiety disorders, autism, bleeding disorders, special education law, individualized healthcare plans and other topics related to providing care for CYSHCN, removing barriers/improving access, and integrating services. BMI-for-Age training supports obesity prevention. Summative evaluations for the studies were excellent.

Technical Assistance, Resource Development, Data Collection
The School Nursing program is home to the State School Nurse Consultants for Ohio. These consultants responded to more than 1,000 requests for technical assistance during the year, providing support to school nurses, school administrators, parents, and others with an interest in school health.

School Nursing program staff create resources for use by those interested in school health. In addition to the usual development of resources for schools such as the revision of the *Emergency Guidelines for Schools*, School Nursing program staff participated on interdisciplinary, interagency work groups to develop pandemic guidance for schools and school nurses. School Nurse FAQs, Resources, Don/Doff Facemask handouts and videos were also created and posted on the ODH coronavirus.oho.gov website.

Another resource in the electronic School Nurse Bulletin Board. This is a one-way communication system from ODH to school nurses on the Constant Contact platform. More than 1,330 school nurses are enrolled in the Bulletin Board; 59 messages were sent this year to school nurses alone, with an additional 53 sent to both the School Nursing and Early Childhood Health Bulletin Boards jointly. The School Nursing messages showed a 59.9% open rated and 18.35% click rate —both above industry average. The average number of messages were up from 9 messages per month last year to 11.75 per month this year; 66 of these messages were pandemic-related, 46% of all messaging this year.

The School Nursing program periodically conducts a survey of health services in Ohio schools. While this year was not a data collecting year, the results from the previous year were compiled, analyzed and published on the ODH website. While there had been plans to be in the field in spring 2020 for data collection, they were deferred due to the pandemic.

Stakeholders and Partnerships
The State School Nurse Consultants in the School Nursing program participate and share their expertise in numerous state level and national committees such as the Ohio Violence and Injury Prevention Program, the Ohio Association of School Nurses, and the Ohio Adolescent Health Partnership, and the National Association of State School Nurse Consultants.

The ODH School Nursing program has partnered with the Ohio AAP, Ohio EMS, and others to create the *Emergency Guidelines for Schools* book. Historically, this book has been printed and disseminated to schools, and is available online. It has been adapted for use in numerous states and jurisdictions across the country. It was last revised in 2007, so the program has pulled together an interdisciplinary team to revise the document. While the goal was to have the revisions completed by next year competing priorities related to the pandemic have delayed the final formatting and production of this resource.

Next Steps

In addition to continuing to offer professional development, the School Nursing program expects to be in the field with the next Survey of Health Services in Ohio Schools in 2021. Title V funding will be used to contract for statistical services to draw a weighted sample and clean and weight the data after collection.

A new project that will be undertaken is that the program will contract with an external evaluator to develop a comprehensive evaluation plan for the School Nursing program. In development of this proposal, it was found that no other state has done this kind of evaluation planning for their school nursing program, so this will be the first of its kind in the country. Title V funding is being used to contract with this external evaluator. Work began in October 2020.

Youth Survey Work

Ohio achieved weighted data on the 2019 Youth Risk Behavior Survey/ Youth Tobacco Survey, which was the first time in six years this was accomplished. One barrier to getting school participation in recent years was an abundance of state and local surveys occurring simultaneously, adding pressure to schools to participate in multiple. ODH staff, including YRBS Coordinator and Data and Surveillance Manager, convened a workgroup of multiple state agencies, including the Ohio Departments of Education, Mental Health and Addictions Services and Medicaid, to discuss coordination of survey efforts. The group was facilitated by staff from the Ohio University, who walked through a process to identify shared goals and work towards a system of surveys for the state.

Youth Homelessness

State Fiscal Year 2020 marked the first time ODH received funds in the General Revenue Fund (state budget, GRF) to address youth homelessness. Former Director of Health, Dr. Amy Acton, actively lobbied that homelessness is a public health issue. The budget line item was specific to addressing homelessness in individuals aged 14-24, with particular emphasis on homeless youth who are pregnant. ODH awarded 7 subgrantees a total of $1,800,000 in grant funds in SFY 20, and to an additional 6 subgrantees for a total of 13 subgrantees that were awarded a total of $2,200,000 in SFY 21.

ODH's funding for this initiative enabled local agencies that serve homeless youth to implement innovative strategies to reach and assist this difficult and vulnerable population. The funding is able to be used for services not typically covered by traditional federal funding for homelessness. Strategies implemented by the subrecipients included expanding/enhancing COVID-safe/socially distanced "drop in" centers for youth; purchasing bicycles to assist with transportation to school/work; purchasing cleaning supplies for housing; supporting the costs of cell phone minutes in order to keep youth connected to case managers, appointments, job/school, etc. Additionally, the funding provided support to smaller agencies that provide specific core services to youth who are homeless (such as education/employment training, or behavioral/substance use counseling/treatment), as well as to larger agencies to expand their comprehensive services for homeless youth.

COVID-19 restrictions in Ohio created barriers in getting this initiative up and running at the local level, which began in February 2020. Many of the grant funded agencies experienced delays in getting their initiatives implemented fully until recently, due to not being able to host face-to-face services. ODH anticipates this initiative will continue to grow as we work through the pandemic. Title V MCH funds support the ODH personnel who administer this GRF funded grant.

Tobacco Use Prevention and Control Program

ODH Title V partners with other funded areas of the agency to improve adolescent health outcomes. Regarding tobacco and e-cigarettes, the CDC funded Tobacco Use Prevention and Control Program (TUPCP) aims to reduce youth use. They fund 30 communities for youth work which includes formation and implementation of counter-marketing campaigns, point-of-sale audits and compliance checks, promotion of point-of-sale policies that limit the availability and accessibility of tobacco to youth, and work with community leaders to increase awareness of the need for policy change. The grant encourages youth involvement in counter-marketing activities and in activities that promote adoption of laws or policies that restrict youth access to and availability of tobacco. Ohio has collected and continues to collect point-of-sale marketing information about tobacco in local retail environments. Youth and public health officials use these data and data gathered from compliance checks and other community assessments to educate community members and decision makers about the impact of tobacco on youth. Between 7/1/19 to 6/30/20, 495 retail compliance checks were conducted with a 73% compliance rate, a decrease of 12% from the previous year. This decrease in compliance rate was anticipated with the adoption and implementation of Ohio's statewide Tobacco 21 law which raised the legal age to buy tobacco from 18 to 21. The advent of the pandemic also most likely impacted the functioning of retail establishments that sell tobacco.

Another grantee activity is store audits. Findings are used to promote awareness among decision-makers and community members and to promote policy change to reduce exposure to tobacco marketing and price discounting. A total of 495 store audits were also completed and these results were much more promising indicating a decrease in community marketing affecting youth including decreases in price promotions for little cigars (from 69% to 49.5% of stores audited), e-cigarettes (from 64.7% to 45.1%) and Juul pods (from 52.4% to 40.7%). Community grantees with ODH tobacco prevention and

control grants continue to work to promote point-of-sale policies that would restrict or eliminate price discounting, would restrict overall marketing on windows in convenience stores, would decrease the availability of flavors, or that would restrict the density of tobacco retailers in a community or limit their proximity to schools or parks where youth spend time.

With the dramatic rise in youth nicotine use, largely through vaping, TUPCP added a vaping deliverable to the local tobacco grant program in November 2019 which continued through 6/30/20 and which will be included in following project periods of the local tobacco prevention and control grant. Objectives related to raising community awareness of youth, parents, school personnel, and healthcare professionals about the dangers of vaping. Additionally, grantees continue working with established task forces to implement community centered objectives to address the vaping epidemic and to promote the My Life, My Quit program, a youth cessation program associated with the Ohio Tobacco Quit Line.

Increasing the number of 100% Tobacco-Free School Districts is an ODH Directive and an indicator in Ohio's State Health Improvement Plan. During the reporting period the total number of school districts that have a 100% tobacco free policy rose from 183 to 285. These districts include an additional 529 schools, protecting an additional 192,642 students.

While the TUPCP is funded by CDC, the Title V program collaborates with and benefits from their strategies and objectives. By decreasing the availability and initiation of nicotine product use, preconception health indicators will improve in addition to overall adolescent health. Title V continues this partnership with the Tobacco Use Prevention and Cessation Program on tobacco issues that impact youth, such as 100% Free School Policies, Tobacco 21 law, and adolescent development and e-cigarette use and cessation efforts.

Adolescent Health, Application Year FY 2022

Within the adolescent population domain key issues emerged from the 2020 needs assessment process and informed the selection of priorities to address adolescent suicide and substance use. The rates of tobacco use, depressive episodes, and suicide among adolescents has increased, as well as the rates of drug overdose deaths among young adults. Ohio's most recent YRBS data, collected in 2019, shows that one-third of Ohio high school students reported feeling so sad or hopeless during the past year that they stopped engaging in normal activities and 16% of Ohio high school students seriously considered suicide during 12 months prior to the survey. Female students and Black and Hispanic students were more likely to report seriously considering suicide. In 2019, 26% of Ohio high school students reported current alcohol use and 16% reported current marijuana use. Vaping is also a significant concern among adolescents, with 48% of Ohio high school students reporting they have tried an electronic vapor product and 30% reporting they currently vape. The priorities have underpinnings in adolescent mental health and approaches to address both priorities will be coordinated using a systems approach that reduces risk and increases protective factors.

Emerging Issues

Since conducting the needs assessment, the COVID-19 pandemic has exacerbated the mental health needs of adolescents and underscored the importance of the selected priorities. With the disruption to school, extracurricular, and social activities due to stay-at-home orders and public health guidance, there is concern about social isolation negatively affecting adolescents. In addition, well-child visits and vaccinations are of particular concern as lockdowns and public concern about COVID-19 affected families' access, comfort, and ability to attend well-child visits over the past year. These will all be areas of focus for FY 22.

Priority: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate

Measures

- NOM 16.3- Adolescent suicide rate ages 15-19 per 100,000
- SPM- Rate of nonfatal intentional self-harm ED visits and hospitalizations ages 15-19, per 100,000 (VIPS)
- ESM: None developed at this time

The SPM was selected to track intentional self-harm, an important indicator for the NOM as suicide attempt is a risk factor for completed suicide, and intentional self-harm without wanting to kill oneself might also result in unintentional suicide. ESM development for this SPM will be explored during FY 22.

Objective 1: By 2025, reduce risk and increase protective factors for adolescents.

Strategies:

1. Implement evidence-based adolescent resiliency projects through MP grant.
2. Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation, and Bullying (HIB) Initiative.
3. Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease HIB.
4. Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP.

Addressing risk and protective factors will continue to be a strategy in FY 22 and beyond. Adolescent resiliency projects through the Maternal and Child Health (MP) program grantees will move from planning to implementation, addressing issues such as mental health, substance use, violence prevention, vaping, obesity, and healthy relationships. The MP grant has been providing support for local health and social services that identify health needs, service gaps, and barriers to care for families since 1983. The MP program is utilizing Results-Based Accountability to ensure programs are measuring progress.

In addition, MCH staff will continue to participation on existing statewide coalitions and workgroups. Workgroups include the Ohio Anti-Harassment, Intimidating, and Bullying group, which is led by the Ohio Department of Education, the Ohio Prevention Partnership (which includes both the Child Injury Action Group and Youth Suicide Subcommittee), the Ohio Interagency Council for Youth and Linking Systems of Care for Ohio Youth. In addition, MCH staff and partners will build upon work started during the ASPIRE learning collaborative to continue assessing shared risk and protective factors both internally and externally, working towards alignment of state agency work on Adverse Childhood Experiences (ACEs).

Additional agency work for FY 22 addressing risk and protective factors include school nurse and early childhood training, and continued community-level work by Sexual Assault and Domestic Violence Prevention Program (SADVPP). The topics for regional conferences for school nurses are not yet determined for FY 22, but typically reflect emerging and relevant issues facing school nurses and have recently included topics on self-harm, suicide, and mental health. In addition,

harassment, intimidation, and bullying content is included in the agenda for the Orientation for School Nurse New to Ohio Schools that takes place every year in September.

SADVPP, in partnership with the Ohio Alliance to End Sexual Violence and eleven local sexual violence prevention programs will implement strategies to end sexual violence including changes to school and workplace policies, social marketing campaigns, community mobilization efforts, and educational programming. Efforts to support survivors of sexual violence include updating and maintaining the protocol for sexual assault evidence collection and supporting crisis services to six agencies in order to provide services to African/African American/Black, Asian/Asian American, and Latinx survivors of sexual violence, as well as providing training opportunities for rape crisis centers on ways to increase effectiveness in working with these survivors. Efforts will continue to work with local health departments, community health centers, and other health and public health service providers to integrate a trauma informed approach to services and promote individual and community resiliency related to trauma.

ODH's Reproductive Health and Sexual Risk Avoidance Education programs provide education to adolescents. ODH Reproductive Health grantees received additional funding to work with faith-based agencies to provide educational programming to youth on healthy life choices, such as healthy life choices and reducing risk. The Sexual Risk Avoidance Program will begin a new competitive grant cycle in 2021 and many of the funded programs provide education to middle-school aged students on a variety of topics, including healthy relationships.

Objective 2: By 2022, develop a plan for MCH to support implementation of Ohio Suicide Prevention Plan among targeted youth population.

1. Increase MCH representation on State Suicide Plan implementation team.
2. Identify gaps in state programming that would fit within MCH work.
3. Explore programs that MCH can support.
4. Coordinate work within MCH to align with state plan and external partner programs.

As part of the activities planned for FY 22, ODH expects to develop a plan to determine the best way to support all the work occurring in this area through our state and local partners.
The selection of reducing youth suicide coincided with the release of the State of Ohio Suicide Prevention Plan in 2020. The state plan created a youth suicide subcommittee to focus specifically on activities in Ohio related to youth suicide prevention. The MCH Adolescent Health Coordinator participates on the youth suicide subcommittee, which is close to finalizing a youth suicide strategic plan. Implementation of the plan will begin in 2021 and MCH will continue to support and align with the strategies in the plan. As part of the ACES focus in the plan, ODH will share information around data sources and ACEs data availability.

ODH is currently finalizing a contract with the Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) to address many health topics for children and adolescents. In FY 22, Ohio AAP will offer monthly trainings for pediatricians on a variety of topics, including adolescent mental health and depression screenings. The Ohio AAP trainings will also help to lay the groundwork for Quality Improvement projects planned for FY 23.

In addition, Ohio was invited to participate in a CoIIN related to adolescent and young adult mental health. The CoIIN kicks off in July 2021 and will run through December 2022. The CoIIN involves a public health arm that will focus on state-level systems and capacity and a clinical care arm that involves a QI program for clinical practices on depression screening. Ohio is currently assembling the team for the project.

Priority: Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

Measures

- SOM- Percent of high school students who have used alcohol within the past 30 days (YRBS)
- SOM- Percent of high school students who have used marijuana within the past 30 days (YRBS)
- SOM- Percent of high school students who have used cigarettes, smokeless tobacco (i.e., chewing tobacco, snuff, or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days (YRBS/OYTS)
- NPM 10: Percent of adolescents (12-17) with a preventive medical visit in the past year
- ESM: Percent of adolescents (12-17) served by Medicaid with adolescent well visit

The SOMs were established to align with measures from the State Health Improvement Plan and will measure the impact of Ohio's efforts to address the adolescent substance use priority. The selected NPM aligns with the priority as adolescent preventive medical visits provide key opportunities for screening, education, and referral on numerous topics including

mental health and substance use. The ESM will measure continued efforts to increase rates of adolescents served by Medicaid with well visits.

Objective 1: By 2025, increase percent of adolescents with a preventive medical visit in past year by 3%
Strategies:

1. Continue collaborative efforts to convert sports physicals to comprehensive well-visits.
2. Partner with payors to incentivize the well-visit.
3. Partner with Medicaid and Education to support School Based Health Care initiatives.

School-based health care has emerged as a priority for many programs and agencies in Ohio, especially for populations of youth that have barriers to accessing a primary care provider. MCH will continue to support and explore ways to support and increase SBHC in Ohio. ODH's Offices of Health Equity and Rural Health are both exploring ways to support and expand SBHCs to focus on expanding access to care for populations most at-risk. MCH staff have been in contact with Nationwide Children's Hospital, which has a robust SBHC model that expands beyond central Ohio, to discuss ways to support the work that is already occurring.

School-based health centers are also planned to be the focus of the CoIIN related to depression screenings. Partnering with SBHCs for the CoIIN will facilitate connections between MCH staff and schools and guide further work.

Objective 2: By 2022, develop plan for promoting comprehensive adolescent well visit that includes:
Strategies:

1. 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).
2. Partnership between programs that can mutually promote comprehensive well-visit (e.g., state immunization).
3. Reviewing state/systems-level policies to assure equitable access to and uptake of high-quality well visit.

Cross-program partnerships and coordination will benefit adolescent well-visits and school-based health centers. ODH programs such as Rural Health and Office of Health Equity are involved in supporting SBHC initiatives. The ODH Immunizations program has been focused on the COVID-19 response, but MCH plans to coordinate work as the pandemic needs decrease and staff can return to normal duties.

ODH MCH has planned for a contract with Ohio AAP to address needs around provider education and quality improvement from many ODH programs. As part of that contract, training will be provided on adolescent well-visits, including Bright Futures.

Objective 3: By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use.
Strategies:

1. Identify existing collaboratives and build MCH representation and support.
2. 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.
3. Explore with partners development of system for tracking and supporting mental health provider partnerships in schools.
4. Analyze existing data to identify priority populations and disparities.
5. Continue trauma-informed care efforts with public health partners (SADVPP).
6. Explore cross-program opportunities with TUPCP for youth tobacco use prevention and cessation (e.g., cross-program referrals, cross-program promotional/marketing opportunities).
7. New strategy: Increase youth voice and engagement in ODH youth-serving programs.

In FY 21, the Ohio Department of Education conducted a survey of all Ohio schools to evaluate prevention efforts. This data will be available after July 1, 2021 and will be shared with state partners. ODH will assess the data and will not plan to conduct a separate environmental scan, unless there are gaps that need to be addressed. In 2021, ODH Tobacco Use Prevention and Cessation program (TUPCP) hired the first ever staff person focused solely on youth tobacco, specifically youth vaping. This staff member has participated on the Adolescent MCH block grant workgroup and is committed to coordinating activities to align priorities. FY 22 activities include further examination of 2019 YRBS data on disparities, especially related to mental health and suicide.

The ODH TUPCP will continue specific and meaningful steps towards protecting Ohio youth from tobacco companies and the health effects associated with using their products. Currently, using CDC funds, ODH funds 29 local health departments as tobacco control subgrantees throughout the state. As a part of this funding, these local health departments work on a number of youth-focused tobacco prevention initiatives- such as passing local youth-focused prevention policies, improving

or adopting tobacco-free policies in schools and public spaces, vaping prevention and education efforts, and promotion of the youth-centered cessation program, My Life My Quit.

Youth engagement has become an important component of the MCH block grant work, which is why a strategy was added to engage youth. In FY 21, the MCH Adolescent Health Coordinator convened an internal ODH workgroup to examine how youth-serving programs utilize youth voice or engage youth in programming. FY 22 activities will include continuing to determine a structure for ODH to coordinate this work, both internally and with external partners. This also includes strengthening youth involvement on the Ohio Adolescent Health Partnership (OAHP), which is a stakeholder group for the adolescent work. The OAHP is due to update its strategic plan in FY 22. ODH plans to contract with an agency to facilitate the planning sessions, which will also include ensuring youth are involved in the process.

Other Efforts Supported by Title V MCH

The majority of MCH programs serving the Adolescent population are represented within the above application narrative. Several program summaries are included below to highlight additional relevant programs, and many of the programs presented in the Perinatal/Infant Application also serve children and adolescents. Please see the Program Map (section V. Supporting Documents) for the full list of programs.

