Maternal and Child Health Services Title V Block Grant

Ohio

FY 2023 Application/ FY 2021 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 2023. 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 2023 and the Block Grant Annual Report for FFY 2021.

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, MBA by AMD

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 advance the health and well-being of all Ohioans by transforming the state's public health system through unique partnerships and funding streams; addressing the community conditions and inequities that lead to disparities in health outcomes; and implementing data-driven, evidence-based solutions. 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 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 health 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. The Ohio MCH program uses a Population Domain Group structure to manage MCH priorities and implement strategies from the five-year plan. Population Domain Groups are 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. Also included in the collaborative efforts are families, youth, and consumers, whose voices lend vital understanding of the unique needs of Ohio's MCH population. All these partnerships are critical because no single agency or system has the resources or capacity to accomplish this goal alone.

The Domain 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 the interventions have been successful. In addition to the Domain Groups, MCH program administrators utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes.

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 priorities reflect an 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 Domain Group will continue to work with multiple 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 a prevention strategy for maternal morbidity, and an opportunity to improve overall women's health. Title X clinics implement Reproductive Life Plans for clients of child-bearing age and offer contraception as requested to assist clients in achieving their reproductive goals. Preconception health efforts also include community assessments to identify pre- and interconception issues and barriers to inform strategies 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 action.

Women in Ohio experience unmet mental health needs and more Ohio women experience postpartum depression compared to the U.S. national rate. 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 Domain 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 supported 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.

Pre-term birth continues to be one of the leading causes of infant mortality in Ohio. 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 highest priority is to support healthy pregnancies and improve birth and infant outcomes. The Domain Group will continue to focus on breastfeeding and safe sleep as key methods for improving infant health 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 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 ten 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 linkages to increase and improve identification and referrals. Ohio ensures newborns receive appropriate screening, diagnostic testing, referral, and intervention through programs including 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 made significant improvements in performance measures for breastfeeding and safe sleep. Title V Breastfeeding and Ohio First Steps for Healthy Babies support breastfeeding in hospitals, worksites, and childcare facilities, improve breastfeeding continuity of care, and provide women direct support through a 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 safe sleep environments for their babies. 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 areas of Ohio with high infant mortality.

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 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. The Domain 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 obesity efforts in childcare settings. 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 Domain 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 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/responding to victims of violence. The Domain Group continues 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, although data shows that well child visits/immunizations, and particularly adolescent well child visits/immunizations declined during the COVID pandemic. BMCFH worked collaboratively with the Immunization Program at ODH on social media campaigns to increase well child visits where providers could also promote immunizations with parents. Other efforts include training to pediatricians and school nurses, School Based Health Center 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 Domain 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 Domain 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 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 (now re-named to the Health Equity Action Team – HEAT) 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 the Ohio Department of Health, Bureau of Maternal, Child and Family Health 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 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 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 Department of Health Pregnancy-Associated Mortality Review (PAMR) program has implemented the AIM Hypertension Bundle has been implemented in 53 participating hospitals across waves 1 and 2. Over 840 data submissions of patient encounters with women who have or are at risk for hypertension have been submitted to date.

Perinatal/Infant Health

Ohio Equity Institute's Neighborhood Navigators (NN) increased efforts to identify women less connected to services in the 9 counties with the highest Black infant mortality. NN served 4,583 women (5% increase over the previous year), 73% self-identified as Black/African American. An average of 4 needs were identified per woman served through OEI. Once referrals were offered, women self-reported utilizing 12,418 referrals (68%) to date, 70% of women served through OEI did not have a safe place to sleep for their baby. Of all women who reported needing safe sleep resources, 96% were referred to Cribs for Kids or another safe sleep organization in their community.

Child Health

The Early Childhood Health and School Nursing team in partnership with Ohio AAP and other community partners, continued to offer a variety of virtual professional development training for medical professionals, home visitors, early childhood professionals, school nurses, and community health workers on relevant topics. To date, over 7,500 professionals have completed the training.

Adolescent Health

State agencies collaborate to address adolescent mental health. Ohio was invited to participate in the Adolescent and Young Adult Behavioral Health CoIIN in 2021 which also includes a diverse group of agency stakeholders. State agencies collaborate to address adolescent mental health. This team is focused on primary care, pediatric or clinical providers. As part of the work, two partners were able to plan a project to leverage resources to expand an existing project related to depression screenings in clinical settings.

Children and Youth with Special Health Care Needs (CYSHCN)

The Infant Hearing Program in partnership with the Ohio Coalition for the Education of Children with Disabilities and the Ohio School established the SKI-HI Snapshots and Deaf Mentor Program. Both are evidence-based programs that require Part C Early Intervention enrollment and are entirely free for families.

Cross-cutting

A state-by-state ACEs plan review helped to inform our ODH workgroup on ACES with an emphasis on staff being trained on ACEs and trauma practices. Several ODH workgroup members have taken the Healthy Outcomes from Positive Experiences (HOPE) training, a project of Tufts Children's Hospital, and will be working together to determine the next steps for both internal and partner implementation of the information.

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 April 28th, 2022, 2.7 million cases, 115,185 hospitalizations, and 38,428 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 2020 population of Ohio was estimated at 11,799,448, a net increase of approximately 287,017 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 905,748 and the fourteenth largest city in the United States (2020 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, 2020

County	Population
Franklin	1,323,807
Cuyahoga	1,264,817
Hamilton	830,639
Summit County	540,428
Montgomery County	537,309
Lucas County	431,279
Butler County	390,357
Stark County	374,853
Lorain County	312,964
Warren County	242,337

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 31.3% 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 4.6% in 2020. 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 (43.4%), followed by Latin America (19.5%), Europe (18.8%) and Africa (15%). One in eight Ohioans working in the life, physical, or social sciences is an immigrant. Seventy-eight percent of foreign-born residents speak a language other than English. Of those, 46.6% speak English less than 'very well'. The most common language spoken in Ohio other than English is Spanish.

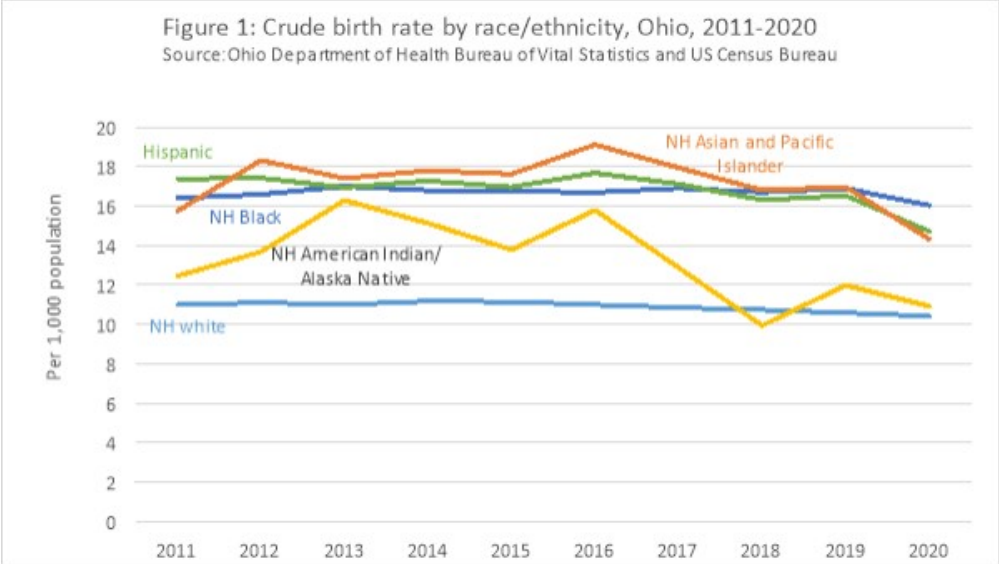
Twelve percent of Ohio's population is Black or African American. Hispanic or Latino people (of any race) make up 4.4% of the population. The percentage of the population that is Black is about the same as the U.S. percentage. However, the Asian and Hispanic population percentages are substantially lower 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, 2020

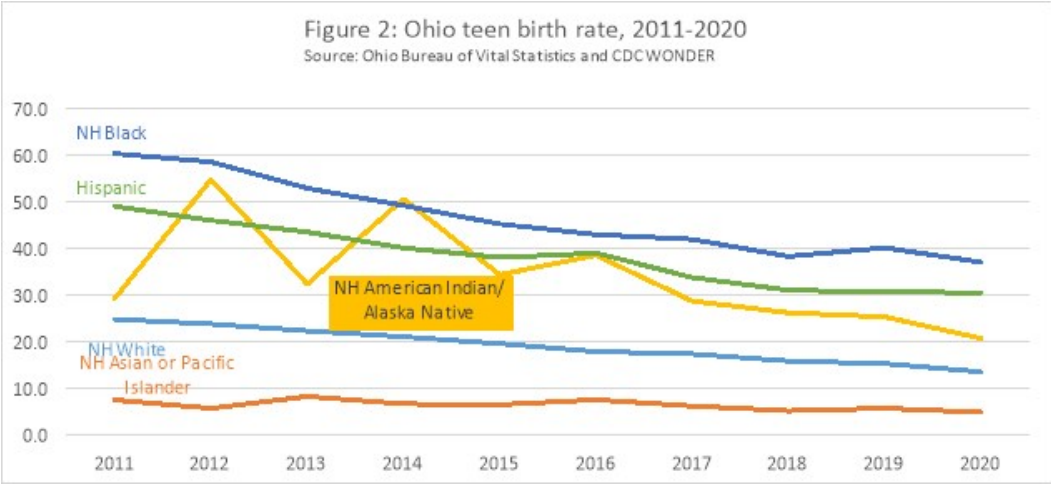
Race	Ohio (Count)	Ohio (%)	U.S. (%)
White	9,080,688	80.5	76.3
Black or African American	1,478,781	12.4	13.4
Asian	298,509	2.3	5.9
American Indian or Alaska Native	30,720	0.2	1.3
Two or more races	681,372	3.6	2.8
Ethnicity			
Hispanic or Latino (all races)	521,308	3.9	18.7
Non-Hispanic or Latino	11,278,140	96.1	81.3

Birth Rates

Between 2011 and 2020, Ohio's crude birth rate has decreased from 12.0 to 11.0 per 1,000 persons (data not shown). Birth rates among Hispanic, American Indian/Alaska Native, and Asian and Pacific Islander populations have decreased over the past decade. Birth rates among non-Hispanic Black and non-Hispanic white populations have remained fairly steady.



Ohio's teen birth rate (ages 15-19 years) has shown a steady decline since 2011 (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 less than half that of Hispanic teens and about 60% lower than that of non-Hispanic Black teens. Unlike other groups, the birth rate among non-Hispanic 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 2020 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, 2020

Disability Type	Percent of Population
Vision	2.4
Hearing	3.8
Ambulatory	7.5
Cognitive	5.8
Self-Care	2.7
Independent Living	6.2
Any Disability	14.0

The prevalence of disabilities was highest among American Indian/Alaska Native Ohioans (25.7%). This is more than double the prevalence among Hispanic Ohioans (11.1%). About fifteen percent of Black Ohioans and 14% of white Ohioans had a disability. Asian Ohioans had the lowest prevalence of disability (5.9%).

Less than one percent (0.7%) of children under the age of five have a disability. The overall rate of disability for children ages 5 to 17 was 6.6%. Among those under age 18, cognitive disability was the most common disability, affecting 5.3% of this population.

Ohio's Social and Economic Indicators

Hospitals

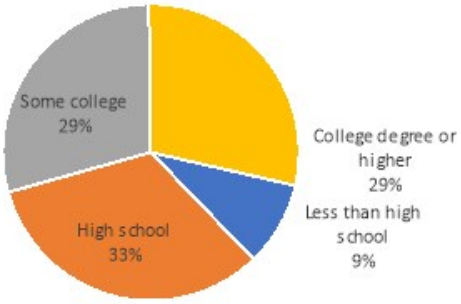
Ohio has six children's hospitals serving children from all 88 counties, all 50 states, and many international countries. According to the Ohio Children's Hospital Association, Ohio ranks 47th in the nation in costs per member per month for pediatric Medicaid expenditures and Ohio's spending is 20% below 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 nine percent of Ohioans aged 25 and older do not have a high school diploma, and about one-third (32.8%) have only a high school diploma. Figure 3 presents a breakdown of educational attainment in Ohio.

Figure 3: Educational attainment among those aged 25 and older, Ohio, 2020



The percentage of women with a bachelor's degree or higher (29.5%) is comparable to the percentage of men with a bachelor's degree or higher (28.2%). However, white adults were more likely to have a bachelor's degree compared with Black adults (29.7% vs. 18%). When examining educational attainment by race and ethnicity, Asian adults were much more likely to have a bachelor's degree or higher (60.5%) when compared with white, Hispanic (21%), and Black adults. The poverty rate for persons who have less than a high school diploma is 27.3% almost seven times higher than the poverty rate among those with a bachelor's degree or higher (3.8%).

According to the Ohio Department of Education, in school year 2020-2021, 15.0% of students enrolled in public schools (primary and secondary) had a disability. Almost half (44.5%) of the students were economically disadvantaged.

Economic Overview

According to the Ohio Development Services Agency, Ohio's gross domestic product (GDP) for 2020 was initially estimated at $677.6 billion, less than the 2019 estimate of $693.2 billion. This ended a 10-year increase in Ohio's GDP, and is likely attributable to the global coronavirus pandemic. In 2021, 197,010 new business were created, a 15% increase over 2020, according to the Ohio Secretary of State. Ohio is one of the nation's leading sources for primary and fabricated metal

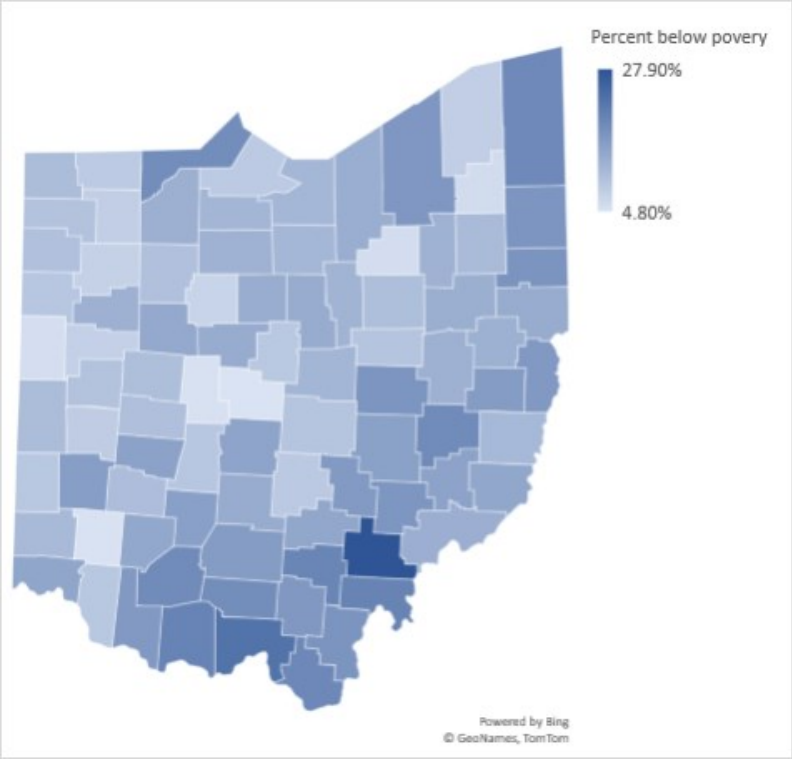
products, as well as plastic, rubber, and non-metallic mineral products, machinery, electrical equipment and appliances, and transportation equipment – especially motor vehicles and the associated parts, trailers, bodies and accessories. According to the National Science Foundation, Ohio ranked 9th nationally in Research and Development contracts in FY 2019, and Ohio State University, Case Western Reserve University, and the University of Cincinnati receive more than a combined $150 million in federal research grants.

Like the United States overall, Ohio's median income decreased from 2019 to 2020. The 2020 median household income in Ohio is $58,116, down from $58,642 in 2019. During April 2020, Ohio's unemployment rate exceeded 15%. Ohio's median annual income is less than that of the United States which was $64,994 in 2020. As of March 2022, the Ohio Department of Job and Family Services reported Ohio's unemployment rate as 4.1%, higher than the 3.6% unemployment for the United States. The 88 counties unemployment ranged from a low of 2.6% in Holmes County to a high of 7.9% in Lorain County.

Poverty

According to 2020 American Community Survey estimates, 13.6% of Ohioans live in poverty, slightly higher than the national rate of 12.8%. 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, 2020 (American Community Survey 5-year estimates)



Children experience higher rates of poverty than the population overall. Nineteen percent of Ohioans under age 18 live below the poverty level, about the same as the U.S. estimate of 17.5%. For younger children, the poverty rate is even higher: in Ohio, more than one in five children under age 5 (21.8%) live below the poverty level. Families with children had poverty rates ranging from 4.7% among married couples to 31.8% percent for those headed by a female single parent.

Women were more likely than men to experience poverty (14.8% vs. 12.4%, respectively). Black and Native Hawaiian/Pacific Islander 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, 2020

Race	Ohio (%)	U.S. (%)
White	10.8	10.6
Black or African American	28.4	22.1
American Indian or Alaska Native	23	24.1
Asian	12.6	10.6
Native Hawaiian and other Pacific Islander	27.2	16.8
Two or more races	23.6	15.1
Hispanic or Latino (all races)	23.9	18.3

Public Assistance
According to the Ohio Department of Job and Family Services (ODJFS), about 1.5 million persons received benefits from Supplemental Nutritional Assistance Program (SNAP) in June 2021. This is a decrease of about 100,000 individuals from the same time period in 2020, likely a result of regained income 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 2022, 35 counties in Ohio have farmers' markets that are currently accepting the Ohio Direction Card, up from 26 in 2021. This includes 102 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 2022 Farmers' Market Directory is accessible at http://www.odjfs.state.oh.us/forms/num/JFS00569/pdf/.

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 2021, OWF provided benefits to 80,929 individuals, 91% 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 8.8% in 2019. In 2019, an estimated 784,706 adults were uninsured in Ohio (2019 Ohio Medicaid Assessment Survey). As of January 2022, the total enrollment for Medicaid and CHIP was 3,188,776, an increase of almost 50% since the first Marketplace Enrollment Period and related changes from 2013 (https://www.medicaid.gov/state-overviews/stateprofile.html?state=ohio).

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 (https://ccf.georgetown.edu/wp-content/uploads/2019/05/Ohio.pdf):

- 82% of Children living in or near poverty
- 43% of infants, toddlers, and preschoolers
- 45% of children with disabilities or other special health care needs
- 100% of children in foster care
- 52% of children born to moms covered by Medicaid

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 worked 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.

In April, the Ohio Department of Medicaid began offering eligible pregnant women a full year of postpartum healthcare coverage. The extended postpartum coverage includes physical recovery from childbirth, behavioral healthcare such as postpartum depression and substance use disorder (SUD) treatment, as well as family planning, and chronic disease management for diabetes, hypertension, and cardiac conditions that predated the pregnancy. The expansion will cover Medicaid-eligible new moms for a five-year period, through April 2027.

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 childcare program, improve workforce recruitment and retention, and increase access for families. A study committee has been established to evaluate both publicly funded childcare 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 adolescents 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 the 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; require the creation of a comprehensive tobacco plan; increase access to long-acting, reversible contraception (LARC); and created a Home Visiting Consortium and a 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, and 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 before 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 reduce 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 2023 Application/FY 2021 Annual Report Update

Ongoing Needs Assessment Activities and Partnership Updates
The Title V program uses a Population Domain Action Group structure to manage its MCH Priorities and implement strategies within the 5-Year Action Plan. Each Priority Domain 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 Domain 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 Domain Groups, program managers utilize data collection, program evaluation, and surveys to solicit feedback and monitor program outcomes. External stakeholders involved in the Domain 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 Domain Groups have worked to operationalize the 5-year needs assessment through the development of workplans detailing implementation of the Action Plan. Each Domain 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 Domain 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 Domain 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 the 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, MD, MBA, 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 Public Health Practice
- 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 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 its 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.

Dr. John M. Weigand, a central Ohio physician who has served as a leader in the state's COVID-19 pandemic response, has been appointed Medical Director at the Ohio Department of Health and the Ohio Department of Aging.
Dr. Tabitha Jones-McKnight, a pediatrician with a master's degree in public health, joined the department as assistant medical director, after serving with Nationwide Children's Hospital and Ohio University.

Jennifer 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.

Rhonda Huckaby serves as the Title V Maternal Child Health Block Grant Coordinator and previously served as a Domain Group leader 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 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.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$21,289,200	$20,208,893	$21,973,210	$21,012,697
State Funds	$57,518,051	$54,510,610	$55,838,575	$43,254,961
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$78,807,251	$74,719,503	$77,811,785	$64,267,658
Other Federal Funds	$171,656,028	$237,055,972	$152,584,198	$196,641,329
Total	$250,463,279	$311,775,475	$230,395,983	$260,908,987

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$22,065,962	$21,462,897	$22,331,382	
State Funds	$67,346,423	$62,539,649	$67,422,505	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$89,412,385	$84,002,546	$89,753,887	
Other Federal Funds	$219,737,929	$200,522,371	$209,018,526	
Total	$309,150,314	$284,524,917	$298,772,413	

	2023	
	Budgeted	Expended
Federal Allocation	$23,427,360	
State Funds	$67,422,505	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$90,849,865	
Other Federal Funds	$208,377,378	
Total	$299,227,243	

III.D.1. Expenditures

Title V. Expenditures Narrative

A. Expenditures

Form 2

Ohio's Title V FY21 expenditures totaled $20,462,897. FY21 expenditures for the Preventive and Primary Care for Children totaled $7,533,736 or 35.1% of the total Title V expenditures. FY21 expenditures for Children with Special Health Care Needs totaled $8,592,049 or 40% of the total Title V FY21 expenditures due to the increase of Direct Services in FY21. FY21 expenditures for the Title V Administrative costs totaled $431,056 or 2.1% of total FY21 Title V expenditures. This expenditure is less than the FY20 budget due to administrative position vacancies and a loss of a long-time administrative staff member in FY21.

The state's expenditures for FY21 totaled $62,539,649.

Total FY21 expenditures for Federal-State Title V Block Grant Partnership was $64,267,658.

Form 3A

Ohio's Title V FY21 expenditures totaled $21,031,052 excluding FY21 Administrative budget costs. FY21 expenditures for Pregnant Women totaled $ 2,844,230 and Infants < 1 totaled $ 1,997,419. The expenditures for the pregnant women and Infant <1 included MCH services such as Reproductive Health and Wellness, Moms and Babies First (MBF), and other Maternal and Child Health services that are dedicated to serving pregnant women and infants < 1. FY21 expenditures for the Preventive and Primary Care for Children totaled $ 7,533,736. These expenditures for Primary Care for Children included 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. FY21 expenditures for Children with Special Health Care Needs totaled $ 8,592,049. FY21 expenditures for All Others was $ 63,618.

Ohio's State Funds FY21 expenditures totaled $62,539,650. FY21 State Funds expenditures for Pregnant Women totaled $3,282,265 and Infants < 1 totaled $3,282,265. FY21 State Funds expenditures for the Preventive and Primary Care for Children totaled $22,871,669. FY21 State Funds expenditures for Children with Special Health Care Needs totaled $32,900,424. FY21 State Funds expenditures for All Others totaled $203,027.

Total expenditures for Federal-State Title V Block Grant Partnership were $83,570,702 excluding FY21 Title V Administrative costs.

Form 3B

Title V FY21 expenditures totaled $21,462,897 for MCH Services. Title V Direct Service FY21 expenditures totaled $ 4,085,989 which included Preventive and Primary Care Services for Pregnant Women and Infants<1 at $ 2,575,890. Expenditures for Preventive and Primary Care Services for Children totaled $ 584,219 and Children with

Special Health Care Needs totaled $ 925,880. These expenditures are direct services related to Reproductive Health and Wellness, Moms and Babies First, Oral Health, and services for children with special health care needs. Title V FY21 expenditures for Enabling Services were at $ 7,732,577 and Public Health and Systems at $ 9,644,331. Historically, ODH MCH expenditures related to Direct Services included Case Management costs 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 FY21 totaled $ 62,539,649 for MCH Services. State Direct Service expenditures totaled $ 28,319,576 which included Preventive and Primary Care Services for Pregnant Women and Infants <1, Preventive and Primary Care Services for Children at $ 178,722 and Children with Special Health Care Needs at $ 28,140,854. The Title V FY21 budget for Enabling Services was at $ 4,106,882 and Public Health and Systems at $ 30,113,191.

FY21 COVID Efforts

In FY21, Title V expenditures toward COVID-19 Efforts were $1,157,734 and $366,460 in state funds. In addition to researcher and epidemiology staff support, the COVID-19 efforts consisted 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 FY21 total expenditure for both state and federal funds for COVID-19 Efforts was $1,524,194. 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.

III.D.2. Budget

Title V. Budget Narrative

A. Budget

Form 2

Ohio's Title V FY23 budget totals $23,427,360. The FY23 budget for Services for Pregnant Women, Mothers and Infants up to age one year is budgeted at $5,974,110. The FY23 budget for Preventive and Primary Care for Children is budgeted at $8,982,755 or 38.3% of the FY23 Title V budget. The FY23 budget for Children with Special Health Care Needs is budgeted at $7,886,905 or 33.6% of the FY23 Title V budget. FY23 Title V Administrative costs are budgeted at $557,041 or 2.4% of the FY23 Title V budget. Historically, the ODH MCH budget has been highly focused on Children 1-22 years of age. The FY23 MCH budget is more well-rounded focusing on all MCH components which aligns with the MCH/CSHCN priorities.

The State MCH Funds budget for FY23 is $67,422,505.

The total budget for Ohio's Federal-State Title V Block Grant Partnership is $90,849,865.

Form 3A

Ohio's Title V FY23 budget totals $22,870,319 excluding FY23 Administrative budget costs. The Title V FY23 budget for Pregnant Women totals $4,118,924 and Infants <1 totals $1,855,186. The FY23 budget for Pregnant Women and Infants <1 consists of MCH services such as Reproductive Health and Wellness, infant mortality reduction efforts, and other Maternal and Child Health services that are dedicated to serving pregnant women and infants <1. The Title V FY23 budget for Children 1 through 21 years of age is budgeted at $8,982,755. The FY23 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. The Title V FY23 budget for Children with Special Health Care Needs is budgeted at $7,886,905. The Title V budget for All Others is budgeted at $26,549.

The State FY23 budget totals $67,422,506. The Title V FY23 budget for Pregnant Women totals $5,886,587 and Infants <1 totals $5,886,587. The Title V FY23 budget for Children 1 through 21 years of age is budgeted at $16,435,205. The Title V FY23 budget for Children with Special Health Care Needs is budgeted at $38,850,008. The Title V budget for All Others is budgeted at $364,119.

The total FY23 Budget for Federal State MCH Block Grant Partnership excluding Administration costs is $90,292,825

Form 3B

Ohio's Title V FY23 budget totals $23,427,360 for MCH Services. The Title V Direct Service budget is $ 5,400,471 which contains Preventive and Primary Care Services for Pregnant Women and Infants <1 at $ 3,904139, Preventive

and Primary Care Services for Children at $1,005,000 and Children with Special Health Care Needs at $ 491,332. The FY23 budget for direct services is related to Reproductive Health and Wellness, Moms and Babies First, Oral Health, and services for children with special health care needs. The Title V FY21 budget for Enabling Services is at $ 7,406,874 and consists of services related to Case Management, Oral Health, Infant Hearing, MCH Genetics and Vision program. The FY23 budget for Public Health and Systems is at $ 10,620,015 which consists of MCH services related to Public Health Systems and policy.

The State budget for FY23 totals $ 67,422,505 for MCH Services. Title V Direct Service expenditures total $ 38,812,798 which contains Preventive and Primary Care Services for Pregnant Women and Infants <1, Preventive and Primary Care Services for Children at $600,000, and Children with Special Health Care Needs at $ 37,812,798. The Title V FY23 budget for Enabling Services is at $ 11,541,619 and Public Health and Systems is at $ 17,422,505.

B. Summary and Budget Justification

Summary Budget Description for FY2023

• 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:	$ 5,974,110
Component B:	$ 8,982,755
Component C:	$ 7,886,905
Other:	$ 26,549
Subtotal:	$ 22,870,339

Administrative Costs: $557,041

GRANT TOTAL: $ 23,427,360

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 2023 federal MCH award is $ 23,427,360 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, and actual expenditures may depend upon executive order reductions, reimbursement limits and

revenue limitations.

Administrative Costs

The administrative costs of Ohio's 2023 MCH Block Grant request are based on the budget and expenditures related to the BMCFH Bureau Chief's Office.

FY22 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, 2022. As of July 2022, a total of $22,331,382 in MCH Block Grant funds was available to the State of Ohio. The projected FY22 MCH expenditures will total $8,520,821. When the total available funds are reduced by total projected expenditures the unencumbered balance will be $13,810,561.

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 the 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 Ohio's Title V 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 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. 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 Statewide Competency was added to the employee performance evaluations for all State of Ohio Employees in 2020 entitled, 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, became 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 Ohio 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 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 193 current staff members with various backgrounds including: medicine, public health, social work, epidemiology, public policy, nutrition, health care administration, education, finance, marketing, and administrative support. 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. The sessions are recorded and archived in a Teams channel for staff to view later. Topics include highlighting priority areas for MCH such as infant mortality, maternal mortality, and using data. All BMCFH staff have been added to the MS Team that 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.

At the beginning of the pandemic in March 2020, Governor DeWine ordered a 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. At that time, BMCFH had several vacancies and approximately 20% of BMCFH staff were re-assigned to COVID response duties during the height of the pandemic. By July 2021, most staff returned from COVID-19 assignments and the BMCFH worked with department leadership and Human Resources to fill vacancies. The BMCFH engages in ongoing planning to retain and recruit a diverse workforce. BMCFH has a bureau planning committee with representatives from programs across the bureau. The committee plans bureau meetings and has also planned virtual activities for staff to stay connected during the extended telework period. Since telework began in March 2020, the BMCFH chief has sent weekly emails to all bureau staff that includes updates, program highlights, and "get to know staff" sections. The bureau also hosts quarterly virtual bureau meetings to share key information and support engagement. Meeting tools to make virtual meetings more participatory and meaningful are employed such as polls, virtual whiteboards, rankings, surveys, etc. 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.

Beginning in June 2022, the Ohio Department of Health and other state agencies began a phased-in return to office plan with hybrid work schedules (part in-office time and part telework.) Each staff member has a hybrid work schedule, dependent on their job responsibilities that defines how often they must be in the office moving forward. Managers and supervisors are encouraged to ensure there are meetings scheduled and opportunities for face-to-face collaboration on work projects when staff are in the office.

BMCFH formed the Health Equity Committee (HEC) [now re-named the Health Equity Action Team – HEAT] in 2020 to develop a plan for addressing internal culture and staff cultural competency alongside a plan for centering health equity through our policies and programs (for details see III.E.2.c. Cross-Cutting Annual Report). The HEAT administered a staff competency survey and is using the results to plan training opportunities available through individual recorded/on-demand sessions as well as bureau-level interactive/live opportunities. The HEAT 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 HEAT participated in the National MCH Workforce Development Center Skills Institute in 2020 and 2021 focused on operationalizing and implementing the newly developed state Action Plan. From those opportunities, the team is currently pilot testing the Wisconsin Community Engagement Assessment Tool (CEAT) in a couple subgrant programs the bureau funds. We plan to obtain feedback from the pilot programs about the ease of using the tool at the local level, as well as whether local subgrantee staff found the tool to be meaningful to improving community engagement (including those with lived experience) in their program planning, implementation, and evaluation.

BMCFH had several staff participate in AMCHP's Leadership Labs including an epidemiologist, a parent consultant, and the Adolescent Health Coordinator. 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 (OSU) 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. The program has operated virtually the past three years.

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	3rd Quarter, 2022	Web Based	1 Hour
Securing Ohio (*annual*)	All ODH Employees	3rd Quarter, 2022	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	4th 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 lack supervisory experience to gain the essential knowledge,

skills, and abilities 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 delayed in 2021 due to the pandemic, but back on track for 2023. 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 since the original offering 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

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.

The Infant Hearing Screening Subcommittee

The Infant 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 newborn 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 family 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 events, including an annual family conference 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

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

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.

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

Objective 1.5: Increase the number of sampled addresses for the National Survey of Children's Health (NSCH).

Objective 1.6: Develop data products from analysis of the Ohio Pregnancy Assessment Survey (OPAS).

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, to calculate infant mortality rates and other perinatal health indicators for the Medicaid population.

Objective 2.6: Development of a Birth and Death Certificate Data Extract to Upload to Maternal Mortality Review Information App (MMRIA).

Objective 2.7: Link COVID-19 case data with birth and fetal death records to monitor COVID-19 related pregnancy and birth outcomes.

Objective 2.8: Link WIC participant data with birth records.

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.

Objective 3.4: Provide data support for HRSA IM CoIIN project(s).

The new 5-year funding cycle for SSDI starts December 1, 2022. We are currently in the process of preparing the application and updating the goals and objectives.

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. This position advises program staff on setting annual objectives and selection of indicators, monitor performance and outcome measures and annual objectives, assists with identification of data sources, performs analysis as needed, and interprets data. The epidemiologist is also responsible for completing data forms for the annual report. The position is currently vacant. Samantha Batdorf, who had occupied this position, resigned in May 2022. We are currently working on hiring a new epidemiologist to fill this position. Once hired, the epidemiologist will continue to work with the MCH Block Grant Coordinator and domain group leads to identify additional data needs and perform analysis as needed.

During the current budget period, December 1, 2021, through November 30, 2022, the Ohio SSDI project accomplished many tasks related to the goals and objectives. The SSDI funded epidemiologist produced multiple data briefs that are currently undergoing internal review. These include data briefs on fetal mortality and racial disparity in infant mortality. Additionally, she assisted with ODH's Annual Infant Mortality Report and presented a poster on postpartum contraceptive use at the 2021 MCH Leadership and Epidemiology Conference in December 2021. She also submitted an abstract that was accepted to the 2022 MCH Leadership and Epidemiology Conference. Since she is no longer working at ODH the Epidemiology Supervisor/SSDI Project Director will present the poster which compares health behaviors and conditions between women experiencing a live birth and those who experienced a fetal death.

The BMCFH Data and Surveillance team has been conducting surveillance on pregnancy associated COVID-19 infection. This involves linking data for the Ohio Disease Reporting System (ODRS) to birth and fetal death records to identify cases of pregnancy-related COVID-19. Additionally, medical record abstraction is currently underway on a sample of identified cases. A preliminary analysis was conducted on data available from ODRS and vital statistics (VS). This report is currently undergoing internal review. Although this activity is not fully funded by SSDI, the SSDI-funded epidemiologist assisted with medical record abstraction and SSDI funds are used to purchase training and supplies, including software, to support the staff involved.

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

The BMCFH Data and Surveillance Section provides 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. PAMR was officially established in 2019 in Ohio Revised Code Chapter 3738. The rules (Ohio Administrative Code 3701-66), which describe the operation of the program, became effective on October 25, 2021.

Fetal Infant Mortality Review (FIMR) is conducted in ten 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 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 Ohio Study of Associated Risks of Stillbirth (Ohio SOARS) and Ohio Pregnancy Assessment Survey (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 2022 (SFY 23) continues as a collaboration funded by ODH and ODM and administered by The Ohio State University Government

Resource Center (GRC).

As a separate, but related surveillance activity, ODH initiated implementation of a stillbirth survey in SFY19. The methodology is identical to the Ohio Pregnancy Assessment Survey, but the target population is fetal death certificates rather than live birth certificates. The survey was first fielded in 2020 and the first data was received in November 2021. 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 Ohio Fatherhood Survey (OFS) started fielding for the first time in June 2022. OFS is an initiative of ODH and the Ohio Department of Medicaid (ODM) that asks fathers about their experiences before and after their child is born. It is representative of fathers of children born in Ohio and asks questions about the transition to fatherhood. It is based on the methodology of PRAMS and PRAMS for Dads, which was piloted in Georgia in 2018-2019. Ohio will be one of the first states to hear directly from fathers, helping pave the way for insights into actionable changes that can support their health during the postpartum period.

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, branding the survey as the YRBS/YTS. Combining the YRBS/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. Combining the YRBS/YTS for both middle schools and high schools continued for the 2021 administration, with results not yet released by the CDC as of July 2022.

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. The NSCH provides data for many Title V National Performance Measures (NPM) and National Outcome Measures (NOM). ODH contracted with the US Census Bureau to sample additional addresses in Ohio for the 2021 and 2022 NSCH. We are currently in the process of establishing a contract to oversample the 2023 NSCH. The oversamples will allow ODH to have more precise estimates on key indicators monitored by the Title V block 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. In 2021, 1,542 interviews were complete. Of those, 136 were Black/African American, 96 were Hispanic and 367 were Children with Special Health Care Needs (CSHCN).

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 expanded collaboration with Ohio Department of Medicaid and the Ohio Department of 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 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 assigning an SSID number 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 champions 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 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, followed-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 contributed to the state's response. Specifically, BMCFH staff were 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 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 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 several forms: ensuring responders serve vulnerable populations, especially women and children who cannot afford to purchase bottled 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 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.

In late 2020, MCH and BHP 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 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. In turn, BHP presented on public health emergency preparedness during Preparedness Month (September '21) 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 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.

Other outgrowths of the Action Learning Collaborative include staff from BMCFH were trained to assist with pushing messages through the public health emergency communication system; staff from BMCFH participated on a small workgroup with staff in Preparedness to work on emergency preparedness for Ohioans with special needs; and in the last year, the chiefs of the bureau of MCFH and Health Preparedness now report to the same up chain manager, facilitating closer collaboration.

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

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 the Ohio Department of Medicaid (ODM). As of March 2022, an estimated 3.37 million Ohioans, including more than 1.32 million children, receive coverage for healthcare services through Medicaid.[i] This is an increase from the March 2021 enrollment of around 3.18 million.

Most beneficiaries now receive Medicaid health care benefits through 1 of 5 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 ODM pays 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 and custody system, individuals enrolled in the 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 streamlines 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.

On Jan. 31, 2020, the U.S. Department of Health and Human Services (HHS) declared a Public Health Emergency (PHE), allowing the federal government to divert federal funds, personnel and services in response to the COVID-19 pandemic. Additionally, the Families First Coronavirus Response Act (FFCRA), passed in March 2020, provided states with a 6.2% in their federal share of Medicaid funding. This increase, which amounts to approximately $300 million per quarter, is in effect until the end of the quarter in which the PHE expires. The increase in the federal share of Medicaid funding is contingent on a "maintenance of eligibility" (MOE) provision in the FFCRA, which prohibits state Medicaid programs from terminating coverage for current enrollees or changing eligibility criteria or requirements during the PHE. On April 12, 2022, the federal government renewed the PHE, meaning that it will be in effect through mid-July 2022.[1]

To prepare for eligibility and enrollment activities to resume, ODM has Initiated system improvements in Ohio Benefits (Ohio's eligibility system for benefits, such as Medicaid and SNAP), contracted with the Public Consulting Group to assist in identifying enrollees who are "likely ineligible" for Medicaid coverage, plans to leverage the passive (ex parte) renewal process prior to the end of the PHE and work with managed care plans to coordinate outreach to Medicaid enrollees to increase the response rate for renewal information requests.[1]

During the past 5 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, Departments of Mental Health and Addiction Services, Higher Education, Aging, and Education. Projects include workforce development; maternal/infant health; health services research/data, including the Ohio Medicaid Assessment Survey (OMAS); and integrated physical & behavioral health. MEDTAPP MCH projects are implemented by the Ohio State University GRC and include:

- 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. In addition, they include screening and education for safe sleep. 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 COVID-19 supplement in 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 provides 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. The survey was first fielded in 2020 and we have received the final weighted data for 2020.
- The Ohio Fatherhood Survey (OFS) 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. This survey started fielding in June 2022.
- 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. Project planning activities for this project, including developing onboarding materials, project curriculum, developing a data plan, hosted a kick-off call, and finalizing data use agreements with 23 participating sites will continue

through FY22 with implementation occurring in FY23.

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[i]https://2ub9uy20anky3zjffr2svyxq-wpengine.netdna-ssl.com/wp-content/uploads/2022/04/MedicaidBasics_COVIDupdate_04.19.2022.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 align investments more effectively 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 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, 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 a Domain Group structure to manage MCH priorities and implement strategies within each Domains' Plans. Domain Groups are 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 Domain Group plans 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 Domain Groups use the logic model version of the Action Plan, available in section V. Supporting Documents (Ohio Title V MCH BG Priority Action Plan FY 21-25). Each year the Domain 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 the interventions have been successful. In addition to the Domain 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

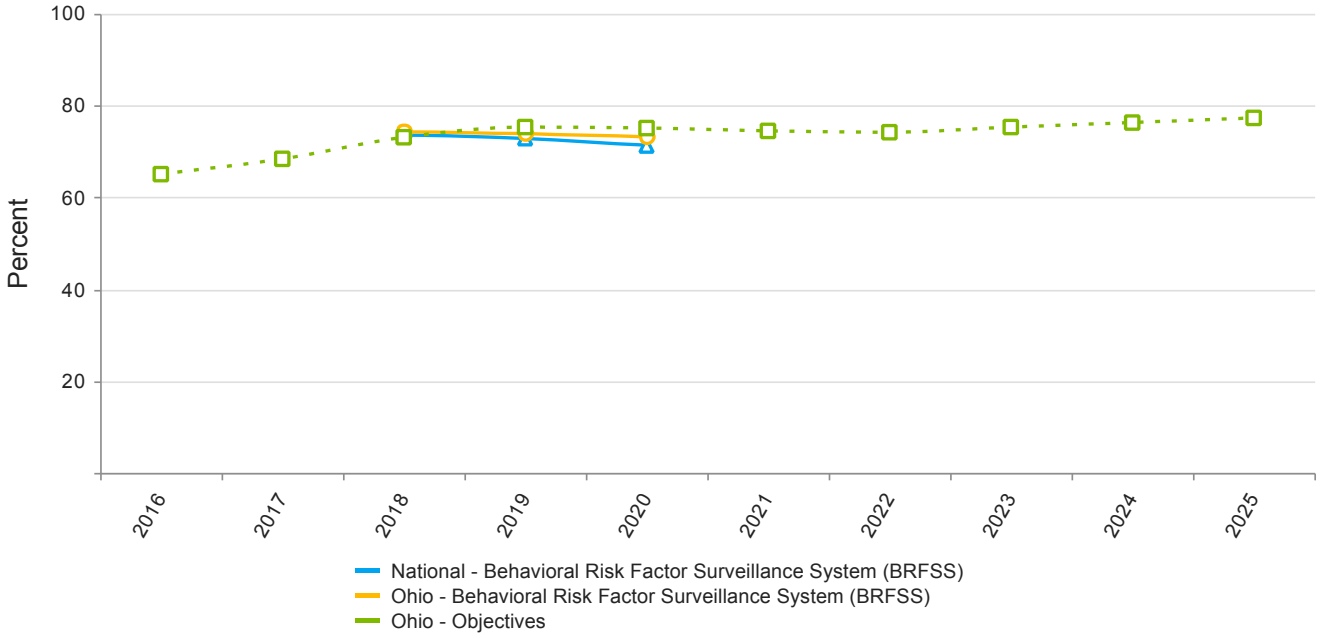
improvement. This is done in coordination with internal and external stakeholders that serve individuals and populations that are disproportionately affected by poor health outcomes under the MCH umbrella. Also included in collaborative efforts are families, youth, and consumers, whose voices lend to 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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				75	74.4
Annual Indicator			74.3	73.7	73.1
Numerator			1,442,216	1,438,131	1,436,365
Denominator			1,941,208	1,951,578	1,964,967
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	74.1	75.2	76.2	77.2

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model

Measure Status:	Inactive - Replaced with an ESM that is more aligned with our well-woman NPM.

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator		0	30.9
Numerator		0	30
Denominator		102	97
Data Source		Program data	Program data
Data Source Year		FY 2020	FY 2021
Provisional or Final ?		Final	Final

ESM 1.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	32.0	33.0	34.0

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	2021
Annual Objective			15.2
Annual Indicator	9.4	15.5	15.5
Numerator	173,603	290,381	290,381
Denominator	1,846,840	1,873,426	1,873,426
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	14.7	14.5	14.2

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			21.2
Annual Indicator	22.2	22.1	21.9
Numerator	426,982	414,681	408,790
Denominator	1,922,700	1,879,577	1,864,493
Data Source	Behavioral Health Risk Factor Surveillance System	Behavioral Health Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.1	19.7	19.4	19.0

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	2021
Annual Objective			121.4
Annual Indicator	118.6	123.9	118.1
Numerator	266	276	270
Denominator	22,422	22,271	22,857
Data Source	HCUP-SID	HCUP-SID	HCUP-SID
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	116.5	114.8	113.2	111.5

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	2021
Annual Objective			10.8
Annual Indicator	8	11	11
Numerator	149,350	209,312	209,312
Denominator	1,866,875	1,902,836	1,902,836
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	10.6	10.5	10.3	10.1

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)	
Increase the percent of uninsured women who are enrolled in or referred to enrollment in health insurance within Title X clinics.	
ESMs	Status
ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model	Inactive
ESM 1.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance	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 protocols for systemic data into action

ESMs	Status
ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model	Inactive
ESM 1.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance	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 Council to Advance Maternal Health (OH-CAMH)

Increase the percent of pregnant and postpartum women who receive urgent maternal warning signs education in WIC, Home Visiting, and Healthy Start programs

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

Train maternal health care providers on how to conduct effective telehealth encounters (project will end in September 2022)

Increase women's health screenings during pediatric well visits

Gestational Diabetes QI projects to improve postpartum visit and testing rates (project ended January 2022)

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

Women/Maternal Health, Annual Report FY 2021

The annual report is organized by the three priorities to address maternal morbidity, mental health, and risk factors for preterm birth.

Priority: Decrease risk factors contributing to maternal morbidity

Measures

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. 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.

- NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations
    - According to data from the Health Care Utilization Project – State Inpatient Database, as analyzed by HRSA in the Federally Available Data (FAD), the rate of severe maternal morbidity per 10,000 delivery hospitalizations was 78.4 in 2019. This is nearly the same as the SMM rate in 2018 (77.8).
- SOM: Disparity- Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations
    - According to data from the Health Care Utilization Project – State Inpatient Database, as analyzed by HRSA in the Federally Available Data (FAD), the rate of severe maternal morbidity per 10,000 delivery hospitalizations among Black women was 118.1 in 2019, about 50% higher than SMM rate overall.
- NPM 1: Percent of women (18-44) with a preventive medical visit in past year
    - According to the Behavioral Risk Factor Surveillance System, 73.1% of reproductive-aged women in 2020 had a preventive medical visit within the previous year. This is consistent with years past.
- ESM: Percent of birthing hospitals that have implemented the AIM hypertension bundle.
    - Thirty of 97 birthing hospitals (30.9%) participated in the first wave of the AIM Hypertension Patient Safety Bundle Quality Improvement Project.

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 Ohio Department of Health (ODH) Reproductive Health and Wellness Program (RHWP) is the umbrella agency that currently holds the Title X family planning grant. This grant funds 42 subrecipient agencies providing services at over 75 sites located in 58 counties in Ohio, with clinics in the northeast, northwest, southeast, southwest, and central regions of the state. The current subrecipient agencies are comprised of a diverse group of local health districts, non-profit agencies, Federally Qualified Health Centers and Community Action Agencies. They provide services not only in traditional clinical settings but also in non-traditional settings, such as, substance abuse treatment facilities, homeless and domestic violence shelters, and rehabilitation facilities. In CY20, the RHWP provided 58,442 clinic visits to 35,173 unduplicated clients including 27,321 women and 7,852 men. Ninety Two percent of these unduplicated clients live at or below 250% federal poverty level. Sixty One percent of these unduplicated clients live at or below 100% of the federal poverty level.

ODH is currently the only funded Title X grantee in Ohio and has been a Title X Grantee since the inception of the grant in 1970. ODH celebrated their 50th anniversary in 2020 and was recognized along with five other Title X grantees for their continued efforts and commitment to ensure quality family planning services accessible to women, men, and adolescents.

The need for family planning services in Ohio is great and is defined by the information below. The most recent U.S. Census American Community Survey (ACS) 2017 1-year estimate data shows an estimated 1,582,931, 14.0 percent, of Ohioans were poor in 2017, which is comparable to the national rate of 13.4 percent. Both the number and percentage of poor people in Ohio are lower than the 1,824,628, 16.3 percent, in 2012, but remain above the 1999 decennial census figures of 1,171,000, 10.6 percent. For a ten-year period, from 2007 to 2017, the percentage of Ohioans in poverty increased from 13.1 to 14.0 percent; 2011 had the highest percentage, 16.4 percent. Nationally, for the same years, rates have increased from 13.0 to 13.4 percent; 2011 and 2012 had the highest percentage, both 15.9%.

During the five-year time, 2012-2016, the U.S. Census ACS data shows county poverty rates ranged from 4.9 percent in Delaware County to 31.2 percent in Athens County. Statewide, 15.4 percent of Ohioans lived in poverty (1,732,839 people). The 32 county Appalachian area had a poverty rate of 17.6 percent, about 342,500 of its 1,951,000 people. The counties with the highest poverty rates, ranging from 31.2 to 22.8 percent, Athens, Adams, Scioto, Jackson, and Meigs, are all Appalachian counties. The counties with the lowest poverty rates, ranging from 4.5 to 6.9, Delaware, Warren, Medina, and Geauga, are all suburban counties. There were relatively high poverty rates in most of the counties with metropolitan area central cities. Allen (Lima), Clark (Springfield), Cuyahoga (Cleveland-Elyria), Franklin (Columbus), Hamilton (Cincinnati), Jefferson (Steubenville), Lucas (Toledo), Mahoning (Youngstown), Montgomery (Dayton), Richland (Mansfield) and Trumbull (Warren) had poverty rates higher than the state average of 15.4%.

Existing gaps in the availability or accessibility of services are addressed annually by program. According to Power to Decide, in Ohio, there are 724,880 women in need live in contraceptive deserts and 66,260 women in need live in counties without access to a single health center that provides the full range of contraceptive methods.

The RHWP has Title X clinics in 58 of the 88 counties in Ohio. The Title X clinics provide direct healthcare services. In addition, the Title X clinics also provide enabling services by offering referrals and outreach. One of the RHWP grant deliverables requires that 100% of subrecipients provide and implement an outreach plan describing at least two outreach activities focused on hard-to-reach and high need populations, as reflected in the needs assessment. Identified populations are women in need of publicly funded contraceptive services, including, but not limited to,

Appalachian, Latina and Non-Hispanic Black or African American women of childbearing age and those with disabilities. Subrecipients are required to use the Social Vulnerability Index to help determine where to focus outreach efforts. Examples of outreach events include group or school presentations, community information events and festivals, educational programming, social media, health fairs, and advertising via billboards, posters, commercials, and flyers. Several of the RHWP subrecipients have mobile units that offer direct reproductive healthcare services at a variety of high need locations (i.e., homeless, and domestic violence shelters, substance abuse clinics, recovery housing, resource centers, LBGTQ youth centers) on a rotating basis.

The RHWP values the input of families, youth, and those with lived experience. All RHWP Title X clinics are required to have an advisory committee and are encouraged to have clients, including adolescent clients, as some of the members. Additionally, the clinics have patient satisfaction surveys which are used to learn from the patients and make changes when needed.

A major anticipated barrier in provided family planning services consists of the continuance or increase in the COVID-19 variants. The RHWP quickly responded to the initial pandemic by educating staff and implementing telehealth services in the clinic sites. RHWP provided additional funding, training, and one on one technical assistance to subrecipients to assist with implementation of telehealth services. RHWP sites held drive-through vaccination clinics; offered curbside medication, lab supplies, and specimen pick-ups and drop-offs; and mailed medication. Once in-person visits resumed, subrecipients contacted clients to reschedule missed or canceled appointments. The RHWP will work with subrecipients to continue providing these services should COVID-19 continue to present a barrier to care.

Anticipated next steps are to expand the RHWP telehealth services to ensure access to high-quality and equitable care. The RHWP will continue to offer educational webinars and clinical newsletters to provide providers with current ACOG clinical guidelines. Title X clinics will continue to track the number of clients referred for mental health or substance use treatment.

The RHWP has worked toward accomplishing providing well-woman visits within the Title X clinics following the American College of Obstetricians and Gynecologists (ACOG) guidelines. This strategy is designed to meet the objective of increasing the percent of women with a preventative medical visit by 5% by 2025 and falls under the priority of decreasing the risk factors contributing to maternal mortality. Following ACOG recommendations, during October 1, 2020 to September 30, 2021 (SFY21), the RHWP Title X clinics offer annual exams (6,011); mental health screenings, counseling (3,743) and referrals (974); nutrition referrals (3,756) and diet/activity counseling (30,669); blood pressure testing (44,772); dental referrals (661); STI prevention counseling (43,248); screenings for gonorrhea (23,932), chlamydia (24,091), Hepatitis B (1,216), Hepatitis C (6,044), and HIV (12,667); and breast (6,992), cervical (6,008), and colorectal (88) cancer screenings.