Ohio Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)

The Ohio YRBS is a CDC-supported, school-based survey that has been administered every other year in Ohio high schools since 1993. The YRBS monitors health risk behaviors of adolescents including injury and violence related behaviors, substance use, tobacco, sexual behaviors, nutrition and physical activity, and other health-related behaviors. In 2019, ODH combined the YRBS with another ODH administered, CDC-supported survey, the Ohio Youth Tobacco Survey (YTS), resulting in the YRBS/YTS. The Ohio YRBS/YTS is administered in middle and high schools across the state and provides valuable data for the state to inform program and policy decisions on many health behaviors of Ohio adolescents.

The 2021 YRBS/YTS includes 16 new ACEs questions that were optional for states to add from the Centers for Disease Control and Prevention (CDC). Due to COVID-19, the survey administration was delayed from Spring to Fall 2021. Data is expected to be received in Spring 2022 and will be examined and disseminated internally and publicly.

MCH staff have also participated on a multi-agency workgroup around coordinating youth survey work across the state. While the work has been stalled a bit in 2021, partners plan to remain involved and MCH staff will participate when meetings resume.

Youth Homelessness

State Fiscal Year 2020 marked the first time ODH received funds in the General Revenue Fund (state budget, GRF) to address youth homelessness. Former Director of Health, Dr. Amy Acton actively lobbied that homelessness is a public health issue. The budget line item was specific to addressing homelessness in individuals aged 14-24, with particular emphasis on homeless youth who are pregnant. ODH awarded 7 subgrantees a total of $1,800,000 in grant funds in SFY 20, and to an additional 6 subgrantees for a total of 13 subgrantees that were awarded a total of $2,200,000 in SFY 21. Title V MCH funds support the ODH personnel who administer this GRF funded grant. ODH's funding for this initiative enabled local agencies that serve homeless youth to implement innovative strategies to reach and assist this difficult and vulnerable population. The funding is able to be used for services not typically covered by traditional federal funding for homelessness. ODH is awaiting the final state budget for SFY 22 to determine the amount allocated for the program. If funding is level, SFY 22 will be a continuation year for the currently funded programs. A focus for SFY 22 is to enhance the data collection to determine more details about the youth experiencing homelessness who are being served, what services are being provided, and program outcomes.

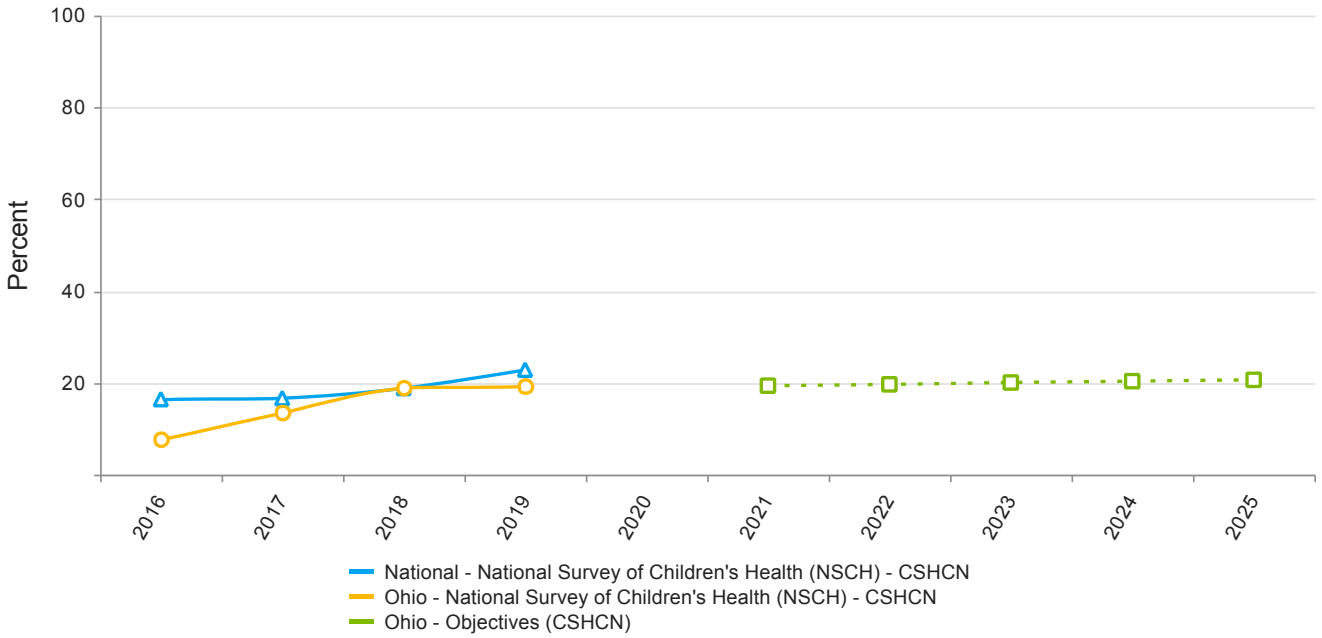
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.2 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.5 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.7 %	NPM 11

National Performance Measures

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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	18.9	19.1
Numerator	48,775	51,261
Denominator	257,717	268,951
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.4	19.7	20.1	20.4	20.7	21.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	25.0	28.0	31.0	33.0	35.0

State Action Plan Table

State Action Plan Table (Ohio) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	
NPM	
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	
Objectives	
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%.	
Strategies	
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 CSHCN population and participate in transition planning	
Work with partners 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	
ESMs	**Status**
ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Ohio) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services

NPM

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

Objectives

By 6/30/2023, develop a plan 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

Strategies

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

ESMs	Status
ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	Active

NOMs

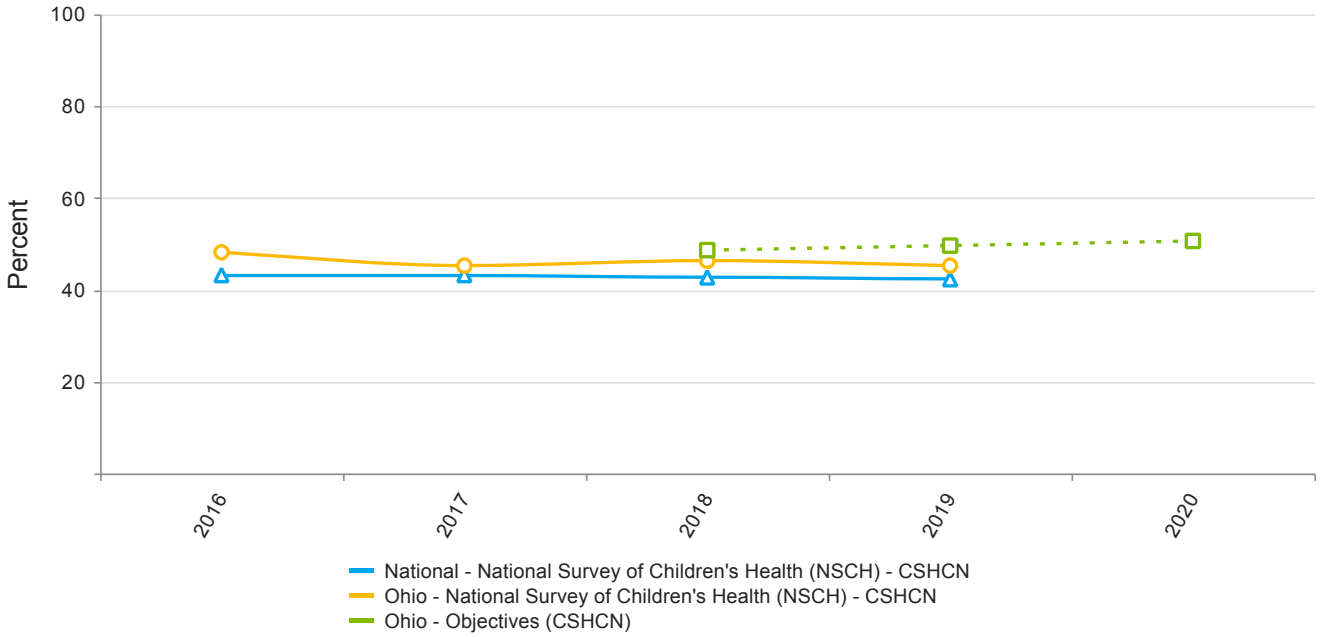
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Ohio) - Children with Special Health Care Needs - Entry 3	
Priority Need	
Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	
NPM	
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	
Objectives	
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%.	
Strategies	
Work with partners to coordinate services within clinical and non-clinical service delivery systems (e.g., explore interagency agreements, automatic referral mechanisms, coordinated outreach and education)	
Leverage partnerships with children's hospitals who provide Hospital-Based Service Coordination (HBSC) for CSHCN 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 CSHCN not enrolled in CMH	
Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems	
Work with partners to develop action team to examine previous preparedness workbook and develop new plan for increasing resources to develop emergency preparedness plans among CSHCN	
ESMs	Status
ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

2016-2020: National Performance Measures

2016-2020: NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



2016-2020: NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			48.6	49.6	50.6
Annual Indicator		48.2	45.1	46.2	45.3
Numerator		288,652	258,614	243,608	245,379
Denominator		598,389	572,934	527,644	541,476
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			48.6	49.6	50.6
Annual Indicator	38				
Numerator					
Denominator					
Data Source	Ohio Medicaid Assessment Survey				
Data Source Year	2015				
Provisional or Final ?	Final				

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 11.1 - Number of stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				12	
Annual Indicator	0	0	0	19	40
Numerator					
Denominator					
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2016	FFY 17	FFY 17	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Children with Special Health Care Needs, Annual Report FY 2020

Priority: **Increase access to care via Patient Centered Medical Home (PCMH) for children with special healthcare needs (CSHCN)**

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

- According to the HRSA Federally Available Data (FAD), in 2018-2019, 55.8% of children and 45.3% of CSHCN in Ohio had a medical home. The rate has been relatively stable at 56.0% and 46.2% in 2017-2018 and 56.1% and 45.1% in 2016-2017.

NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

- According to the FAD, in 2018-2019 15.2% of CSHCN received care in a well-functioning system, compared with 13.4% in 2017-2018 and 15.1% in 2016-2017.

ESM 11.1: Number of stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families and children with special health care needs

- In FY 20, ODH collaborated with over 40 stakeholder groups to share information about PCMH with families and CSHCN at over 100 events.

The Ohio Department of Health (ODH) serves children and youth with special healthcare needs (CYSHCN) through several distinct programs that work collaboratively. The CMH (Children with Medical Handicaps) Program is provided for in Ohio statute, as are programs that serve Ohioans with Sickle Cell Anemia, genetic disorders, and hearing loss. ODH programs also provide screenings for critical congenital heart disease, hearing and vision problems, and facilitates an amblyopia registry. These programs work collaboratively with sister state agencies, condition-specific organizations, Ohio's two University Centers for Excellence in Developmental Disabilities, six children's hospitals, 113 local public health departments, and a network of thousands of healthcare providers across the state to connect families to high-quality services to assist in meeting the unique needs of their child(ren). ODH's Title V CYSHCN programs focus on policy and systems change and enabling activities while leveraging partnerships to improve access for families to direct services such as Early Intervention, specialty medical care and therapies, and care coordination. Each program regularly engages with families of CYSHCN and several programs have advisory committees comprised of parent and advocate representation.

During FY 20, work continued on the selected priority to connect CYSHCN with a PCMH. The originally established workgroup included some practitioners, advocacy representation, and key State agencies, but did not include the voice of the parent. Additionally, ODH discovered that many primary care practices (PCP) in Ohio were operating using the PCMH model but were not investing in the national registration and certification process. This means that those PCPs are not listed in a directory and prevents ODH from providing a comprehensive list of PCMH providers for Ohioans to utilize.

The group determined that the value of a PCMH was in the quality of care, coordination, and accessibility provided to a family, and that this is often present even in the absence of an official PCMH designation. To this end, the workgroup designed a messaging strategy around the qualities of care that a family should look for in their medical practice (example: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/children-with-medical-handicaps/resources/medicalhome). As such, materials were developed, made available online, presented during stakeholder meetings, and shared by organizations including Developmental Disabilities Council, CMH PAC, Ohio's Interagency Workgroup on Autism (IWGA), and other organizations who have the ability to widely disseminate messaging to CYSHCN. The lessons learned from the PAC engagement reached beyond the PCMH project. The parents expressed the need for better transition supports when CYSHCN are required to change providers or educational settings. Spring boarding from the 2019 work, the PCMH project continues to be a high focus. The CMH Parent Advisory Committee (PAC) report having their child's specialist at the center of care (Medical Home) supports a more positive outcome. Prior authorizations have proven to be timelier with the specialist at the helm. The brochure is helping many CYSHCN families navigate pathways of care in a more effective and supportive manner.

During FY 20, work continued through the PAC regarding when CYSHCN are required to change providers or educational settings. The PAC appreciates the opportunity to provide direct parent feedback. The CMH PAC successfully participated in Health Equity/Implicit Bias training led by Tif Huber, Asthma Program Manager and an Ohio Department of Health Equity Lead. Two sessions occurred with all PAC members participating. PAC members reported the experience was valuable and they will apply the information they learned as they interact with other CYSHCN families and care teams. We also have involved multiple members of the PAC within the ODH CYSHCN BG workgroups.

The results of the needs assessments identified the need to hire fulltime parent consultants whose lived experience would provide an informed voice for Maternal Child and Family Health programs at ODH (see the ODH Parent Consultant flier attached in V. Supporting Documents). The Parent Consultants continue to work towards diversifying the CMH PAC. They

continue to involve our PHNs and Field Nurse Managers to share the word by revising the PAC application and making it more accessible to parents. There are several candidates who have expressed an interest to join, and we hope to bring them on in early 2021. The Parent Consultants also networked with Equitas Institute in Columbus OH to help identify CYSHCN parents who may be interested in serving on the PAC. The PAC began work to update their By-Laws to reflect a stronger emphasis on Health Equity and diversity. In addition, the Parent Consultants published a Parent 2 Parent newsletter (located here) in July 2020.

Our Parent Consultants were asked to participate in a variety of webinars hosted by non-profits and sister agencies to share specifically about the CMH program and how the program supports Ohio families, explain varying components of the CMH program including service coordination and the metabolic formula program. The consultants also are working hard within ODH to build strength in collaborating program to program in all areas of ODH. Our Parent Consultants partnered with the Ohio Family 2 Family to work on an Emergency Preparedness Telehealth Fact Sheet for families to utilize during emergency/pandemic situations. This work also supports the great collaboration between the Ohio Department of Health and the Ohio Family 2 Family organization. The parent consultants were invited to join in with our CMH Field Nurse Supervisors and Managers as they met in a virtual meeting with local public health nurses (due to COVID). Our parent consultants were able to share about their roles within ODH and how they help support families in collaboration with the local public health nurses.

During FY 20, in an effort to get pediatric cancer placed in Ohio's State Cancer Plan, a group of individuals from a variety of backgrounds (state staff, nonprofit leaders, medical professionals, advocates, and parents of pediatric cancer patients), came together to form a plan to better support Ohioans impacted by pediatric cancer. All of their efforts centered around the notion of helping families alleviate the long-lasting, devastating effects of childhood cancer. As their work continues, their goal is to address the medical, emotional, and financial toll cancer brings, while increasing awareness, and targeting major pain points, such as transitioning care and fertility. Both of our Parent Consultants serve on this team with one helping to co-chair the workgroup.

The CMH Hospital Based Service Coordination (HBSC) Program, has long served as a model for patient and family-centered care coordination that predates but operates under similar principles as a PCMH. The ODH created the HBSC decades ago as a means for bringing together all providers who provide care for an individual child with complex needs once annually to develop a coordinated care strategy and to designate which provider would be responsible for each component of the plan. The desired outcome was quality care delivered in a way that avoids duplication of services (e.g., diagnostics, blood draws, scans) and streamlines clinic visits to the extent possible. Each of the six children's hospitals in Ohio participate in the program that is facilitated by hospital personnel who coordinate the convenings and compile the plan into a document that is accessible to the child's medical team, provided to the child's parents or guardian, and can also be shared (with parental permission) with educators and other people who provide supports to the child. While this service was initially offered only to children enrolled in the CMH Program, and ODH continues to maintain minimum standards for the program, hospitals now provide HBSC to families regardless of payer source. In 2018 and 2019, CMH Nurse supervisor, Jennifer Warfel, worked closely with Ohio's children's hospitals providing technical assistance as they converted the HBSC documentation into their electronic medical records system. This not only makes the HBSC documents more accessible for a child's medical team and parents, but also demonstrates the importance and sustainability of the program.

Enhanced, regular interaction with our peers at the Ohio Department of Medicaid (ODM) and Ohio Department of Developmental Disabilities (DODD) are proving to not only address challenges for individual families who experience difficulties in accessing services, but also are driving systems change. The ODH CMH Program holds a weekly case conference with ODM to review both individual situations where a child with Medicaid coverage is experiencing delay or denial of a needed service. The case reviews are valuable in correcting misunderstanding that sometimes occur through an impersonal prior authorization process, particularly in serving children with medical complexity. As part of the process, the CMH team tracks trends of denials for requested services by managed care organizations (MCOs). This trend data provides ODM with needed information to correct systemic problems with the MCOs. A similar, but less frequent, process takes place with DODD as ODH identifies challenges for Ohio's CYSHCN families who are served in the developmental disabilities system. While this process with DODD often proves effective, we continue to seek better collaboration with stakeholders representing Ohio's children with hearing disorders.

In FY 20, the Ohio Department of Health began referring all children less than 36 months of age with confirmed elevated blood lead levels to the Ohio Department of Developmental Disabilities for enrollment in Early Intervention services. This new referral program ensures that a child receives comprehensive services related to any potential impacts of lead, while the Ohio Department of Health and its delegates provide direct services to identify and eliminate lead hazards from the child's environment. The Ohio Department of Health and a network of local health departments also work to educate families impacted by lead on how to reduce a child's lead level over time.

Both ODH and DODD engage with a stakeholder group that includes parents of children with hearing loss, medical providers and other interested parties on a quarterly basis. However, the group continues to experience difficulties in coming

to consensus in establishing priorities which stalls progress and contribution.

The ODH holds Governor's appointment on the Ohio Developmental Disabilities Council. The ODH representative holds a seat on the following committees: Public Policy, Children and Health, and Outreach and Membership. In 2020, the Council Outreach Committee focused efforts toward both gaining a better understanding among members about diversity and equity and applying that knowledge to improve diversity of council representation and in improving our messaging and outreach to Ohioans. Council members participated in a variety of trainings and self-assessments about implicit bias and diverse populations. Additionally, we learned from several organizations that serve Ohioans with disabilities about their data-driven approaches to ensuring that the needs of diverse populations are met. The Down Syndrome Association of Central Ohio (DSACO) provided their model for utilizing data to determine which populations were underrepresented in their enrollments. DSACO further shared their approach in utilizing community influencers for outreach activities to identified populations. This initial engagement was foundational for an ODH-specific outreach project that launched in fall 2019, highlighting the benefit of our participation in external stakeholder groups and community engagements.

Our Parent Consultants have brought a deep family focus within the ODH. They are both serving on our Health Equity Committee within the BMCFH and are co-leading in our BG workgroups related to child and CYSHCN. They are also serving as members on all the BG workgroups. Prior to the pandemic, one of our Parent Consultants traveled to several local health departments to meet local PHN/DON staff and help raise awareness for the ODH MCH programs, with a deep focus on the CMH program. They are also connecting with families, who the ODH programs serve to help answer questions and provide support in identifying and locating resources/programs to help meet their needs. The Parent Consultants are networking with staff to bring more awareness to the needs of families of CYSHCN within the ODH programs and with a variety of state agencies. They are also connecting with non-profits and other associations. A few of their projects include serving on boards and workgroups with: Interagency Workgroup on Autism, ODE Early Childhood Preschool for CSHCN – ECTA Project, Ohio Partners for Cancer Control, Ohio Collaborative to Advance Maternal Health (OH-CAMH), and Pregnancy Associated Mortality Review (PAMR).

Children and Youth with Special Health Care Needs (CYSHCN), Application Year FY 2022

The 2020 needs assessment process identified that CYSHCN, ages 12-17, in Ohio were 17% less likely than U.S. peers to receive the services necessary to transition to the adult healthcare system in 2016-2017. Results from the needs assessment and stakeholder meetings with families and clinicians held on a quarterly basis emphasized the continued need for improved care coordination and additional planning for CYSHCN transitions from adolescence to adulthood. As such, ODH developed strategies to address these needs and work towards identified objectives.

Emerging Issues

Due to the COVID-19 pandemic, beginning March 2020 through February 28, 2021, the Children with Medical Handicaps Program (CMH) auto renewed treatment for families enrolled in the treatment program. Beginning with cases that expire March 1, 2021 or later, providers will receive renewal applications and families will receive financial packets. Families experiencing a financial hardship that have been denied for income reasons may file an appeal or contact the CMH call center for assistance. Telehealth visits will continue to be an option for families to utilize during the ongoing pandemic.

The CMH program continues to serve families through Field Nurse Managers and Parent Consultants partnering with the local county/health district Public Health Nurses. Some counties are reporting that nurses are beginning to return to CMH work, but there are many still focused on COVID-19 response within their county/health district.

The CYSHCN group has identified 5 sub workgroups for stakeholders and internal team members to implement strategies and activities. Each workgroup will include the cross-cutting priority for health equity/Social Determinants of Health (SDOH). Each workgroup will also include a member of the CMH Parent Advisory Committee to be sure and include a strong family/parent perspective. These workgroups will meet at the least bi-monthly to ensure the projects within the workplan is followed.

1. Family Engagement
2. Physician Work Group/Provider Outreach
3. Care Coordination
4. Transition Health Care
5. Transition Non-Health Care

Priority: Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services.

Measures:

- NOM 17.2: Percent of children with special health care needs (0-17) who receive care in a well-functioning system
- NPM 12: Percent of adolescents (12-17) who received services necessary to make transitions to adult health care
- ESM: Percent of CYSHCN ages 12-17 and older enrolled in CMH with a transition plan in place.

Stakeholders recommended the priority to increase the prevalence of children with special health care needs to receive integrated services as a result of the state needs assessment. The selected NPM directly relates to the need for transition services identified through the needs assessment. The ESM for the NPM is percent of CYSHCN enrolled in CMH with a transition plan in place. The selected ESM will help to measure our progress in ensuring young adults transition into being able to participate as the primary decisionmaker more fully in their care moving forward.

Objective: 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%.

Strategies:

1. Work with adult and pediatric medical providers to assure knowledge and awareness of transition.
    - Representation on the CYSHCN group includes members from Ohio children's hospitals and adult care hospitals to learn from current transition teams in place.
2. Work with partners to increase the number of adult providers that serve CYSHCN population and participate in transition planning.
    - The CMH program is actively working with varying specialty clinics to onboard adult hospitals/providers who are now actively providing care to youth/young adults who are active on the CMH program.
3. Work with partners to assure family and teen knowledge and support regarding transition.
    - Ohio Family 2 Family (F2F)/ODH hosted a Transition Bootcamp workshop in March to discuss emergency preparedness and focus on transition. Ohio F2F/UCCEEDD also hosted a Transition Bootcamp conference

that highlighted many topics re: transition both inside and outside of healthcare. The conference was very well attended.
    - Our Parent Consultant is working with the CMH program to form a Youth Advisory Committee that will be established in Fall 2021.
4. Support children's and adult hospital systems in the same geographic area to conduct pilot transition projects.
    - Strategy updated with new language to represent broader approach to increasing pilot transition support. Previous language: "Release RFP for children's and adult hospital system in the same geographic area to conduct pilot transition project that includes a coordinator in each system and standard model for charting and implementing a life course plan." Development of the RFP was delayed due to the COVID-19 pandemic and since then meetings with hospitals systems have commenced with conversations on supporting such projects without the RFP constraints.
5. Identify social determinant barriers in medical transition and require transition planning model to address.
    - Explore opportunities to raise awareness of social determinant barriers during orientation of CMH hospital-based team service coordinators.
    - Work with community partners on several SDOH projects regarding insurance, housing, financial support, etc.
    - Utilize Charting the LifeCourse framework with CYSHCN families to help their lived experience voice be better understood in service/support settings both inside and outside of healthcare (specialty physicians/hospitals, schools, job placement, local DD SSA teams, etc.).

Objective: By 6/30/2023, develop a plan 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.
Strategies:
1. 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).
    - Develop additional partnerships with Job and Family Services (JFS foster care/bridges), Department of Developmental Disabilities (DODD), military, Social Security Administration (SSA), Opportunities for Ohioans with Disabilities (OOD), Ohio Department of Education (ODE), and other entities who assist with non-health care transition.
    - Develop additional partnerships with county level providers, adult practitioners, non-profits, WIC, housing, employment (ref stakeholder list email from 1/6/21) to serve on external work group and/or sub work groups.
    - Explore ideas for a pilot program with CMH Field Nurse Managers/PHNs utilizing the Charting the LifeCourse tools (this will help with guiding teens/young adults participating in the CMH program who are transitioning from child specialists to adult specialists).
2. Explore mechanisms for automatic referrals for children at certain age to those other programs that would help transition to other supports/systems.
    - Explore automatic resource sharing for services available through community systems, OCALI, OOD, DODD, OCECD, Medicaid, State Support Teams, etc. who are serving the same populations.

Objective: 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%.
Strategies:
1. Work with partners to coordinate services within clinical and non-clinical service delivery systems (e.g., explore interagency agreements, automatic referral mechanisms, coordinated outreach and education).
    - Explore partnerships with programs within BMCFH, WIC, Birth Defects (OCCSN), Infant Hearing Program, Lead, and Early Intervention.
    - Explore activities to eliminate disparities and ensure equitable health care for children with special health care needs.
2. Leverage 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.
    - Explore opportunities to capture social determinant barriers in systems such as electronic medical records and in the current PHN manual.
3. Seek ways to expand HBSC for CYSHCN not enrolled in CMH.
    - Working on ways to partner with children's hospital teams to identify ways to expand services.
4. Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems.
    - Promote the Ohio F2F has implemented a P2P (Parent to Parent) peer program - https://www.ohiof2f.org/ohiop2p/.

5. Work with partners to develop action team to examine previous preparedness workbook and develop new plan for increasing resources to develop emergency preparedness plans among CYSHCN.
    - ODH has formed a partnership with Ohio F2F on an Emergency Situations Toolkit. This work will be highlighted at a session during the June 2021 national Family Voices Conference.
    - ODH is partnering with Ohio F2F on creating a Telehealth fact sheet to distribute to families.

Other Efforts Supported by Title V

The majority of MCH programs serving the CYSHCN population are represented within the above application narrative. Several program summaries are included below to highlight additional relevant programs, and many of the programs presented in the Perinatal/Infant, Child, and Adolescent Applications also serve CYSHCN (notably: Comprehensive Genetics Service Program, Sickle Cell Services Program, Newborn Screening for Clinical Congenital Heart Disease, Infant Hearing Program, and Ohio Connections for Children with Special Needs- Birth Defects Surveillance). Please see the Program Map (section V. Supporting Documents) for the full list of programs.

Ohio Hearing Aid Assistance Program (OHAAP)

The Ohio Hearing Aid Assistance Program (OHAAP) is an earmarked program funded by the Ohio legislature, in Section 285.20 of Amended Substitute HB 59 of the 130th General Assembly in 2013. OHAAP provides assistance to eligible families with children up to twenty-one years of age with permanent hearing impairments to purchase hearing aids. Eligibility requirements include Ohio residency for family and child; hearing loss diagnosis; and, family's income is below 400 percent of the federal poverty guidelines based upon adjusted gross income or annual salary. Children enrolled or who can qualify for Medicaid or the Children with Medical Handicaps Program (CMH) are not eligible for OHAAP. Families who apply for hearing aid assistance may be required to pay a fee based on a sliding scale schedule for audiological services.

Metabolic Formula Program

The Ohio Department of Health (ODH) provides metabolic formula to individuals born with inborn errors of metabolism which are flagged on the Ohio Newborn Screening Panel. Examples of these disorders include phenylketonuria (PKU), maple syrup urine disease (MSUD), tyrosinemia, and propionic acidemia. A full list of eligible disorders can be found on the Children with Medical Handicaps page at the Ohio Department of Health website. Without these special formulas, individuals, especially infants and young children, may develop poor health outcomes and irreversible developmental delays. Every year in Ohio, more than 30 babies are born with a metabolic disorder resulting in a diagnosis eligible for receiving metabolic formula from the Ohio Metabolic Formula Program. It is recommended that individuals with these diseases remain on metabolic formula for their lifetime.

Cross-Cutting/Systems Building

State Performance Measures

SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	23.5	20.4
Numerator	594,643	515,502
Denominator	2,531,859	2,526,971
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	19.9	19.4	18.9	18.4	17.9	17.4

SPM 5 - Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	40	50
Numerator	4	5
Denominator	10	10
Data Source	Action Plan	Action Plan
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	80.0	90.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Ohio) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Prevent and mitigate the effects of adverse childhood experiences
SPM
SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)
Objectives
By 2022, enhance data collection to inform ACEs prevention and intervention
Strategies
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

State Action Plan Table (Ohio) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Prevent and mitigate the effects of adverse childhood experiences

SPM

SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)

Objectives

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:

Strategies

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 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

State Action Plan Table (Ohio) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

SPM

SPM 5 - Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities

Objectives

By 2025, implement plan to developed by bureau Health Equity Committee to build system to advance health equity in MCH staff and programs

Strategies

Select and implement health equity-increasing strategies in all state priority areas

Build bureau equity workgroup

Develop plan for improving internal MCH organization equity and staff capacity through bureau workgroup

Develop plan to institutionalize health equity in policy, program, grant, and contract administration through bureau workgroup

Build diversity in CMH Parent Advisory Committee

State Action Plan Table (Ohio) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Prevent and mitigate the effects of adverse childhood experiences

SPM

SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)

Objectives

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

Strategies

Leverage and expand the state team from the ASPIRE project to continue strategic planning on ACEs

Continue coordination of efforts around shared risk and protective factors identified through the ASPIRE project

Cross-Cutting/Systems Building, Annual Report FY 2020

Cross-cutting/Systems Building priorities were not selected for the FY 16-20 cycle. As a result of the 2020 Five-Year Needs Assessment, two cross-cutting priorities were selected for the FY 21-25 cycle. This report details activities during FY 20 contributing to the FY 21-25 cross-cutting priorities.

Cross-Cutting Action Plan Development

As reported in the Five-Year Needs Assessment Summary, to strengthen and streamline state-level health assessments and planning, the Title V MCH and MIECHV assessments were developed in conjunction with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). ODH entered into contract with the Health Policy Institute of Ohio to facilitate the large, multi-faceted needs assessment and state planning process, with final reports delivered in September 2019. The final priorities from the needs assessment included two cross-cutting priorities focused on Equity and ACEs: Improve healthy equity by addressing community and social conditions and reducing environmental hazards that impact infant and child health outcomes; Prevent and mitigate the effects of adverse childhood experiences (ACEs).

Action Plan components for the FY 21-25 cross-cutting priorities were developed during FY 20. The goal throughout the Action Plan development was to include the Equity and ACEs priorities within each population domain, as well as create specific systems-level objectives and strategies. Each population group was presented with their population specific priorities as well as the cross-cutting priorities. In March 2020, BMCFH engaged the National MCH Workforce Development Center to conduct a Results Based Accountability (RBA) training. Initially designed to be an in-person workshop, plans were altered to accommodate a distance learning format with a pre-recorded webinar and three working sessions for staff by grouped population domains: Women and Infant, Child and Adolescent, and CSHCN. Staff learned the RBA framework and applied the concepts and tools to the MCH BG planning process to ensure alignment of performance measures, selection of evidence-based strategies, and development of high value evidence-based strategy measures. Throughout these planning sessions, health equity and ACEs were included for each population, including in Turn the Curve thinking exercises and through examination of data on variations in measures by demographic characteristics. From this framework the Action Plan components for the FY 21-25 cross-cutting priorities were developed during FY 20.

In addition, the Cross-Cutting Action Plan was included in the 2021 public comment survey administered in summer 2020. The full report of comments was shared with all co-leads after submission of the application in September 2020. In fall 2020, the cross-cutting co-leads completed an in-depth review of the public comments and presented the findings to workgroup members.

Adverse Childhood Experiences (ACEs)

During FY 20 significant partnership and infrastructure building activities were initiated to support the Adverse Childhood Experiences (ACEs) priority, including state collaboration and data collection.

In FY 20, partners in the ODH Violence and Injury Prevention Section (VIPS) coordinated with Bureau of Maternal, Child, and Family Health (BMCFH) during the planning of a grant application regarding ACEs. While funding for the grant was not awarded, VIPS and BMCFH used the proposed grant framework to apply to the ASPIRE Project (ACEs and Suicide Prevention in Remote Environments Learning Institute). The application submission proposed to build a team with multiple state agency and non-agency representatives to build partnership and shared focus around primary risk and protective factors for ACEs. The Ohio Team was accepted and participated during FY 21, and plans to build upon the ASPIRE project to continue the cross-agency momentum around ACEs in FY 22.

In addition, significant changes to advance data collection for ACEs in Ohio occurred in FY 20 as ODH applied for funding from the CDC to add 16 ACEs questions to the Youth Risk Behavior Survey (YRBS). In order to make room on the survey, the advisory committee worked to build consensus around the importance of adding the ACEs questions and determine which other questions to remove to stay within the CDC's question limit. Due to COVID-19, the survey administration will be moved from Spring 2021 to Fall of 2021. Survey results are expected to be received in Spring 2022.

Establish Bureau Health Equity Committee

The Ohio Department of Health (ODH) is committed to the elimination of health inequities. Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence, and mortality of certain diseases or health conditions. These are commonly referred to as health disparities. Health disparities are not limited to one disease or health condition and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors.

People in such groups also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, and freedom from racism and other forms of discrimination. These are referred to as social determinants. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants

among these groups is referred to as health inequities. As long as health inequities persist, marginalized groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as health equity.

To address this priority, the Bureau of Maternal, Child, and Family Health (BMCFH) formed a Health Equity Committee (HEC) to advance health equity within MCH staff and through MCH programs. During FY 20 significant infrastructure building activities were initiated including establishing the HEC and planning the structure and activities for the HEC. The goals for the HEC were to develop a plan to address the internal culture within the bureau and improve health equity through the bureau's programs and initiatives. During FY 20 the HEC began developing the structure necessary to both improve internal MCH organization equity and staff capacity, and institutionalize health equity in policy, program, grant and contract administration.

The foundation for the committee was research. To determine a proven path based on science and research Ohio could replicate, the strategy was to create a process in which Ohio could make informed decisions on how to bring health equity to the bureau. The shift in approach to decision making that ensures that all policies, procedures, rules, regulations, funding, decisions, etc., are designed, implemented, and evaluated through a health equity lens.

Since the HEC's inception in summer 2020, the team has developed a plan to assess health equity capacity within MCH staff and programs to inform the development of a plan for improvement. The HEC reviewed the findings from an Implicit Bias training that the bureau completed in September 2019, but felt that additional information was needed to fully assess the current staff capacity and program inclusion of equity. The cross-cutting co-leads completed a literature review of what worked across the U.S., including over 38 journal articles on health equity and multiple state and national plans. Using the findings from this review, the HEC decided to conduct a three-pronged assessment including a staff competency survey, facilitated program review exercise, and community engagement survey to subgrantees funded through RFPs.

The staff competency assessment was adapted from the Health Equity Skills for Public Health Professionals survey, which was designed by a partnership with the CDC and the National Association of Chronic Disease Directors' Health Equity Council. The survey is organized into competencies of Communication, Cultural Competency, Program Planning and Development, Analytic Assessment, Community Practice, and Leadership and Systems Thinking. The survey planning was completed in FY 20 and the survey was administered in FY 21 with analysis and reporting taking place in FY 21. The HEC working groups will use the results to inform multiple initiatives, including training and engagement of staff.

The second assessment, the facilitated Program Review tool, was adapted from Massachusetts' internal action steps to develop and implement an operational framework to incorporate health equity principles and lens in all workstreams. The Program Review tool was built in Google Jamboard in FY 20. The tool walks staff through Health Equity changes in four buckets to facilitate learning, reflection, brainstorming, and recommendations in each area: 1. Build Internal infrastructure, 2. Work across government, 3. Foster community partnerships, and 4. Champion transformative change. Several programs were selected to go through a pilot facilitated review process in FY 21.

The third assessment, the Community Engagement Assessment survey as adapted from Wisconsin, is slated to begin after the Program Review is completed by the bureau. The plan is to administer the survey through bureau programs that subgrant money to local agencies through the Request for Proposals (RFPs) process in FY 21 or FY 22. The survey assesses family, youth, and community engagement as a means of improving planning and policies resulting in services more directly responsive to their needs, as well as measuring healthy equity efforts.

The HEC meets with the full committee monthly and also began developing several working groups during FY 20 and FY 21 to delegate activities around key areas of need as identified through the three-pronged assessment. The workgroups meet between the full committee meetings and provide updates and request full committee approval of activities. The workgroups and their focus areas:

- Data- developing standards for data collection, analysis, and reporting to make data-driven decisions, programs, policies with equity at the core.
- Onboarding and Mentoring- develop an onboarding tool that prepares all BMCFH staff with a foundational knowledge of the bureau, public health, and health equity; and create a process to pair experienced employees with incoming employees to review the onboarding tool.
- Participation- create a process to encourage participation in training created by Training workgroup and make health equity learning efforts fun and engaging.
- Training- utilize the three assessments to plan individual-level and bureau-level training opportunities to enhance staff knowledge, attitude skills, and self-efficacy around health equity.
- RFP- review the bureau Request for Proposals (RFP), or sub-granting, processes and procedures to improve health equity.

CMH Parent Advisory Committee Diversity

The CMH Parent Advisory Committee (PAC) is composed of a 15-member team of parents who advise the Children with Medical Handicaps (CMH) program regarding care for children with special health care needs. The results of the 2020 needs assessments identified the need to hire fulltime parent consultants whose lived experience would provide an informed voice for Maternal Child and Family Health programs at ODH. Two parent consultants were hired in FY 20. Our Parent Consultants have brought a deep family focus within the ODH. They are both serving on our Health Equity Committee within the BMCFH and are co-leading in our BG workgroups related to child and CYSHCN. They are also serving as members on all the BG population workgroups.

Within the new Action Plan a strategy to build diversity in the CMH PAC was established. In FY 20 the Parent Consultants began to work towards diversifying the CMH PAC. They continue to involve our PHNs and Field Nurse Managers to share the word by revising the PAC application and making it more accessible to parents. There are several candidates who have expressed an interest to join, and we hope to bring them on in early 2021. The Parent Consultants also networked with Equitas Institute in Columbus to help identify CYSHCN parents who may be interested in serving on the PAC.

In FY 20 the PAC began work to update their By-Laws to reflect a stronger emphasis on health equity and diversity. The CMH PAC also participated in Health Equity/Implicit Bias training led by Tif Huber, Ohio Health Equity Lead. Two sessions occurred with all PAC members participating. PAC members reported the experience was valuable and they will apply the information they learned as they interact with other CYSHCN families and care teams.

Cross-Cutting/Systems Building, Application Year FY 2022

The 2020 needs assessment resulted in the creation of two cross-cutting priorities for the first time in Ohio. The new FY 21-25 priorities include addressing health equity and Adverse Childhood Experiences (ACEs), and both priorities are addressed at the systems-level through the cross-cutting Action Plan and were included as priorities to address for each population workgroup throughout the development of the Action Plan. Cross-cutting priority strategies are included in this section and incorporated throughout the population domains in the Action Plan.