Ensuring women receive high-quality reproductive health care that adheres to ACOG guidelines is important in Ohio because reducing health disparities and increasing health equity is of critical importance. According to the Guttmacher Institute, 524,810 non-Hispanic white women, 146,910 non-Hispanic Black women, and 38,110 Hispanic women in Ohio were likely in need of public support for contraceptive services and supplies in 2016. There were 394,490 non-Hispanic white women, 120,720 non-Hispanic Black women, and 30,480 Hispanic women aged 20-44 and below 250% of the federal poverty level who likely need public support for contraceptive services and supplies.

Unfortunately, Ohio has residents who are uninsured, do not receive care from a doctor, and/or live in poverty. According to the Kaiser Family Foundation, 7% of women ages 15-49 were uninsured in Ohio in 2020. 16% of Black women in Ohio, ages 18 and older, did not see a doctor in the prior 12 months due to cost in 2019, followed by 14% of Hispanic women, and 12% of white women. 29% of Hispanic women in Ohio, ages 18 and older, do not have a

personal doctor or healthcare provider in Ohio, followed by 22% of Black women, and 13% of white women.[8] Additionally, 27.3% of the Black or African American Ohio population was below the poverty level in 2019, compared to 10.4% of the white Ohio population. Nationwide, the Black or African American population below the poverty level was lower than Ohio at 21.2%, whereas the white population below the federal poverty level was nearly equal at 10.3%. 14.3% of the female population and 11.7% of the male population in Ohio was below the poverty level. Both were higher than the national levels, 13.5% and 11.1% respectively.

During SFY21, the RHWP has conducted many activities to help meet this goal. For example, quarterly newsletters were created and sent to Title X clinic physicians, nurse practitioners, and nurses containing clinical updates and recommendations by national organizations such as ACOG. To illustrate, in the July 2021 newsletter, one article focused on ACOG well-woman exam recommendations for a patient's initial reproductive health visits. Additionally, the RHWP Title X Clinical Services and Protocol Manual was updated and sent to all Title X clinics. This book of clinical policies and procedures is based on national standards of care set forth by medical organizations such as ACOG. Furthermore, the RHWP medical consultant provided a lecture 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. Over 100 healthcare providers attended this learning session. Lastly, RHWP program consultants review encounter level data to ensure patient visits are following Title X and ACOG standards of care. At Ohio Title X clinics, there has been a 13.5% increase in well-woman annual comprehensive exams from SFY20 to SFY21. Over the same time period, there has been a 4.7% increase in the number of pap smears conducted at annual comprehensive well-woman exams.

The Maternal and Child Health Program (MP Program) funds three main strategies focused on 1) Preconception and Inter-conception Care for Women's Health, 2) Peer Support Person-Centered Wellness, and 3) Adolescent Health Evidence-Based Resiliency. The first strategy focused on Preconception and Inter-conception Care for Women's Health provides funding to subrecipients to support the health and well-being of women ages 18-44 before they get pregnant and between pregnancies. The goals of this strategy are to (1) Reduce maternal morbidity and mortality by increasing equitable access to women well visits and preventative health services to women ages 18-44; (2) Increase the value of preconception health through education and awareness to women ages 18-44; and (3) Increase the capacity of local public health systems to support partnerships that address social determinants impacting preconception health services.

To decrease risk factors for maternal morbidity in Ohio, it is important to increase access and uptake of well-woman visits and other vital preconception and inter-conception health services. The percentage of women with a live birth who had one or more chronic conditions during pregnancy has increased annually since 2016 (OPAS, 2016-2010). Additionally, only about 70% of Ohio women with a live birth reported attending a health care visit in the 12 months prior to their pregnancy (OPAS, 2016-2020). Non-Hispanic Black women are consistently disparately impacted by chronic conditions and likewise access preventative care less compared to non-Hispanic white women (OPAS, 2016-2020). Consequently, non-Hispanic Black women in Ohio are two and a half times more likely to die from pregnancy related conditions (PAMR, 2018). Thus, increasing access and uptake of well-woman visits and other vital preconception and inter-conception health services is essential to improving health outcomes for Ohio's women.

The Preconception and Inter-conception Care objective of the MP Program started in FY21, funded 18 entities across 18 counties in Ohio to increase the percent of women with a preventative medical visit through FY24, and utilized Title V Block Grant funding. In FY21, each entity conducted a health and environmental scan to explore gaps, opportunities, and challenges for clinical and social service providers who support preconception and inter-conception health for women ages 18-44. These health and environmental scans were tailored to each community and therefore incorporate the voices of those living within those communities. Each entity utilized REDCap to

document their health and environmental scans. The final results of these surveys are still being evaluated. The 18 funded entities are utilizing the findings to design interventions to improve the quality, access, and delivery of preconception and inter-conception services in their respective communities. These interventions also include addressing social determinants that create barriers for women to lead optimal lives. They are utilizing community-specific findings to implement culturally relevant community, clinical, or community-based services to address unique pre- and inter-conception issues for women 18-44 and implement education and awareness for pre-conception and reproductive health targeting high-risk women. These interventions are to be designed, implemented, and evaluated over the next two years of the grant program.

Related to preventative health visits and collaboration with providers, the Ohio Department of Health Oral Health Program (OHP) oversees statewide efforts to improve oral health and access to dental care for all Ohioans. The Program oversees and funds prevention and treatment activities statewide through community efforts including but not limited to community water fluoridation, safety net dental clinics, integration of oral health into early childhood health and education programs and school-based oral health programs.

The OHP is working to distribute guidelines on managing oral health care during pregnancy to perinatal and dental care providers. Managing oral health care during pregnancy is important because poor oral health can lead to poor health outcomes for the mother and her baby. Up to 75% of women develop gingivitis during pregnancy due primarily to hormonal changes. Left unchecked, gingivitis can progress to periodontal disease which affects up to 40% of all pregnant women. Women are also at risk for tooth decay during pregnancy due to changes in eating habits, frequent bouts of morning sickness and possibly less attention being paid to their oral hygiene practices.

Two agencies, Nationwide Children's Hospital and Columbus Neighborhood Health Centers, both located in Columbus, received Title V MCH Block Grant funding for the Integration of Oral Health into Prenatal Care grant which began on April 1, 2021. Guidelines for prenatal and dental care providers on managing oral health during pregnancy have been integrated into this grant. During the first six months of the grant program, 33 prenatal care providers completed training on oral health and pregnancy, 339 pregnant women with dental needs were referred for dental care and 115 women have completed dental care. Additionally, Title V Block Grant funds have been awarded to three agencies/health care systems to provide oral health services to uninsured MCH population from low-income families, which will help to impact this strategy. Funded agencies are Cincinnati Health Department, Columbus Neighborhood Health Centers, and Mercy Health Youngstown. During fiscal year 2021, 2,130 unduplicated MCH clients were served through this program. 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. ODH is continuing to work with Communications staff to produce the online training.

The OHP is working to 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) through the Oral Health Care and Primary Care Learning Collaborative. Integrating oral health education, assessment and referrals for dental care into community-based health care systems that serve women of reproductive age is important because maternal oral health can affect infant oral health. Babies are not born with the bacteria that causes tooth decay. These bacteria are transmitted, usually by the mother, through saliva-sharing activities such as kissing, the use of shared utensils or other common behaviors. Oral health interventions targeting women before, during and after pregnancy can help prevent or reduce the risk of dental caries in their children.

Ohio is one of nine states selected to participate in the Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership project. The focus of the project is to integrate oral health risk assessment and evaluation, education, and navigation for oral health care into primary care practice in a community health center (CHC). The Oral Health Program is currently in the process of selecting one CHC that provides both prenatal and

oral health services to participate in the learning collaborative. The project will be implemented from January 2022 through March 2024 and is being led by the National Maternal and Child Oral Health Resource Center, in collaboration with the Association of State and Territorial Dental Directors and the Dental Quality Alliance. In addition, experts from the National Network for Oral Health Access will provide technical assistance to the CHC.

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 Council 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.

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, the Ohio Department of Health (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.

All case reviews are complete for 2008 through 2018 and the ODH PAMR program is in the process of developing a report summarizing findings from deaths that occurred in 2017 and 2018. From 2008 to 2017 there were 731 pregnancy-associated deaths in Ohio; 30 percent were pregnant at time of death, 20 percent were pregnant within 42 days of death, and 50 percent were pregnant within 43 to 365 days of death.

- 31% were determined to be pregnancy-related.
- 59% of pregnancy-related deaths were deemed preventable.

In 2019, PAMR was competitively awarded the Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees (CDC-RFA-DP19-1908) and the HRSA State Maternal Health Innovation Program (HRSA-19-107) through September 2024. 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 FY21:

- Ohio Council to Advance Maternal Health (OH-CAMH).
- ODH is working with the Government Resource Center (GRC) to implement the Alliance for Innovation on Maternal Health (AIM) hypertension patient safety bundle in all delivery hospitals across Ohio to reduce preventable hypertension-related maternal morbidity/mortality.
- ODH is working with GRC and the Ohio Chapter of the American Academy of Pediatrics (AAP) to implement this project 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 is to enhance access to a health care provider especially for women who may not otherwise seek care.
- ODH subcontracted with The Ohio State University College of Medicine Clinical Skills Education and Assessment Center (CSEAC) to provide virtual obstetric emergency simulation training to emergency

department staff and first responders to increase their ability to identify, recognize, and treat leading causes of pregnancy-related deaths.

- ODH subcontracted with The Ohio State University College of Medicine Clinical Skills Education and Assessment Center (CSEAC) to provide virtual telehealth delivery simulation training to women's health providers to increase their ability to deliver high-quality, culturally appropriate care to pregnant and post-partum patients.
- ODH has implemented statewide implicit bias training for public health and healthcare providers to increase their ability to recognize the influence of bias on health disparities.
- ODH is focusing implementation of strategies aimed at addressing disparities on populations experiencing the greatest disparities through the Disparities in Maternal Health Community Grant Program. The goal of this grant program is to fund solutions identified by communities and address unmet needs through a disparities-focused, equity-driven lens.

Title V Block Grant funding partially funds the PAMR program staff that manage and evaluate these federally funded initiatives.

Mothers experience substantial health and safety issues, throughout the duration of their pregnancy and after childbirth, including severe maternal morbidity and pregnancy-related death. There were 186 pregnancy-related deaths in Ohio from 2008-2016. The top underlying causes of pregnancy-related death in Ohio include cardiovascular and coronary conditions, infections, hemorrhage, preeclampsia and eclampsia, and cardiomyopathy (Ohio Department of Health, 2019). A review of all pregnancy-related deaths in Ohio from 2012-2016 found that over half of all deaths during this time were potentially preventable (Ohio Department of Health, 2019). Among the pregnancy-related deaths due to preeclampsia or eclampsia, 85% were found to be preventable and 68% were found to occur in the postpartum period (the first 42 days) (Ohio Department of Health, 2019). Preeclampsia is a condition in pregnancy that is characterized by persistent high blood pressure and is a leading cause of maternal and infant illness and death in the US (Preeclampsia Foundation, 2019). In addition, hypertensive diseases of pregnancy, specifically preeclampsia, are leading causes of inpatient severe cardiovascular morbidity and mortality (Hitti, Sienas, Walker, Beneditti, & Easterling, 2018). Black women are disproportionately affected by preeclampsia, display signs of preeclampsia earlier in pregnancy, and are at higher risk of developing preeclampsia related morbidity than white women (Shahul, Tung, Minhaj, Nizamuddin, & Wenger, 2015). To reduce the preventable deaths due to hypertensive diseases of pregnancy, specifically preeclampsia in Ohio, continued targeted interventions at the provider, facilities/hospital level, and system level are needed. The ODH PAMR program has partnered with The Ohio Colleges of Medicine Government Resource Center (GRC), The Ohio State University, MetroHealth Medical Center, The Cleveland Clinic Foundation, University Hospitals, Ohio Hospital Association, Ohio Perinatal Quality Collaborative (OPQC), to reduce the rate of maternal mortality in Ohio by September 2024 through increasing use of AIM safety bundles in healthcare systems for at-risk pregnant women.

During the FY 21, the first implementation phase focused on the implementation of the Maternal Safety: Best Practices in Hypertension toolkit in each of the participating 34 delivery hospitals throughout Ohio. Action Period (AP) calls have focused on reviewing each of the four domains in the hypertension patient safety bundle (Readiness, Recognition, Response, and Reporting) and relating them to potential interventions on the project Key Driver Diagram (KDD). Participating delivery hospitals have been engaged in QI coaching calls to examine the current state of their organization's implementation of the hypertension patient safety bundle, establishing specific goals for each organization in the project based on the identified project SMART aims.

GRC and the subject matter experts (SMEs) utilized the AP calls to train participating sites on best practices for implementing the AIM HTN bundle. In addition to the monthly AP calls, a series of educational modules were developed by a subcommittee of clinical advisors. These modules serve as supplemental material intended to

expand upon subjects addressed during the AP calls. Data is collected from participating sites in real time via the secure REDCap form on pregnant and postpartum women who present with a severe hypertensive event and analyzed monthly at the site and aggregate level. The data dashboard is updated on a weekly basis and is accessible to sites in real time. GRC and the AIM HTN QIP Project Team continue to use a set of process, outcome, and balancing measures to measure project success. A mean of 63% of patients were scheduled for a follow-up appointment within 10 days, up from 43% at baseline. Other aggregate process and outcome data is pending review for this QIP and will be available at a later date.

Additionally, GRC considered the health equity gap, specifically focusing on the disproportionate effect of maternal mortality on black women and has identified ways to stratify measures to track disparities. The AIM HTN QIP has established a Health Equity Subcommittee which meets bi-weekly to plan and implement interventions related to reducing disparities in maternal morbidity and mortality with hypertension. The Health Equity Subcommittee created and implemented a Staff Equity Survey across all Wave 1 participating sites from early November 2020 through early January 2021. The topics covered on the survey included: 1) Health Outcome Knowledge 2) Discussions with patients on socioeconomic/racial disparities 3) Implicit bias or anti-racism training 4) Health Equity challenges 5) Shared Decision-making Approach and 6) General Demographics. The vast majority of respondents were white (83.3%), with other responses including Asian (2.7%), Black (2.4%), Other (2.1%), or unknown/no response (9.5%). Similarly, a majority of respondents reported being non-Hispanic (79.1%). Based on the results from the various sections of the Staff Equity Survey, the Health Equity Subcommittee has made the priority to focus on providing Implicit Bias/Anti-Racism training to all participating hospitals

GRC has worked to identify each participating site's current state of implementation of the AIM HTN patient safety bundle and established specific goals for each site based on the identified project measures and SMART aims. In FY22, GRC will administer a survey to assess knowledge/awareness, skill in treating women who present during pregnancy or postpartum with a hypertensive event, self-efficacy in treating the target patient population, and behaviors/ practices that led to improvement. This survey will subsequently be repeated during the sustainment period in future funding cycles.

At this time, GRC has begun to engage ODH and SMEs in planning discussions for statewide spread. Spread activities are being built on lessons learned from Wave 1 and consider geographic location of hospital in Ohio, levels of care, and unique patient population challenges. The spread plan incorporates a focus on equity, and includes the number of target sites for recruitment, a recruitment timeline, a finalized scope of work for spread activities, and two additional unique waves of site engagement. Additionally, the project team will refine the project SMART aims, KDD, and refine measures specific to spread activities that can be used for real time rapid cycle data feedback in spread sites.

GRC will also develop a plan to spread and implement the AIM HTN Bundle QIP with Wave 3 of delivery hospitals who have not previously implemented the bundle or effectively addressed maternal safety. GRC will continue coordinating the team of clinical experts and leadership teams from each site to contribute to the implementation of the AIM HTN Bundle. Like Waves 1 and 2, Wave 3 will need early site engagement to ensure the success of the spread activities.

Next steps for the Health Equity Subcommittee include administration of a Patient Equity Survey that will return results from all participating hospitals from the patient perspective. Based on the results of this survey with the staff survey results and OPAS data, the subcommittee will make recommendations to the QIP for disparity focused action-oriented interventions to implement alongside current testing taking place at the participating sites.

Risk factors among 2018 infant deaths in Ohio revealed that 42% of infants were conceived less than 18 months after a prior birth; 20% of mothers smoked during their first trimester of pregnancy; and 40% of mothers did not have first-trimester prenatal care2. Among women with Medicaid, 26% and 36% reported pre-pregnancy depression and anxiety, respectively. The effect of these high-risk health behaviors and access to care on future pregnancies urges the need to provide medical care for women of childbearing age during the interconception period. By the time a woman begins prenatal care, it is often too late to modify many of the high-risk health behaviors associated with poor birth outcomes. Studies have shown that mothers regularly attend their child's health care visits and are highly receptive to health advice at well-child visits. Through focusing on interconception health through screenings and interventions for birth mothers during well child visits 0-18 months, this QIP aims to address health behaviors and access to care that affect maternal and infant health in Ohio.

Healthy Mom, Healthy Family is a QIP designed to impact maternal and infant health and is sponsored by the ODH and administered by GRC in partnership with Ohio Chapter-American Academy of Pediatrics (OhioAAP) and March of Dimes. Healthy Mom, Healthy Family is based on the national network model: Interventions to Minimize Preterm and Low Birth Weight through Continuous Improvement Techniques (IMPLICIT) Interconception Care (ICC). Healthy Mom, Healthy Family seeks to improve interconception care for women of reproductive age to reduce risk factors that might impact future pregnancies and long-term health of mothers in Ohio by September 2024 by increasing women's health screenings during pediatric well visits**.** The interconception health of birth mothers of patients in participating pediatric sites is assessed through a series of interventions during well child visits 0-18 months. These interventions will engage mothers through a series of discussions with their child's pediatrician on four high-risk behaviors during interconception: tobacco usage, multivitamin usage, depression and anxiety, and healthy birth spacing. Through these interventions, Healthy Mom, Healthy Family will provide mothers with a forum to discuss healthy behaviors, receive health screenings and education, as well as resources to connect with primary care providers or health specialists to seek appropriate health care.

Eleven pediatric practices were actively engaged with the QIP in FY21. QI and data/research progress included analyzing submitted data collection forms by practice and aggregate, data collection form submissions, finalization of change package, education materials, patient materials in Arabic, Somali, Mandarin and Spanish, provider quick reference guide, practice cover sheet, final evaluation outline, data collection form, training video on completing data collection form, REDCap portal, pre/baseline data survey, data linkage manual, data dictionary, data variables, data measures sampling frame, workflow, recruitment materials, pre-implementation survey, patient screening note, recruitment registry, and registration survey. Recruitment for Wave 2 has been initiated and will continue through FY22. Regular meetings with project partners and sponsor occurred bi-weekly and with project clinicians- monthly. In FY 21, participating sites performed depression/anxiety screenings on 93.8% of patients, tobacco use screenings on 94.3% of patients, multivitamin use screenings on 94% of patients, and family planning screening on 91% of patients. Referrals and educational materials were provided to patients screening positive.

Site engagement in FY21 was low, with several sites not submitting regular monthly data and/or participating in the monthly Action Planning (AP)calls. Sites have been contacted individually following absences at AP calls to explain absences and receive the educational recordings. Engagement has been discussed with sites during quarterly coaching calls. Sites have been polled on availability to attend future AP calls. A monthly newsletter highlighting data including reminders to submit data is being sent to sites.

In FY 22, GRC will continue to analyze collected data and use data to work with practices on PDSA cycles and implement plan for recruitment of Wave 2 sites. The online resource and participant dashboard will continue to be updated with final materials and Action Period call recordings. The Ohio AAP and clinical lead will continue to join bi-weekly calls to review materials, report on progress toward full practice participation, and provide feedback. The clinical team will meet via webinar (date TBD due to conflicts) for further discussion and feedback on project

activities, data collection, PDSAs, and Action Period training webinars. Wave 2 recruitment will be continued, including distribution of marketing materials, and following the actions of the marketing plan.

The Ohio Council to Advance Maternal Health (OH-CAMH) was established as Ohio's Maternal Health Task Force to fulfill the requirements of the Health Resources Services Administration (HRSA) State Maternal Health Innovation (MHI) Program grant, which was awarded to ODH in 2019. Through the State MHI Program grant, HRSA and ODH seek to reduce the increasing rates of preventable maternal mortality and severe maternal morbidity (SMM). Each state in the MHI Program is expected to convene a task force to identify state-specific gaps and assist in the development of a state-focused strategic plan. There are currently almost 200 individuals across 80 organizations in OH-CAMH. OH-CAMH has successfully built trust and lasting relationships with individuals from over 80 organizations across the state since June 2020. At least 50% of OH-CAMH membership has attended each OH-CAMH meeting to date.

Over FY21, OH-CAMH had a total of four general OH-CAMH membership meetings were held. The November 2020 meeting was focused on co-creating the OH-CAMH Charter, a document meant to provide guidance and structure to this new group. OH-CAMH is intentionally rooted and guided by the experiences of those impacted by maternal morbidity and mortality. The basis of the OH-CAMH Strategic Plan are the voices of those who it seeks to represent. Thus, during the February 2021 Meeting, we shared additional ways OH-CAMH membership survey, one-on-one stakeholder meeting, and Title V Needs Assessment data was used to develop the OH-CAMH Needs Assessment and called on OH-CAMH membership to volunteer to participate in the OH-CAMH Strategic Plan Workgroup to refine and prioritize the OH-CAMH Needs Assessment into the statewide strategic maternal health plan (OH-CAMH Strategic Plan). Eleven draft strategies were identified through discussions with the Workgroup and through the Needs Assessment process and are included in the first draft of the OH-CAMH Strategic Plan. The first version of the strategic plan was shared with the rest of OH-CAMH during the June 2021 meeting. The draft OH-CAMH Strategic Plan is still under review by ODH leadership and will be shared publicly once approved. To put the draft Strategic Plan into action, 11 OH-CAMH implementation teams (one team for each draft strategy) were formed. Each team is led by volunteer OH-CAMH members and is composed of multiple OH-CAMH members from varying fields of expertise and experience. During the September 2021 OH-CAMH meeting, OH-CAMH implementation team leads introduced themselves to the rest of OH-CAMH and asked if other individuals would like to join their teams.

Throughout FY22, each of the 11 implementation teams has been tasked with completing initial implementation steps, such as building their team, assessing membership gaps, and developing an implementation plan. Team leads will then share their progress with the rest of OH-CAMH at the next general membership meeting on February 23, 2022. Planning and implementation will continue throughout the duration of FY22 with TA provided by ODH PAMR staff as needed.

One in three pregnancy-related deaths occur one week to one year after delivery. Hemorrhage, hypertensive disorders of pregnancy, and infection are the leading causes of death during the first six days postpartum (Davis, Smoots, & Goodman, 2019). In Ohio, 46% of pregnancy related mortality occurs in the early postpartum period (the first 42 days) and 19% from days 43-365 (Davis, Smoots, & Goodman, 2019). Every woman who gives birth has the potential to experience a postpartum complication, and women who are educated on the specific urgent maternal warning signs and symptoms of the leading causes of maternal morbidity and mortality may act more quickly to seek care and receive more timely and appropriate interventions.
There are groups of mothers who are more likely to experience adverse events, including those who are of advanced maternal age, who are enrolled in Medicaid or uninsured, or who are Hispanic or non-Hispanic Black (Ohio Department of Health, 2017). From 2008-2016, Ohio women died from pregnancy-related causes at a rate of 14.7

per 100,000 live births, with Black women disproportionately affected at a rate 2.5 times greater than white women (Ohio Department of Health, 2019). This difference has not changed for the past six decades (Maternal Health Task Force, n.d.). Black women are disproportionately affected by preeclampsia, display signs of preeclampsia earlier in pregnancy, and are at higher risk of developing preeclampsia related morbidity than white women (Shahul, Tung, Minhaj, Nizamuddin, & Wenger, 2015).

To reduce the preventable deaths due to hypertensive diseases of pregnancy, specifically preeclampsia in Ohio, targeted interventions at the provider, facilities/hospital level, and system level are needed. ODH is using HRSA MHI funds to increase the percent of pregnant and postpartum women who receive urgent maternal warning signs (UMWS) education in WIC and Home Visiting programs through this QIP. Sponsored by ODH and administered by the GRC in partnership with The Ohio State University's Wexner Medical Center and College of Social Work, the UMWS QIP aims to increase knowledge of and improve health outcomes among women at risk for an adverse event related to hypertensive events in the prenatal and postpartum period.

Twenty-six out of 74 WIC sites in Ohio participated in Wave 1 of the UMWS QIP in FY21. These 26 sites spanned 4 counties in Ohio. Out of the 5,087 patient encounters, 93.6% were provided both verbal and written education on UMWS, 97% were provided written education on UMWS, and 96% were provided verbal education on UMWS.

During FY 22, GRC will continue distribution of education material throughout Wave 1 sites and begin onboarding remaining Ohio WIC sites into Wave 2. Project evaluation will also continue, and pre-/post-test knowledge surveys administered to WIC employees will be used to measure change over time. GRC will also begin to plan for implementation in other public health settings in Ohio, such as Home Visiting.

Emergency medicine staff and first responders are often the experts women turn to when they are experiencing acute distress during and after pregnancy. Data from the ODH Pregnancy-Associated Mortality Review program revealed that 23% of pregnancy-related deaths in Ohio from 2008-2016 occurred in an emergency department or in an outpatient setting and 41% of pregnancy-related deaths in Ohio from 2010-2016 involved a maternal transport. Despite this data, a needs assessment of Ohio's delivery hospitals found that only 30% of obstetric emergency simulations involve emergency department staff. ODH has partnered with the Clinical Skills Education and Assessment Center (CSEAC) at The Ohio State University's College of Medicine to develop and deliver simulation trainings for emergency medicine physicians, physician assistants, nurse practitioners, nurses, and first responders to recognize, triage, and treat obstetric emergencies. Training content includes but is not limited to identification, treatment and management of hemorrhage, hypertension, cardiac conditions with pregnant and postpartum patients. The CSEAC has also developed Train-the-Trainer sessions offered to emergency medicine physicians and nurse educators throughout Ohio to learn how to facilitate low cost, low fidelity obstetric emergency simulation scenarios at their home hospitals. Participants can win a MamaNatalie Birthing Simulator for their home hospitals to train their emergency department staff on obstetric emergencies.

In FY 21, the CSEAC created and delivered two types of trainings – direct simulation education and train-the-trainer. Three simulation cases were developed for the direct simulation education training focused on topics identified in PAMR data as maternal health emergencies that contributed to maternal mortality throughout Ohio. The topics were post-partum hemorrhage, pre-eclampsia, and cardiomyopathy. Throughout the delivery of the trainings, small adjustments to improve the cases for use in both the direct training and the train the trainer sessions were made based on evaluation data. The project planning team closely works with the audience they are building training content for to ensure it is relevant, applicable, and useful. The project planning team conducted needs assessment surveys of the target audiences often and utilized training participant evaluations to constant improve training delivery and content. Additionally, an Emergency Medicine physician and an emergency department nurse are both active leaders in the project planning team. They utilize their past and current experience of working in the emergency

department to inform all curriculum development.

Over the course of the last year, a total of 9 trainings for this project (6 Direct Training Sessions and 3 Train the Trainer sessions) were delivered. In total, 123 attendees participated in all 9 trainings. across all sessions. Training outcomes among past participants to date include a significant increase in knowledge related to identification, treatment and management of postpartum hemorrhage, hypertensive emergency, peripartum cardiomyopathy, resuscitation on a pregnant patient, self-efficacy in managing/caring for obstetrical cases, confidence in their ability to perform life-saving clinical skills, including how to quantify blood loss, perform CPR on a pregnant patient, and use of intrauterine tamponade balloon. Additionally, participants reported that they highly intend to use what they learned in the training back at their job. As a result of the train-the-trainer sessions, participants developed and implemented new tools because of knowledge they gained from the training, such as a debriefing tool, simulation tips, high-fidelity obstetric emergency simulations, and an educational obstetric bundle that includes simulation for ER nursing staff related to obstetrical emergencies

The need to be agile and adaptable due to the COVID-19 pandemic was the largest challenge for getting this project off the ground in the past year. The pandemic impacted staffing and required trainings to remain virtual. CSEAC's team developed a Remote Experiential Simulation (RES) tool that allows us to deliver simulation activities via Zoom. This was instrumental to our ability to shift these trainings into a remote format to meet the restrictions in place due to COVID-19.

In FY 22, CSEAX will continue delivering training sessions, collecting attendee responses, and analyzing aggregate data. Training offerings will expand to include new target audiences, including state level professional groups (Ohio Emergency Nurses Association) first responders, and trainee groups (emergency medicine residency programs). Additionally, a point of increasing focus will be seeking out opportunities to present and/or publish on work at the local, state, and national levels.

The ODH PAMR program has identified disparities, poor access to care, and sub-optimal care coordination as key contributors to maternal mortality in Ohio. We also know that while more than 90% of Ohio women live within 50 miles of an obstetric critical care hospital, women living in areas of southeast, Appalachian, Ohio lack this access. Additionally, the COVID-19 pandemic has proven that telehealth is a needed service for all patient populations. This holds true especially when considering access to vital peripartum services for women in Ohio. Telehealth is a valuable strategy in addressing these issues. ODH has partnered with the Upper Midwest Telehealth Resource Center and the CSEAC to develop free, interactive, virtual simulation training opportunities aimed training maternal health care providers on how to conduct effective telehealth encounters.

A needs assessment survey was conducted among women's health providers, including residents, medical students, advanced practice practitioners, and WIC health professionals to learn:

- Learn the method of communication women's health professionals throughout Ohio were providing services to their clients since COVID-19 has necessitated virtual care.
- Gauge interest in tailored training focused around telehealth delivery training
- Learn about content-specific needs of women's health professionals to aid in training development.

Results from this needs assessment indicated that more providers are utilizing telehealth to deliver care than they were prior to the COVID-19 pandemic, and that there was a need for training to enhance providers' skills and knowledge related to providing care virtually.
In FY21, CSEAC and UMTRC created tailored trainings for specific target audiences to make the trainings more interesting and compelling. A significant amount of outreach to various professional groups was executed to determine the professional groups with the most need and interest. The three main groups who indicated interest

and need for telehealth training was OB/GYN residents, Family Medicine residents, and Ohio WIC health professionals. The planning committee created new curriculum based on the specific needs of each audience. The project planning team closely worked with the audiences they built training content for to ensure it was relevant, applicable, and useful. The project planning team conducted needs assessment surveys of the target audiences often and utilizes training participant evaluations to constant improve training delivery and content.

Overall, the project team delivered 11 trainings to a total of 173 attendees in FY21. Training outcomes among past participants to date include a significant increase in:

- Knowledge related to telehealth best practices.
- Self-efficacy scores related to confidence in conducting telehealth visits.
- Perceived skills in conducting telehealth visits.

Additionally, results suggest that trainees highly value the training, learn, and retain knowledge, improve their confidence, and some have reported positive impacts on their jobs.

The COVID-19 pandemic was a tremendous stressor. Navigating the statewide public health restrictions, mitigating risks associated with in-person trainings, managing the impact on the planning team, all while developing and delivering these training continued to be a huge challenge over the past year. To overcome the challenges created by the COVID-19 pandemic, the CSEAC's Standardized Patient (SP) Program worked closely with this project to develop cases, train SP's to engage via Zoom, and to deliver simulated patient encounters via Zoom. Though transitioning these trainings to a fully remote format added a layer of unanticipated complexity to this project, this was instrumental to the project's ability to mitigate risks associated with in-person interaction during the COVID-19 pandemic while providing high-quality trainings.

Approximately 25 additionally trainings will take place between FY 22 and FY 24. Over the next year, the project team will continue delivering and evaluating trainings for OB/GYN and Family Medicine residents and medical students. The project team is also in the process of partnering with the ODH Reproductive Health and Wellness program (RHWP) to create telehealth training content for women's health providers at Title X clinics throughout Ohio. The ODH RHWP is in the process of applying for a funding opportunity that would equip Title X clinics with technology and infrastructure to increase the ability to provide care via telehealth. This project will help train and prepare Title X providers to deliver high-quality care via telehealth.

Gestational Diabetes Mellitus (GDM) affects an estimated 3 to 9 percent of all pregnancies or 13,000 moms-to-be in Ohio each year. Over 50% of women who have GDM during pregnancy will develop type 2 diabetes (T2DM) before their child is 10 years old. By getting active, losing weight, and eating healthy, women can prevent or delay their chances of getting T2DM. It is important for women with a history of GDM to talk to their healthcare provider about what they can do to prevent T2DM and get tested for it after their delivery. But we know that the transition from pregnancy to primary care for women does not happen as often as it should. Chronic disease screening is seen as the role of the primary care provider (PCP), not an OB/GYN. For women who utilize their OB/GYN as their PCP, there are often missed opportunities for screening for chronic diseases such as type T2DM. Getting OB/GYNs to help provide a 'warm hand off' to primary care after a GDM pregnancy and getting PCPs to 'assess history of GDM' to prompt them to test for T2DM, would result in meeting recommendations for type 2 diabetes screening after a GDM pregnancy.

The Ohio GDM Collaborative aims to increase the number of women who receive postpartum testing and education for T2DM, so health risks are addressed early and effectively. The Office of Health Improvement and Wellness and the Bureau of Health Promotion form the Ohio Department of Health's (ODH) Ohio (GDM) Collaborative. Ohio

Medicaid is an additional partner. The group is a unique collaboration between chronic disease and maternal child health with the over-arching goal to prevent or delay the onset of T2DM in women who have a history of GDM. The team formed in the spring of 2010 when ODH competitively applied and was selected to participate in a national, year-long learning collaborative administered by Centers for Disease Control and Prevention (CDC), Association of Maternal and Child Health Programs (AMCHP), and the National Association of Chronic Disease Directors (NACDD). An extensive series of focus groups were conducted to find out the general knowledge and attitudes about GDM among women in Ohio. Information learned from these focus groups informed the creation of the education and programming with Ohio GDM Learning Collaborative. The team has worked to improve preventive healthcare provision in Ohio in accordance with national guidelines, increase the public's knowledge about gestational diabetes, reduce the T2DM risk, and increasing access to preventive care. In addition, it has worked to improve the understanding of the epidemiology of gestational diabetes in Ohio by increasing the availability, use and dissemination of public health data. These activities led to planning the quality improvement initiative with the Government Resource Center (GRC) with a focus on increasing attendance of the postpartum visit and postpartum testing rates for T2DM.

The first 5 waves of the Gestational Diabetes QIP 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 QIP implementation will come to an end between Q2 and Q3 of SFY22. A new QI project titled, "Women's Behavioral Health Learning Collaborative" will use lessons learned from the Gestational Diabetes project will be initiated in SFY22 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). Title V Block Grant funding partially funds the staff that manage and evaluate the GDM and Women's Behavioral Health Learning Collaborative.

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

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 systematic data into action.

The Data and Surveillance section exists within the Bureau of Maternal, Child, and Family Health at ODH to support data, evaluation, surveillance, and monitoring needs of programs within the Bureau. The Data and Surveillance section is composed of epidemiologists, researchers, health policy analysts, and program managers. The following programs sit within the Data and Surveillance section:

- Child Fatality Review (CFR)
- Fetal Infant Mortality Review (FIMR)
- Ohio Medicaid Assessment Survey (OMAS)
- Ohio Pregnancy Assessment Survey (OPAS)
- Ohio Study of Associated Risks of Stillbirth (SOARS)

- Pregnancy-Associated Mortality Review (PAMR)
- Shaken Baby Syndrome Education Program (SBS)
- Sudden Infant Death Syndrome (SIDS) Program
- Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)

These programs serve as valuable data sources that inform programmatic work throughout the Bureau and Department as a whole. These data sources and the Title V Block Grant funded staff that work within the Data and Surveillance section are working to develop expanded maternal health surveillance to allow for adequate monitoring and tracking to inform programmatic interventions, including COVID-19 in Maternal Populations Surveillance, Maternal Morbidity Surveillance, Maternal Substance Use Disorder Surveillance and Developing Protocols for Systematic Data into Action.

According to the CDC, people with COVID-19 during pregnancy are more likely to experience preterm birth (delivering the baby earlier than 37 weeks) and stillbirth and might be more likely to have other pregnancy complications compared to people without COVID-19 during pregnancy. In FY21, Data and Surveillance staff continued to leverage current BMCFH related surveillance activities to expand data collections for COVID-19 for maternal population to collect additional data on how COVID-19 is impacting Ohio's MCH population. They continued doing so by utilizing the amended 2020 Ohio Pregnancy Assessment Survey (OPAS; Ohio's PRAMS-like survey) and the 2020 Ohio Study of Associated Risks of Stillbirth (SOARS) questionnaires that include 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 utilized the CDC 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, adverse fetal and birth outcomes of infants born to mothers with SARS-CoV-2 infection, and frequency and risk factors for neonates testing positive for SARS-CoV-2 infection. ODH utilized modified fields within the Ohio Disease Reporting System (ODRS) to capture information within the pregnancy module and create files for export to CDC's Data Collation and Integration for Public Health Event Response (DCIPHER) platform.

Staff also continued performing a retrospective data linkage using the ODRS and Vital Statistics (VS) data, including birth and death certificates. Through this linkage, staff quantified the missingness, and accuracy (sensitivity, (predictive value positive and predictive value negative) of the pregnancy variable. Using the linked ODRS and VS data, BMCFH Epidemiology staff examined 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.

Data and Surveillance staff used these enhanced data collection activities to assess health-related outcomes of mothers and infants among COVID-19 affected pregnancies. A preliminary document was created and submitted for ODH Communications review and approval. This document is still under review and has not been released publicly yet. This document is a preliminary examination of completed pregnancies from ODH Vital Statistics (VS) records that have been linked to confirmed cases of COVID-19 in the Ohio Disease Reporting System (ODRS). These linked cases will be referred to as pregnancy-related COVID-19 infections (PRIs). The data examined is current as of March 2, 2021, when the most recent linking of VS and ODRS data was performed and includes completed pregnancies from March 2020 through February 2021. This preliminary analysis only includes completed

pregnancies that resulted in a live birth and were linked to PRIs that occurred during 2020 (N=3,798). It does not at this time include records of completed pregnancies that resulted in fetal death (n=26), but this data will be analyzed later in 2021 to maximize the available sample size for analysis. Live births linked to PRIs that occurred in 2021 (n=585) were also excluded to better align with the Centers for Disease Control and Prevention's (CDC's) sampling method and ODH data submissions to CDC. PRIs that occurred in 2021 will be analyzed for the next CDC submission.

Data and Surveillance staff will continue to leverage current BMCFH related surveillance activities to collect additional data on how COVID-19 is impacting Ohio's MCH population throughout FY22.

Severe maternal morbidities (SMM) are unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health (Kilpatrick 2016). SMM is measured by identifying women with at least 1 of 19 medical conditions while hospitalized for a delivery. Maternal mortality rates receive significant public attention in discussions of maternal health, yet SMM occurs nearly 100 times more frequently than maternal deaths (Callaghan 2012), and represents a "near miss", or an unplanned event that doesn't result in death, but could have. Because SMM is closely related to maternal death and occurs much more frequently, examination of SMM provides important data on pregnancy-related risk and population health. Understanding the incidence of severe maternal morbidity enhances Ohio's ability to implement programs that improve maternal health and prevent maternal deaths. Over the past year, ODH's PAMR program staff used de-identified hospital discharge records from the Ohio Hospital Association (OHA) to analyze Severe Maternal Morbidity (SMM) incidence in Ohio and perform enhanced surveillance of maternal morbidity. These data represent approximately 98% of hospital-based births in Ohio and exclude non-hospital births and births occurring in military facilities or other states. Births to out-of-state residents are also excluded from the SMM estimates.

The ODH PAMR program successfully created and published a report on severe maternal morbidity racial disparities in Ohio from 2016-2019 in FY21. From 2016-2019, the number of SMM events were greatest for non-Hispanic white women (n=2009), and non-Hispanic white women also had the most deliveries (n=359,546). During this period, SMM events were highest for deliveries to women between the ages of 30-34 (n=1,044). However, the highest number of deliveries were to women aged 24-29, with 18,165 more deliveries to women aged 24-29 than to women aged 30-34. Similarly, SMM events were highest for deliveries to women with Medicaid (n=1,870), but there were 46,567 more deliveries to women with private insurance than to women with Medicaid. Women in metropolitan areas had the highest number of SMM events (n=2,316), and the highest number of deliveries (n=296,315). Nationally, risk factors for SMM are highest for women ages 35–44, Black women, women without insurance, and women in southern states (Robbins 2018). Ohio trends are comparable to the United States in SMM rates by race/ethnicity, age, type of health insurance, and region.

Since the Ohio Hospital Association (OHA) is the agency that collects maternal morbidity data from Ohio hospitals that is used for enhanced surveillance for maternal morbidity, ODH will continue to foster a collaborative relationship with OHA. The ODH PAMR will develop a plan to continue enhanced surveillance of SMM. Additionally, the ODH PAMR program will continue to share this data with key stakeholders throughout Ohio and encourage programming to target populations and drivers of SMM.

In 2019, Ohio ranked third highest in the nation for drug overdose deaths with a rate of 38.3 per 100,000 and fourth in the number of overdose deaths (n=4,251) (Drug Overdose Mortality by State, 2021). This represents a 7% increase from 2018 to 2019. The highest rates of unintentional overdose deaths among women were among non-Hispanic white females. In 2018, non-Hispanic Black females had the largest increase, particularly non-Hispanic Black females of reproductive age which increased by 407.7% between 2013 and 2018. The trend towards overdoses occurring during reproductive age can have severe consequences for both mother and baby. Substance use during

reproductive age can lead to poor outcomes and unintentional consequences, including unintended pregnancy, or pregnancies that are unplanned, unwanted, or mistimed. Substance use during and after pregnancy can also have severe implications for both the mother and baby, including poor physical, mental, and social outcomes.

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. To enhance surveillance of these issues, the ODH Data and Surveillance section matched with a CSTE Applied Epidemiology Fellow for 2020 – 2022. The fellow was employed by ODH through April 2021 completed the following two projects throughout her employment:

- The development of a data book to help inform development of a new perinatal substance use surveillance system in Ohio that will take advantage of multiple existing data sources. This data book includes .
- A qualitative analysis of pregnancy-associated unintentional overdose deaths that occurred between 2008 and 2017 in Ohio. The results of this analysis are in a data brief that is currently under review by ODH Communications. This data brief will be published once approved.

Staffing capacity was a barrier to completing the following activities that were included in the previous FY22 application narrative:

- 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.

Staff capacity to accomplish these activities will be revisited routinely to develop a plan to continue progress on the tasks listed above over the coming year.

BMCFH has numerous programs aimed at improving infant and maternal health outcomes. Bureau leadership is working to encourage programs to use existing data sources to inform programmatic initiatives, establish protocols to make it easier for programs to access new data reports to inform programmatic initiatives, enhance staff understanding of using data to inform programming, and to streamline data sharing and dissemination internally and externally. In FY21, a small workgroup of individuals across various programs convened to being planning to develop protocols to use population and program data to inform programmatic activities. Throughout the planning phase, this workgroup identified an existing workgroup within BMCFH, the Bureau Data Equity Workgroup, and recently made the decision to merge to streamline Bureau level planning and implementation of data to action activities as to reduce duplication of efforts. In FY22, the newly merged workgroup, the BMCFH Title V Bureau Data Team, will work together to develop protocols that promote the use of equitable program and population data to inform program design, activities, administration, evaluation, data analysis, and dissemination to achieve equitable health outcomes among populations of interest.

Priority: Increase mental health support for women of reproductive age

Measures

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.

- NOM 24: Percent of women who experience postpartum depressive symptoms following recent live birth.
    - According to the Ohio Pregnancy Assessment Survey, 15.8% of women with a recent live birth

experienced postpartum depressive symptoms in 2020. This is relatively unchanged since 2016.

- SOM: Percent of women (18-44) with 14 or more mentally distressed days in past month (OMAS)
    - According to the 2019 Ohio Medicaid Assessment Survey (OMAS), 11% of women of reproductive age experienced 14 or more mentally distressed days in the past month. (2021 OMAS data are expected this spring.)
- SPM: Percent of women (18-44) with unmet mental health care or counseling services need in past year (OMAS)
    - According to the 2019 OMAS, 15.5% of reproductive-aged women had unmet mental health or counseling needs. This is an increase from 2017 (9.7%) and 2015 (7.2%). 2021 (OMAS data are expected this spring.)
- ESM: None developed at this time.

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.

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. The following are examples of coordination and referral to increase the update of mental health services.

The OH-CAMH Strategic Plan consists of 11 draft strategies to improve maternal health outcomes in Ohio. Strategy 8 within the OH-CAMH Strategic Plan is focused around maternal mental and behavioral health in Ohio and is co-lead by a BMCFH staff member who is partially funded by the Title V Block Grant. Among other activities, one objective of this implementation team is to work toward improving coordination, referral, and uptake of mental health services for women of reproductive age. In FY21, Strategy 8 worked to build a strong team of stakeholders from across Ohio to accomplish this objective. This team consists of individuals from the Ohio Hospitals Association, community-based organizations, the Ohio Practitioners' Network for Fathers and Families, advocacy organizations, the Ohio Children’s Trust Fund, and the Ohio Association of Community Health Centers. This group will continue to work together throughout FY22 to develop a plan to improving coordination, referral, and uptake of mental health services for women of reproductive age throughout the state. Potential future activities include inviting the Ohio Mental Health and Addiction Services (OhioMHAS) and Ohio Department of Medicaid (ODM) to join the team.

The Sexual Assault and Domestic Violence Prevention Program (SADVPP) works to build trauma informed care into interventions in community-based settings for mental health through a statewide integrated system of sexual violence prevention and intervention strategies that are relevant and culturally sensitive. The SADVPP supports efforts to respond to and prevent domestic violence and human trafficking, and works to reduce and address adverse childhood experiences (ACEs) and trauma with a focus on the role of public health and health care systems.

Being trauma responsive in provision of health care is an important factor in both reducing ACES and mitigating the impact of ACES across the lifespan. The Health Policy Institute of Ohio has linked ACEs to poor health. Exposure to ACEs is a pervasive problem in Ohio, with nearly two-thirds of Ohioans having been exposed to ACEs. Ohioans of color and Ohioans with low incomes, disabilities and/ or who are residents of urban and Appalachian counties are more likely to experience multiple ACEs. Preventing ACEs can improve health. For example, if exposure to ACEs were eliminated in Ohio, an estimated 36% of depression diagnoses could be prevented. Without a trauma

approach, other efforts to reduce negative health outcomes are less effective.

Health center staff are in a unique position to initiate conversations with their patients about healthy relationships and violence, offer universal education on the health impact of intimate partner violence (IPV), human trafficking (HT), and exploitation and promote harm reduction strategies. Especially now during COVID-19 and increased isolation and experiences of abuse, health providers have a critical role to support their patients. Building local partnerships with domestic violence or community-based programs will help facilitate warm bi-directional referrals and promote the short- and long-term safety needs of patients for vulnerable populations.

The work completed for this strategy supports the Public Health Services and System through workforce development, as well as supporting program planning and implementation of policies and procedures in health centers and advocacy organizations to ensure a trauma response to survivors and support meeting the health care needs of survivors. In partnership with the Ohio Association of Community Health Centers and the Ohio Domestic Violence Network, and under the leadership of the national domestic violence technical assistance provider Futures Without Violence, the SADVP program provided trainings for community health centers and domestic violence and human trafficking advocates on trauma-informed care, intimate partner violence and human trafficking. SADVPP staff members in positions partially funded through the MCH Block Grant, were members of the leadership team for this project. All trainings were for three hours each, with a track for staff at community health centers and a track for domestic violence shelter staff or human trafficking advocacy staff. A total of eight trainings were offered among the two cohorts of trainees.

The first cohort of trainings was held in May and June of 2021 with 135 people trained. The second cohort was held in July with 155 people trained. In addition to the trainings, in eight communities where representatives from both the community health centers and one or more victim service agency participated in the training, a “debrief” meeting was held to facilitate discussion among the participants about working together going forward to meet victim needs.

The development of the partnership among the state agencies was itself an important outcome of this project. This project built and strengthened statewide connections which will support on-going efforts in this area of need. Because the project was a component of a national initiative of Futures Without Violence, there was a nine-page evaluation provided for Ohio. Summary from that evaluation including, provision of technical assistance for creation of models for Electronic Health Record integration of IPV and/or trafficking into health center workflow, state capacity created for routine related training, encouragement to all Community Health Centers to have a policy that every patient is seen alone for some part of the visit, participating sites implemented related policies and protocols, began offering related universal education to patients, increased related documentation of harm reduction strategies and referrals, provide sample wording or scripts about what to say when a patient discloses IPV or HT, including safety strategies, provide specific related support and referrals, and have memorandums of understanding with appropriate related local organizations. Sites have additionally addressed staff support and safety, including protocol for what to do if a staff person is experiencing IPV/HT/exploitation, responding to a perpetrator on-site, support for staff around related topics, provision of written information on site, and providing community or client education on related topics. To continue to increase coordination, referral, and uptake of mental health services for women of reproductive age, SADVPP staff are leading an OH-CAMH strategy area to continue building relationships with organizations throughout the state of Ohio and synergize efforts. The work of this strategy team is ongoing and more information will be available as the group continues to convene.

The RHWP continued screenings for mental health and substance abuse and provide referrals through the Title X program in FY21 and will continue working toward this strategy in FY22. Only 47% of adults with mental illness in Ohio receive any form of treatment from either the public system or private providers. The remaining 53% receive no mental health treatment. According to America’s Health Rankings, 22% of Adults in Ohio suffer from depression and

15.3% suffer from frequent mental distress. In addition, there are 37.1 drug related deaths per 100,000 making Ohio the 47th worst state. Self-reported pre-pregnancy, gestational, and postpartum depression in Ohio have increased annually since 2016 (OPAS, 2016-2020) and pregnancy-related deaths related to mental health conditions and substance use disorder are prevalent (PAMR, 2019). Thus, increasing coordination, referral, and uptake of mental health services for women aged 18-44 and increasing mental health support for women of reproductive age is specifically important in the Ohio context.

The RHWP continues to implement best practices regarding screening for mental health and/or addiction issues (e.g., Edinburgh Screening tool, Alcohol Screening Brief Intervention). Every client has a Reproductive Life Plan (RLP) and is screened for mental health needs. If necessary, 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 FY21, Title X clinics increased 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.

In terms of female mental health counseling and referrals, Ohio Title X clinics reported a 76% counseling increase from SFY20 to SFY21 (1,629 vs 2,865) and a 61% referral increase from SFY20 to SFY21 (554 vs 894). Similarly, Ohio Title X clinics reported a 66% increase in female substance abuse referrals during the same time (211 vs 351). The number of RLP discussions also increased by 4.9% (25,232 vs 26,457). While health relationship counseling is not equivalent to mental health screening or referral, relationships may cause stress in a woman's life. Ohio Title X clinics reported a 90% increase from SFY20 to SFY21 (8,691 vs 16,472).

The RHWP also created a new deliverable within the grant application that provides additional funding to Title X clinics that wish to provide enhancements to services to special populations, including individuals with substance use disorder. From October 1, 2020, through September 30, 2021, there were 176 female visits provided to women with substance use disorder through this deliverable. Of all the substance use disorder visits from this deliverable, 41% of visits were provided at a treatment center and the remaining visits were at a Title X clinic (104 offsite, 147 onsite). These efforts will continue throughout FY22. Please see Priority 1, Objective 1 of this section of the report for more information about the RHWP.

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.

The Maternal and Child Health Program (MP Program) funds three main strategies focused on 1) Preconception and Inter-conception Care for Women's Health, 2) Peer Support Person-Centered Wellness, and 3) Adolescent Health Evidence-Based Resiliency. The second strategy focused on Peer Support Person-Centered Wellness provides support for assessing, planning, and implementing peer support systems and screening tools (behavioral and/or physical health) available within a designated target area or region that support pregnant and/or post-partum women within one year of pregnancy. The goals of this strategy are to reduce maternal morbidity and mortality by increasing access, referral, and coordination of mental health services for pregnant and postpartum women 18-44 and increase the capacity of local public health systems to support partnerships that address social determinants impacting

mental health services.

As was mentioned previously in this report, self-reported pre-pregnancy, gestational, and postpartum depression in Ohio have increased annually since 2016 (OPAS, 2016-2020) and pregnancy-related deaths related to mental health conditions and substance use disorder are prevalent (PAMR, 2019). Additionally, data from the Ohio Pregnancy Assessment Survey (OPAS) has shown that self-reported social support during pregnancy among women with a live birth has decreased annually since 2016 (OPAS, 2016-2020). Additionally, pregnancy-related deaths associated with mental health conditions and substance use disorder are prevalent (PAMR, 2019). To decrease risk factors for maternal morbidity in Ohio, it is important to increase access, referral, and coordination of mental health services for pregnant and postpartum women Thus, the MP Peer Support Person-Centered Wellness strategy is using Title V Block Grant funds to support Public Health Services and System infrastructure to increase access and uptake of mental health services on a local level.

In FY21, six subgrantees across 6 different counties in Ohio developed comprehensive plans to implement culturally relevant peer support behavioral health services for high risk pregnant and postpartum women. In FY22, through continued funding from the MP program, grantees will implement their approved plans within their respective communities. The plans developed focused on:

- 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.

These interventions are to be implemented and evaluated through FY23.