Emerging Issues

The COVID-19 pandemic shined a light on Ohio's continued racial disparities in health outcomes. As reported in the COVID-19 Ohio Minority Health Strike Force Blueprint, "Black/African American Ohioans make up 13% of the state's population but account for larger percentages of COVID-19 cases, hospitalizations, and deaths." One of the recommendations of the Blueprint supports the direction of BMCFH's Health Equity strategies around workforce development. Specifically, in the work around dismantling racism and the systems that support this oppression. The Blueprint also identified the gap in working in partnership with our primary stakeholders (i.e., people with lived experienced) to co-create programs within the community and strategies that will improve health outcomes.

The stress created by COVID-19 also has had a cumulative effect on Ohio's population. Ohio's youth suicide rates had spiked in 2019. OhioMHAS believes that the spike will have grown during COVID-19 based on their initial data. The Ohio Domestic Violence Network released their 2020 Fatality Report, which shows a 35% increase in domestic violence related fatalities between June 2019 to June 2020 in Ohio. Even with stay-at-home orders lifting during the summer 2020, stressors like financial strain and school and childcare closures supports the need building a system in Ohio that prevents, increase resiliency and heals traumatic outcomes resulting from ACEs.

Priority: Prevent and mitigate the effects of adverse childhood experiences

Measures

- SPM: Percent of children, ages 0 through 17, who have experienced two or more adverse childhood experiences (NSCH)
- ESM: None developed at this time.

The SPM aligns with the measure included in the State Health Improvement Plan. ESM development will continue to be considered as activities are planned and implemented.

Objective: By 2022, enhance data collection to inform ACEs prevention and intervention.

Strategies:

1. Apply for funding from CDC to add ACEs questions to the Youth Risk Behavior Survey (YRBS) (completed in FY 20)
2. Coordinate YRBS and OHYes data collection efforts
3. Develop and implement a plan to share YRBS data (including ACEs) to inform state and local programming (ADDED for FY 22)

ODH applied for and received funding from CDC to add the ACEs questions in the next Youth Risk Behavior Survey (YRBS). This survey is being combined with Ohio's Youth Tobacco Survey (YTS) and coordinated with OHYes collection efforts. The 2021 YRBS/YTS includes 16 new ACEs questions. Due to COVID-19 the survey administration will be moved from Spring 2021 to Fall of 2021. Survey results are expected to be received Spring 2022. A strategy was added to ensure the newly collected ACEs data is shared broadly to inform programming.

Objective: By 2025, reduce the number of children 0-17 who experience two or more ACEs by 10%.

Cross-strategies with other priorities:

1. 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).
2. Implement evidence-based adolescent resiliency projects through MP grant (Adolescent).
3. Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation, and Bullying Initiative (Adolescent).
4. 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).
5. Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP (Women & Adolescent).
6. Support MCH programs to further integrate ACEs and Health Equity priorities within each population Action Plan (ADDED for FY 22).

The strategies within this objective are included in the other population Action Plans and activities for the upcoming year are reported within those narratives. An additional strategy was added to continue integration of both ACEs and health equity within each population's strategies and activities. During FY 21 the cross-cutting co-leads presented to each population on the systems-level progress for the cross-cutting priorities to increase awareness and lay the foundation for further integration in FY 22.

Objective: 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. (ADDED for FY 22).

1. Leverage and expand the state team from the ASPIRE project to continue strategic planning on ACEs.
2. Continue coordination of efforts around the three risk and protective factors identified through the ASPIRE project (Caring Adult, Economic Stress, Stigma Associated with Seeking Help).

This new objective and associated strategies are informed by Ohio's participation in the ASPIRE (ACEs and Suicide Prevention in Remote Environments) collaborative learning institute which began in November 2020. The ASPIRE project included multiple state agencies and the Health Policy Institute of Ohio working as a team to identify shared risk and protective factors across programs. The resulting crosswalk identified two risk factors and one protective factor to focus on: economic stress, stigma associated with seeking help, and association with a caring adult. Another outcome from the ASPIRE project included the need to emphasize primary prevention, resiliency, and trauma informed care. NOTE: Ohio was the only state level collaborative at the institute and the other teams were from local communities.

An agency wide workgroup made up of ODH staff, primary and secondary stakeholders, and key/influencer stakeholders will be built to develop a strategic plan the further the work of the ASPIRE project. In addition, based on the results of the ASPIRE crosswalk, in FY 21 the cross-cutting co-lead reviewed each population's portion of the Action Plan and shared the results with each group that many are already preventing ACEs, increasing resiliency, and providing healing through trauma informed care. However, not all are using the shared ACEs language, and in addition to highlighting where current efforts exist the mapping project identified areas for improvement in FY 22. Potential areas for improvement include identifying new and lower resource partners in addition to the usual partners to better reach communities; advancing efforts in co-create with primary stakeholders; and exploring shared marketing campaign(s) focused on "caring adults."

Priority: Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

Measures

- SOM: (Women/Maternal) Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations
- SOM: (Perinatal/Infant) Black infant mortality rate per 1,000 live births
- SOM: (Child) Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl)
- SPM: Percent of Performance Measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities.
- ESM: none developed at this time.

SOMs from the Women and Infant populations are relevant to this health equity priority. In addition, the lead poisoning SOM from the Child population is also relevant to reducing environmental hazards. The SPM reflects the commitment to incorporating the priority into each population. During the first year BMCFH established the Health Equity Committee, which developed a plan to advance health equity within BMCFH and through our policies and programs. ESM development will continue to be considered during activity planning and implementation.

Objective: By 2025, implement plan developed by the bureau health equity committee to build system to advance health equity in MCH staff and programs.

Strategies:

1. Select and implement health equity-increasing strategies in all state priority areas
2. Build bureau equity workgroup
3. Develop plan for improving internal MCH organization equity and staff capacity through bureau equity workgroup
4. Develop plan to institutionalize health equity in policy, program, grant, and contract administration through bureau equity workgroup
5. Build diversity in CMH Parent Advisory Committee (PAC)

During FY 20 and FY 21 the BMCFH Health Equity Committed (HEC) was established and the group developed a plan after reviewing literature and other state's health equity efforts. The objective was updated to focus on implementation of the plan to advance health equity as developed by the HEC. During FY 22 the HEC will continue implementation of the three-pronged assessment approach (staff survey, program review, and community engagement subgrantee assessment) as well as use

the results of the assessments to inform efforts of the working groups (Data, Onboarding and Participation, Training, and RFP).

The SPM provides an indicator of the integration of the equity priority within each of the priority population Action Plans. The Action Plan submitted in FY 20 had four performance measures with specific strategies focused on social determinants of health, at-risk populations, or health equity. These performance measures with equity strategies were in the Women and CYSHCN populations. Activities planned for FY 22 will focus on working with the population action teams for the populations without specific equity strategies associated with their performance measures, that is Infant, Child, and Adolescent. In addition to providing support for the population groups in reviewing approaches and evidence for equity increasing strategies, activities will also include further integration of equity within the existing strategies. During FY 21 the cross-cutting co-leads presented to each population action team on the cross-cutting priorities to set the stage for further integration during FY 22. The population teams expressed interested in the equity in all strategies approach in addition to adopting specific equity increasing strategies for each of the performance measures.

In FY 22 the CMH Parent Consultants will continue their efforts to maintain and increase diversity in the CMH PAC.

Other Efforts Supported by Title V MCH

BMCFH Parent Consultants
Parent consultants were hired in FY 20 and are tasked with improving parent perspective in BMCFH. In FY 21 they will be developing plans to assess family and/or community engagement for BMCFH programs. We anticipate this work will help to function as an assessment to inform future efforts and to be compared with results of parent consultant efforts.

III.F. Public Input

The Ohio Department of Health (ODH), Bureau of Maternal, Child, and Family Health (BMCFH) seeks vital input and feedback from stakeholders through ongoing engagement and also during the annual public comment period. The public comment survey provides stakeholders the opportunity to comment on the Maternal and Child Health (MCH) Block Grant (BG) Priorities, Objectives, and Strategies. The survey data complements ongoing feedback through committees, boards, and program monitoring and evaluation activities.

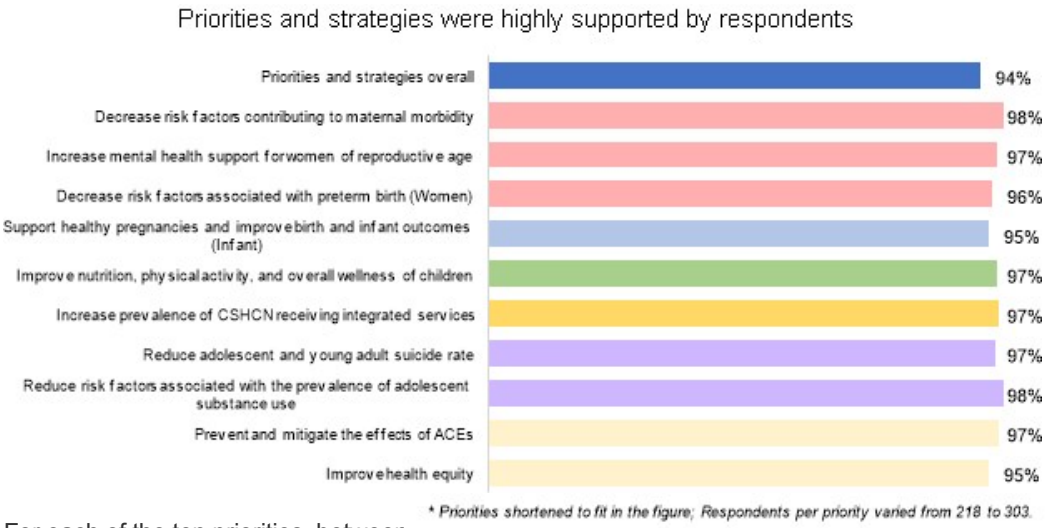
The 2022 Title V MCH Block Grant public comment survey was available for public input from July 1 to August 1, 2021. Prior to opening the survey, an email was sent to all contacts (over 1,600) that had been collected during the 2020 Five-Year Needs Assessment process. Each needs assessment contact was sent an email updating them on the Title V program, progress made since the needs assessment, a link to the five-year action plan, and advanced notice of the public comment survey. Several comments were received from the pre-notification and were shared with the relevant Action Groups. During the public comment period, invitations to comment were shared in a variety of methods to gather input from a broad group of stakeholders including: announcements on the Title V webpage and agency social media; direct email notification to contacts from the needs assessment process; BMCFH staff shared with their networks of local grantees, stakeholders, consumer groups, parent groups, listservs, and interested parties; invitations were issued from the CYSHCN Director and Parent Consultants to the Medical Advisory Council and Parent Advisory Committee, local public health nurses that work with the CMH program, and parent groups; and the WIC director shared the announcement with WIC projects.

The survey was created via Survey Monkey, allowing the public to provide feedback and input or simply comment on the five-year priorities and the content of Ohio's MCH BG Action Plan. Preliminary results from the survey are outlined below. Further analysis of the results is planned, and feedback will continue to be incorporated into plans after submission of the application and annual report. Action Group co-leaders will receive the detailed results and comments for review and application to their workplans. The five-year priorities selected after the 2020 Needs Assessment represent some new areas of activity for our Title V program and the responses will help during the continued planning by providing valuable feedback and potential partners for planning and intervention.

Three hundred and fifty-six individuals responded to the public comment survey (as compared with 320 in 2020 and 134 in 2019). Respondents could select multiple affiliations: most respondents represented local health departments (111), followed by parents (80), healthcare providers (61), community-based organizations (58), home visiting (36), advocacy organizations (36), parents of children with special healthcare needs (26), WIC (24), and community health centers/clinics (21). Less than 20 respondents represented university faculty, school district staff, the state health department, other state agencies, businesses, insurance providers, and students.

Respondents represented 82 of Ohio's 88 counties, plus 25 selected statewide instead of a specific county representation. Most respondents were from counties with or near urban centers; Franklin County had the most representation with 47 respondents. At the halfway point of the public comment period, responses included at least one respondent from 68 of Ohio's 88 counties and additional outreach was conducted to solicit responses from counties without representation. By the end of the public comment period, 14 counties added at least one respondent, but no representatives from Adams, Auglaize, Columbiana, Guernsey, Logan, or Vinton counties completed the survey.

Overall respondent feedback indicates that 94% of those completing the survey felt Ohio's ten MCH priorities reflect the needs of their community. MCH needs identified as not being reflected in the priorities include the need to explicitly call out racism and equity, oral health, substance use, children with special healthcare needs, and violence as a health issue.



For each of the ten priorities, between ninety-five and ninety-eight percent of responders felt that the strategies and objectives listed were applicable and would be useful in meeting the needs of their communities. The number of respondents to each priority area varied from 218 to 303. Respondents were asked to provide suggestions for improving or adding strategies associated with each priority, with an average of sixty suggestions per priority, summarized below.

Women

- Priority A: Decrease risk factors contributing to maternal morbidity
  - 98% responded “Yes” when asked “Are the strategies associated with this priority applicable and useful in meeting the needs of the MCH population.”
  - Suggestions focused on oral health, data needs for understanding substance use during pregnancy, bias and racism in healthcare, access to doula care, breastfeeding support, paid parental leave, father and family involvement, transportation, expanded home visiting, and engaging youth before they become adults and possibly mothers.
- Priority B: Increase mental health support for women of reproductive age
  - Yes – 97%
  - Suggestions focused on culturally competent care, funding for mental health services, mental health education for healthcare providers, the role of social determinants in mental health, nontraditional avenues to support maternal mental health, the need for better data systems, addressing mental health across all ages (not just women 18-44), and reducing stigma.
- Priority C: Decrease risk factors associated with preterm birth
  - Yes – 96%
  - Suggestions focused on increased eligibility for home visiting, including vaping and marijuana use in smoking cessation efforts, and oral health.

Infant

- Priority: Support healthy pregnancies and improve infant and birth outcomes
  - Yes – 95%
  - Comments: Add breastfeeding support services; improve workplace environments to support breastfeeding and paid maternity leave; recruit and train IBCLCs, especially in communities with low breastfeeding rates; engage fathers, partners, and families in infant health; coordinate efforts; address social determinants and explicitly name institutional racism.

Children

- Priority: Improve nutrition, physical activity, and overall wellness of children
  - Yes - 97%
  - Suggestions focused on “fed is best” breastfeeding messaging, breastfeeding-supportive workplace policies, culturally sensitive safe-sleep messages that take a harm reduction approach, paid parental leave, increasing diversity among healthcare providers, access to doula care, and oral health.

Children and youth with special health care needs

- Priority: Increase prevalence of children with special healthcare needs receiving integrated physical, behavioral, developmental, and mental health services
  - Yes - 97%
  - Suggestions focused on improved access to care for CHSCHN that minimizes the burden on families,

financial support for families with CSCHN, oral health, and providing education and opportunities to build life skills.

Adolescents

- Priority A: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
  - Yes – 97%
  - Suggestions focused on racism and equity, healthcare and healthcare providers, mental health needs, violence and injury, and data needs and opportunities.
- Priority B: Increase protective factors and improve systems of care to reduce risk factors associated with the prevalence of adolescent substance use
  - Yes – 98%
  - Suggestions focused on the role of schools, including vaping in anti-smoking messaging, culturally competent care providers, working in collaboration with MHAS and organizations already proficient in this work, and oral health.

Cross-cutting

- Priority A: Prevent and mitigate the effects of adverse childhood experiences
  - Yes – 97%
  - Suggestions focused on support within families and support for families, surveillance for ACEs and protective/resiliency measures, trauma-informed care, the role of schools, oral health, addressing social determinants of health that contribute to ACEs, home visiting, and the need for a strengths-based approach in this work.
- Priority B: Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes
  - Yes – 95%
  - Suggestions focused on policy and practice within the Ohio Department of Health, equitable partnerships, explicitly naming racism as a public health issue, universal access to safe housing and financial security, and oral health.

III.G. Technical Assistance

The Title V Program within the Ohio Department of Health (ODH) routinely explores needs for technical assistance. One area under consideration is assistance in moving data into action for gaps identified by the Bureau of Maternal, Child and Family Health (BMCFH) Staff Competency Survey and Program Review pilots administered by the Health Equity Committee (HEC). Additional detail available in the Cross-Cutting Annual Report and Application Year narratives in section III.E.2.c.

The staff competency assessment was adapted from the Health Equity Skills for Public Health Professionals survey, which was designed by a partnership with the CDC and the National Association of Chronic Disease Directors' Health Equity Council. The survey is organized into competencies of Communication, Cultural Competency, Program Planning and Development, Analytic Assessment, Community Practice, and Leadership and Systems Thinking. The BMCFH HEC has prepared a report of findings from the survey and has worked to identifying existing training resources to support staff development in the areas identified with lower competency; however, the bureau is also interested in more targeted bureau-level training opportunities.

The Program Review was adapted from the was adapted from Massachusetts' internal action steps to develop and implement an operational framework to incorporate health equity principles and lens in all workstreams. The Program Review tool was built in Google Jamboard in FY 20. The tool walks staff through Health Equity changes in four buckets to facilitate learning, reflection, brainstorming, and recommendations in each area: 1. Build Internal infrastructure, 2. Work across government, 3. Foster community partnerships, and 4. Champion transformative change. Several programs were selected to go through a pilot facilitated review process in FY 21 and initial findings have been documented.