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 the Ohio Department of Health. The FASD Steering Committee updates a strategic plan yearly, conducts trainings on FASD prevention, screening, and treatment, and holds an annual forum with the goal of decreasing alcohol use during pregnancy. Professional and public education occur through informational brochures on the risks of drinking alcohol during pregnancy, information dissemination though conferences and hosting vendor tables, and radio and video prevention messaging regarding alcohol in the preconception and pregnancy stages
In FY21 the FASD program implemented a multi-media campaign to increase awareness of the impact of alcohol-exposed pregnancies. The campaign targeted women, Black & Hispanic women ages 14-45 in 35 counties with the highest infant mortality risk. The campaign produced at least 4.3 million impressions. Five FASD trainings were conducted statewide virtually, and fifteen training modules were created through funding from Ohio Department of Mental Health and Addiction Services. The 2022-2027 Ohio FASD steering committee strategic plan was completed and will be implemented starting in FY22. Feedback was solicited from community members and other stakeholders on the draft strategic plan and will include older adult education as they care for kin, and integrate trauma informed and health equity strategies.

The ODH Early Childhood Home Visiting Program, Help Me Grow, administers and supports the implementation of three evidence-based models (Healthy Families America, Nurse Family Partnership, and Parents As Teachers) and one promising-practice model (Moms & Babies First (MBF)). Moms & Babies First, Ohio's Black Infant Vitality

Program, serves pregnant, Black/African American women in communities with the highest rates of infant mortality, and is focused on improving maternal and infant health outcomes and eliminating racial disparity.

Throughout FY21, two ODH staff participated in the Practice and Policy Academy. They served as liaisons and communicated information from the Academy to the ODH Home Visiting team and ODH Ohio Connections for Children with Special Needs (OCCSN, Birth Defects Surveillance program) to inform implementations of plans of safe care**.** 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 and 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. At the November 2021 technical assistance meeting, home visiting staff presented to the communities participating in the pilot. Information about Home Visiting, including the benefits to families, the referral process, and partnership opportunities with local Home Visiting programs was shared. There is no end date for implementation, the Plans of Safe Care work with be ongoing.
As mentioned previously, Healthy Mom, Healthy Family (IMPLICIT Network) was implemented in Ohio. o increase referral and coordination of mental health services for pregnant and postpartum women 18-44, access to services and screening must first be established. Only about 70% of Ohio women reported attending a health care visit in the 12 months prior to their pregnancy, but mothers regularly attend their child's health care visits and are highly receptive to health advice at well-child visits. Through focusing on interconception health through screenings and interventions for birth mothers during well child visits 0-18 months, the Healthy Mom, Healthy Family QIP aims to address increase women's postpartum depression/anxiety screening during pediatric well visits.

Staff from the PAMR program in positions partially funded through the MCH Block Grant manage a contract with GRC and the Ohio AAP to implement a statewide QIP to implement maternal health screenings at well-child visits. This project provides funding to GRC to help service providers at pediatric clinics the process and infrastructure to carry out screening and referrals for mental health needs for pregnant and postpartum women. GRC analyzed submitted data collection forms by practice and aggregate, finalized a change package, education materials, translated patient materials in Arabic, Somali, Mandarin and Spanish, and developed a provider quick reference guide, practice cover sheet, final evaluation outline, data collection form, training video on completing data collection form, REDCap portal, pre/baseline data survey, data linkage manual, data dictionary, data variables, data measures sampling frame, workflow, recruitment materials, pre-implementation survey, patient screening note, recruitment registry and registration survey. In FY21, 11 pediatric practices in 7 counties throughout Ohio have participated in Wave 1 of the project. Participating sites participated in monthly coaching calls and have submitted data to the REDcap data portal developed to evaluate QI metrics related to this project. To date, 94% of participating sites have reported screening pregnant/postpartum women for depression and anxiety at their well-child appointments. 18.1% of those screened positive for having depression/anxiety. Of those that screened positive for depression/anxiety, 30.6% consented to referral to a mental health provider.

Data use agreements (DUAs) are in progress for project sites and completed with ODH and Ohio AAP. Recruitment for Wave 2 has been implemented and will continue over SFY 22 to increase the reach of women's postpartum depression/anxiety screening during pediatric well visits. Please see Priority 1, Objective 2 of this section of the report for more information about the Healthy Mom, Healthy Family project.

Priority: Decrease risk factors associated with preterm birth

Measures

Ohio continues to have high rates of infant mortality, with prematurity as the leading cause of infant death in Ohio. 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 measures efforts contributing to addressing the priority.

- NOM 5: Percent of preterm births (<37 weeks)
    - According to the Ohio Bureau of Vital Statistics resident birth files, 10.3% of births occurred prior to 37 weeks gestation in 2020. This is unchanged from years past. Black infants were more likely to be born preterm (14.2%) compared to white infants (9.4%).
- SPM: Percent of women (18-44) smoking in reproductive age
    - According to the 2020 Behavioral Risk Factor Surveillance System, 21.9% of reproductive-aged women currently smoke. While down slightly from 24.7% in 2016, this prevalence has remained stable since 2018 (hovering around 22%).
- 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.

Over FY21, the Tobacco Use Prevention and Cessation Program and BMCFH initiated a bi-monthly meeting series to re-engage this partnership and identify strategies for addressing smoking use among women of reproductive age. 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
- Reproductive Health and Wellness Program (RHWP)
- Fetal Alcohol Spectrum Disorders (FASD)
- Mother and Child Health Program (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 Perinatal Smoking Cessation Program aims to reduce smoking among Ohio women before, during and after pregnancy and to reduce exposure to second-hand smoke by increasing the adoption, reach and impact of evidence-based behavioral cessation programs. According to American College of Obstetricians and Gynecologist pregnant women should be advised of the significant perinatal risks associated with tobacco use, preterm pre labor rupture of membranes, low birth weight, increased perinatal mortality, ectopic pregnancy, and decreased maternal thyroid function. Women who quit before or during pregnancy can reduce or eliminate these risks. According to the American Risk Ranking of 2020, 13.2% of mothers reported smoking while pregnant. Data collected from the Ohio Pregnancy Assessment Survey, focusing on 2016-2019 indicated that 20% of pregnant women smoked cigarettes at least three months before becoming pregnant. Further the survey produced results that at least 10% of women were smoking with in the last three months of pregnancy. Thus, the Perinatal Smoking Cessation Program seeks to serve high-risk women, and the children that live with them, in counties with the highest incidence of infant mortality and/or prenatal smoking rates to reduce the proportion of women of reproductive age smoking in Ohio.

The Perinatal Smoking Cessation Program funds implementation of the evidence-based model Baby & Me Tobacco Free through the Moms Quit for Two subgrant program. The subgrant currently funds 18 entities throughout Ohio to provide in-person and telehealth support and resources for pregnant women to quit smoking. The Moms Quit for Two program recruits program participants through cross-referrals among programs, such as WIC and Home Visiting, as well as through OBGYN offices, local shelters, birthing centers, community centers, fairs/festivals, local probation offices, and billboards.

In FY21, the Moms Quit for Two program had a total of 687 referrals to the program with 593 clients enrolled. Of that 81.2% of babies born to program participants were not lower than the goal birth weight of 5.5 pounds. 86.4% of the babies were born at term of 37 weeks and 77.9% were at the combination of the goal weight and term of delivery. Though the COVID-19 pandemic was a major barrier in participant recruitment and retention for all 18 agencies, grantees were able to use new, innovative ways to reach their clients, such as utilizing Facebook, Twitter, phone calls, online personal computers, e-mails, some even used mailings to remain in contact with their clients when face-to-face contact was restricted in effort to minimize spread of the disease.

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. Grantees and program staff will receive additional training on Baby and Me, Tobacco Free curriculum in FY22. ODH Perinatal Smoking Cessation will continue to partner with programs such as Tobacco Use and Cessation, infant safe sleep, Ohio Equity Institute, and WIC to improve cross-program referrals.

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. 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.

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 Ohio Department of Health supports the implementation of four home visiting models: Healthy Families America (HFA), Moms & Babies First (MBF), Nurse Family Partnership (NFP) and Parents as Teachers (PAT). All models 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. Even during the pandemic, ODH was able to provide services to more families and to retain families longer between July 1, 2019 through June 30, 2021 (9,627 to 11,250 families).

ODH continues to work with home visiting providers to expand services to meet the needs of families in their communities, focusing attention where 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.
   Status: Rules became effective 1.31.22 and allow additional families to qualify for home visiting services due to rules now matching model fidelity on eligibility policies allowing for families to enroll later and remain in services longer in Healthy Families America and Parents As Teachers programs.
2. Strengthened, streamlined referral process from Child Protective Services to HMG Home Visiting, allowing more high-risk families to be referred.
   Status: In early 2021, ODH and DODD updated the Public Children Services agencies (PCSAs) referral form to streamline referrals. Then in December 2021, ODH began a Continuous Quality Improvement (CQI) project with five local Public Children Services agencies (PCSAs) to improve the success of referrals for home visiting services.
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).
   Status: ODH has supported three NFP providers with obtaining the required training to expand eligibility (Dayton region, Columbus region and the Mahoning region) to multiparous women and women later into their pregnancies.
4. Parents as Teachers expansion in Ohio to meet the need for increased home visiting capacity.
   Status: As of January 2022, Parents as Teachers has expanded into 3 additional counties (Fayette, Holmes, Summit).

Please see Objective 4 of the Infant section of the report for more information about the Home Visiting Program and how it has worked to improve access to home visiting services for at-risk pregnant and postpartum women throughout Ohio.

Women/Maternal Health, Application Year FY 2023

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 in program newsletters which is emailed to over 200 Title X staff, as well as updating and publishing the RHWP/Title X Clinical Services and Protocol manual. Additionally, the MCH Bureau Medical Consultant delivered a presentation to over 100 Title X physicians, nurse practitioners, nurses and program directors on the ACOG well-woman and postpartum exam recommendations, Fourth Trimester Project, and data from Pregnancy-Associated Mortality Review during the July 2021 project director meeting. RHWP will offer information on ACOG's recommendations for postpartum exams during the Jul 2022 project director meeting, include information on ACOG's well-woman recommendations and articles for providers in program newsletters to Title X staff, update and publish the RHWP/Title X Clinical Services and Protocol manual, and continue to track the number of well-woman visits following ACOG guidelines provided at Title X clinics over the year.

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 18 subgrantees completing community health needs assessment in their respective counties and findings from these needs assessments will be used to address strategies C-F through SFY23 and beyond (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). Preliminary findings from the community health needs assessments include services and education focused on the following topics: obesity prevention, healthy eating, active living, improving chronic disease management, improving mental health, community and clinical coordination, screening, and referral, and addressing social determinants of health.

During FY 23, the Title V epidemiologist position will be backfilled. The epidemiologist will work on finding and reviewing 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). Additional information about our plans to continue to use quality improvement science and partner to increase coordination, referral, access, and uptake of high-quality services for at-risk women 18-44 are also found in the following objectives and in Other Efforts Supported by Title V MCH.

The Oral Health Program continues to distribute guidelines on managing oral health care during pregnancy to prenatal and dental care providers through the Integration of Oral Health into Prenatal Care Grant in FY22 and will continue through FY23. The Oral Health Program requires that subrecipients of this grant complete the Pregnancy and Women's Oral Health module that is part of the Smiles for Life curriculum. Subrecipients have been provided educational resources to deliver to both providers and patients. Two agencies are currently being funded to provide oral health assessment, education, and referral and case management to their prenatal patients. Funding for this subgrant program will continue and the program will expand to include three agencies in FY23. Additionally, through another Oral Health subgrant program, funds have been awarded to 3 four agencies/health care systems to provide oral health services to uninsured MCH population from low-income families, which will help to impact this strategy. This subgrant program will continue through FY23. 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. Oral Health Program staff are in the process of getting the training program uploaded onto the web-based training site, OhioTrain, and Ohio-Approved through OCCRRA by the end of FY22. The oral health and pregnancy continuing education module will be available in OhioTrain for MCH programs to access in FY23.

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. Train emergency department providers to recognize, triage, and treat obstetric emergencies.
6. 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 has been implemented in 53 participating hospitals across waves 1 and 2. Wave 1 concluded in October of 2021, though wave 1 sites can continue to submit data, attend action period, and coaching calls. Over 840 data submissions of patient encounters with women who have or are at risk for hypertension have been submitted to date. Recruitment for wave 3 implementation of the AIM Hypertension bundle is underway with plans to kick off in summer 2022. The planning for implementation of the AIM Obstetric Hemorrhage bundle is also underway with plans to begin recruitment in late summer/early fall. Wave 3 of the AIM Hypertension bundle and wave 2 of the AIM Obstetric Hemorrhage bundle will continue FY23.

The PAMR program subcontracts 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. Wave 1 included 9 family and pediatric practices. Wave 1 concluded in early 2022 and has now entered a sustainability phase. Wave 2 kicked off with 20 participating sites in February of 2022 and has seen continued engagement with data collection, submission, and attendance of action period calls. Wave 3 of the IMPLICIT project will kick off in FY23, and wave 2 will enter a sustainability phase.

The Ohio Council to Advance Maternal Health (OH-CAMH) is the statewide maternal health task force. OH-CAMH consists of over 82 external organizations working together to implement the co-created OH-CAMH strategic plan. Partner organizations include local organizations, state organizations, national organizations, Title V staff, and patients/families. In FY22, 11 implementation teams were formed to address each of the 11 strategies included within the OH-CAMH Strategic Plan. Volunteer implementation team leads worked to build their teams, assess membership gaps, and develop an implementation plan in September 2021. Two quarterly OH-CAMH general membership meetings took place to continue making progress on OH-CAMH Strategic Plan implementation. Strategic plan implementation will continue throughout SFY23.

The ODH PAMR program subcontracts with GRC to implement urgent maternal warning signs education in public health settings. Wave 2 of this project spread to an additional 46 WIC sites, from the original 26 sites in wave 1 for a total of 72 participating WIC clinics. Educational webinars about urgent maternal warning signs, offered by region, were delivered to Wave 2 sites and were very well attended. The planning phase for wave 3 is occurring through the end of SFY 22, Wave 3 will include expanding implementation of this project into ODH Home Visiting sites. Wave 3 kick off in the fall of 2022, with two opportunities for home visitors to attend the UMWS educational webinars throughout FY 23.

The PAMR program continues to contract with the Clinical Skills Education and Assessment Center (CSEAC) 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. Three trainings were conducted in FY22 with 3 more scheduled to occur by September 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. Four abstracts on this project have been accepted by different professional associations at conferences to disseminate scholarly findings. In FY23, additional funds will be allocated to this program to increase the number of trainings that can be provided per year and expand trainings to reach to more providers in rural/Appalachian areas of Ohio. CSEAC will also assess feasibility and need to provide obstetric simulation trainings to first responders in FY23.

The PAMR program continues to contract with the CSEAC 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. Two telehealth trainings have taken place so far in SFY22, with seven trainings targeting Title X providers and staff scheduled to take place from mid-May through the end of August. Pre/post test data from participants have shown a significant increase in knowledge related to using telehealth care and a significant increase self-efficacy related to the different aspects of conducting a telehealth visit with a patient. One abstract on this project has been accepted for presentation at a professional conference and a poster will be presented at the 2022 AMCHP conference. Due to decreased need and interest in these trainings, the telehealth contract will be ending at the end of FY22. Funds originally allocated to this project will be reallocated to the obstetric simulation project mentioned above.

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

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 protocols for systemic data into action.

BMCFH continues to leverage related surveillance activities to collect additional data on how COVID-19 is impacting

Ohio's MCH population. These activities include continuing to utilize data from the 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. This work will continue through SFY23.

The Data and Surveillance section continued the two following projects regarding COVID-19 in pregnancy in FY22. Both projects will continue through FY23.

1. BMCFH epidemiology staff continued performing a retrospective data linkage using the Ohio Disease Reporting System (ODRS) and Vital Statistics (VS) data, including birth, fetal death, and pregnancy-associated death certificates and examine outcomes of pregnancies with confirmed SARS-CoV-2 infection. BMCFH Epi staff will calculate frequency of adverse outcomes among women with confirmed cases of COVID-19 infection and will stratify analyses by race.
2. ODH continues to utilize ODRS for COVID-19 to capture data and create files for export to CDC's Surveillance for Emerging Threats to Mothers and Babies Network (SET NET). 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 on a random sample of cases, and abstracting relevant information.

The Ohio Hospital Association (OHA) is the agency that collects severe maternal morbidity (SMM) data from Ohio hospitals. ODH PAMR requests this data from OHA and performs analyses. The latest SMM data report was published on ODH's website in FY22. The ODH PAMR program is in the process of requesting updated data from OHA and will plan to analyze and publish an updated data report in FY23.

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 FY22. 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.

The OH-CAMH Strategic Plan consists of 11 draft strategies to improve maternal health outcomes in Ohio. Strategy 8 within the OH-CAMH Strategic Plan is focused around maternal mental and behavioral health in Ohio and is co-lead by a BMCFH staff member who is partially funded by the Title V Block Grant. In FY22, OH-CAMH Strategy 8 continued to build a strong team of stakeholders from across Ohio to accomplish this objective. This team consists of individuals from the Ohio Hospitals Association, community-based organizations, the Ohio Practitioners' Network for Fathers and Families, advocacy organizations, the Ohio Children's Trust Fund, and the Ohio Association of Community Health Centers. IN FY22, this team worked together to identify key action steps needed to improving coordination, referral, and uptake of mental health services for women of reproductive age throughout the state. In FY23, the Strategy 8 team will invite the Ohio Mental Health and Addiction Services (OhioMHAS) and Ohio Department of Medicaid (ODM) to join the team, and plan to explore leveraging an existing funding opportunity from OhioMHAS to support this work. Additionally, Strategy 8 co-leads to streamline and synergize work that comes from the new Maternal Mental Health Task Force OhioMHAS intends to initiate in FY23.

The ODH Sexual Assault and Domestic Violence Prevention (SADVP) program finished delivering trainings for community health centers, on trauma-informed care, intimate partner violence and human trafficking in partnership with key stakeholders (e.g., Ohio Domestic Violence Network, Ohio Association of Community Health Centers) throughout the state in FY22. To continue building trauma informed care into interventions in community-based and state agency settings for mental health, staff from the ODH SADVP program lead the OH-CAMH Strategy 7 team, which focuses on promoting organizational shifts in culture that support a trauma-informed approach to clinical and public health services. This group consists of external stakeholders throughout the state to accomplish this goal. The ODH SADVP program also convened the Adverse Childhood Experiences (ACEs) workgroup at ODH to provide technical assistance, training, and organizational development for ODH programs and employees. Both groups will continue to work together through FY23 to implement this work in community-based settings.

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 in the areas of substance abuse, children's services, social services, domestic violence, mental health, primary care, and insurance enrollment assistance. To continue encouraging care coordination and quality assurance of linkages of women to care, all FY23 subrecipients will continue to be required to be co-located with a primary care provider or have formal agreements with a primary care provider.

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.
5. Implement the Women's Behavioral Health Support Learning Collaborative

Six subgrantees of the MP grant are in the process of implementing their approved comprehensive plans to accomplish the following:

- 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.

This subgrant program will continue through the end of FY23.

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. A contract was established with the Ohio Hospital Association to receive data on the number of infants born with FASD in Ohio as indicated by ICD-10 codes. Over the coming year, the FASD program will evaluate this data and use it to inform future programming. Additionally. FASD Prevention brochures have been sent out to WIC clinics, Safe Sleep subgrantees, and Baby and Me Tobacco Free subgrantees. FASD prevention information has been shared with OEI, HMG, and adolescent health programs within the Bureau.

ODH Home Visiting staff and Birth Defects Surveillance Coordinator continue to be members of the Practice and Policy Academy. Staff participated in a joint presentation to Plans of Safe Care county-level groups of over 150 people, focused on early childhood systems, and how home visiting can support families with a Plan of Safe Care. Additionally, ODH Home Visiting will continue to be a member of the Education Subcommittee of the Practice and Policy Academy who put together a professional guidance resource document for professionals in the field. The group is also working on developing a website with implementation resources for local communities. There is no end date for implementation, the Plans of Safe Care work with be ongoing.

For information about how ODH PAMR program is working to increase women's postpartum depression/anxiety screening during pediatric well visits, please refer to Strategy B under Objective 2: By 2025, reduce the rate of severe maternal morbidity by 12%.

The Gestational Diabetes QIP implementation came to an end between Q2 and Q3 of SFY22 and a new QI project titled, "Women's Behavioral Health Learning Collaborative" was initiated using lessons learned from the Gestational Diabetes project. The Women's Behavioral Health Support Learning Collaborative project is a quality improvement project aimed at improving health outcomes for women of childbearing age by implementing best practice mental health interventions in a primary care setting with a specific focus on health equity. Project planning activities for this project continued through FY22, including developing onboarding materials, project curriculum, developing a data plan, hosted a kick-off call, and finalizing data use agreements with 23 participating sites. Project planning activities will continue through FY22 with implementation occurring in FY23.

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 Tobacco Use Prevention and Cessation Program and BMCFH continued meeting bi-monthly to share programmatic updates and identify strategies for addressing smoking use among women of reproductive age. The following programs will continue to work together over FY23 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
- Reproductive Health and Wellness Program (RHWP)
- FASD
- MP (Maternal and Child Health Program)
- 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 18 entities throughout Ohio to provide support and resources for pregnant women to quit smoking. In FY22, one subgrantee withdrew from the program due to low recruitment. This grant program will continue throughout FY23 with modified deliverables aimed at increasing recruitment and enrollment into the program.

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 FY22, the

Home Visiting program accomplished the following:

1. OAC Home Visiting rule went into effect for home visiting and major changes included:
    a. Expanded eligibility to 24 months and expanded services to 5 years.
    b. Added flexibility for home visiting workforce to align with home visiting model specifications.
    c. Removed risk factors for determining eligibility.
2. ODH completed a training, in collaboration with the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Developmental Disabilities (DODD), on how and why families should be referred for Early Intervention and/or Home Visiting Services. In November 2021, ODH started a Continuous Quality Improvement Project in 5 counties working with the Public Children's Services Agency (PCSA) and the Home Visiting Central intake and Referral vendor to increase the quality and volume of referrals sent from PCSAs. Referrals from PCSAs have increased from a monthly average of 399 in SFY 21 to 527 so far in SFY 22; an increase of 24%. 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).
3. ODH has supported the Nurse Family Partnership programs with the cost to expand their eligibility (NFP fees and training) through Help Me Grow Bright Beginnings (Dayton region), the Center for Family Safety and Healing (Columbus region) and through the Educational Service Center of Eastern Ohio (Mahoning region). All teams had staff trained during the last nine months and are currently enrolling women under the new criteria.
4. Beginning in April 2021, ODH expanded Parents As Teachers services into several new counties.

In FY23, the Home Visiting program will design and implement expansion grant applications and funding to support local organizations will the start-up costs of implementing evidence-based home visiting services with the goal of adding 400 slots. The Home Visiting program will also begin leveraging federal Medicaid funding and Title IV-E Families First Funding to support evidence-based home visiting services. Additionally, the program will work to increase access to Nurse Family Partnership in 5 new counties

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.