The Title V Program is seeking technical assistance in identifying actionable items or trainings with a vendor who can frame around specific gaps identified in the staff competency survey and program reviews.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Fully Executed A-2021-04-0061 ODH Master and Attachments A-J.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Ohio Title V MCH BG Priority Action Plan FY21-FY25.pdf

Supporting Document #02 - Program Map.pdf

Supporting Document #03 - Program Map- Program Descriptions.pdf

Supporting Document #04 - ODH Parent Consultants.pdf

Supporting Document #05 - MEDTAPP Multi-Agency Agreement.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ODH TO_6-25-2021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Ohio

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 22,331,382	
A. Preventive and Primary Care for Children	$ 8,255,443	(36.9%)
B. Children with Special Health Care Needs	$ 7,750,427	(34.7%)
C. Title V Administrative Costs	$ 651,538	(3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 16,657,408	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 67,422,505	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 67,422,505	
A. Your State's FY 1989 Maintenance of Effort Amount $ 23,812,983		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 89,753,887	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 209,018,526	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 298,772,413	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,511,473
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,800,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 186,799,674
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,197,074
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 700,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,110,305

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 21,973,210		$ 21,012,697	
A. Preventive and Primary Care for Children	$ 7,185,492	(32.7%)	$ 6,572,946	(31.2%)
B. Children with Special Health Care Needs	$ 7,504,399	(34.2%)	$ 8,143,943	(38.7%)
C. Title V Administrative Costs	$ 1,146,511	(5.2%)	$ 1,045,076	(5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 15,836,402		$ 15,761,965	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 55,838,575		$ 43,254,961	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 55,838,575		$ 43,254,961	
A. Your State's FY 1989 Maintenance of Effort Amount $ 23,812,983				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 77,811,785		$ 64,267,658	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 152,584,198		$ 196,641,329	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 230,395,983		$ 260,908,987	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 700,000	$ 304,531
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,197,074	$ 2,352,826
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 100,000	$ 76,272
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000	$ 60,786
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,547,944	$ 6,164,441
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 241,699
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,300,000	$ 7,353,343
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 137,239,180	$ 180,047,504
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 39,927

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
The State Funds are lower do to the bureau re-organization of the Tobacco program as well as less spending during the COVID-19 Pandemic.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Ohio

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 3,340,613	$ 3,327,883
2. Infants < 1 year	$ 2,225,052	$ 1,810,839
3. Children 1 through 21 Years	$ 8,255,443	$ 6,572,946
4. CSHCN	$ 7,750,427	$ 8,143,943
5. All Others	$ 108,309	$ 112,010
Federal Total of Individuals Served	$ 21,679,844	$ 19,967,621

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 5,886,587	$ 2,095,992
2. Infants < 1 year	$ 5,886,587	$ 2,095,992
3. Children 1 through 21 Years	$ 16,435,205	$ 6,032,902
4. CSHCN	$ 38,850,008	$ 32,900,424
5. All Others	$ 364,119	$ 129,649
Non-Federal Total of Individuals Served	$ 67,422,506	$ 43,254,959
Federal State MCH Block Grant Partnership Total	$ 89,102,350	$ 63,222,580

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Ohio

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 3,852,748	$ 3,972,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,993,834	$ 2,874,750
B. Preventive and Primary Care Services for Children	$ 705,000	$ 541,478
C. Services for CSHCN	$ 153,914	$ 555,772
2. Enabling Services	$ 8,168,723	$ 8,165,549
3. Public Health Services and Systems	$ 10,309,911	$ 8,875,148
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 1,437,375
Physician/Office Services		$ 1,437,375
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 555,772
Dental Care (Does Not Include Orthodontic Services)		$ 541,478
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 3,972,000
Federal Total	$ 22,331,382	$ 21,012,697

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 40,318,136	$ 30,024,752
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 350,000	$ 244,956
C. Services for CSHCN	$ 39,968,136	$ 29,779,796
2. Enabling Services	$ 10,507,311	$ 10,595,989
3. Public Health Services and Systems	$ 16,597,058	$ 2,634,220
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 11,900,247
Physician/Office Services		$ 2,082,639
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 7,503,011
Dental Care (Does Not Include Orthodontic Services)		$ 651,197
Durable Medical Equipment and Supplies		$ 2,855,310
Laboratory Services		$ 45,298
Other		
Public Health Nursing and Public Health Dietitia		$ 4,987,050
Direct Services Line 4 Expended Total		$ 30,024,752
Non-Federal Total	$ 67,422,505	$ 43,254,961

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Ohio

Total Births by Occurrence: 129,865 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	129,382 (99.6%)	8,385	481	286 (59.5%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Multiple CoA Carboxylase Deficiency (MCD)	129,382 (99.6%)	46	0	0 (0%)
2-Methylbutyrylglycinuria (2MBG)	129,382 (99.6%)	64	2	2 (100.0%)
Short Chain Acyl-CoA Dehydrogenase Deficiency (SCAD)	129,382 (99.6%)	52	1	1 (100.0%)
Carnitine Acylcarnitine Translocase Deficiency (CACT)	129,382 (99.6%)	19	0	0 (0%)
Carnitine Palmitoyltransferase Type II Deficiency (CPT-II)	129,382 (99.6%)	19	0	0 (0%)
Glutaric Acidemia Type 2 (GA-2)	129,382 (99.6%)	6	0	0 (0%)
Argininemia (ARG)	129,382 (99.6%)	18	0	0 (0%)
Hypermethioninemia (MET)	129,382 (99.6%)	362	0	0 (0%)
Hawkinsinuria	129,382 (99.6%)	158	0	0 (0%)
S,D Disease	129,382 (99.6%)	156	0	0 (0%)
S,E Disease	129,382 (99.6%)	156	1	1 (100.0%)
C,C Disease	129,382 (99.6%)	156	1	1 (100.0%)
C, Beta-Thalassemia	129,382 (99.6%)	156	1	1 (100.0%)
D,D Disease	129,382 (99.6%)	156	0	0 (0%)
E,E Disease	129,382 (99.6%)	156	1	1 (100.0%)
E, Beta-Thalassemia	129,382 (99.6%)	156	1	1 (100.0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Krabbe Leukodystrophy	127,638 (98.3%)	50	0	0 (0%)
Spinal Muscular Atrophy (SMA)	121,848 (93.8%)	9	9	9 (100.0%)
Hyperphenylalinemia	129,382 (99.6%)	90	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Ohio Department of Health Genetic Services Program collects information on patients with disorders on Ohio's newborn bloodspot screening panel, that are managed by geneticists. This excludes endocrine disorders, hemoglobin disorders, CF, SCID, hearing loss, CCHD, etc. ODH-funded genetic centers report data on all patient visits, services received at those visits, basic information on whether the patient is compliant with the treatment plan, and whether patients under age 18 years have achieved developmental milestones for their age and disease state.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 2020 data are preliminary. These data were last updated 7/30/2021.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: There were 257 confirmed cases of infants with hearing loss. Rather than referred to "treatment" options, all 257 confirmed cases were given unbiased communication options.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Ohio

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	8,928	63.6	0.0	3.3	6.0	27.1
2. Infants < 1 Year of Age	11,488	44.6	0.7	48.3	6.3	0.1
3. Children 1 through 21 Years of Age	69,465	46.3	0.0	22.3	4.6	26.8
3a. Children with Special Health Care Needs 0 through 21 years of age^	39,824	57.7	0.0	32.5	4.6	5.2
4. Others	65,160	23.3	0.0	61.9	14.8	0.0
Total	155,041					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	134,461	No	129,317	100.0	129,317	8,928
2. Infants < 1 Year of Age	134,854	No	129,862	100.0	129,862	11,488
3. Children 1 through 21 Years of Age	3,053,323	Yes	3,053,323	65.2	1,990,767	69,465
3a. Children with Special Health Care Needs 0 through 21 years of age^	666,043	Yes	666,043	46.3	308,378	39,824
4. Others	8,502,290	Yes	8,502,290	2.5	212,557	65,160

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**

Field Note:
Over the past year, our Bureau has been working to complete a "Program Map" that captures the types of services provided and to what populations. This has resulted in a more comprehensive accounting of pregnant women served through Title V than we were able to report last year. In addition, the Appalachian Breastfeeding Network is a new service launched in March 2020.
- Moms and Babies First (home visiting services): 1,974 caregivers (mostly mothers)
- Moms Quit for Two (smoking cessation program): 747 pregnant women/mothers
- Appalachian Breastfeeding Network (breastfeeding support hotline): 2,385 calls
- Ohio Equity Institute (support services): 3,502 pregnant women
- Reproductive Health & Wellness (clinical services): 320 pregnant women
Total: 8,928

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**

Field Note:
Infants served includes:
- Cribs for Kids* (Infants who received a crib from the Cribs for Kids program, a safe sleep program, were approximated by the number of cribs distributed): 6,019
- Moms and Babies First (home visiting): 588 infants
- Infant Hearing Program (infants receiving follow-up services--our most recent data is from the 2019 calendar year): 4,881
Total: 11,488

* Primary source of insurance coverage was estimated using Form 5a reference data.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
In FY 2020, we saw a drop in the number of children served. The Children with Medical Handicaps Program served roughly 10,000 fewer children than FY 2019. Oral Health served about 9,000 fewer children than in FY 2019. In addition, about 2,000 fewer children received hearing/vision screening made possible by equipment loans to schools. These drops were likely a result of the COVID-19 pandemic and virtual school.

- Moms and Babies First (home visiting): 1,092 children
- Oral Health Program (school-based sealants, fluoride mouthrinse, dental safety net program): 24,284 children
- Lead Poisoning Prevention Program (children receiving case management; includes children 0-6 yrs): 2,872
- Hearing/vision screening equipment loans* (children who received these services through loaned equipment): 4,265. Note, these data are from 7/1/19 to 6/30/20.
- Hearing Aid Assistance Program: 125. Note, these data are from 7/1/19 to 6/30/20.
- Children with Medical Handicaps Program: 36,827
Total: 69,465

* Primary source of insurance coverage was estimated using Form 5a reference data.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Estimate of total CSHCN served: 308,415. There is likely overlap between CMH clients and the other programs listed here, but we could not de-duplicate. There was a drop in the number of CSHCN served in 2020.
This includes:
- Hearing Aid Assistance Program* (note: these data are for SFY 2020 which runs from July 1, 2019 to June 30, 2020): 125 children
- Children receiving case management through Lead Poisoning Prevention Program (ages 0-6): 2,872 children. Note that children served through LPPP were not included in the CSHCN counts last year.
- Children receiving services through the Children with Medical Handicaps program: 36,827
Total: 39,824

* Primary source of insurance coverage was estimated using Form 5a reference data.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
This includes:

- Women and men aged 22+ receiving services through the Reproductive Health & Wellness program (clinical services): 24,430
- Those receiving services through the Genetics Services program* (note: these data could not be disaggregated by population group and age): 39,291. Note that Genetics Services were not reported in 5a last year. The development of the Program Map helped us identify that the Genetics Program provides enabling services and should be reported here.
- Women and men aged 22+ receiving services through the Oral Health Program (dental safety net program): 1,439
Total: 65,160

*The insurance categories for Genetics Services were unknown and calculated using reference data.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Denominator is all occurrence births. The numerator is occurrence births that took place in a hospital. These data are preliminary and were last updated 8/6/21.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: This is the number of infants who received newborn screening (occurrence births). These data are preliminary and were last updated 7/19/21.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Estimated total children served: 1,989,532. This includes: - School nurse reach approximated via public school enrollment: 1,792,055 - Lead screening program for children ages 1-3: 115,902 - Lead case management services (ages 0-6): 2,872 - Early Childhood Health Program (approximated): 30,000 - Breastfeeding and postpartum women under age 22 served by WIC: 14,478 - Children with Medical Handicaps: 36,827 Total: 1,992,404	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Estimate of total CSHCN served: 308,415 This includes: - Hearing Aid Assistance Program: 125 - Children receiving lead case management services: 2,872 - Children with Medical Handicaps program: 36,827 - Ohio Department of Education public school enrollment data for students with disabilities: 268,591 Total: 308,415	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Estimate total of others served: 209,798
This includes:
- Family members receiving safe sleep education at time of delivery (estimated using half of occurrence births): 64,933
- Those receiving genetics services: 39,291 (could not be disaggregated by age)
- Reproductive health and wellness services for those 22 and older: 24,430
- Breastfeeding and postpartum women aged 22 and older enrolled in WIC: 46,496
- Childcare professionals who completed the Supporting Breastfeeding in the Early Care and Education Setting training: 1,040
- Maternity staff who completed the First Steps for Healthy Babies training: 1,804
- Families receiving SIDS support services (estimated by average household size and number of SIDS deaths): 340
- Estimate of those completing domestic violence training: 30,000
- Number who completed trauma-informed care training: 25
- Those aged 22 and older who received oral health services: 1,439
Total: 209,565

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Ohio

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	129,855	84,012	19,485	7,715	86	3,847	77	3,275	11,358
Title V Served	129,855	84,012	19,485	7,715	86	3,847	77	3,275	11,358
Eligible for Title XIX	52,889	24,268	14,325	4,163	45	1,137	27	1,978	6,946
2. Total Infants in State	129,310	81,114	19,351	7,672	84	3,777	77	3,219	14,016
Title V Served	126,331	81,114	19,351	7,622	84	3,777	77	3,219	11,087
Eligible for Title XIX	53,257	23,808	14,257	4,149	44	1,132	44	1,954	7,869

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**

Field Note:
2020 births data are preliminary. These numbers are based on the 2020 occurrence births dataset last updated 6/9/21.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Ohio

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 755-4769	(800) 755-4769
2. State MCH Toll-Free "Hotline" Name	Help Me Grow & Maternal, Child, & Family Health	Help Me Grow & Maternal, Child, & Family Health
3. Name of Contact Person for State MCH "Hotline"	Dyane Gogan Turner	Dyane Gogan Turner
4. Contact Person's Telephone Number	(614) 752-7464	(614) 752-7464
5. Number of Calls Received on the State MCH "Hotline"		15,399

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Children Medical Handicaps Help Line	Children Medical Handicaps Help Line
2. Number of Calls on Other Toll-Free "Hotlines"		20,220
3. State Title V Program Website Address	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/title-v-maternal-and-child-health-block-grant/title-v	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/title-v-maternal-and-child-health-block-grant/title-v
4. Number of Hits to the State Title V Program Website		162,700
5. State Title V Social Media Websites	https://www.facebook.com/ODHMaternalChildFamilyHealth	https://www.facebook.com/ODHMaternalChildFamilyHealth/
6. Number of Hits to the State Title V Program Social Media Websites		20,576,219

Form Notes for Form 7:

The Social Media Websites hits represents Total Impressions (including organic and paid impressions; 20,576,219 in FY 20). In previous years we only reported Organic Impressions (only those from people who follow us, not counting media campaigns; 89,143 in FY 20); however, during FY 20 MCH BG funds were used to increase the impressions and to increase the number of media campaigns on Facebook during the fiscal year.
The list of websites for the Title V program includes the bureau webpage, Title V webpage, and webpages for programs supported by Title V (Adolescent Health, Birth Defects, Breastfeeding, Child Fatality Review, Childhood Lead Poisoning, Children with Medical Handicaps, Children's Hearing and Vision, Critical Congenital Heart Disease, Early Childhood Health and Safety, Early Childhood Obesity Prevention, Fetal Infant Mortality Review, Genetic Services, Hearing Aid Assistance, Help Me Grow, Infant Mortality, Infant Hearing, Infant Vitality, Maternal and Child Health, Oral Health, Pregnancy Associated Mortality Review, Reproductive Health and Wellness, Sexual Assault and Domestic Violence Prevention, School Health, School Nursing, Sickle Cell, Shaken Baby, SIDS, and YRBS).

Form 8
State MCH and CSHCN Directors Contact Information

State: Ohio

1. Title V Maternal and Child Health (MCH) Director	
Name	Dyane Gogan Turner
Title	Title V MCH Director
Address 1	246 N High Street
Address 2	
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 752-7464
Extension	
Email	dyane.goganturner@odh.ohio.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Patrick Londergan
Title	Title V CSHCN Director
Address 1	246 N High Street
Address 2	
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 728-7039
Extension	
Email	pat.londergan@odh.ohio.gov

3. State Family or Youth Leader (Optional)	
Name	Kim Mathews
Title	Parent Consultant
Address 1	246 N High Street
Address 2	
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 644-7563
Extension	
Email	kimberly.mathews@odh.ohio.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Ohio

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Decrease risk factors contributing to maternal morbidity	New
2.	Increase mental health support for women of reproductive age	New
3.	Decrease risk factors associated with preterm births	New
4.	Support healthy pregnancies and improve birth and infant outcomes	New
5.	Improve nutrition, physical activity, and overall wellness of children	New
6.	Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate	New
7.	Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	New
8.	Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	New
9.	Prevent and mitigate the effects of adverse childhood experiences	New
10.	Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Decrease risk factors contributing to maternal morbidity	New
2.	Increase mental health support for women of reproductive age	New
3.	Decrease risk factors associated with preterm births	New
4.	Support healthy pregnancies and improve birth and infant outcomes	New
5.	Improve nutrition, physical activity, and overall wellness of children	New
6.	Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate	New
7.	Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use	New
8.	Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services	New
9.	Prevent and mitigate the effects of adverse childhood experiences	New
10.	Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Ohio

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

Last year, this SPM was incorrectly described as pertaining to women ages 19-44. It is for women ages 18-44.

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	77.0 %	0.1 %	102,809	133,503
2018	76.6 %	0.1 %	102,559	133,904
2017	75.6 %	0.1 %	102,309	135,286
2016	75.4 %	0.1 %	102,674	136,189
2015	75.3 %	0.1 %	102,946	136,696
2014	74.4 %	0.1 %	101,765	136,840
2013	71.7 %	0.1 %	94,841	132,198
2012	72.8 %	0.1 %	94,837	130,334
2011	73.6 %	0.1 %	95,495	129,804
2010	73.4 %	0.1 %	94,320	128,486
2009	71.6 %	0.1 %	95,382	133,244

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	77.8	2.5	1,012	130,046
2017	72.6	2.4	962	132,500
2016	76.8	2.4	1,022	133,108
2015	83.3	2.9	840	100,841
2014	84.4	2.5	1,132	134,047
2013	85.1	2.5	1,131	132,979
2012	79.0	2.4	1,056	133,636
2011	85.7	2.6	1,131	132,007
2010	85.8	2.5	1,147	133,744
2009	84.7	2.5	1,181	139,509
2008	81.3	2.4	1,125	138,303

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	19.7	1.7	135	683,776
2014_2018	17.6	1.6	121	688,782

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	8.6 %	0.1 %	11,533	134,341
2018	8.5 %	0.1 %	11,471	135,036
2017	8.7 %	0.1 %	11,854	136,716
2016	8.7 %	0.1 %	11,981	137,927
2015	8.5 %	0.1 %	11,807	139,089
2014	8.5 %	0.1 %	11,800	139,325
2013	8.5 %	0.1 %	11,808	138,786
2012	8.6 %	0.1 %	11,857	138,348
2011	8.6 %	0.1 %	11,901	137,776
2010	8.6 %	0.1 %	11,899	138,982
2009	8.6 %	0.1 %	12,378	144,670

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	10.5 %	0.1 %	14,120	134,358
2018	10.3 %	0.1 %	13,845	135,048
2017	10.4 %	0.1 %	14,168	136,744
2016	10.4 %	0.1 %	14,388	137,967
2015	10.3 %	0.1 %	14,300	139,169
2014	10.3 %	0.1 %	14,302	139,362
2013	10.3 %	0.1 %	14,259	138,355
2012	10.5 %	0.1 %	14,438	138,075
2011	10.2 %	0.1 %	14,083	137,615
2010	10.3 %	0.1 %	14,308	138,719
2009	10.4 %	0.1 %	15,060	144,476

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	26.9 %	0.1 %	36,130	134,358
2018	26.3 %	0.1 %	35,461	135,048
2017	25.8 %	0.1 %	35,345	136,744
2016	25.5 %	0.1 %	35,200	137,967
2015	25.1 %	0.1 %	34,983	139,169
2014	24.7 %	0.1 %	34,491	139,362
2013	24.5 %	0.1 %	33,849	138,355
2012	24.7 %	0.1 %	34,084	138,075
2011	24.7 %	0.1 %	34,015	137,615
2010	25.4 %	0.1 %	35,282	138,719
2009	26.6 %	0.1 %	38,401	144,476

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.0	0.2	943	135,579
2017	7.1	0.2	971	137,245
2016	7.3	0.2	1,012	138,507
2015	7.1	0.2	994	139,710
2014	7.3	0.2	1,021	139,910
2013	7.6	0.2	1,059	139,396
2012	7.5	0.2	1,038	138,921
2011	7.7	0.2	1,064	138,365
2010	7.2	0.2	1,010	139,524
2009	6.7	0.2	974	145,217

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.9	0.2	938	135,134
2017	7.2	0.2	983	136,832
2016	7.4	0.2	1,026	138,085
2015	7.2	0.2	1,000	139,264
2014	6.9	0.2	959	139,467
2013	7.3	0.2	1,019	138,936
2012	7.5	0.2	1,034	138,483
2011	8.0	0.2	1,102	137,918
2010	7.7	0.2	1,074	139,128
2009	7.7	0.2	1,116	144,841

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.7	0.2	632	135,134
2017	5.0	0.2	686	136,832
2016	5.1	0.2	710	138,085
2015	4.8	0.2	663	139,264
2014	4.9	0.2	689	139,467
2013	5.2	0.2	724	138,936
2012	5.1	0.2	710	138,483
2011	5.3	0.2	735	137,918
2010	5.2	0.2	730	139,128
2009	5.2	0.2	755	144,841

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.3	0.1	306	135,134
2017	2.2	0.1	297	136,832
2016	2.3	0.1	316	138,085
2015	2.4	0.1	337	139,264
2014	1.9	0.1	270	139,467
2013	2.1	0.1	295	138,936
2012	2.3	0.1	325	138,483
2011	2.7	0.1	367	137,918
2010	2.5	0.1	344	139,128
2009	2.5	0.1	361	144,841

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	234.6	13.2	317	135,134
2017	284.3	14.4	389	136,832
2016	259.3	13.7	358	138,085
2015	267.8	13.9	373	139,264
2014	278.2	14.1	388	139,467
2013	273.5	14.1	380	138,936
2012	290.3	14.5	402	138,483
2011	313.2	15.1	432	137,918
2010	295.4	14.6	411	139,128
2009	291.4	14.2	422	144,841