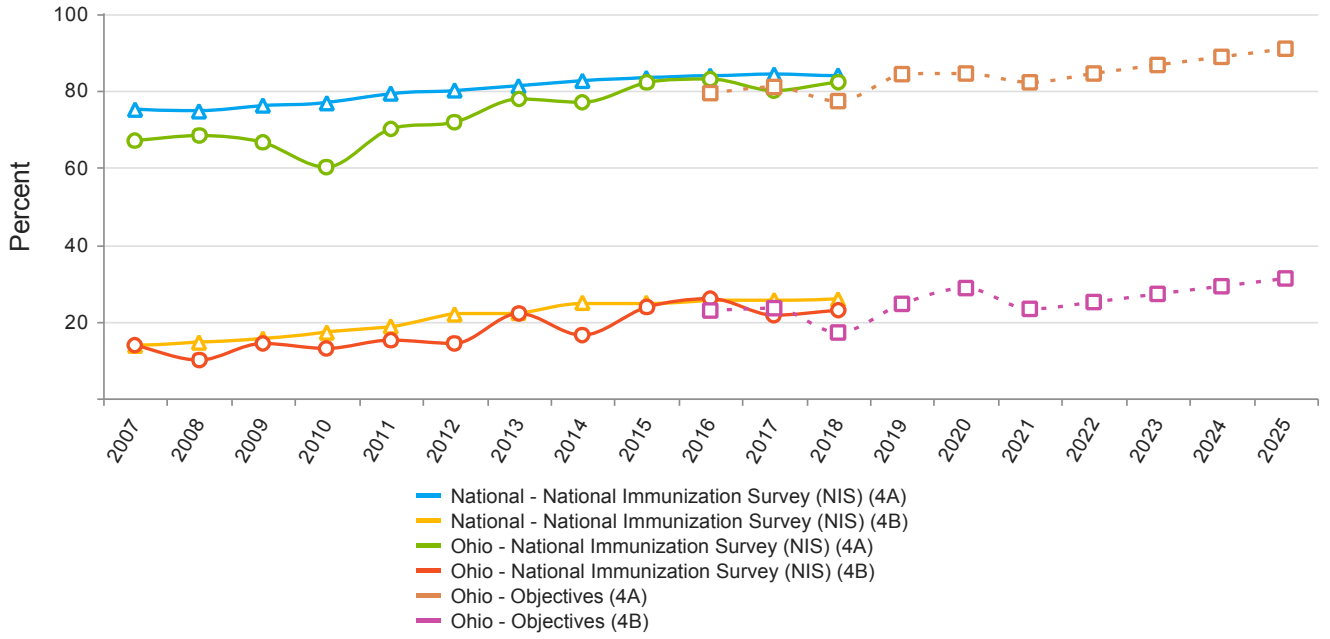
Comprehensive Genetics Services Program

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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	80.9	77.2	84.2	84.4	82.1
Annual Indicator	76.8	81.9	82.8	80.1	82.3
Numerator	101,413	106,884	110,538	101,710	108,381
Denominator	132,017	130,510	133,422	127,037	131,672
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.4	86.6	88.7	90.8

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.5	17.2	24.6	28.7	23.3
Annual Indicator	16.7	23.7	26.0	21.6	23.1
Numerator	21,279	30,504	33,213	26,964	29,092
Denominator	127,543	128,458	127,978	124,604	126,012
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.1	27.2	29.2	31.2

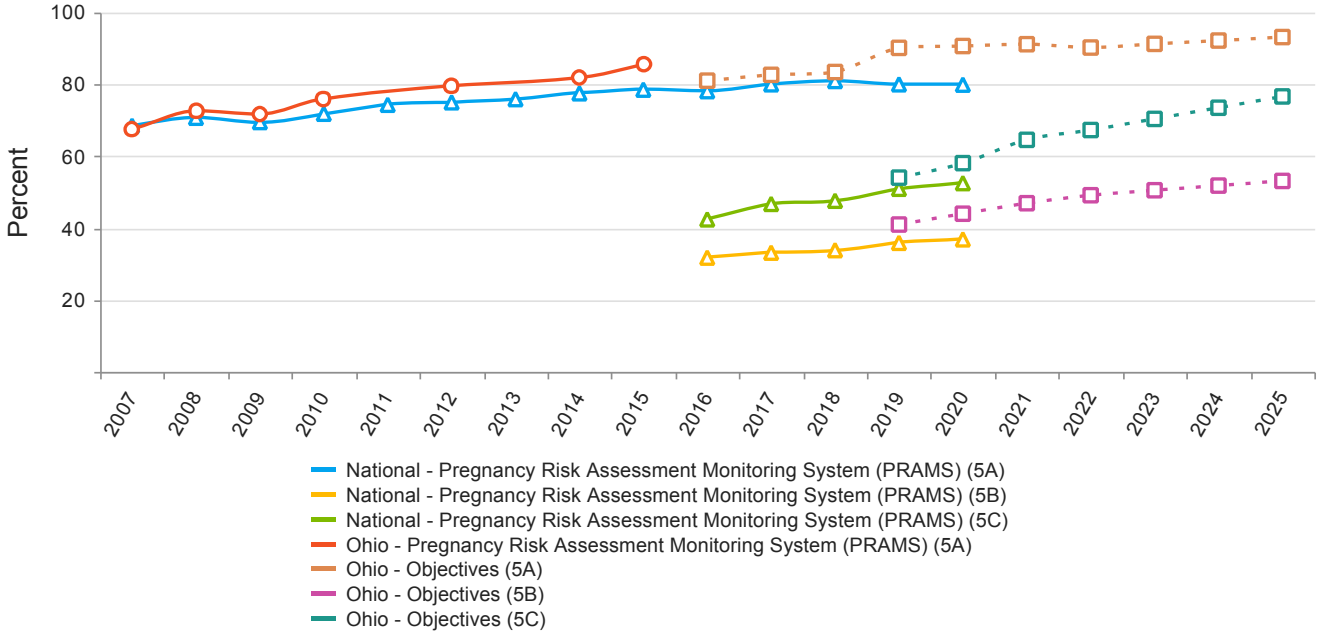
Evidence-Based or –Informed Strategy Measures

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

Measure Status:					Active
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	66	72.6	82.7	84.5	86.4
Annual Indicator	67.9	77.9	82.5	86.1	90.7
Numerator	72	81	85	87	88
Denominator	106	104	103	101	97
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.3	90.3	92.2	94.2

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	82.5	83.3	90	90.5	91
Annual Indicator	85.5	85.5	85.5	85.5	85.5
Numerator	111,358	111,358	111,358	111,358	111,358
Denominator	130,239	130,239	130,239	130,239	130,239
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2015	2015	2015

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	82.5	83.3	90	90.5	91
Annual Indicator	82.7	85.5	86.6	87.6	89.1
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.1	91.1	92.0	93.0

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	2021
Annual Objective			41	44	46.9
Annual Indicator	39	40.4	42.3	45.4	47.8
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.1	50.5	51.8	53.1

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	2021
Annual Objective			54	58	64.5
Annual Indicator	40.9	51.9	57.7	61.5	64.1
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.2	70.3	73.4	76.5

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**	**2021**
Annual Objective			5,500	5,500	5,750
Annual Indicator			5,961	6,019	5,379
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	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**	**2021**
Annual Objective			15.5	12.9	12.6
Annual Indicator	15.2	15.6	13.9	14.3	13.6
Numerator	369	384	339	356	326
Denominator	24,316	24,542	24,359	24,971	23,941
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	OH Department of Health Bureau of Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	11.7	9.8	7.9	6.0

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

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

Perinatal/Infant Health, Annual Report FY 2021

Priority: Support healthy pregnancies and improve birth and infant outcomes

In 2020, 864 Ohio infants died before their first birthday. The number of white infants who died was 493, a decrease of 25 from 2019. Additionally, there were 326 Black infant deaths in 2020, a decrease of 30 from 2019. Both the white and Black death counts are the lowest they have been in the last 10 years.

The infant mortality rate is the number of infant deaths per 1,000 live births. Ohio infant mortality across all races was 6.7 per 1,000 live births in 2020, compared to 6.9 in 2019. The Black infant mortality rate was 13.6 in 2020, down from 14.3 in 2019. Black infants were more than 2.7 times more likely to die than white infants.

Although the number of Black deaths has been trending downward each year since 2016, so have the number of Black births. The infant mortality rate accounts for changes in population, which explains why there have not been significant decreases in the Black infant mortality rate.

Black infants die at a rate almost three times as that of white infants. The racial disparity between Black and white infant mortality is amplified due to decreases in white infant mortality without significant change in Black infant mortality.

Neonatal deaths occur during the first 27 days of life. Neonatal mortality is associated with prematurity (birth before 37 weeks gestation), low birth weight, congenital anomalies, and health problems originating in the perinatal period, such as infections or birth trauma. There were 16 less Black neonatal deaths between 2019 and 2020, whereas there were 22 more Black neonatal deaths between 2018 and 2019.

Between 2011 and 2020, the overall neonatal mortality rate decreased by an average of 1.7% per year, and the white neonatal mortality rate decreased an average of 2.6% per year during the same period. The Black and Hispanic neonatal mortality rates have not changed significantly during this time. Both the Black and white neonatal mortality rates decreased from 2019—from 9.2 to 8.9 and 4.6 to 4.4, respectively. Other than in 2018, the Black neonatal mortality rate is lower than anytime between 2011 and 2020.

Measures

The 2020 needs assessment process resulted in a strong and leading identification of infant mortality and birth outcomes as a priority health need. Addressing the disparity in birth and infant outcomes will be measured through the SOM. Both NPMs improve infant outcomes and the ESMs measure progress in improving both.

- 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
    - In 2020, the overall infant mortality rate was 6.7 per 1,000 live births. This is a slight decrease from 6.9 in 2019. Eight hundred and sixty-four Ohio infants died before their first birthday.
    - In 2020, the neonatal mortality rate was 4.4 per 1,000 live births. Still, the Black neonatal mortality rate was more than twice as high as the white neonatal mortality rate (8.9 vs. 3.4, respectively).
    - In 2020, there were 326 Black infant deaths in 2020, a decrease of 30 from 2019, corresponding to a Black infant mortality rate of 13.6, down slightly from 14.3 in 2019. This is the lowest Black infant mortality rate in at least 10 years in Ohio. Still, Black infants were more than 2.5 times more likely to die than white infants.
- NPM 4: Percent of infants ever breastfed, and percent breastfed exclusively through 6 months.

    - According to the National Immunization Survey (NIS), 82.3% of Ohio infants born in 2018 were ever breastfed and 23.1% were exclusively breastfed for six months.
- NPM 5: Percent of infants placed to sleep on their back, alone on separate approved sleep surface, without soft objects or loose bedding
    - A: The percent of infants placed to sleep on their backs was 89.1% (2020 OPAS). This is the fifth straight year of increase, from 82.7% in 2016.
    - B: The percent of infants placed to sleep on a separate approved sleep surface was 47.8% (2020 OPAS). This is also the fifth straight year of increase, from 39% in 2016.
    - C: The percent of infants placed to sleep without soft objects or loose bedding was 64.1% (2020 OPAS). This is also the fifth straight year of increase, from 41% in 2016.
- ESM: Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies
    - As of the end of FY 21, 88 (90.7%) hospitals had received recognition from Ohio First Steps for Healthy Babies. This exceeds our 2021 objective of 86.4%.
- ESM: Number of families provided with a crib and safe sleep education through Cribs for Kids
    - The number of families provided with a crib and safe sleep education through Cribs for Kids® programs during FY 21 was 5,379.

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.

Launched in March 2020, the Ohio 24/7 statewide breastfeeding hotline, operated by the Appalachian Breastfeeding Network (ABN), continues to provide services with live, trained lactation professionals that 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. Hotline usage continued to increase each month, resulting in an average of 25.6 calls/day by the end of FY 21. For the latter half of FY 20, the hotline averaged 12 calls/day. Nearly 50% of the calls occur “after-hours,” between 4 p.m. to 8 a.m. ABN also planned for the launch of texting services in addition to the hotline, with implementation beginning in October 2021.

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 initiative launched in March 2015, with the first round of applications accepted in July 2015. Throughout FY21, there were four rounds of applications. In total, there have been 25 rounds of applications at the end of FY21 and 90.7% (88 of 97) hospitals were recognized. This is an increase of one hospital from FY20 and exceeds our FY 20 objective of 86.4%. 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 FY21, 342 health professionals completed Part 1 of the training and 332 health professionals completed Part 2 of the training. Upon completion of 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.

The *First Steps for Healthy Babies*, in partnership with the Ohio Breastfeeding Alliance (OBA) and the Ohio Lactation Consultant Association (OLCA), accepted applications and presented awards for the "Maternity Care Best Practice Award 2020" bag-free recognition in March 2021. 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. Seventy-eight (of 97) received recognition for 2020. In 2019 82 (of 101) received recognition. In 2018, 80 hospitals received recognition. In 2017, 73 hospitals received recognition while 59 hospitals received recognition in 2016.

Additionally, the *First Steps* team began planning for a voluntary father/partner award for hospitals to apply for in recognition of their efforts for including fathers and partners in the breastfeeding process and implementation of the *Ten Steps to Successful Breastfeeding.*

With continued 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. Eight additional counties received funding for FY21 for a combined total of 17 counties that received training and participated in the project. The counties worked with employers in their community to improve lactation accommodations and policies in the workplace. A total of 74 policies and lactation accommodations were implemented.

In FY20, ODH launched the toolkit, *Ohio Workplace PLUS (Providing Lactation Upgrades and Support)*, for employers and employees. In FY21, ODH and Every Mother, Inc. began planning for a video that features several Ohio businesses and how they were able to make their lactation accommodations work.

Also with funding from the CDC SPAN grant, ODH continued to implement the Breastfeeding Friendly Child Care Award. Early Childhood Education (ECE) providers can apply for this voluntary award to be recognized for implementation of their breastfeeding supportive practices. A total of nine ECEs are designated, all with gold status.

The Ohio WIC Program continued to partner 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, 12 WIC Projects participated in coaching with 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.

All 74 WIC projects continue to have access to a Community Match Platform to help them connect with community partners and community members. 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. Local community organizations have a strong interest in coordinating, but often face barriers in doing so effectively.

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.

In FY21, 5,379 cribs were distributed, and safe sleep education was provided to families by 24 subgrantees through the Cribs for Kids Program. Support and technical assistance for Cribs for Kids grantees was provided by the ODH Safe Sleep Coordinator as well as the statewide Ohio Injury Prevention Partnership Child Injury Action Group Safe Sleep Sub Committee.

ODH has partnered with Singleton & Partners to create a Safe Sleep media outreach campaign. The goal of the campaign is to educate mothers ages 16-45, fathers and grandparents the correct way to put infants ages 0-1 to bed in safe sleep environments. There are 13 targeted counties: 9 OEI counties and 4 Moms & Babies First counties. The mediums are billboards, digital display ads, social media, transit ads, and YouTube. Due to COVID the 2021 activities have been shifted to 2022.

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.

As part of efforts to enhance partnerships, 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. You can read a comprehensive update on OH-CAMH's FY21 progress in the women's section of Ohio's Title V report.

As in previous years, the Ohio Department of Health provided collaborative support to the Ohio Department of Medicaid on the development of their infant mortality community funding opportunity facilitated by Ohio's seven Medicaid managed care plans titled: *Coordinated Community Approaches to Target the Disparity in the Black Infant Mortality Rate in Ten Specific Ohio Counties*. Two key changes occurred in this funding opportunity as a result of intentional coordination of pregnancy and postpartum supports: 1. ODM retracted funding for the startup and expansion of evidence-based group prenatal care, currently funded by ODH, and instead increased reimbursement for group pregnancy education and group prenatal care to ensure sustainability of models, and 2. Sustainability for evidence-based home visiting models was shifted to ODH. The new round of funding will begin July 1, 2022.

A state team to support the implementation of recommendations developed by the Eliminating Disparities in Infant Mortality Task Force (IMTF) was developed. This state team includes staff from 10 Ohio state agencies/offices: Health, Medicaid, Job and Family Services, Commission on Fatherhood, Mental Health and Addiction Services, Education, Rehabilitation and Corrections, Transportation, Development Services and the Governor's Office. The purpose of the state team is to implement recommendations from the IMTF; provide regular updates on progress being made on the recommendations; discuss possible collaborative and cross agency opportunities; develop and share good practices for including families and communities in planning and the design of interventions; review infant mortality data regularly to track progress; advise the Governor's Office of Children's Initiatives on policy and funding priorities.

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.
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. One initial step included collaboration between the infant and women's MCHBG workgroups. The women's workgroup is also working on developing a plan to streamline strategies for addressing smoking among women of reproductive age, identify/leverage cross promotional/marketing opportunities, and enhance cross-program referrals. Members of the infant workgroup have joined these efforts in alignment with our smoking cessation messaging goals.

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.

In recognition that the Black infant mortality rate needs to be decreased at an accelerated pace, Governor Mike DeWine established the Ohio Eliminating Racial Disparities in Infant Mortality Task Force to work with local, state, and national leaders to identify needed changes to address racial disparities in infant mortality. The task force was charged with creating actionable recommendations for interventions, performance and quality improvement, data collection, and policies with the overall goal of eliminating racial disparities in infant deaths.

Task force members devoted countless hours and energy to this effort. What follows are the results of, and a guide to, the collaborative and community-centered efforts to respond to the racial inequity crisis in maternal and infant mortality in Ohio.

From March 2021 to September 2021, the Eliminating Disparities in Infant Mortality Task Force held 41 listening sessions in 11 counties (Allen, Butler, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Stark, and Summit) to gather primary experiences of Black families, mostly moms, about the realities of delivering healthy babies and raising their children. The first round of sessions sought guidance from Black families about their priority needs for forthcoming recommendations and the second series of sessions requested feedback about recommendations drafted in response to their experiences. Local organizations applied to recruit and host listening sessions, with organizational support from Groundwork Ohio, using a state facilitator or co-facilitator and a standardized discussion guide. The initial and follow-up family sessions were instrumental in forming the recommendations and reflecting the needs and ideas from Black communities. In addition to the family sessions, the task force invited stakeholders to complete a survey about the priorities and opportunities to advance the work. Nearly 300 survey responses were received. Final recommendations are anticipated in 2022.

The Ohio Equity Institute (OEI) continued implementation in the third and final year of the current grant cycle while state OEI staff designed the next competitive solicitation. The grant includes three key strategies: 1) upstream—policy change-- Local entities facilitate the development, adoption, or improvement of policies and/or practices that impact the social determinants of health related to preterm birth and low birth weight, which often drive the inequities in birth outcomes within the OEI counties; 2) downstream—Neighborhood Navigation—Local Neighborhood Navigators identify and connect a portion of each county's Black prenatal population to clinical and social services to reduce stress and improve access to resources needed for a new and growing family. Efforts prioritize non-traditional avenues of outreach designed and tailored to identify pregnant people where existing systems and programs do not currently reach; and 3) data—MCH epidemiology capacity. The grant was extended an additional three months to ensure adequate time for ODH to design the upcoming grant opportunity. In the 2021 grant year (including the 3-month extension), OEI teams served 78% of their goal of women served (4,541 women). Seventy-three percent of the women served self-identified as Black and/or African American. Nearly 80% of women served were identified through non-traditional avenues of outreach. The OEI state team reflected on program monitoring and evaluation outcomes and worked closely with the nine OEI project teams to determine opportunity for quality improvements for the 2022 grant year. Feedback from OEI teams to inform future grant changes were collected in the following way: through regular reporting and requests for technical assistance, surveys, focus groups and interviews. This process resulted in the following key changes for the upcoming grant year: inclusion of Lorain Co. as the 10th OEI county; increase in funding of ~$1.4M; addition of racial equity organizational capacity scope of work, supporting 1 FTE health equity position in each OEI county; increase required proportion of Black/African American pregnant people served by Neighborhood Navigators to 80% (currently 75%); built in accountability to leveraging non-traditional outreach to identify pregnant people for Neighborhood Navigation services; monitoring of reporting on use of priority service areas for pregnant people served by Neighborhood Navigators.

The ODH Early Childhood Home Visiting Program, Help Me Grow, administers and supports the implementation of three evidence-based models (Healthy Families America, Nurse Family Partnership, and Parents As Teachers) and one promising-practice model (Moms & Babies First). Moms & Babies First, Ohio's Black Infant Vitality Program, serves pregnant, Black/African American women in communities with the highest rates of infant mortality, and is focused on improving maternal and infant health outcomes and eliminating racial disparity. In FY21 7,896 families were enrolled in Help Me Grow Home Visiting, and 4,911 primary caregivers identified as Black/African American. 1,339 of those families were enrolled in MBF. Across all Help Me Grow Home Visiting programs, 91% of caregivers who identify as Black/African American have Medicaid insurance. 60% of all Black/African American index children enrolled in Help Me Grow Home Visiting have a medical home identified. 62% of Black/African American Index Children enrolled in MBF have a medical home.

During FY 21 home visits continued to be delivered virtually, or in combination with in-person visits. ODH shared guidance from the national evidence-based models on best practice for delivering home visiting services virtually.

During FY 21 ODH began the process of revising Help Me Grow Home Visiting rule (OAC) to align with model best practice; and remove barriers to eligibility. New rule allows any pregnant, Black/African American woman to enroll in MBF if that program is available in her community.

In FY 21 ODH prepared MBF for transition to the fee for service system of reimbursement, based on programmatic and fiscal assumptions that create parity with the other evidence-based models, the opportunity to increase revenue, and a path toward growth and expansion of services. ODH staff met with MBF providers in a series of quarterly calls in March, June, and September 2021 to discuss rule change, provide OCHIDS training around billing (fee for service), and introduce the process of reviewing MBF Program Standards.

In May through July 2021, ODH convened a workgroup to review the MBF Program Standards that consisted of MBF providers and other HMG evidence-based model providers, ODH staff, and external early childhood partners. In July 2021, the workgroup submitted to ODH leadership recommendations for revisions designed to align the standards with new home visiting rule, support administration, recruitment and retention of qualified staff, professional development, quality home visits, supervision, and continuous quality improvement. A draft of the new MBF Program Standards was shared with MBF providers during the quarterly call on September 9, 2021. Later in September, feedback was collected on the initial draft from MBF providers and workgroup participants. Completion of an implementation Plan to accompany the new MBF Program Standards is underway.

The Disparities in Maternal Health Community Grant was awarded to the Cleveland Clinic in Cuyahoga County, an Ohio Equity Institute community. Cleveland Clinic is piloting a Maternal Health Navigator to target Black mothers and/or patients who present pregnancy co-morbidities (i.e. hypertension, diabetes) and/or patients who have a history of pre-term birth/short cervix. The Navigator will connect patients to social services as well as clinical services within the Cleveland Clinic Hospital System. In grant year 2021 the following outcomes were achieved:

- 100% of referrals from OB Navigation are screened for food, transportation, housing, finance, etc.
- 84% of women served reported a need and opted into navigation process
- 86% of those who opted in were connected to a resource
- 59% gap closure for those who had been connected to a resource
- 29% of participants who reported a SDOH resided in the identified priority zip codes of 44105, 44125, 44137
- 23% of participants participated in CenteringPregnancy(c)

The Infant Vitality – Produce Prescription (IV-PRx) program was developed and designed in partnership with Produce Perks Midwest, Inc. Within IV-PRx we established partnerships with healthcare providers within select Ohio

Equity Institute (OEI) counties. After a successful first year pilot program, the program was expanded into additional OEI counties. By the close of year two IV-PRx programs were operated in five of the nine OEI counties and is currently in the planning phase to expand to Lorain County. In the 2021 project year, 467 pregnant women and their families were provided with $132,298 in produce purchased through PRx. The FY21 year also brought intentional discussions around prescription produce sustainability and its alignment with WIC. From July 2021-December 2021, the ODH Bureau of Maternal, Child and Family Health staff collaborated with WIC and Produce Perks Midwest to redesign the prescription produce protocol to include nutrition education from local WIC offices. The revised protocol began implementation in 2022.

During FY21, Ohio was selected to participate in two Alignment for Action Learning Collaborative (AAC) supported by CityMatCH. The two-year learning collaborative with the goal of aligning state and local public health across the nation is occurring with partners in Akron City and Canton City, two Ohio Equity Institute communities. Partners in Canton City are working towards increasing the percent of adolescents (12-17) with a preventive medical visit in the past year in Stark County; while partners in Akron City are working towards effective messaging and reduction in sleep-related deaths for Black families specifically.

A cohort of seven Ohio communities represented by seven of the nine Ohio Equity Institute counties began to 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 seeks 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. In FY21 three cohort sessions were held.

As we use data to examine variations, in 2021, Perinatal Periods of Risk (PPOR) Phase 1 and initial steps of Phase 2 were completed and presented to appropriate internal workgroups for feedback. Additional Phase 2 analyses are currently being conducted and will be shared more widely with BMCFH programs once a final presentation is available. The results of the PPOR analysis will contain data pertaining to the probable causes of feto-infant mortality among the population with the greatest excess risk in Ohio, which can then be used to improve programs across ODH.

The Child Fatality Review (CFR) program for Ohio was mandated in July 2000, establishing local boards in all 88 counties to review the deaths from all causes to children under the age of 18 years old. The mission is to reduce the incidence of preventable child deaths in Ohio. The Ohio Department of Health (ODH) and the Ohio Children's Trust Fund are responsible for administration and program support. Funding for the program comes from the Maternal and Child Health Block Grant. CFR teams use the national Child Death Review Case Reporting System to record case information. Each local board enters case data into a Web-based system which allows ODH to access data for aggregate state reports. The Ohio Department of Health produces an annual state report, which is distributed as required by law to elected state officials, additional interested parties and is posted on the ODH website for public viewing. The report includes review findings for all causes of death as well as recommendations and initiatives for prevention of further deaths. Many of the local teams produce county level reports. In addition to the 88 local county boards maintained throughout the state of Ohio, the State CFR Advisory Committee was recently restored, holding their first meeting in October 2021. The purpose of the committee is to review Ohio's child mortality data and CFR data to identify trends in child deaths; to provide expertise and consultation in analyzing and understanding the causes, trends and system responses to child fatalities in Ohio; to make recommendations in law, policy and practice to prevent child deaths in Ohio; to support CFR and recommend improvements in protocols and

procedures; and to review and provide input for the annual report. The committee membership represents diverse professions, state agencies and external partners. ODH also provides quarterly training and ongoing technical assistance to all 88 local CFR boards.
Details about initiatives can be found in the CFR Annual Report on the ODH website at:
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/child-fatality-review/resources/cfr-reports

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 teams to develop recommendations and initiatives to reduce infant deaths. There are FIMR teams in Ohio's ten most populous counties. Lorain County was added in 2021 to FIMR. The FIMR teams are funded by the Ohio Department of Health (ODH) through the Ohio Equity Institute (OEI) program. The OEI FIMR program began in 2014. Our local FIMR teams include two components: a case review team (CRT) and a community action team (CAT). During the FIMR process, local teams collect data that is shared with CRT members, where cases are reviewed. FIMR teams also enter their cases into the National Review Case Reporting system. FIMR teams are required to submit quarterly program and expenditure reports to ODH. At the state level, we coordinate funding, provide quarterly state-wide trainings, data support, and technical assistance to all local FIMR teams. FIMR is a legislatively mandated program and ODH is currently working on the RULES for further guidance. While our FIMR program does not currently publish an annual report, some of the teams develop annual reports at the local level. As a result of the efforts of our FIMR teams, there has been local policy development and an increase in collaboration and partnerships among multiple agencies, local organizations, and providers.

Results Based Accountability (RBA)- BMCFH has furthered the use of the Results for performance management of programs that address infant mortality. ODH invested in the Clear Impact software to support RBA across the agency and to track the progress on the priority areas identified in the State Health Improvement Plan (SHIP). Each ODH bureau was asked to develop program performance scorecards to assist in tracking program contributions to the SHIP priorities. BMCFH selected the infant mortality (IM) priority to begin the development of program scorecards. In FY 21, 13 programs that contribute to addressing IM developed scorecards and two additional programs are in the process of development. The scorecards include brief overviews of the program activities and population served along with key program performance measures designed to help programs track their performance and contributions to reducing IM. To ensure the scorecards are useful as we specifically strive to eliminate the disparities in IM for Black/African American infants in the counties with the highest rates (the OEI counties), each program was asked to include disaggregated measures for Black/African American mothers and infants and by county when possible. The programs that have developed scorecards have begun entering data on a regular basis (quarterly or annually depending on the measure). The scorecards are designed to help programs use the data to have conversations and take action, also known in RBA as Turning the Curve. Programs are expected to routinely review their data and use the RBA tools to inform, plan, and implement next steps to do better. Updates on how programs transition to using the scorecards will be included in FY 22. In addition, the bureau plans to expand the scorecard project to additional programs outside of those specific to IM in FY 22. Below is an example of a scorecard developed for the Ohio Equity Institute program. (Data for the totality of the OE21 grant year has not yet been added as the grant year wrapped less than 2 weeks ago and final data is under analysis.):

Measures	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM # African American women served by OEI Neighborhood Navigators	Q2 2021	644.0	692.0	↘ 3	7056% ↑
PM # policies adopted	2020	9.0	9.0	→ 1	0% →
PM % of women served who self-identified as Black and/or African American	Q2 2021	70.0%	75.0%	↗ 1	-30% ↓
PM % of adopted policies implemented	2021	–	100.0	→ 0	0% →
PM Preterm birth rate for Black women served	2020	17.0	–	↗ 1	42% ↑
PM Low birth weight rate for Black women served	2020	16.0	–	↗ 1	23% ↑
PM Infant Mortality rate for Black women served	2020	6.0	–	↘ 1	-40% ↓

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 continued to engage partners and collaborate on identifying gaps in screening and education. As referenced above, PPOR Phase 2 was completed and additional analysis is underway, including investigating opportunities and gaps to discover which risk and preventive factors are likely to have the largest effect on improving our state's infant mortality. As we gain more insight from this process, we plan to align and refine our strategies and activities.

The Preventive Health Program (PHP) is a new program that in November 2021 to improve outcomes through enhancing screenings and education provided during well-visits. PHP is partnership between the ODH and the Ohio Chapter of the American Academy of Pediatrics (AAP). PHP will consist of a Webinar of the Month, new resources, and a QI Project in 2023 Each webinar will have CME/MOC Part 2 credit available and will be on emergent child health topics. The first training was in February 2022 (https://ohioaap.org/education-cme-moc-ii/preventive-health-program/).