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	119.1	9.4	161	135,134
2017	104.5	8.7	143	136,832
2016	106.5	8.8	147	138,085
2015	110.6	8.9	154	139,264
2014	91.1	8.1	127	139,467
2013	103.6	8.6	144	138,936
2012	108.3	8.9	150	138,483
2011	132.7	9.8	183	137,918
2010	120.8	9.3	168	139,128
2009	147.1	10.1	213	144,841

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.4 %	0.8 %	8,459	132,677
2014	5.0 %	0.6 %	6,633	133,036
2012	6.0 %	0.7 %	7,779	130,109
2010	6.8 %	0.9 %	8,969	131,982
2009	7.4 %	0.9 %	10,154	137,557
2008	5.9 %	0.8 %	8,191	139,062
2007	5.2 %	0.8 %	7,337	140,215

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.7	0.3	1,504	129,074
2017	11.0	0.3	1,460	132,268
2016	12.0	0.3	1,603	133,273
2015	11.6	0.3	1,176	101,019
2014	10.6	0.3	1,423	134,581
2013	9.3	0.3	1,251	133,812
2012	8.0	0.3	1,076	134,168
2011	5.9	0.2	788	133,148
2010	4.7	0.2	639	135,587
2009	3.4	0.2	477	141,468
2008	2.6	0.1	360	140,146

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	12.2 %	1.4 %	293,077	2,403,649
2017_2018	10.0 %	1.4 %	243,867	2,437,953
2016_2017	9.9 %	1.3 %	246,014	2,483,421
2016	11.4 %	1.7 %	286,046	2,500,554

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	16.6	1.1	210	1,265,808
2018	19.2	1.2	244	1,268,935
2017	20.8	1.3	264	1,271,286
2016	20.7	1.3	264	1,272,482
2015	17.0	1.2	217	1,276,004
2014	15.8	1.1	202	1,281,460
2013	20.6	1.3	265	1,289,005
2012	18.4	1.2	238	1,296,123
2011	18.7	1.2	244	1,307,412
2010	20.2	1.2	268	1,329,703
2009	18.2	1.2	243	1,332,597

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	35.0	1.5	520	1,487,578
2018	36.1	1.6	542	1,499,684
2017	38.7	1.6	582	1,505,430
2016	32.5	1.5	490	1,506,080
2015	33.8	1.5	514	1,518,794
2014	28.4	1.4	434	1,528,625
2013	26.8	1.3	413	1,540,846
2012	31.7	1.4	492	1,553,131
2011	31.1	1.4	490	1,573,090
2010	29.6	1.4	473	1,598,381
2009	32.2	1.4	519	1,612,480

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	11.5	0.7	262	2,285,147
2016_2018	11.8	0.7	271	2,297,438
2015_2017	12.5	0.7	289	2,307,564
2014_2016	11.4	0.7	264	2,312,566
2013_2015	11.0	0.7	255	2,324,758
2012_2014	11.1	0.7	260	2,339,385
2011_2013	11.9	0.7	281	2,369,514
2010_2012	12.4	0.7	299	2,412,947
2009_2011	12.2	0.7	299	2,460,109
2008_2010	12.8	0.7	320	2,498,282
2007_2009	14.7	0.8	370	2,515,249

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	12.6	0.7	288	2,285,147
2016_2018	11.9	0.7	274	2,297,438
2015_2017	10.8	0.7	250	2,307,564
2014_2016	9.1	0.6	211	2,312,566
2013_2015	8.0	0.6	185	2,324,758
2012_2014	7.4	0.6	174	2,339,385
2011_2013	8.5	0.6	201	2,369,514
2010_2012	9.0	0.6	218	2,412,947
2009_2011	8.7	0.6	214	2,460,109
2008_2010	8.5	0.6	213	2,498,282
2007_2009	8.5	0.6	214	2,515,249

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	20.9 %	1.5 %	541,476	2,588,014
2017_2018	20.3 %	1.6 %	527,644	2,599,575
2016_2017	21.9 %	1.6 %	572,934	2,614,721
2016	22.8 %	1.8 %	598,389	2,625,279

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.2 %	2.9 %	82,383	541,476
2017_2018	13.4 %	3.0 %	70,586	527,644
2016_2017	15.1 %	2.9 %	86,640	572,934
2016	14.9 %	2.9 %	88,999	598,389

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.7 %	0.6 %	58,338	2,149,374
2017_2018	2.6 %	0.7 %	58,008	2,219,100
2016_2017	2.4 %	0.7 %	54,349	2,226,299
2016	1.7 %	0.7 %	38,604	2,247,514

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	9.3 %	1.1 %	196,980	2,122,895
2017_2018	9.3 %	1.3 %	205,042	2,202,662
2016_2017	11.4 %	1.4 %	253,534	2,216,075
2016	12.0 %	1.6 %	267,540	2,237,276

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	53.2 %	5.5 %	160,383	301,352
2017_2018	57.9 %	6.3 %	163,985	283,008
2016_2017	55.0 %	5.8 %	160,206	291,455
2016	53.4 %	6.5 %	153,089	286,622

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	90.5 %	1.3 %	2,338,440	2,584,060
2017_2018	90.6 %	1.4 %	2,336,152	2,578,489
2016_2017	89.9 %	1.4 %	2,331,480	2,592,401
2016	90.4 %	1.5 %	2,365,370	2,616,471

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	12.6 %	0.1 %	8,339	66,169
2016	12.4 %	0.1 %	9,274	74,753
2014	13.1 %	0.1 %	10,631	81,440
2012	13.0 %	0.1 %	12,405	95,493
2010	12.6 %	0.1 %	13,000	102,803
2008	12.4 %	0.1 %	11,430	92,285

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.8 %	1.6 %	68,410	407,295
2013	13.0 %	1.2 %	70,345	542,462
2011	14.7 %	1.5 %	81,443	555,335
2007	12.3 %	1.1 %	73,178	594,890
2005	12.7 %	1.4 %	83,482	658,382

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.7 %	2.0 %	174,861	1,115,307
2017_2018	17.1 %	2.6 %	195,374	1,143,657
2016_2017	18.6 %	2.5 %	209,779	1,128,915
2016	18.6 %	2.7 %	209,408	1,125,170

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.7 %	0.2 %	121,397	2,571,440
2018	4.8 %	0.2 %	124,082	2,587,952
2017	4.0 %	0.2 %	103,979	2,596,335
2016	3.4 %	0.2 %	87,515	2,606,575
2015	4.3 %	0.2 %	113,587	2,622,951
2014	4.9 %	0.3 %	128,291	2,634,140
2013	5.1 %	0.3 %	133,687	2,642,435
2012	5.4 %	0.3 %	143,315	2,652,169
2011	6.1 %	0.3 %	164,248	2,686,075
2010	5.9 %	0.3 %	161,314	2,718,837
2009	6.4 %	0.3 %	173,264	2,713,290

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	72.3 %	3.8 %	100,000	138,000
2015	58.6 %	3.8 %	81,000	139,000
2014	67.1 %	4.1 %	93,000	139,000
2013	65.4 %	4.3 %	92,000	140,000
2012	77.0 %	3.6 %	107,000	139,000
2011	56.8 %	4.3 %	79,000	139,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	59.7 %	1.7 %	1,516,990	2,541,021
2018_2019	60.3 %	1.7 %	1,476,199	2,446,874
2017_2018	56.2 %	1.8 %	1,381,460	2,457,284
2016_2017	51.5 %	1.8 %	1,260,087	2,447,246
2015_2016	55.1 %	2.1 %	1,380,323	2,503,760
2014_2015	54.3 %	1.9 %	1,362,796	2,511,140
2013_2014	54.5 %	1.8 %	1,383,400	2,538,022
2012_2013	54.1 %	2.2 %	1,381,635	2,551,792
2011_2012	50.9 %	2.6 %	1,281,153	2,517,652
2010_2011	50.3 %	2.4 %	1,281,995	2,548,697
2009_2010	44.2 %	3.5 %	1,162,894	2,630,981

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	69.7 %	3.1 %	515,977	739,821
2018	68.3 %	3.0 %	509,290	745,905
2017	64.1 %	2.8 %	483,907	755,375
2016	56.2 %	3.4 %	429,426	763,732
2015	52.2 %	3.5 %	401,180	769,044

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	94.2 %	1.4 %	696,664	739,821
2018	89.1 %	2.0 %	664,590	745,905
2017	90.6 %	1.6 %	684,096	755,375
2016	90.8 %	2.2 %	693,729	763,732
2015	86.7 %	2.6 %	666,523	769,044
2014	83.0 %	2.4 %	641,602	772,912
2013	84.4 %	2.5 %	652,870	773,341
2012	73.8 %	3.4 %	571,542	774,236
2011	72.7 %	2.8 %	568,059	781,425
2010	60.3 %	3.1 %	474,966	787,989
2009	50.2 %	3.2 %	399,069	795,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	91.9 %	1.7 %	679,678	739,821
2018	85.2 %	2.2 %	635,674	745,905
2017	87.3 %	1.8 %	659,363	755,375
2016	79.6 %	2.9 %	608,059	763,732
2015	76.1 %	3.1 %	585,470	769,044
2014	73.7 %	2.8 %	569,518	772,912
2013	69.2 %	3.1 %	535,214	773,341
2012	66.4 %	3.5 %	513,723	774,236
2011	66.0 %	3.1 %	515,872	781,425
2010	61.6 %	3.1 %	485,080	787,989
2009	53.7 %	3.2 %	427,204	795,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	18.8	0.2	6,926	369,297
2018	18.9	0.2	7,044	371,956
2017	20.8	0.2	7,788	374,594
2016	21.8	0.2	8,151	374,550
2015	23.3	0.3	8,755	375,680
2014	25.2	0.3	9,473	376,461
2013	27.2	0.3	10,352	379,993
2012	29.7	0.3	11,437	384,554
2011	31.4	0.3	12,338	392,939
2010	34.3	0.3	13,752	401,420
2009	37.9	0.3	15,445	407,433

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	16.2 %	1.5 %	21,399	132,529
2014	15.3 %	1.3 %	20,445	133,460
2012	13.2 %	1.1 %	17,150	130,094

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.7 %	0.9 %	94,233	2,580,993
2017_2018	2.8 %	0.8 %	72,117	2,581,002
2016_2017	3.1 %	0.8 %	80,515	2,583,565
2016	3.0 %	0.9 %	78,102	2,597,517

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Ohio

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					75
Annual Indicator				74.3	73.7
Numerator				1,442,216	1,438,131
Denominator				1,941,208	1,951,578
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	74.4	75.1	75.8	76.5	77.2	77.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We used the same trend as predicted by JoinPoint last year (0.7% absolute increase), adjusted for the updated 2020 baseline (2019 data).	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: We used the same trend as was predicted by JoinPoint last year (0.7% absolute increase per year), adjusted for the new baseline value (73.7% for 2020). Continuing this trend puts our 2026 goal at 77.9%.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79.3	80.9	77.2	84.2	84.4
Annual Indicator	77.7	76.8	81.9	82.8	80.1
Numerator	101,883	101,413	106,884	110,538	101,710
Denominator	131,148	132,017	130,510	133,422	127,037
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.1	84.2	86.4	88.6	90.8	93.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been updated based on JoinPoint trend analysis including data from the 2017 NIS birth cohort. Joinpoint suggested an annual percent change of 2.55%. Objectives for 2021-2026 were based on this updated JoinPoint trend analysis and the new 2020 baseline (2017 data).

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	22.9	23.5	17.2	24.6	28.7
Annual Indicator	22.3	16.7	23.7	26.0	21.6
Numerator	27,862	21,279	30,504	33,213	26,964
Denominator	125,021	127,543	128,458	127,978	124,604
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.3	25.0	26.9	29.0	31.2	33.6

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Sine we observed a drop in this measure, we updated JoinPoint trend analysis with the most recent NIS data. Joinpoint still suggested an increase, this time, it predicted a 7.6% annual percent change. Annual objectives for 2021-2026 are based off the 2017 NIS cohort and the percent increase predicted by JoinPoint.

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	80.9	82.5	83.3	90	90.5
Annual Indicator	79.3	85.5	85.5	85.5	85.5
Numerator	100,183	111,358	111,358	111,358	111,358
Denominator	126,366	130,239	130,239	130,239	130,239
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2012	2015	2015	2015	2015

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	80.9	82.5	83.3	90	90.5
Annual Indicator		82.7	85.5	86.6	87.6
Numerator					
Denominator					
Data Source		OPAS	OPAS	OPAS	OPAS
Data Source Year		2016	2017	2018	2019
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	91.0	91.5	92.0	92.5	93.0	93.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Ohio no longer participates in PRAMS. However, we are conducting a similar survey, Ohio Perinatal Assessment Survey (OPAS). The first year of data from OPAS will be available sometime in June.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Ohio no longer participates in PRAMS. However, we are conducting a similar survey, Ohio Perinatal Assessment Survey (OPAS). The first year of data from OPAS recently became available.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: A report on safe sleep practices was produce and posted to the Ohio Department of Health website: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/ohio-pregnancy-assessment-survey-opas/resources/safe-sleep-practices-among-ohio-mothers-2016/.	
4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We continue to make progress on this objective. Given that, we left the annual objectives for 2021-2025 unchanged from last year's application.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: We maintained the same target setting method (absolute increase of 0.5% per year from prior year's target) to identify the 2026 target.	

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			41	44
Annual Indicator	39	40.4	42.3	45.4
Numerator				
Denominator				
Data Source	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.9	48.4	49.9	51.4	52.9	54.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We used the same target setting method as last year (1.5% absolute increase per year), readjusted based on the updated baseline data from the 2019 OPAS.	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The same target-setting method (absolute 1.5% increase) was extended to 2026.	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			54	58
Annual Indicator	40.9	51.9	57.7	61.5
Numerator				
Denominator				
Data Source	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.5	67.5	70.5	73.5	76.5	79.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
We have exceeded our target for 2020! For 2021-2026 targets, we used the same target setting method as last year (3% absolute increase per year), readjusted with updated baseline data from the 2019 OPAS.

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			41.6	42.1	29
Annual Indicator		41.1	33.3	28.5	34.3
Numerator		114,362	95,915	73,603	105,296
Denominator		278,232	287,752	258,257	306,997
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	34.9	35.4	36.0	36.6	37.2	37.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note:	As this measure has fluctuated, we remain consistent with last year's method for setting objectives, a simple 10% increase over the new 2020 baseline for 2026. Prior years' objectives are set to be equal increments between the baseline and 2026 target (roughly 0.6% absolute increase).
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note:	This is a 10% relative improvement over the new baseline from 2018-2019 NSCH.

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78.6	79.6	79.6
Annual Indicator		78.1	79.1	79.1	83.1
Numerator		694,854	708,785	708,785	747,153
Denominator		889,704	895,626	895,626	899,030
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78.6	79.6	79.6
Annual Indicator	42.6	43.9	44.3		
Numerator	137,032	144,230	140,942		
Denominator	321,606	328,769	318,477		
Data Source	Ohio Mediciad	Ohio Medicaid	Ohio Medicaid		
Data Source Year	SFY 16	SFY 17	SFY 18		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.6	84.1	84.6	85.1	85.6	86.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: These data only represent the Medicaid population.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: These data only represent the Medicaid population. Absolute percent change ranged from 8.9% to -10.9%. Nine of the 10 counties with the greatest improvement are either rural or Appalachian (as defined by the Appalachian Regional Commission).	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: These data only represent the Medicaid population. County percentages ranged from 19.2% to 54.9%. Rural counties tended to have lower percentages of adolescents receiving a well visit. However, Appalachian counties tended to have better rates than non-Appalachian rural counties. Appalachian counties also tended to have higher increases between 2016 and 2018.	
4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We used the same target-setting method as last year (0.5% absolute increase per year), readjusted for the new baseline data from the 2019 NSCH.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: We continued the same absolute 0.5% increase per year to arrive at the 2026 target.	

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 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	18.9	19.1
Numerator	48,775	51,261
Denominator	257,717	268,951
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.4	19.7	20.1	20.4	20.7	21.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The 2026 target is a 10% increase over the updated baseline (19.1%).

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Ohio

2016-2020: NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			48.6	49.6	50.6
Annual Indicator		48.2	45.1	46.2	45.3
Numerator		288,652	258,614	243,608	245,379
Denominator		598,389	572,934	527,644	541,476
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			48.6	49.6	50.6
Annual Indicator	38				
Numerator					
Denominator					
Data Source	Ohio Medicaid Assessment Survey				
Data Source Year	2015				
Provisional or Final ?	Final				

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The Ohio Medicaid Assessment Survey (OMAS) is an additional source of data that includes the percentage of CSHCN having a medical home. In 2015, OMAS estimated that 38% of CSHCN (0-18 years) had “care consistent with a PCMH” (CC-PCMH). Additionally, CSHCN who had CC-PCMH had fewer reports of fair/poor health compared to those who did not (6% versus 15%).

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15.7	15.1	13.6	12.8	12.1
Annual Indicator	15.2	14.4	13.8	13.2	11.8
Numerator	21,150	19,764	18,917	17,760	15,906
Denominator	138,801	137,722	136,641	134,979	134,293
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Ohio

SPM 1 - Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	9.4	15.5
Numerator	173,603	290,381
Denominator	1,846,840	1,873,426
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.2	15.0	14.7	14.5	14.2	14.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The value of this indicator changed a lot from 2017 to 2019. We used the same target-setting method as last year (10% improvement), recalculated based on the new (2019) baseline and a 10% improvement by 2026. Targets for 2021-2025 targets were set by dividing the difference in the baseline and target by 6 to get equal increments between years (0.26).

SPM 2 - Percent of women ages 18-44 who smoke

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	22.2	22.1
Numerator	426,982	414,681
Denominator	1,922,700	1,879,577
Data Source	Behavioral Health Risk Factor Surveillance System	Behavioral Health Risk Factor Surveillance System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	21.2	20.1	19.7	19.4	19.0	18.6

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Targets for 2022 and 2025 align with our SHIP targets for overall adult smoking. The "in-between" years are set using equal increments between baseline/SHIP targets.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: This aligns with our 2022 SHIP target for adult smoking.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This aligns with our 2025 SHIP target for adult smoking.	
4.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2026 target was set by using the same trend for 2022-2025 (annual decrease of 0.37).	

SPM 3 - Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	489.2	465.9
Numerator	3,727	3,521
Denominator	761,856	755,742
Data Source	Ohio Hospital Association	Ohio Hospital Association
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	453.7	441.5	429.3	417.1	404.9	392.7

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Based on our new baseline (2019 data), we have surpassed our objectives we stated in last year's application for 2021 and 2022. We used the same target-setting method (12.2 absolute decrease in rate), starting from our new baseline and extending to 2026.	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: For the 2026 target, we continued the same trend (a 12.2 absolute decrease in the rate).	

SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	23.5	20.4
Numerator	594,643	515,502
Denominator	2,531,859	2,526,971
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	19.9	19.4	18.9	18.4	17.9	17.4

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This measure is taken from the NSCH measure, "Adverse childhood experiences - 9 items."	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We are using the same target-setting method as before, a 0.5% decrease each year. These targets have been readjusted using the new 2019 baseline.	

SPM 5 - Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	40	50
Numerator	4	5
Denominator	10	10
Data Source	Action Plan	Action Plan
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	80.0	90.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Once we achieve our goal of 100% of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities, we aim to maintain it.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	3	5	6	7
Annual Indicator	4	5	5	6
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The following benchmarks have been completed: 1) Report of refusals across the three screenings completed and disseminated for discussion, 2) Development of a combined newborn screening brochure, 3) Hiring and onboarding a contractor to conduct a review of the three systems and provide a review of solutions, 4) Final report from contractor received, with review of Ohio newborn screening systems and analysis of potential solutions

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Benchmarks include:
1. Report of refusals across the three screenings completed and disseminated for discussion. COMPLETED
2. Development of a combined newborn screening brochure. COMPLETED
3. Hiring and onboarding a contractor to conduct a review of the three systems and provide a review of solutions. COMPLETED
4. Consolidating reports of newborn screening results to providers.
5. Final report from contractor received, with review of Ohio newborn screening systems and analysis of potential solutions. COMPLETED
6. Develop technical specifications and system requirements for competitive bid process with Ohio Department of Administrative Services to select vendor for system implementation COMPLETED
7. Implement solution.