As described in the Woman Domain narrative, ODH participants in the Healthy Mom, Healthy Family quality improvement project, with the goals of impacting maternal and infant health. It's designed for postpartum women and their children with a special emphasis on non-Hispanic Black women and women who are eligible for or enrolled in Medicaid or are uninsured. Healthy Mom, Healthy Family seeks to improve interconception care for women of reproductive age to reduce risk factors that might impact future pregnancies and long-term health of mothers in Ohio. The interconception health of birth mothers of patients in participating pediatric sites is assessed through a series of interventions during well child visits 0-18 months. Implementation of Healthy Mom, Healthy Family begins with the integration of mother's care with baby's well child visit in a pediatric setting, if the accompanying caregiver is the biological mother.

Ohio Title V coordinates with the Bureau of Infectious Disease (BID) to promote immunizations. The Title V director meets with the administrator of the Vaccines for Children (VFC) Program at least quarterly and the school nursing administrator meets with BID more frequently. The Ohio Title V Program plans to collaborate with BID on a media campaign in FY 22.

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
One in 33 children is born with a birth defect. Birth defects, or congenital anomalies, are the second leading cause of infant mortality, accounting for approximately 19 percent of infant deaths in Ohio. For those who survive, birth defects are a major cause of morbidity and mortality throughout childhood. 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 Director of Health to require hospitals, physicians, and freestanding birthing centers to report children from birth to five years of age with certain reportable birth defects to the Ohio Department of Health (ODH).

The OCCSN data system utilizes passive case ascertainment whereby hospitals report data to the online database after a child has an encounter at that facility. Genetic counselors at the eight state-funded genetic centers across the state conduct case reviews on selected birth defects to provide data validation. Approximately 130 hospitals, including birthing and children's hospitals, report cases to ODH through the OCCSN data system. Contact information for children under the age of three years confirmed with certain birth defects are sent via automatic email to the Help Me Grow Central Coordination for referral to early intervention services.

In 2020, hospitals began reporting suspected cases of neonatal abstinence syndrome (NAS) in the OCCSN system. During the period 1/1/2020 to 6/31/2021, a total of 1304 suspected NAS cases were reported to the Birth Defects Program. Of those cases reported, 540 cases were confirmed through case review. Every confirmed case of NAS is sent to the Department of Developmental Disabilities (DODD) so they may reach out to families for Part C Early Intervention Services.

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. 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.

The Comprehensive Genetics Services Program also provides newborn screening follow up for bloodspot screening. In SFY2021, a total of 38,223 encounters occurred for genetic counseling. A total of 1,084 were a result of newborn screening follow up. A total of 628 educational events were provided with 113 of those events focused on preconception and birth defects prevention topics, 105 on newborn screening, and 136 on the importance of family health history.

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 IHP ensures that all newborns receive universal newborn hearing screenings in the hospital setting and receive 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. 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

Congenital heart defects are the leading cause of birth defect-associated infant illness and death in the United States. Critical congenital heart defects (CCHD) usually require clinical intervention, often surgery, during the first year of life. Screening for heart defects can lead to early diagnosis and treatment for critical defects and may provide better health outcomes as well as save newborns' lives. The Ohio Department of Health (ODH) CCHD program collects newborn screening results from hospitals and birthing centers. 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/professional education to increase awareness and knowledge about sickle cell disease, sickle cell trait, and other hemoglobinopthies; and, increase strategies to maximize collaboration, coordination and utilization of all sickle cell-related services and resources in Ohio. The Sickle Cell program provides newborn screening follow up for disease and trait cases as a result of the newborn screening in the hospital setting. Families are provided counseling and education regarding sickle cell trait and sickle cell disease.

Perinatal/Infant Health - Application Year

Perinatal/Infant Health, Application Year FY 23

In 2020, the infant mortality rate fell to 6.7 from 6.9 in 2019 for all races. The rate among Black infants fell to 13.6 in 2020 from 14.3 in 2019. However, the Ohio and national goal is 6.0 or fewer infant deaths per 1,000 live births in every racial and ethnic group. Racial and socio-economic inequities persist. Black infants die at a rate almost three times as that of white infants. Eight hundred sixty-four (864) Ohio infants died before their first birthday in 2020. (493 white; 326 Black)

A deeper dive into the data presented the following results:

- Prematurity remains the leading cause of death among all infants.
- Black infants died from prematurity-related causes at three times the rate of white infants.
- White infants were more likely to die of congenital anomalies than prematurity-related causes.
- Thirty percent of infants who died were born before 24 weeks gestation despite only accounting for 0.2% of all live births.
- Nearly half of infants who died were born with very low birth weight (less than 1,500 grams or about 3.3 pounds).

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. We must prioritize our understanding of the unique experiences of Ohio's Black/African American moms as well as social and structural determinants leading to babies being born too early.

Emerging Issues

In response to our FY22 application emerging issue of COVID-19, we wanted to provide the following analysis of the impact of COVID-19 on birth outcomes:

- 7,126 live births and 42 fetal deaths were linked to a maternal COVID-19 infection during pregnancy, also known as a pregnancy-related infection (PRI).
- The fetal death rate for pregnancies linked to a 2020 PRI was not significantly different than that of non-linked pregnancies during that time.
- Sixteen infants had a possible perinatal COVID-19 infection; none died.
- Thirty of the 7,126 infants born to mothers with a confirmed PRI died.
    - Twenty-one infants whose mother had a confirmed PRI, died during the neonatal period.
    - Nine infants whose mother had a confirmed PRI, died during the postneonatal period.
- There was no significant association between PRI and preterm birth.

We continue to work to understand the short- and long-term impacts of COVID-19 on the pregnant people, infants and families we serve.

In Ohio, congenital CS cases increased 146% from 13 cases in 2016 to 32 cases in 2020, including two syphilitic stillbirths. While CS cases represent less than 2% of total syphilis cases reported in Ohio, rising incidence is especially concerning for this preventable but potentially life-threatening condition. At both the state and national levels, the increase in CS cases parallels the increase in cases of infectious syphilis among women of reproductive age. This upward trend continued through 2021. In 2021, there were 49 CS cases reported in Ohio, five of which were stillbirths, though data is still preliminary. BMCFH is coordinating with the Bureau of Infectious Diseases to identify opportunities for enhanced surveillance and avenues of prevention.

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 continue to engage partners to identify new strategies and activities as well as improve and enhance current activities. Additionally, ODH released a competitive funding opportunity for *Innovations to Advance Breastfeeding and Health Equity*. Up to $250,000 is available for this one-year period (July 1, 2022 – June 30, 2023).

ODH extended the contract with Appalachian Breastfeeding Network to continue 24/7 breastfeeding support throughout FY 23. Data will continue to be collected and reported monthly.

The Ohio First Steps for Healthy Babies hospital initiative launched an optional Father/Partner engagement award. Hospitals that apply are 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 the final year (Year 5) of the CDC State Physical Activity and Nutrition (SPAN) Cooperative Agreement. Activities planned include implementing a new Breastfeeding Worksite Award. The 17 counties receiving funding to educate local businesses and assist with development of lactation policies and accommodations in FY 22 will continue their work and expand to new worksites. Additional breastfeeding funds were awarded by the CDC and will be used to increase education and promote and implement the Breastfeeding Worksite Award at the local level. The Ohio Workplace PLUS Toolkit features strategies for different work

environments. The video also highlights different companies who have been successful. Success stories include drug stores, restaurants and early childhood care providers.

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 Direct on Scene Education train the trainer program (DOSE). DOSE is an innovative attempt at eliminating sleep related infant death due to suffocation, strangulation, or positional asphyxia by using First Responders to identify and remove hazards while delivering education on scene. Ohio has contracted for a Safe Sleep campaign that includes billboard and digital displays. Ohio is working toward statewide crib distribution. Ohio is also participating in creating the Community Injury Action Group (CIAG) safe sleep strategic plan.

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 82 member organizations to implement a statewide strategic plan. Partner organizations include local organizations, state organizations, national organizations, Title V staff, and patients/families. In FY22, 11 implementation teams were formed to address each of the 11 strategies included within the OH-CAMH Strategic Plan. Volunteer implementation team leads worked to build their teams, assess membership gaps, and develop an implementation plan in September 2021. Two quarterly OH-CAMH general membership meetings took place to continue making progress on OH-CAMH Strategic Plan implementation. Strategic plan implementation will continue throughout SFY23.

Last year, Ohio Governor Mike DeWine developed and tasked the Eliminating Racial Disparities in Infant Mortality Task Force (IMTF) with developing recommendations to achieve racial equity in outcomes for all infants by 2030. The

Task Force's recommendations 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. The recommendations are still awaiting finalization but were drafted on the experiences and recommendations of Ohio's Black families. Along with the IMTF a State Implementation Team has been developed with support of the Governor's Office. This team is responsible for the implementation of IMTF recommendations. Representation is included from the following state agencies: Rehabilitation and Corrections, Health, Mental Health and Addiction Services, Job and Family Services, Development, Medicaid, Transportation, Education, Developmental Disabilities and Governor's Children's Initiatives. The FY23 year will prioritize the coordination of the State Team to achieve the following goals: 1. Identify specific policies, practices, initiatives, and programs responsive to the recommendations of the Ohio Black Infant Mortality Task Force Report and 2. Develop practices for cross sector engagement, accountability and shared benefit to support cross departmental decision making, shared action and communication within the State Team.

In partnership with the Ohio Department of Medicaid (ODM) and their distribution of $26.8M to the ten Ohio Equity Institute communities to support strategies that seek to improve equity in infant and maternal outcomes, ODH will continue to serve as a primary support to ODM and their managed care plans in these investments. Local projects will begin implementation on July 1, 2022; projects include community health worker, doula, home visiting and locally designed strategies. During the design of this funding opportunity, ODM and ODH agreed all funded home visiting projects will be transitioned to ODH funding long-term for service sustainability. This investment serves as an important opportunity to continue to improve the quality and alignment of diverse funding streams to address racial inequities in maternal and infant outcomes.

During the two-year long ODFS Families First planning process, stakeholders were convened to discuss ways to prevent families from needed support and monitoring through the Child Welfare system. The process resulted in ODJFS identifying evidence-based practices know to support families and their collective growth and development. Two evidence-based home visiting programs, Healthy Families America and Parents as Teachers, were prioritized for implementation during the first phase of the work. ODH and ODJFS are partnering on this process to leverage the existing home visiting system infrastructure operated by ODH. ODJFS is supporting the funding of home visiting in the following ways:

- Professional Development- Through the creation of the Center of Excellence, operated by Case Western, approximately $95,000 is allocated to the Ohio Child Care Resource and Referral Association to support the quality and availability of professional development for home visiting staff.
- Expansion Grants- Through an Interagency Agreement, ODJFS is provided ODH will $1,000,000 to provide existing home visiting providers with start-up funding to expand their teams and capacity. Grants will be awarded by June 30, 2022.
- On-going Services- For families identified as needed "prevention services" by the local Public Children's Services Agency (PSCA), ODJFS will reimburse ODH for 50% of the costs associated with the delivery of home visiting services. All information will be documented in OCHIDS and SACWIS in order to accurate report and track the families and the investments. Reimbursement is expected to begin in SFY 23. A data sharing agreement, critical to the implementation of the project, was just completed by the two agencies.

ODH has been working with colleagues at ODM to design a system of funding to support Governor DeWine's goal of expanding evidence-based home visiting. ODM will be offering reimbursement for nurse home visiting, aligned with the Nurse Family Partnership model, to address maternal and child health outcomes for Medicaid enrolled and eligible women. Funding should begin in October 2022.

In addition to standing up this sustainable source of funding, ODM through its partnership with the Managed Care

Organizations, has supported providers in local Ohio Equity Institute counties with expansion activities.

Beginning in 2022, 44 community-based organizations were funded to provide services in 41 Ohio counties through the Community and Faith-based Infant and Maternal Health Support Services Funding. While this funding is not directly supported by federal Title V funds, it serves as an important alignment of strategies and goals. This project provides funding with expanded access to community- and faith-based organizations to implement community-level projects to improve infant and maternal health outcomes. These dollars seek to strengthen the unique work of community- and faith-based organizations (CBOs) as trusted partners of Ohio's pregnant women and new families. Funded organizations will reduce barriers to wellness for participants by providing physical and social supports that address gaps in existing maternal and infant systems and supports pregnant women and newly parenting families (up to 12-months postpartum). These one-time funds may support the establishment, expansion or enhancement of programs and special projects for pregnant women and new families.

The Bureau of Maternal, Child and Family Health will implement the following media campaigns during FY 23: *Move Your Way, Hear Her,* Fetal Alcohol Spectrum Disorder, Safe Sleep and Breastfeeding. The campaigns align with programming throughout our bureau and department. The Ohio Title V Program will consider continued collaboration with BID on a media campaign in FY 22.

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.

In addition to the goals identified above for the IMTF, two additional goals are prioritized for the FY23 year: 1.Develop a cross-agency feedback loop with counties to co-design, implement and monitor programs and services to benefit Black women, infants, fathers, families, and communities; and 2. Establish benchmarks for reporting to counties, providers, and the members of the Task Force. In response to the IMTF recommendations, the State Implementation team will be identifying existing programs and strategies that require tailoring to better meet the needs of Ohio's Black women and families.

The Ohio Equity Institute (OEI) will continue to support the facilitation of local upstream (policy change addressing social determinants of health that impact poor birth outcomes) and downstream (clinical and social resource navigation for Black pregnant people) strategies in the ten Ohio counties who carry the greatest burden of Black infant deaths and the greatest racial inequities in birth outcomes.

Both the Association of State and Territorial Health Officials (ASTHO) and the U.S. Department of Health and Human Services Centers for Disease Control and Prevention recognize health equity in public health won't be achieved without "organizational structures and functions that support health equity." According to the ASTHO's Health Equity and Public Health Department Accreditation Report, "An infrastructure that advances health equity implements supportive organizational policies, encourages cross-sector partnerships, and is responsive to emerging priorities."

In July 2018 the Public Health Accreditation Board published a brief (Version 2.0 Work in Progress: Health Equity—

What Have We Learned From Accredited Health Departments?) about the challenges accredited health departments are challenged with engaging in health equity work, particularly related to PHAB Measure 3.1.3, “Efforts to specifically address factors that contribute to specific populations’ higher health risks and poorer health outcomes.” According to this brief, the most common challenges were:

- Internal policies and procedures for the inclusion of health equity considerations of specific populations in program development
- Lack analysis of health equity; and
- Lack plans and/or efforts to address social change, social customs, community policy, level of community resilience, or the community environment to impact on health.

In addition to the long standing upstream and downstream OEI strategies, ODH is also investing in building the internal organizational capacity of subrecipients, all of which are local health departments, to engage in racial equity work effectively. Additional funding for a full-time health equity coordinator has been provided to each local OEI team. The Health Equity Coordinator in collaboration with a Racial Equity Core Team will develop an action plan to normalize, organize and operationalize organizational change to advance racial equity. Local health departments will use a racial equity framework to develop organizational goals and objectives to address, reduce, and eliminate racial disparities and inequities. Entities will build organizational capacity and partner with other institutions and communities to strengthen internal health equity core competencies. OEI teams will seek to implement racial equity tools to change the policies, programs, and practices that perpetuate inequities within their communities and use data to develop baselines, set goals, and measure progress.

A vendor will be identified to provide coaching and technical assistance to OEI health equity coordinators and teams to support integration of racial equity in the foundation of entity policies and initiatives by building health equity core competencies of the OEI-funded health equity role. Examples of core competencies include:

- Social Determinants of Health
    - Understands and applies social justice principles
    - Understands the underlying causes of health inequities
    - Understands connection between race, class, gender and health
- Community Knowledge
    - Builds on strengths and assets of self and the community
    - Comfortable working in communities
    - Works well within the LHD and in the community and serves as liaison between the two
    - Engages, mobilizes, coaches and mentors
    - Understand and navigates power dynamics
- Collaboration Skills
    - Shares power
- Cultural Competency
    - Communicates effectively across cultures
    - Interprets data effectively across cultures
    - Appreciates that diverse perspectives and roles are necessary to promote public health issues

Beginning in 2021, a cohort of Ohio communities representing seven of the ten Ohio Equity Institute counties (more information in the next objective) joined for technical assistance and training around the Queens Village model, a supportive community of powerful Black women who come together to relax, repower, and take care of themselves and each other. Beginning in the summer of 2022, a second cohort will launch, including the three remaining Ohio Equity Institute counties, to replicate the Queens Village standards and principles within their communities. Branding, design and communication support will be provided to all ten Queens Village cohort participants. As well as ongoing

technical assistance and coaching from the developers of Queens Village, Cradle Cincinnati.

The Disparities in Maternal Health Community Grant Program will fund two new subgrantees in FY23 to implement design innovative and culturally humble initiatives to address racial/ethnic and/or geographic health disparities related to maternal health in Ohio. Applications are currently being reviewed.

Beginning in 2022, $2.25 million was awarded to help improve birth outcomes and reduce infant mortality by providing stable housing for low-income families. The Housing Assistance to Improve Birth and Child Outcomes Program will assess the impact and effectiveness of housing and rental assistance to reduce risk factors for infant mortality, increase housing stability of low-income households with children, while improving maternal and infant health outcomes. Through the program, the funded entity will enroll and support pregnant women and households in Franklin and Summit counties. The program will allocate 24 months of rental assistance and intensive housing stabilization services, including landlord mediation, financial assistance, health care coordination, and person-centered planning and motivational interviewing to support the attainment of basic needs and achieve long-term economic stability. Franklin and Summit counties are among the most housing cost-burdened areas in Ohio.

In addition, ODH has administered two youth homelessness grants since FY20, funded through the state General Revenue Fund (GRF). Thirteen community agencies have been funded through the two grant programs to serve youth and pregnant youth ages 14-24 who are experiencing homelessness. In addition to providing housing services, program deliverables include outreach, health or mental health services, education or employment services and community or social connection. In 2021, ODH contracted with the Coalition on Homelessness and Housing in Ohio (COHHIO) to data support and technical assistance to ODH and the 13 subrecipients to improve data collection in the program. In addition, COHHIO will provide program recommendations based on the comprehensive data reports submitted to ODH during FY22. If funding continues to FY24, ODH will release a competitive solicitation, guided by data.

The Ohio WIC program and ODH Infant Vitality program will continue its partnership with Produce Perks Midwest (PPM) to implement the Produce Prescription (PRx) Program. Nutrition incentive programming is an evidence-based, nationally recognized model for impacts on increased food and nutritional security, improved health outcomes, and strengthening of localized food systems. Given prematurity conditions are leading causes of infant death, PPM collects data on birth outcomes, including preterm birth and low birth weight.

PRx connects patients with diet-related disease (diabetes, obesity, cardiovascular, etc.) to health care providers who write prescriptions for free fruits and vegetables. Patients are screened for food insecurity within their household, and providers issue monthly prescriptions to meet the entire family's recommended daily servings of fruits and vegetables. Up to five family members are eligible to receive prescriptions. Women are eligible to participate during pregnancy and up to one year postpartum. Participating PRx health care providers refer eligible patients to the WIC program. WIC provides nutrition education, including cooking demonstrations, and breastfeeding support. Additionally, participating women can receive both the PRx benefits in additional to all applicable WIC benefits.

PRx programming will continue in the four currently participating OEI counties and expand to two additional OEI counties. A combined total of 175 women will be served with a target population of at least 50% African American program participants.

Ninety five percent of the previously referenced Community and Faith-based Infant and Maternal Health Support Services Funding is supporting some level of service and programming in the 10 OEI counties. Examples of activities tailored for Black families and communities include:

- Perinatal physical and social support services for Black pregnant and postpartum mothers, and their families
- Breastfeeding support programming
- Provide or expand locally-designed parenting education and social support programs
- Fatherhood programs
- Job readiness classes
- Nutrition education, prescription produce and food access
- CHW services; including recruitment of Black, Latinx, Asian, and Indigenous students for Community Health Workers Certification Program classes
- Supportive housing and comprehensive services
- Mental health services and support to future and newly parenting fathers

Results of the Perinatal Periods of Risk (PPOR) Phases 1 and 2 will be synthesized and communicated to MCH staff to inform the design of activities aligned with Block Grant workplan strategies. A report focused on safe sleep practices, highlighting Ohio Pregnancy Assessment Survey (OPAS) data and Child Fatality Review data, is under development and will be disseminated to key partners to inform strategy development.

Contributing program scorecards for infant mortality have been created in Clear Impact. 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 has created a program scorecard to track key performance measures. Analysis of this data will be used to 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 have included 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. As mentioned above, results from our PPOR Phase 1 and 2 data will help inform this objective. 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.

The Preventive Health Program (PHP) is a new program that in November 2021 to improve outcomes through enhancing screenings and education provided during well-visits. PHP is partnership between the ODH and the Ohio Chapter of the American Academy of Pediatrics (AAP). Through FY 23, PHP will consist of a Webinar of the Month, new resources, and a QI Project launch in 2023. Each webinar will have CME/MOC Part 2 credit available and will be on emergent child health topics. The first training was in February 2022 (https://ohioaap.org/education-cme-moc-ii/preventive-health-program/).

Ohio Title V coordinates with the Bureau of Infectious Disease (BID) to promote immunizations. The Title V director

will continue to meet with the administrator of the Vaccines for Children (VFC) Program at least quarterly and the school nursing administrator will meet with BID more frequently. The Ohio Title V Program plans to collaborate with BID on a media campaign in FY 22.

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).

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. The Comprehensive Genetics Centers conducted multiple education events in SFY2021 that impact infants. The events' topics included: Fetal Alcohol Spectrum Disorders (96 events), Folic Acid (93 events), General Genetics and Malformations (342 events), Newborn Screening (105 events), Preconception and Birth Defects Prevention (113 events).

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 screening for hearing loss by one month of age, diagnosing a suspected hearing loss by three months of age, and receiving early intervention services by six months of age. National averages indicate that about three infants per 1,000 births are identified with a hearing loss. The IHP has several objectives that align with the national EHDI principles. These programmatic goals include ensuring that all infants receive a hearing screening in the hospital before discharge. Infants who do not pass their hospital hearing screening receive no more than two screenings before hospital discharge and receive a referral for a diagnostic evaluation. The IHP also provides follow-up coordination for tracking and monitoring 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 to help them build the best possible foundation during the developmental stages for communications skills. FY23 for the IHP will involve advancing diversity and inclusion efforts for families served by the program and improving hospital reporting procedures to reduce hospital reporting time and improve data efficiency.

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. Current data (2019) indicate 96% of all newborns in Ohio are screened for heart disease prior to discharge and an additional 3% are documented upon transfer to another facility for further heart health care. 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.

Ohio Connection for Children with Special Needs – Birth Defects Surveillance

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.

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 re-established 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. The Advisory Board will meet

2-3 times per year and is currently considering establishing sub-committees to focus on specific issues.

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:

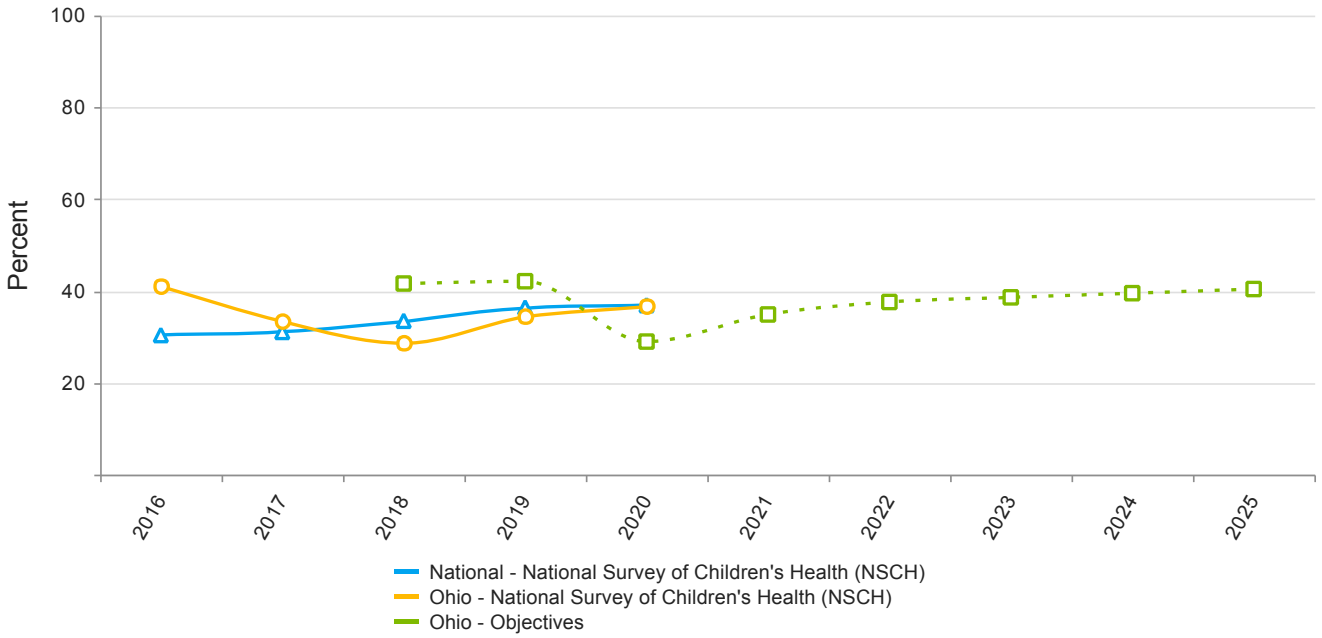
- Identification of cases based on the infant mortality issues of the community.
- Collection of appropriate records from medical, social service, and other providers.
- Maternal interview.
- Abstraction of available records to produce a de-identified case summary.
- Presentation of de-identified case 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.

Plans for the upcoming year include reviewing recommendations generated by Child Fatality Review, Fetal-Infant Mortality Review and Pregnancy-Associated Mortality Review to determine areas of alignment for future prevention initiatives.

Child Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		41.6	42.1	29	34.9
Annual Indicator	41.1	33.3	28.5	34.3	36.7
Numerator	114,362	95,915	73,603	105,296	129,873
Denominator	278,232	287,752	258,257	306,997	353,406
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	37.6	38.6	39.5	40.4

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	2021
Annual Objective			50	70	72
Annual Indicator			70	65.4	65.1
Numerator			5,879	5,251	5,632
Denominator			8,394	8,027	8,652
Data Source			OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys
Data Source Year			FFY 2019	FFY 2020	FFY 2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	74.0	76.0	78.0	80.0

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	2021
Annual Objective			1.8
Annual Indicator	2.3	2.1	1.9
Numerator	3,856	3,533	2,776
Denominator	168,352	165,832	143,705
Data Source	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.5	1.3	1.2	1.0

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

Child Health, Annual Report FY 2021

Priority: Improve nutrition, physical activity, and overall wellness of children

Measures:
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.