Notes:
#4 – we have explored ways to consolidate reports, but have not achieved this yet.
#7 – an RFP was recently released by DAS and is currently posted (as of 06/13/2019) for proposals to implement a comprehensive, integrated newborn screening system.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The final benchmark was not met due to the inability to identify a successful vendor to implement an integrated newborn screening system.

2016-2020: SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			17.2	16.2
Annual Indicator	18.6	18.9	16.9	16.9
Numerator	96,692	97,851	87,675	87,675
Denominator	519,849	517,730	518,787	518,787
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2015	2017	2019	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
We do not have more recent data to report for this SPM.

Form 10
State Outcome Measures (SOMs)

State: Ohio

SOM 1 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	118.6	123.9
Numerator	266	276
Denominator	22,422	22,271
Data Source	HCUP-SID	HCUP-SID
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	121.4	118.9	116.5	114.0	111.5	109.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: We readjusted our targets based on the new baseline value for 2020 (2018 data) and used the same target-setting method as last year (relative 12% improvement over baseline). The target for 2026 is 109 per 10,000 delivery hospitalizations. Targets for years 2021-2025 are in equal increments between baseline and the 2026 target (about 2.5%).	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: This is a 12% improvement from the 2020 (2018 data) baseline.	

SOM 2 - Percent of women ages 19-44 with 14 or more mentally distressed days in past month

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8	11
Numerator	149,350	209,312
Denominator	1,866,875	1,902,836
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.8	10.6	10.5	10.3	10.1	9.9

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Unfortunately, this measure has worsened. We adjusted our targets based on the new 2020 baseline (from 2019 data) and a 10% improvement goal by 2026. Targets for years 2021-2025 are in equal increments between baseline and 2026 (about 0.2% decrease).	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: This is a 10% improvement over the new (2019 data) baseline.	

SOM 3 - Percent of children ages 0-5 with confirmed elevated blood lead levels

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2.3	2.1
Numerator	3,856	3,533
Denominator	168,352	165,832
Data Source	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.8	1.5	1.3	1.2	1.0	0.9

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The 2021 target was set by assuming equal intervals between the new baseline (2019 data) and the new 2022 target (0.3% decrease).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: 1.5% is the new 2022 target set by the Lead Poisoning Prevention program. Targets were reset since we surpassed our goals set through 2028.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2023 and 2024 targets was set by assuming equal intervals between the new 2022 target and the new 2025 target (0.17 decrease each year).	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The 2023 and 2024 targets was set by assuming equal intervals between the new 2022 target and the new 2025 target (0.17 decrease each year).	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: 1.0% is the new 2025 target set by the Lead Poisoning Prevention program. Targets were reset since we surpassed our goals set through 2028.	
6.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2026 target was set by assuming equal intervals between the new 2025 objective and the new 2028 target (0.1 decrease each year).	

SOM 4 - Percent of high school students who have used alcohol within the past 30 days

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	25.9	25.9
Numerator	104,317	104,317
Denominator	402,688	402,688
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.9	24.4	23.9	23.4	22.9	22.4

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2021 SHIP target.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2021 SHIP target.	
4.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2021 and 2025 objectives align with Ohio SHIP targets. Since we don't have updated data, the 2026 target was set using a continued downward trend of 0.5% per year.	

SOM 5 - Percent of high school students who have used marijuana within the past 30 days

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	15.8	15.8
Numerator	65,023	65,023
Denominator	410,565	410,565
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.8	14.3	13.8	13.3	12.8	12.3

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2021 SHIP target.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2025 SHIP target.	
4.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2021 and 2025 targets align with the Ohio SHIP. Without more recent data, we continued the same trend for target setting for 2026 (0.5% decrease).	

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	36.7	36.7
Numerator	155,186	155,186
Denominator	422,534	422,534
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.5	34.0	33.4	32.9	32.3	31.8

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2021 SHIP objective.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This aligns with the 2025 SHIP objective.	
4.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: The 2021 and 2025 targets align with the Ohio SHIP. Without more recent data, we set the 2026 target using a continued 0.55% decrease from the prior year.	

SOM 7 - Black Infant Mortality Rate (per 1,000 live births)

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			15.5	12.9
Annual Indicator	15.2	15.6	13.9	14.3
Numerator	369	384	339	356
Denominator	24,316	24,542	24,359	24,971
Data Source	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics	OH Department of Health Bureau of Vital Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.6	11.0	9.3	7.7	6.0	4.3

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The 2022 annual objective for the Black infant mortality rate aligns with the 2022 target set forth by the Ohio State Health Improvement Plan and puts Ohio on track to target a rate of 6 Black infant deaths per 1,000 live births by 2028.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2025 annual objective for the Black infant mortality rate is 6.0. Targets prior to 2025 and the 2026 target are based on equal intervals between the updated baseline (2019 data) and the 2025 target.	
3.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: This aligns with a continual improvement (decrease of 0.8) for our goal of 6.0 black infant deaths by 2028, also an Ohio SHIP goal.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Ohio

ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		0
Numerator		0
Denominator		102
Data Source		Program data
Data Source Year		FY 2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	40.0	80.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
During FY 20 recruitment for the first wave began with implementation to begin in FY 21.

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		66	72.6	82.7	84.5
Annual Indicator	49.1	67.9	77.9	82.5	86.1
Numerator	52	72	81	85	87
Denominator	106	106	104	103	101
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.4	88.3	90.3	92.2	94.2	96.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The Ohio First Steps for Healthy Babies initiative launched in March 2015, with the first round of applications accepted in July 2016. Throughout FFY16, there were 4 rounds of applications and 48.6% (52 of 106) hospitals were recognized. Hospitals continue to apply as they achieve more steps. Our goal is to add 5 hospitals each year. We are on track to meet that goal.	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: This is an absolute 2% increase over the 2025 target.	

ESM 5.1 - Number of families provided with a crib and safe sleep education through Cribs for Kids

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			5,500	5,500
Annual Indicator			5,961	6,019
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			FY 2019	FY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5,750.0	6,000.0	6,000.0	6,000.0	6,000.0	6,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			50	70
Annual Indicator			70	65.4
Numerator			5,879	5,251
Denominator			8,394	8,027
Data Source			OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	74.0	76.0	78.0	80.0	82.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Children were included in the denominator if the family had at least 1 home visit during the time period (making them “enrolled”) and if they were 30 days or older during the time period (making them “due” for a screen). Children meeting those criteria were also included in the numerator if they had 1 or more developmental screens during the time period (ASQ3 or ASQE2).

There may be some differences in numerator/denominator criteria that are affecting the year-to-year variation. Also, we are cautious when comparing FFY18/19 data (pre/post-OCHIDS launch) because we have less confidence in pre-OCHIDS data (Early Track).

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
We expected the number of completed screens to be lower this year due to COVID-19. ODH advised home visiting providers to use only telehealth visit options (phone, video, text message, and drop off materials) since mid-March 2020; providers have indicated it is challenging to complete required screening and assessments due to technological issues and distractions during telehealth visits

3.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Since we expect that the dip in children receiving a developmental screening was related to COVID, we did maintained our targets from last year and set 2026 the same way (absolute 2% increase).

ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	48	44.4
Numerator	149,363	139,489
Denominator	311,048	313,853
Data Source	Ohio Department of Medicaid	Ohio Department of Medicaid
Data Source Year	SFY 2019	SFY 2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.3	46.2	47.1	48.1	49.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Title V did not continue a contract with AAP to provide training in FY 19 but Title V continued to collaborate with AAP on webinars and large conference both providing education on Bright Futures topics.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Unfortunately we observed a decline in this measure. We maintained the same target-setting method (2% relative increase per year), adjusted for the new baseline (SFY 2020 data) and extended through 2026.	

ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	25.0	28.0	31.0	33.0	35.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
We do not yet have data to report for this ESM. We will have baseline data next year.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		66.5	67.2	69.2	71.3
Annual Indicator	64.6	65.2	64.4	58.7	61
Numerator	18,653	18,672	18,160	16,570	
Denominator	28,865	28,623	28,209	28,229	
Data Source	Ahlers Title X Database	Ahlers Title X Database	Ahlers Title X Database	Ahlers Title X Database	Ahlers Title X Database
Data Source Year	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
In FY16, for those served by the Ohio Department of Health RHWP, 64.6% of female, unduplicated clients had primary care coverage. This is a 46% increase since the same time in FY2012 when only 44.2% of women had primary care coverage. Of those with primary care coverage, 74.5% had public insurance and 25.5% had private. We believe this increase is related to two major factors. First, Ohio was one of 31 states that expanded Medicaid under the ACA. Additionally, as of April 1, 2016 local RHWP sites were required to ensure that a Certified Application Counselor (CAC) or Navigator was available to assist Title X clients with Marketplace enrollment as well as ensuring eligible Title X clients are assisted with enrollment into Medicaid.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This represents a 47.6% increase since the same time in FY2012 when only 44.2% of women had primary care coverage.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
For those served by the Ohio Department of Health RHWP, 58.7% of female, ages 18 through 44, unduplicated clients had primary care coverage. This is a decrease from 64.4% in FY 18. All clients are offered assistance with enrollment, however some decline to enroll. Overall, this is a 32.8% increase since the same time in FY2012 when only 44.2% of women had primary care coverage.

2016-2020: ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				100	100
Annual Indicator	50	77	140	100	80
Numerator					
Denominator					
Data Source	Training Registration Logs	Training Registration Logs	Training Registration Logs	Estimate	Estimate
Data Source Year	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: We exceeded our annual objective to train 100 providers. Detail sheet was updated for this measure to allow for entering values up to 200. Annual objective for 2016 and 2017 were also 100.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Title V did not continue a contract with AAP to provide training in FY 19 but Title V continued to collaborate with AAP on webinars and large conference both providing education on Bright Futures topics.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: In FY 19, ODH did not renew the contract with Ohio's American Academy of Pediatrics and instead collaborated with Ohio AAP on webinars and a statewide conference to train 100 clinical providers on Bright Futures clinical recommendations, and in FY 20 an additional 80 clinical providers were trained	

2016-2020: ESM 11.1 - Number of stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				12	
Annual Indicator	0	0	0	19	40
Numerator					
Denominator					
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2016	FFY 17	FFY 17	FFY 2019	FFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 19 organizations share information (both that ODH produces and their own communications) about the importance of receiving care via an officially recognized PCMH or practices that operate under the same guiding principles (7 children's hospitals/specialty care centers and 12 ODCC member organizations/agencies). While there are other organizations that likely have shared the information we have provided, these are the organizations we partnered to ensure the information is shared.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We updated the detail sheet to reflect that ODH collaborated with over 40 stakeholders in FY 2020.	

2016-2020: ESM 14.1.2 - Number of pediatric and obstetric practices participating in the Smoke Free Family quality improvement project

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			15	15
Annual Indicator			16	18
Numerator				
Denominator				
Data Source			Project data	Project data
Data Source Year			FY 2019	FY 2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In FY 2019, there were 16 pediatric sites participating in the SFF QI project. ODH stopped participating in obstetric portion of project and we don't have that data after FY 2018.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: These 18 sites are all pediatric sites.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Ohio

SPM 1 - Percent of women ages 19-44 who had unmet mental health care or counseling needs in the past year
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the percent of women ages 18 to 44 who had unmet mental health care or counseling needs in the past year</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of women ages 18 to 44 who had an unmet mental health care or counseling need in the past year</td></tr>
<tr><td>Denominator:</td><td>Number of women ages 18 to 44</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>n/a</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ohio Medicaid Assessment Survey (OMAS)

OMAS is a random digit dial telephone survey that was first fielded in 1997. It is an Ohio-specific assessment that provides health care access, utilization, and health status information about residential Ohioans at the state, regional and county levels. The main topics for OMAS are health care access, health care utilization, insurance status, chronic and acute health conditions, mental health, health risk behaviors, and health demographics such as employment, income, and socioeconomic indicators. Data are weighted to be representative of the Ohio population.</td></tr>
<tr><td>Significance:</td><td>Depression can interfere with daily life and can be a chronic condition. According to 2018 BRFSS data, almost one-quarter (24.5%) of Ohio women (ages 18 and older) report that they have been told that they have a form of depression. Treatment is available, but CDC reports that over half of pregnant women with depression were not treated. It is crucial that women with mental health needs be able to access care in a timely manner, so that they can receive mental health care that enables them to lead healthy, happy, and productive lives.</td></tr>
</table>

SPM 2 - Percent of women ages 18-44 who smoke
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the percent of women ages 19-44 who smoke
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 19-44 who smoke. **Denominator:** Number of women ages 19-44.
Healthy People 2030 Objective:	Related objective: TU-02 — Reduce current cigarette smoking in adults to 5% by 2030.
Data Sources and Data Issues:	Behavioral Health Risk Factor Surveillance System
Significance:	Smoking is harmful to human health. In addition to causing illnesses such as cancer, heart disease, stroke, lung disease, diabetes, COPD, and others, smoking also has detrimental effects on developing fetuses, infants, and children. Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS. Given the high proportion of unintended pregnancies, as well as the serious effects of smoking on pregnancy, it is important to reduce the rate of smoking among all women of reproductive age, rather than just those who are known to be currently pregnant.

SPM 3 - Rate of emergency department visits and hospitalizations for nonfatal intentional self harm among adolescents ages 15-19, per 100,000
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the rate of nonfatal intentional self-harm among adolescents ages 15-19
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of nonfatal ED visits and hospitalizations from the injury ED visit subset and injury hospital discharge subset with nonfatal intentional self harm injury codes **Denominator:** Number of adolescents ages 15-19
Healthy People 2030 Objective:	Related objective: IVP-19 — Reduce emergency department visits for nonfatal intentional self-harm injuries among those aged 10 and up
Data Sources and Data Issues:	Ohio Hospital Association. ED Visits and Hospitalizations are combined. Intentional self-harm ED visits are based on any mention of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) external cause codes (X71-X83, T36-T50 with 6th character=2, [expect when T36.9, T37.9, T39.9, T41.4, T42.7, T43.9, T45.9, T47.9, T49.9 with 5th character=2], T51-T65 with 6th character=2 [except T51.9, T52.9, T53.9, T54.9, T56.9, T57.9, T58.0, T58.1, T58.9, T59.9, T60.9, T61.0, T61.1, T61.9, T62.9, T63.9, T64.0, T64.8, T65.9 with 5th character=2], T71 with 6th character=2, T14.91) and exclude hospital admitted cases. Injury hospital inpatient visits were defined as a hospital admission with an injury listed in the principal diagnosis discharge field (ICD-10-CM S00-S99, T07-T34, T36-T50 with a 6th character of 1-4 [except for T36.9, T37.9, T39.9, T41.4, T42.7, T43.9, T45.9, T47.9, and T49.9 which are included if the 5th character is 1-4], T51-T65, T66-T76, T79, O9A.2-O9A.5, T84.04, M97). From the injury hospital subset, intentional self-harm was defined by any mention of the ICD-10-CM codes listed above. Includes Ohio residents. Excludes fatal cases.
Significance:	Intentional self-harm is preventable. Suicide attempt is a risk factor for completed suicide, and intentional self-harm without wanting to kill oneself might also result in unintentional suicide. Suicide and suicidal ideation may be indicative of mental health problems or stressful and traumatic life events. In Ohio, intentional self-harm is unfortunately prevalent in the adolescent population. According to Ohio's 2019 YRBS, 19% of middle school students and almost 18% of high school students purposely hurt themselves without wanting to die. Just 28% of middle school and high school students who reported feeling sad, empty, hopeless, angry, or anxious said they always or most of the time get the help they need. The suicide rate among adolescents ages 10 to 24 in Ohio increased over 60% between 2007 and 2018 in Ohio, but until now, we have not routinely studied the rate of intentional self-harm in the adolescent population.

SPM 4 - Percentage of children ages 0-17 who have experienced 2 or more adverse childhood experiences (ACEs)
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Reduce the percent of children ages 0-17 who have experienced 2 or more ACEs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Ohio children ages 0-17 who have experiences two or more ACEs **Denominator:** Number of Ohio children ages 0-17
Healthy People 2030 Objective:	Related objective: IVP-D03 -- Reduce the number of young adults (18-25) who report 3 or more adverse childhood experiences
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	According to CDC, adverse childhood experiences (ACEs) are potentially traumatic events or household conditions that occur in childhood. ACEs have been linked to poor health outcomes in adulthood, including increased risk of chronic health conditions, mental illness, substance use, and negative impacts on education and employment. Having 6 or more ACEs has been linked to a 20-year reduction in life expectancy. ACEs are more common among Ohio's child population compared to the US as a whole. In Ohio, about 40% of children have experienced at least one ACE, and 17% have experienced two or more. Nationally, 33% of children have experienced at least one ACE, and 14% have experienced two or more (NSCH 2017-2018). While ACEs are common, and can negatively impact children into adulthood, many are preventable.

SPM 5 - Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percent of performance measures that include at least one strategy focused on reducing disparities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of national and state performance measures that include at least one strategy focused on reducing disparities. **Denominator:** Number of selected national and state performance measures (excluding this SPM)
Data Sources and Data Issues:	Program data
Significance:	This measure will help us monitor and maintain accountability for the presence of strategies aimed to decrease health disparities and increase health equity across all performance measures.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 5 - Number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Newborns in Ohio are screened shortly after birth for a number of disorders through three methods: bloodspot screening, hearing screening, and screening for seven critical congenital heart defects (CCHD). The goal of this priority is to improve linka</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10</td></tr>
<tr><td>Numerator:</td><td>The number of performance measure benchmarks Ohio has reached toward improving Ohio's newborn screening system.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>MICH-32 Increase appropriate newborn blood-spot screening and follow-up testing</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Benchmarks include:
1. Report of refusals across the three screenings completed and disseminated for discussion.
2. Development of a combined newborn screening brochure.
3. Hiring and onboarding a contractor to conduct a review of the three systems and provide a review of solutions.
4. Consolidating reports of newborn screening results to providers.
5. Final report from contractor received, with review of Ohio newborn screening systems and analysis of potential solutions.
6. Develop technical specifications and system requirements for competitive bid process with Ohio Department of Administrative Services to select vendor for system implementation
7. Implement solution.</td></tr>
<tr><td>Significance:</td><td>All three newborn screening programs focus on: 1) ensuring newborns are screened and that physicians receive timely notification of screening results; 2) that those newborns with abnormal (out of range) screening results receive diagnostic testing; and 3) those diagnosed with disorders have access to appropriate treatment or intervention. Work to address this important newborn health priority is focused on improving the linkage/integration and/or inter-operability of data between Ohio's three newborn screening programs and with vital records for a population-based denominator. There are efficiencies to be gained in streamlining common data elements between the programs, as well as making timely and comprehensive (i.e., from all 3 screenings) results available to primary care providers responsible for working with parents on follow-up testing that may be needed. Overlaid in this priority measure is the use of technology and IT solutions to streamline data availability and use at the Ohio Department of Health, as well as the interface with electronic medical records from the birth and children's hospitals, and local pediatricians.</td></tr>
</table>

2016-2020: SPM 6 - Percent of 2-5 years old children consuming 1 or more sugar sweetened beverages per day
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Decrease the percent of 2-5 year old children consuming 1 or more sugar sweetened beverages (SSB) per day
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of 2-5 year olds consuming 1 or more SSB in a day, as reported by parents **Denominator:** # of parents with 2-5 year old children
Healthy People 2020 Objective:	NWS-1 Increase the number of States with nutrition standards for food and beverages to preschool-aged children in child care NWS-10.1 Reduce the proportion of children aged 2 to 5 years who are considered obese NWS-11.1 Prevent inappropriate weight gain in children aged 2 to 5 years NWS-17 Reduce the consumption of calories from solid fats and added sugars in the population aged 2 years and older
Data Sources and Data Issues:	Ohio Medicaid Assessment Survey (OMAS) OMAS is a random digit dial telephone survey that first fielded in 1997. It is an Ohio-specific assessment that provides health care access, utilization, and health status information about residential Ohioans at the state, regional and county levels. The main topics for OMAS are health care access, health care utilization, insurance status, chronic and acute health conditions, mental health, health risk behaviors, and health demographics such as employment, income, and socioeconomic indicators. Data are weighted to be representative of the Ohio population. This question is self-reported by parents, and is likely an underestimation of the number of sugar sweetened beverages children drink.
Significance:	Sugar sweetened beverage intake has been linked to early childhood obesity. The American Academy of Pediatrics recommends that children aged 2-5 consumer no sugar sweetened beverages.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Ohio

SOM 1 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations among non-Hispanic Black women
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the rate of severe maternal morbidity among non-Hispanic Black women
Definition:	**Unit Type:** Rate **Unit Number:** 10,000 **Numerator:** Number of delivery hospitalizations with an indication of severe morbidity from diagnosis or procedure codes among non-Hispanic Black women **Denominator:** Number of delivery hospitalizations among non-Hispanic Black women
Data Sources and Data Issues:	Healthcare Cost and Utilization Project (HCUP) - State Inpatient Database (SID)
Significance:	Severe maternal morbidity is more than 100 times as common as pregnancy-related mortality—affecting about 52,000 women annually—and it is estimated to have increased by 75 percent over the past decade. Rises in chronic conditions, including obesity, diabetes, hypertension, and cardiovascular disease, are likely to have contributed to this increase. Minority women and particularly non-Hispanic black women have higher rates of severe maternal morbidity. Non-Hispanic Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women had 2.1, 1.3, 1.2, and 1.7 times, respectively, higher rates of severe morbidity compared with non-Hispanic white women.

SOM 2 - Percent of women ages 19-44 with 14 or more mentally distressed days in past month
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the percent of women ages 19-44 with 14 or more mentally distressed days in the past month.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 19-44 who experience 14 or more mentally distressed days in the past month. **Denominator:** Number of women ages 19-44.
Data Sources and Data Issues:	Ohio Medicaid Assessment Survey. OMAS is a random digit dial telephone survey that was first fielded in 1997. It is an Ohio-specific assessment that provides health care access, utilization, and health status information about residential Ohioans at the state, regional and county levels. The main topics for OMAS are health care access, health care utilization, insurance status, chronic and acute health conditions, mental health, health risk behaviors, and health demographics such as employment, income, and socioeconomic indicators. Data are weighted to be representative of the Ohio population.
Significance:	Mental distress is a key component of health-related quality of life and poor mental health is a major source of distress and disability. Adults with serious mental illness are more likely to have physical health problems and die earlier than others. Women are more likely to experience frequent mental distress compared to men, and certain mental disorders are unique to women at times of hormone change, such as pregnancy, menstruation, and menopause. Postpregnancy, mental health conditions can affect bonding with a new baby and other children as well. While mental disorders are often underdiagnosed, they can be treated.

SOM 3 - Percent of children ages 0-5 with confirmed elevated blood lead levels
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce the percent of children ages 0-5 with elevated blood lead levels.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 0-5 with confirmed elevated blood lead levels **Denominator:** Number of children ages 0-5 tested for lead
Healthy People 2030 Objective:	Related objective: EH-04 -- Reduce blood lead levels in children aged 1 to 5 years to (1.18 micrograms per deciliter is the target concentration level of lead in blood samples at which 97.5 percent of the population aged 1 to 5 years by 2030)
Data Sources and Data Issues:	Children tested more than once in a calendar year are shown only once in these data. Unless otherwise noted, blood lead levels reflect the highest confirmed test during the year if a confirmed test exists for a child, or the highest test for the year, otherwise.
Significance:	Lead poisoning can have long-term detrimental health effects, especially for young children. Many children with lead poisoning have no signs at first, which makes it hard to diagnose and treat their poisoning early. Even small amounts of lead can cause learning and behavior problems in children. Lead replaces iron and calcium and affects many parts of the body, especially the nervous system. Lead is most harmful to children under the age of six, because a child's growing body takes up lead easily. Lead can also be dangerous to a baby during pregnancy. Problems related to lead poisoning can last the child's whole life. Even at low levels, lead can lower IQ, cause attention disorders, make it difficult for a child to pay attention in school, delay growth, impair hearing, and more.Though no level of lead in the body is considered safe, medical attention is needed when a child under six years of age is confirmed to have an elevated blood lead level of 5 micrograms per deciliter (µg/dL) or higher.

SOM 4 - Percent of high school students who have used alcohol within the past 30 days
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the percent of high school students who use alcohol</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of high school students who used alcohol in the past 30 days</td></tr>
<tr><td>Denominator:</td><td>Number of high school students</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related objective: SU-4 — Reduce the proportion of adolescents who drank alcohol in the past month to 6.3% by 2030</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ohio Youth Risk Behavior Survey/Youth Tobacco Survey

The Youth Risk Behavior Survey is part of a nationwide surveying effort conducted every two years in a sample of high schools across the state. This effort is led by the U.S. Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories identified as most likely to result in adverse outcomes. These categories include unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and disease; dietary behaviors; and physical inactivity. The YRBS is the largest public health surveillance system in the U.S. and the only reliable source of state-level, health behavior data for the teen population in Ohio. Ohio has participated in the YRBS since 1993. In 2019, the Ohio Department of Health combined the YRBS with another CDC survey, the Youth Tobacco Survey (YTS), resulting in the Ohio Youth Risk Behavior Survey/Youth Tobacco Survey. The combination of the surveys also resulted in expanded the survey population to middle schools. The 2019 YRBS/YTS resulted in weighted high school and middle school data.</td></tr>
<tr><td>Significance:</td><td>Alcohol use among adolescents is associated with many adverse outcomes. Youth who drink alcohol are more likely to experience a range of consequences related to school, social life, and health. These include physical and sexual assault, higher risk for suicide and homicide, alcohol-related car crashes, and misuse of other drugs. Early initiation of drinking alcohol is associated with development of alcohol use disorder later in life. According to the most recent available data for Ohio, about 1 in 4 high school students reports having had at least one alcoholic drink in the month prior to being surveyed.</td></tr>
</table>

SOM 5 - Percent of high school students who have used marijuana within the past 30 days
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the percent of high school students who use marijuana
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school students who have used marijuana in the past 30 days **Denominator:** Number of high school students
Healthy People 2030 Objective:	Related objective: SU-06 -- Reduce the proportion of adolescents who used marijuana in the past month to 5.8% by 2030
Data Sources and Data Issues:	Ohio Youth Risk Behavior Survey/Youth Tobacco Survey The Youth Risk Behavior Survey is part of a nationwide surveying effort conducted every two years in a sample of high schools across the state. This effort is led by the U.S. Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories identified as most likely to result in adverse outcomes. These categories include unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and disease; dietary behaviors; and physical inactivity. The YRBS is the largest public health surveillance system in the U.S. and the only reliable source of state-level, health behavior data for the teen population in Ohio. Ohio has participated in the YRBS since 1993. In 2019, the Ohio Department of Health combined the YRBS with another CDC survey, the Youth Tobacco Survey (YTS), resulting in the Ohio Youth Risk Behavior Survey/Youth Tobacco Survey. The combination of the surveys also resulted in expanded the survey population to middle schools. The 2019 YRBS/YTS resulted in weighted high school and middle school data.
Significance:	Marijuana use in adolescence can negatively affect other aspects of adolescents' lives, such as school, health behaviors, and mental health. Youth who use marijuana may attain lower grades in school and be more likely to drop out of high school. Driving under the influence of marijuana can affect the skills necessary to drive safely, like reaction time and coordination. Aside from these more acute effects, regular or heavy marijuana use, starting in adolescence, may have permanent effects on brain function.

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
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the percent of high school students who use tobacco or vaping products</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of high school students who report having used cigarettes, smokeless tobacco, cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days</td></tr>
<tr><td>Denominator:</td><td>Number of high school students</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related objective: TU-04 -- Reduce current tobacco use (cigarettes, e-cigarettes, cigars, smokeless tobacco, hookah, pipe tobacco, and/or bidis) in adolescents to 11.3% by 2030</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ohio Youth Risk Behavior Survey/Youth Tobacco Survey

The Youth Risk Behavior Survey is part of a nationwide surveying effort conducted every two years in a sample of high schools across the state. This effort is led by the U.S. Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories identified as most likely to result in adverse outcomes. These categories include unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and disease; dietary behaviors; and physical inactivity. The YRBS is the largest public health surveillance system in the U.S. and the only reliable source of state-level, health behavior data for the teen population in Ohio. Ohio has participated in the YRBS since 1993. In 2019, the Ohio Department of Health combined the YRBS with another CDC survey, the Youth Tobacco Survey (YTS), resulting in the Ohio Youth Risk Behavior Survey/Youth Tobacco Survey. The combination of the surveys also resulted in expanded the survey population to middle schools. The 2019 YRBS/YTS resulted in weighted high school and middle school data.</td></tr>
<tr><td>Significance:</td><td>Across the US, tobacco use among adolescents is increasing, and this is attributable to the increase in use of electronic cigarettes specifically. Most tobacco product use begins in adolescence. Cigarette smoke contains chemicals that can cause cancer, and use of any tobacco products can lead to addiction and may harm an adolescent's developing brain, which can impact learning and memory. In Ohio, more than 1 in 3 high school students reported using a tobacco product on at least one day in the month prior to taking the Ohio YRBS survey.</td></tr>
</table>

SOM 7 - Black Infant Mortality Rate (per 1,000 live births)
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Decrease Ohio's overall infant mortality and racial disparity by decreasing the mortality rate among black infants
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of deaths of black infants under 1 year of age (birth through 364 days) **Denominator:** Number of live births to black mothers during the same period
Healthy People 2030 Objective:	Related objective: MICH-02 -- Reduce the rate of infant deaths within 1 year of age to 5.0 by 2030
Data Sources and Data Issues:	Ohio Vital Statistics. Ohio birth and death files are usually not finalized until late summer of the following year. All statistics are preliminary until that time.
Significance:	Although Ohio's IMR has declined over the past couple of decades, the state still ranks poorly among other states in the nation. In 2017, Ohio's IMR was 7.2 per 1,000 live births. This was above the national average of 5.8 per 1,000 and the HP 2020 objective of 6.0. Additionally, black infants are about twice as likely to die as white infants. The Ohio Department of Health (ODH) has formed the Ohio Equity Institute (OEI) to improve birth outcomes and reduce racial disparities in infant deaths. By focusing on the nine communities that make up OEI, ODH aims to strengthen the scientific focus and evidence base for reducing racial and ethnic disparities in birth outcomes.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Ohio

ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of birthing hospitals who implement the AIM hypertension model.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing hospitals who implement the AIM hypertension model</td></tr>
<tr><td>Denominator:</td><td>Number of birthing hospitals</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program data</td></tr>
<tr><td>Significance:</td><td>Mothers can experience substantial health and safety issues throughout the duration of their pregnancy and after childbirth, including severe maternal morbidity and pregnancy-related death. The top underlying causes of pregnancy-related death in Ohio include cardiovascular and coronary conditions, infections, hemorrhage, preeclampsia and eclampsia, and cardiomyopathy. To address these issues, the Ohio Department of Health (ODH) has initiated the Ohio Maternal Safety Quality Improvement Project (QIP). The QIP aims to implement a data-driven model created by The Alliance for Innovation on Maternal Health (AIM) to establish interventions in maternity care hospitals in Ohio, with the goal of reducing preventable maternal mortality and severe maternal morbidity and a focus on women who are Medicaid eligible or enrolled, uninsured, black, and/or have a mental health diagnosis.</td></tr>
</table>

ESM 4.1 - Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	By tracking the percentage of hospitals receiving this recognition, we are able to measure our progress/success in obtaining buy-in from hospitals on fostering a breastfeeding friendly environment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Ohio hospitals who are recognized by the Ohio First Steps for Healthy Babies initiative. **Denominator:** Number of Ohio birthing hospitals
Data Sources and Data Issues:	The source of the data will be from the Ohio First Steps for Healthy Babies review committee and their data tracking sheet. Limitations are that data are self-reported by the hospitals and some of the objectives can be based on estimates instead of chart reviews and patient interviews. The First Steps for Healthy Babies is a voluntary initiative—not all of Ohio's birthing hospitals participate.
Significance:	This measure is significant because it tracks overall hospital participation as well as the individual progress hospitals are making towards the Ten Steps to Successful Breastfeeding. When hospitals have more of the Ten Steps in place, mothers breastfeed longer. The goal of the First Steps initiative is to encourage and support hospitals to implement the Ten Steps to Successful Breastfeeding and become a Baby-Friendly USA designated hospital. Mothers who give birth at Baby-Friendly hospitals are more likely to initiate exclusive breastfeeding and more likely to sustain breastfeeding at six months and one year of age.

ESM 5.1 - Number of families provided with a crib and safe sleep education through Cribs for Kids
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of infants who sleep in a safe sleep environment.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of families who were provided a crib and safe sleep education through the Cribs for Kids program. **Denominator:**
Data Sources and Data Issues:	Reported by local grantees
Significance:	Sleep-related infant deaths are the third leading cause of infant death in Ohio. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding.

ESM 6.1 - Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of children in a home visiting program that receive a developmental screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children receiving home visiting services, ages 1 through 66 months, that have completed the Ages & Stages (ASQ-3 or ASQE2) questionnaire.</td></tr>
<tr><td>Denominator:</td><td>Number of children receiving home visiting services, ages 1 through 66 months</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS) – currently under development.</td></tr>
<tr><td>Significance:</td><td>Many children with developmental delays or behavior concerns are not identified as early as possible. As a result, these children must wait to get the help they need to do well in social and educational settings (for example, in school, at home, and in the community).

According to the CDC, in the United States, about 1 in 6 children aged 3 to 17 years have one or more developmental or behavioral disabilities, such as autism, a learning disorder, or attention-deficit/hyperactivity disorder. In addition, many children have delays in language or other areas that can affect how well they do in school. However, many children with developmental disabilities are not identified until they are in school, by which time significant delays might have occurred and opportunities for treatment might have been missed.

Ohio Department of Health's Home Visiting programs utilize the Ages & Stages Questionnaires, Third Edition. This is a parent completed questionnaire with 9 versions based on the baby's age.</td></tr>
</table>

ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the percent of adolescents ages 12-17 in county served by Medicaid with adolescent well visit
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents ages 12 to 17 in counties served by Medicaid with adolescent well visit **Denominator:** Number of adolescents in counties served by Medicaid ages 12 to 17
Data Sources and Data Issues:	Ohio Department of Medicaid
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. National Adolescent and Young Adult Health Information Center (2016). Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to age 18. http://nahic.ucsf.edu/adolescent-guidelines.

ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place
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

Measure Status:	Active
Goal:	Increase the percent of CSHCN ages 12-17 enrolled in the Children with Medical Handicaps program who have a transition plan in place
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents ages 12-17 enrolled in the Children with Medical Handicaps program who have a transition plan in place **Denominator:** Number of adolescents ages 12-17 enrolled in the Children with Medical Handicaps program
Data Sources and Data Issues:	Data will be pulled from the system used by the Children with Medical Handicaps program, CMACS.
Significance:	CSHCN enrolled in CMH have complex medical needs that require coordination of numerous actors to ensure adequate management. To ensure this population is prepared to transition to adult health care and participate fully in this process, a transition plan is necessary. By tracking progress in increasing the proportion of CSHCN in CMH with a transition plan in place, we can measure our efforts to increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care, among the most medically complex CSHCN.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Increase by 3% the percent of women with primary care coverage who are receiving services through RHWP clinics
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>BMCH clinics are working to make sure women who are eligible are covered by private or public insurance. Tracking this measure will help us know if we are providing the support needed for women to access this coverage.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of women covered by either private or public insurance seen in ODH RHWP clinics</td></tr>
<tr><td>Denominator:</td><td>The total number of women seen in ODH RHWP clinics</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ahler’s & Associates Title X Database</td></tr>
<tr><td>Significance:</td><td>This measure will be used to document whether women being seen in a Reproductive Health and Wellness Program clinics who do not currently have coverage for primary care services are being provided the support necessary to obtain such coverage. In 2012 the Kaiser Women’s Health survey found that more than half of uninsured women ages 18-65 reported going without or delaying needed care because they could not afford the cost.</td></tr>
</table>

2016-2020: ESM 10.1 - Number of clinical providers in Ohio trained on Bright Futures clinical recommendations. NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Improved uptake of preventative visits and quality of care during adolescent preventative medical visits. Track characteristics of trained providers (e.g., geographic distribution, characteristics of patients served race, etc.).
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of physician or registered nurse clinicians (including pediatric, adolescent medicine, family practice) who are trained in Bright Futures clinical recommendations. **Denominator:**
Data Sources and Data Issues:	The data source will be training registration data maintained by the training contractor and shared with ODH.
Significance:	This measure is significant because it will inform the state on progress towards having a workforce trained in adequate provision of preventative medical visits to adolescents. A trained clinician will be a clinician who has registered for and completed a training (provided by a contractor to the state) on the Bright Futures Clinical Recommendations and adolescent-centered environments.

2016-2020: ESM 11.1 - Number of stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs.
2016-2020: NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase access to care via PCMH for CSHCN by educating families of CSHCN about the importance and benefits of receiving patient-centered, comprehensive, coordinated, accessible, and high quality primary care in a medical home.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>40</td></tr>
<tr><td>Numerator:</td><td>Number of stakeholder groups that share information about the importance of patient-centered medical homes (PCMH) with families with children with special health care needs.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data will be tracked by the workgroup</td></tr>
<tr><td>Significance:</td><td>In order to increase awareness for families of CSHCN about the importance of receiving care through a PCMH, it will be necessary to work with stakeholders who serve families to educate them about the importance of PCMHs for families with CSHCN. Through better informing stakeholders and providing them with the training and resources to educate families with CSHCN, it is hoped that there will be a significant increase in the number of CSHCN who receive comprehensive coordinated care through PCMHs. This education will happen through working with and training key stakeholder groups to disseminate medical home resources to families of CSHCN. Working with a diverse group of stakeholders who work with CSHCN will enable us to get the message about the benefits of PCMH to many Ohio families with CSHCN.</td></tr>
</table>

2016-2020: ESM 14.1.2 - Number of pediatric and obstetric practices participating in the Smoke Free Family quality improvement project
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To reduce the rate of smoking among pregnant women, women of childbearing age, and caregivers to children.
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of participating practices **Denominator:**
Data Sources and Data Issues:	Data will be collected in program data base
Significance:	Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications including placenta previa, placental abruption, premature rupture of the membrane, preterm delivery, restricted fetal growth, and sudden infant death syndrome [SIDS]. Secondhand smoke exposure causes numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, and ear infections. The chemicals in secondhand smoke appear to affect the brain in ways that interfere with its regulation of infants' breathing and increases risk for SIDS.

Form 11
Other State Data

State: Ohio

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Ohio

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	More often than monthly	0	Yes	
3) Medicaid	Yes	Yes	Quarterly	6	Yes	
4) WIC	Yes	Yes	More often than monthly	2	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	No	Quarterly	4	No	
8) PRAMS or PRAMS-like	Yes	No	Annually	12	Yes	

Form Notes for Form 12:

Hospitals send discharge data to the Ohio Hospital Association (OHA) on a quarterly basis. The Ohio Department of Health submits data requests to OHA as needed. Personal identifying information is not shared.

Although WIC is not linked with birth records, we are in the process of completing a project to link WIC participant data to birth records to evaluate birth outcomes in participants versus non-participants as well as other outcomes such as breastfeeding.

Along with the WIC/Birth Record linkage project, we are planning to link home visiting data to birth and infant death records to evaluate birth outcomes in women served by home visiting.

Field Level Notes for Form 12:

None