- NOM 19: Percent of children (0-17) in excellent or very good health
    - According to the National Survey of Children's Health via the Federally Available Data (FAD), 91.1% of Ohio children were excellent or very good health during 2019-2020. This has remained stable since 2016.
- NOM 20: Percent of children (2-4) and adolescents (10-17) are obese
    - According to the WIC Participant and Program Characteristics file via the FAD, 12.6% of children ages 2-4 were obese in 2018. This has not changed substantially since 2008. According to the National Survey of Children's Health via the FAD, 17.2% of adolescents aged 10-17 were obese during 2019-2020. This is about the same as has been reported since 2016.
- NOM 25: Percent of children (0-17) who were not able to obtain needed health care in the last year
    - According to the National Survey of Children's Health via the FAD, 4.1% of children were not able to obtain needed healthcare during 2019-2020. This is a small increase over 2018-2019 (3.7%).
- SOM: Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) (confirmed only)
    - According to Ohio's data on lead screening in children, 1.9% of children who were tested for lead had confirmed elevated blood lead levels (≥5 ug/dL). This continues a steady decline in the percent of children with elevated blood lead levels and is half the percentage of children tested with confirmed elevated blood lead in 2017.
- NPM 6: Percent of children ages 9-35 months who received developmental screening using a parent-completed screening the past year.
    - According to the National Survey of Children's Health via the FAD, 36.7% of children ages 9-35 months received a parent-completed developmental screening in 2019-2020. This is an increase from 2017-2018, when 28.5% of children ages 9-35 months received a parent-completed developmental screening.
- ESM: Percent of children, ages 1 through 66 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 21, 65.1% of children ages 1-66 months had a developmental screening. In FY 20, 65.4% of enrolled children received a developmental screen. We expected the number of completed screens to be lower in FY 20-21 due to COVID-19. ODH advised home visiting providers to use only telehealth visit options (phone, video, text message, and

drop off materials) starting mid-March 2020; providers have indicated it is challenging to complete required screening and assessments due to technological issues and distractions during telehealth visits. In FY 19, 70% of children who were enrolled received the developmental screening with the ASQ3 or ASQE2. Children are 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).

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).

In effort to increase education and training on comprehensive well visits, in FY 21, Title V worked with the Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) to develop a contract for Ohio AAP to create and implement trainings and resources for medical and allied professionals around key topics appropriate for children and their caregivers. The Preventive Health Program (PHP) trainings will be delivered in FY 22. Developmental screening will be the focus of one of the trainings, and other topics include breastfeeding, messaging immunizations to teens and families, trauma informed care and ACEs, adolescent behavioral health: suicide prevention, anxiety and depression, child and adolescent well care and bright futures, adolescent vaping prevention, adolescent contraception and reproductive health, healthy night routines for infants including oral health, early literacy, and safe sleep, how to connect with your families on child health topics through technology, and top five screening tools used in pediatric practice. The Ohio AAP trainings will also help to lay the groundwork for Quality Improvement projects during FY 23.

Ohio Title V coordinates with the Bureau of Infectious Disease (BID) to promote immunizations. The Title V director meets with the administrator of the Vaccines for Children (VFC) Program at least quarterly, and the school nursing administrator meets with BID more frequently. The Ohio Title V Program plans to collaborate with BID on a media campaign in FY 22.

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 many of the 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.

In addition, training and resources related to ACEs, risk and resiliency and other mental health topics addressing children over the age of 10 are included in the adolescent section of the report. School nurse trainings and other school-based trainings and programs cover both the child and adolescent population, as school staff can work with preschool-aged children up to twelfth grade. There is ongoing collaboration between child and adolescent workgroups to coordinate strategies included in each action plan, including co-leading of the two workgroups by three MCH staff (Adolescent Health Coordinator, Early Childhood Health staff and Parent Consultant). The groups each meet bi-monthly, as there are many MCH staff who sit on both workgroups. The workgroups meet as a large group to share updates and discuss coordination twice a year.

In FY 20, Ohio Title V joined a state team supporting the 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 were 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. In FY 21, achievements of this grant included reaching a multitude of families, professionals, and communities throughout Ohio. The physician toolkit strategy has touched 50 pediatric practices across 26 counties in Ohio. Dr. Weber and her team also presented on family-engaged developmental monitoring and the Learn the Signs, Act Early (LTSAE) program to Ohio AAP. The social media influencers, recruited and trained by the Act Early team have reached thousands of Ohio caregivers through Facebook, Instagram, and YouTube, using creative ways of showing milestones in real time with their own children. Act Early ECHO has been an effective cross-state collaboration with Massachusetts, Wyoming, and Virginia, reaching early childhood professionals and caregivers with topics on building resiliency and cultural responsiveness. The outreach to the Hispanic and Latinx communities has resulted in a variety of outreach including through the state-level Commission on Hispanic and Latino Affairs social media and statewide newsletters.

Act Early Ohio engaged with a number of other communities. The team connected with more than half of the library systems across Ohio to circulate three children's books as well as display LTSAE brochures. Dr. Weber has also connected with hospital-based Child Find Specialists to build in LTSAE materials especially in the process of follow up with families not yet enrolled in Part C. She provided ongoing consultation and collaboration through the Cincinnati Children's Hospital Medical Center Physician Liaison program as well as their counterparts at Nationwide Children's Hospital, which connects community providers to updated information and resources.

The Ohio Department of Health (ODH) Children's Hearing and Vision Program sets the screening requirements and guidelines for school-based preschool and K-12 schools. These requirements include grades that are routinely screened each year; equipment is acceptable to use; specific hearing and vision tests are needed to perform the screenings; and the referral criteria. Schools providing medical services are required to screen school-aged students for vision screenings. Regular school hearing and vision screenings are an important method of identifying children who are at risk for hearing and/or vision loss. In addition to establishing school screening requirements, the program conducts annual reporting of hearing and vision screening data to determine compliance with screening requirements, plan statewide vision screening trainings, establish and revise Ohio hearing and vision screening

guidelines and provide resources for Ohio's schools. During the 2019-2020 school year, the program was greatly impacted due to the COVID-19 pandemic and schools opting for remote learning. Due to this shift, it did not allow for schools to complete the hearing and/or vision screenings in a timely fashion. Schools were encouraged to inform parents and caregivers to their child's primary care providers to receive hearing and vision screenings as part of the annual well child visit schedule.

According to the preliminary data from the 2020-2021 Annual Vision Screening Report, the highest percentage of students who were screened in a required grade was preschool (64.42%) followed by kindergarten (57.19%), first grade (51.16%), third grade (50.42%), fifth grade (46.77%), seventh grade (42.28%), ninth grade (34.60%), and eleventh grade (28.45%). The 2020-2021 Annual Vision Screening Report also identified the highest percentage of a required grade to complete follow up after a referral was Kindergarten (24.57%) followed by third grade (23.44%), first grade (22.25%), preschool (21.15%), fifth grade (19.42%), seventh grade (15.50%), ninth grade (10.32%), and eleventh grade (8.99%).

According to the preliminary data from the 2020-2021 Annual Hearing Screening Report, the highest percentage of students who were screened in a required grade was kindergarten (55.8%) followed by preschool (51.00%), first grade (49.0%), third grade (48.0%), fifth grade (45.3%), ninth grade (32.1%), and eleventh grade (27.6%). The 2020-2021 Annual Hearing Screening Report also identified the highest percentage of a required grade to complete follow up after a referral was kindergarten (22.2 percent) followed by first grade (18.3percent), followed by followed by third grade (18.7 percent), preschool (14.9 percent), followed by fifth grade (14.2 percent), then ninth grade (11.1 percent) and eleventh grade (8.5 percent).

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.

During FFY21 ODH continued to see a slight decrease in the numbers of children receiving at least one developmental screening through Help Me Grow Home Visiting, 65.4% in FFY 20 and 65.1% in FFY 21. Nearly all home visits conducted from October 2020 through May 2021 were virtual, either by phone or video. (More visits were conducted by phone than video.) We begin to see an increase in in-person visits May – June 2021. In July through September 2021, most families received a combination of virtual and in-person visits, with more in-person than virtual.

While home visitors and families adjusted to virtual visits and generally felt they were able to stay connected, virtual visits presented unique challenges for home visitors when attempting to conduct screenings, assessments, and observations. ODH expected the decrease in completion of developmental screenings and other screenings and assessments to persist during the pandemic due to the challenges facing both home visiting providers and participating families.

During FY 21 ODH shared guidance and resources on virtual home visits from the national evidence-based home visiting models; provided resources to help families with emergency needs due to COVID; and, worked with other state partners to develop safety guidelines for returning to in-person visits.

Through enhancements to the Ohio Comprehensive Home Visiting Integrated Data System, and the roll out of 66 unique home visiting data reports, including completion rates of screenings and assessments, home visiting providers can now use data to inform daily practice and focus efforts on quality improvement.

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.

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, there are racial, educational, and economic disparities in asthma prevalence. Non-Hispanic Black children in Ohio visit the emergency room for asthma at a rate more than 4 times that of non-Hispanic white children. Hispanic children visit the emergency room for asthma at a rate nearly double that of non-Hispanic white children. Non-Hispanic Black children are hospitalized for asthma at a rate more than 6 times that of white children. Hispanic children are hospitalized for asthma at a rate double that of non-Hispanic white children. Children under the age of five had the highest rates of emergency department visits due to asthma (96.9 per 10,000 residents) and asthma-related hospitalizations (13.5 per 10,000 residents) out of any other age group. (OHA 2019). 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.

Early Childhood Health and Safety (ECH)

The Early Childhood Health (ECH) program offered 19 recorded Health and Safety trainings that were approved for professional development credit for Early Childhood Professionals. In FY 21, there were six new trainings added on the following topics; Social Determinants of Health, Making Referrals in Early Childhood Settings, Sickle Cell Disease in the Childcare, Vision Eye Health and Developmental Milestones for Ages 3-5 Setting, Tobacco Effects in early Care Settings, and Supporting Students in an Inclusive Setting. Each recorded webinar was produced in partnership with other ODH programs, community entities, and state partners such as Nationwide Children's Hospital, The Ohio State University, Cincinnati Children's Hospital, Ohio Department of Developmental Disabilities, Ohio Department of Education, and Bright Beginnings. In 2021, over 21,305 professionals completed the course for Ohio Approved credit. Each year, the ECH program invites early childhood professionals from around the state to a virtual discussion group to share current trainings and gather information on training needs for the next year. After the community discussion, the ECH program invites other state agencies to discuss current trainings, results of the community session, and brainstorm about future trainings. This collaboration has encouraged partnerships between agencies to reduce redundancy and to expand the offerings to early childhood professionals in the state.

Early Childhood Obesity Prevention Program (ECOPP)

The Early Childhood Obesity Prevention Program (ECOPP) 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. ECOPP is a program within the Early Childhood Health Program. The Early Childhood Obesity Prevention Program (ECOPP) encompasses the Ohio Healthy Programs and the Parenting at Mealtime and Playtime program.

Ohio Healthy Programs (OHP)

Ohio Healthy Programs (OHP) is a designation for Early Childhood Education (ECE) programs that aims to increase the adoption of healthy eating, activity, and screen time behaviors among children aged 0-5 years. OHP is based on a curriculum called *Healthy Children, Healthy Weights,* which has received various recognitions including the National Association of County and City Health Officials (NACCHO) Model Practice Award. To apply, ECE programs must (1) have staff complete trainings on healthy eating and physical activity topics, (2) complete the OH PANA (see below for more information), (3) submit new sample menus and policy statements, and (4) documentation of parent engagement activities. Designation lasts for two years, at which time programs must go through a re-designation process. Technical assistance providers from local public health departments and community organizations help ECE professionals implement practice changes and complete the application. ODH coordinates and funds this work in collaboration with key organizations across the state, including Ohio Child Care Resource and Referral Association (OCCRRA), Columbus Public Health (CPH), and Children's Hunger Alliance (CHA). In 2021, there are 205 OHP designated programs across the state.

For the purposes of the Ohio Healthy Programs (OHP) Technical Assistance for Child Care Centers and Public Preschools grant, the population of focus was children and families of different racial, ethnic, and geographical areas that are disproportionately affected by poor health outcomes, highest need, that seek childcare services at an ODJFS center or ODE public preschool. The state was divided into 12 regions. Priority was given to the following regions which indicate highest need based on a weighted ranking system analyzing obesity rates of under five-year-olds, poverty rates of under five-year-olds, and percent of children (under 18) who are black or Hispanic. These rankings were also compared to the number of childcare centers available in each region of the state. Applicants had to prove that they were able to provide services to an entire region.

Ohio Physical Activity and Nutrition Assessment (OH-PANA)

ECH worked with external evaluators to create a self-assessment tool for early care and education (ECE) and school-age childcare programs. This Ohio-specific assessment measures nutrition, physical activity, and related environments, practices, and policies in these settings. It provides the programs with the opportunity to identify changes they want to make in these areas in the next year. It is designed to be completed by family childcare professionals and administrators of ECE centers and school-age childcare programs (such as before/after school programs) across the state. Any ECE or other childcare professional in the state may choose to complete the assessment, however, it is a requirement as part of the OHP application. This also allows ODH to collect data on the practices of ECE programs in order to identify future activity needs. A study conducted from 6/1/2020-6/30/2021 where 257 ECE programs included in the total sample, about half of which (132) were ready to submit their initial application and half (125) were already OHP designated. Most ECE programs met two-thirds of nutrition and physical activity practices, while less than half met all of the practices measured. Programs that were ready to submit their initial application for OHP (post-intervention) were less likely to meet all nutrition and physical activity best practices than OHP-designated programs (follow-up); they were also less likely to meet at least two-thirds of physical activity best practices and less likely to have policies that address child nutrition, physical activity, or screen time.

Parenting at Mealtime and Playtime (PMP)

The Parenting at Mealtime and Playtime (PMP) program provides primary care office staff with strategies to enhance counseling during well child visits for children. The goal of PMP is to promote a shift towards earlier intervention in children at risk, as well as a shift from unhealthy to healthy habits, through physician discussions with families. PMP has shifted from a quality improvement (QI) project to an education-based model. In addition to the

resources already created, PMP will be offering new handouts expanding beyond the age of 5. This will provide education to caregivers and youth of those in the pre-k to kindergarten and 7-10 year age groups. There will also be trainings available to educate on topics related to these age groups. The toolkit that was created in SFY 20 will be updated and promoted throughout this year. In 2021, there are over 75 registrants with 30 new primary care providers such as MD, DO, NP added from July 1- Dec. 30, 2021. This new educational model has allowed for dissemination of the PMP resources and new educational topics for primary care providers and staff. In addition to the toolkit, educational trainings are offered for MOC credits. The topics are determined by the PMP Advisory Group and feedback from surveys distributed to past participants. In 2021, some topics included Social Determinants and Body Positivity, Addressing Obesity, Healthy Eating, and Physical Activity Post COVID, How to Engage Patients and Families via Social Media, and How to Navigate Screening Questionnaires. In addition to the live and recorded trainings, OAAP updates and creates handouts about relevant topics for families and children such as complimentary feeding for infants, playing inside, social media use, and lunch time packing and choosing healthy lunch items. Also, ODH offers recorded webinars on PMP topics for community health workers, home visitors, allied medical professionals, and any professional that might work with families in the community. In FY 21, over 875 professionals completed the recorded webinars on OhioTRAIN that could be used for professional development credits.

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.

Ohio has been accepted to participate in the 2021-22 ASPHN (Year 2) Farm to ECE Implementation Grant (FIG). The Year 2 FIG will fund and provide TA to advance farm to ECE initiatives at the state level. During the FIG project period, Ohio will receive $90,900 and $9,500 in carry over funds, for a total year 2 budget of $104,000. In addition to funding, FIG teams will receive technical assistance to achieve the farm to ECE state-level policy, systems, and environmental changes described in each state's FIG application update. Year 2 FIG has a one-year project period, November 1, 2021, through October 31,2022. The Ohio State University Extension office has hired a part time staff person to support the implementation of the FIG initiatives.

Ohio Healthy Homes and Lead Poisoning Prevention Program

Ohio has made significant strides toward the elimination of childhood lead exposure, but the work is not done. There is no safe level of lead in a child this means that we must ensure that all potential sources of lead exposure for children are eliminated or controlled. Lead exposure is not limited to homes, schools, and childcare settings, children are exposed to lead from the soil in their play areas, the water they drink, the work their guardians perform, and family cultural practices. It is going to require a concerted effort by all involved to keep children safe from lead in their environments.

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 the reporting period of 10/1/2020 to 9/30/2021, 153,022 Ohio children under age 6 received a blood lead screening test. 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 18.95% of children under age six were tested for lead exposure in this time frame.
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 2020, there were 768 Ohio children with confirmed blood lead levels of 10 µg/dL or greater (0.53% of the total tested population) and 2,776 children with confirmed blood lead levels of 5 µg/dL or greater (1.93% of the total tested population).

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.

Healthy Homes Awareness Month (HHAM) activities were conducted across the state in April 2021. 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 home. During HHAM 2021, ODH awarded 6 local health jurisdictions up to $10,000 each to increase public awareness about lead poisoning prevention. 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. Local health jurisdictions also pursued virtual outreach, which included hosting virtual trainings and community meetings, and provided digital 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.

The lead measure for within the MCHBG is percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) (confirmed only). Baseline 2.8% 2017, Short term outcome 1.5% (2022), Intermediate outcome 1.0% (2025), Long-term outcome .7% (2028).

Childhood lead levels are most often tracked using the percent of children tested for lead, less than six years of age, who had a confirmed elevated blood lead level of 5 micrograms of lead per deciliter of blood (µg/dL). This figure is usually calculated, published, and tracked by calendar year, but can be calculated for other time ranges where needed. So that the measure shows number of children tested and with elevated blood lead levels, when a child is tested more than once in the calendar year, only one test for that child is counted. The chosen test to represent their blood lead level in that year is their highest confirmed test, if they had a confirmed test in that year, or their highest overall test, otherwise. We call this their "best test." A confirmed test is one that uses a venous sample (blood was drawn from the vein) and where the sample was not analyzed on a point-of-care device

Oral Health

The Oral Health Program has finalized the scripts for each of seven education modules for ECE, WIC and healthcare providers. We are working with ODH staff for the taping of each module. Topics for the education modules include: The Basics About Teeth, Tooth Decay in Primary and Permanent Teeth, How to Prevent Tooth Decay, Identifying Child Abuse in the Mouth and Dental Neglect, Handling Dental Emergencies, Helping Families Get Dental Care and Oral Health for the Pregnant Mom and her Newborn. The Oral Health Program also funds 12 subrecipients for the School-based Dental Sealant Program. The 12 programs provide dental sealants to students in 33 counties in Ohio. Qualifying schools have at least 40% of the students eligible for the Free and/or Reduced-Price Meal Program. The sealant programs primarily target students in 2nd and 6th grades. Currently nine programs have been able to return to the schools and provide services since the COVID shut down.

Violence & Injury Prevention Section (VIPS)

ODH funded and provided guidance for the practices that were selected, although Title V funding was not utilized for this project. Funds were leveraged from CDCs Core SVIPP grant, supplemental COVID-19 funding. VIPS used some of the extra Covid-19 funding provided by CDC Core SVIPP grant to implement remote/virtual delivery of a strategy related to Adverse Childhood Experiences (ACEs), specifically the Safe Environment for Every Kid (SEEK) screening tool. VIPS partnered with Ohio Academy for American Pediatrics (AAP) for this project. This is the third wave of the SEEK project, but this funding specifically allowed for further expansion into new practices/communities and required to have both the tool and resources available virtually, which was important during this pandemic.

During the six-month (December 2020 and January 2021) quality improvement Collaboratives, participating practices incorporated the Injury + SEEK age-appropriate screening tools at well child visits for children birth to 5 years of age to identify unsafe or risky behaviors, and discuss or provide resource/referral for all identified needs.

The third wave launched as a part of COVID-19 response. An electronic screening option was used at half of the sites via tablets. Physicians were also able to participate without any in person training/meetings. This project was a state-wide effort for high-risk families. Approximately 50% of families were Medicaid patients and materials were translated into Spanish and Japanese. Providers have increased discussion of risky behaviors from an average of 14% of the time at baseline to an average of 79% of the time during the final sustainability period, by age group and month of the project. An additional measure of resource provision also showed increases from an average of 9% of the time at baseline to an average of 100% of the time by September (the sustainability period). From December 2020 to January 2022: 22 new pediatric health care professionals implementing SEEK + Injury screening tool;6 new locations implementing SEEK + Injury screening tool; 202 families screened using SEEK + Injury screening tool in-person; 205 families screened using SEEK + Injury screening tool virtually; and 278 families were provided resources as a result of the screenings. The total children impacted is higher than 278 but unknown, as families often have multiple children.

Practices in Wave 3 of the Injury Prevention Plus SEEK Project were required to complete three “Plan, Do, Study, Act” cycles during the project implementation period. There were two groups of practices for a total of six active locations in the project. Each group worked together to develop and implement PDSAs, documented through worksheets or written descriptions of the work. PDSA’s are developed to impact the Key Driver’s identified in the project Key Driver Diagram (KDD), and a goal is established for each PDSA to advance the overall project goal. increasing screening. The total number of families screened increased by nearly 400% from March to April as teams completed PDSA cycles on screening all families. In the month of May 2021.

Ohio AAP recruited, trained, collected data and implemented the quality improvement plans for each practice. Ohio AAP and the providers/practices represented the population they serve. Families were reached through the SEEK screening tool and were provided resources as a result of the screening. During this project 6 sites remained engaged and fully implemented the program, and at least 22 healthcare providers were engaged. Providers participated in the wave fully virtually, with webinar trainings including action period calls, sustainability training, and exit interviews. ODH is working to continue to expand SEEK in rural areas of Ohio not connected to a pediatric hospital system.

Tobacco Use Prevention and Cessation Program (TUPCP)

The Tobacco Use Prevention and Cessation Program (TUPCP) is engaged in several activities that impact the burden of tobacco on children under 10 years of age. Globally, the TUPCP works to prevent initiation of tobacco use, to increase quitting, to prevent exposure to secondhand smoke and to eliminate health inequities that result in disparate burden of tobacco on specific Ohio subpopulations. At the state level we work to enforce the state level policies such as the Smoke Free Workplace Law as well as to promote voluntary adoption of smoke-free and tobacco-free comprehensive policies. Evidence shows us that successful policy work not only protects children from SHS where they live, learn, and play but it increases quitting of adults in children’s lives and decreases initiation of smoking by youth. In terms of quitting, TUPCP collaborates with the Bureau of Maternal and Child Health (BMCH) Asthma Program and this past year funded a campaign focused on reducing home exposure to secondhand smoke for children with asthma. TUPCP also aids and supports the BMCH Baby and Me Tobacco Free program that incentivizes pregnant mothers to quit smoking and stay quit after her baby is delivered. The Ohio Tobacco Quit Line also offers a special protocol for pregnant women to quit and stay tobacco free following delivery which includes

incentives to increase and maintain participant engagement. Additionally, TUPCP is collaborating with Partners for Kids (PFK) which is the oldest and largest pediatric accountable care organization in the United States responsible for the care of more than 400,000 children covered by Medicaid Managed Care across 47 counties in Ohio. Program has collaborated with the BMCH Asthma Program at ODH to offer a presentation to their family practice QI projects in October 2021 and is continuing to work with PFK to reach additional providers and coordinate strategies to further engage providers in reaching family and youth about tobacco cessation options for parents and youth.

Child Health - Application Year

Child Health, Application Year FY 23

The 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.

In-person visits were gradually re-introduced in late spring 2021, and fluctuated with the resurgence of COVID in the fall and winter of 2021-22. To date, a significant number of virtual visits are continuing across the home visiting system. ODH has recently shared guidance with home visiting providers on best practices around in-person visits. Developmental screenings are being completed and referrals made when appropriate. The full set of Tools Completion dashboards is nearly complete in DataOhio, which will allow home visiting providers and ODH to see their screening completion rates.

The COVID-19 pandemic also highlighted the importance of the Cross-Cutting equity and ACEs priorities. In FY 23 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 2025, 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 23 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 23, 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. Educating primary care providers on billing for the provision of services will continue to be provided under the Save Our Sight Vision Screening Training and Equipment grant component in SFY23; however, it will not be a separate QI with Ohio AAP. Statewide vision screening training for primary care providers will continue to incorporate billing education for the provision of vision screenings in the primary care setting during SFY23.

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 and vision 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 screening tests and equipment and referral criteria. In addition to establishing school screening requirements, the program conducts annual statewide surveys of school hearing and vision screening to monitor compliance with screening requirements.

Oral Health

The Oral Health Program is near completion of the development of “Help Me Smile: Ensuring the Oral Health of Young Children”. This course is made up of 7 educational modules that will be Ohio Approved for professional development. The goal of this course is to equip early childhood educators, healthcare professionals, and providers of home visiting services with the knowledge and tools needed to educate young children and parents about oral health, help them establish good oral health practices, and help parents ensure that their children’s oral health needs are met.

The Oral Health Program is in the very early stages of planning a combined oral health/BMI screening for 3rd grade students. At this point, the screening would take place during the 2023-24 school year.

The Oral Health Program currently funds 12 subrecipients for the School-based Dental Sealant Program, providing services in 34 counties in Ohio. Qualifying schools have at least 40% of the students eligible for the Free and/or Reduced-Price Meal Program. The sealant programs primarily target students in 2nd and 6th grades and follow-up with students in 3rd and 7th grades. (The Oral Health Program just completed the 2023 competitive solicitation for the Dental Sealant Program, which should be posted on 6-15-22.)

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)

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 0-10 years of age. In FY 23, the PMP material will include information and education for children up to the age of 18. 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.

Ohio's Farm to ECE team will continue to implement a key system change by expanding and strengthening our state-level coalition to include diverse representation from affected communities and establishing sustainable and equitable coalition recruitment and governance.

The coalition focuses our scalable strategies and intended impacts on children, families and caregivers who lack access to healthy food in care settings and at home, farmers, and food distributors. Through a very deliberate process, a diverse, cross-sector coalition with partners who would bring new perspectives, resources, and skills was created. The number of members tripled in year one, however there are many more layers of the community we must seek out and engage. This will be guided by our Equity Consultant.

The expanded coalition of diverse early childhood educators, young families, farmers, distributors, educators, and others affected by food procurement at ECE sites is accomplishing most of the work through three subgroups: Coalition Expansion/Development, Policy Guidance, and Procurement Innovation. The Coalition Development group will continue to conduct assessments, monitor needs, and recommend and guide practices for sustaining the coalition.

The Ohio Farm to Early Care and Education Coalition is working to become a sustainable group working towards

advancing F2ECE in Ohio that is integrated into the Ohio Farm to School Network at the state and regional levels.

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.

Using ARPA funding, ODH School Nursing program is hiring 6 special project nurses to provide additional support and the state level and within five identified regions of the state. These nurses will work with schools and community organizations to support child health through the school through June 20, 2023.

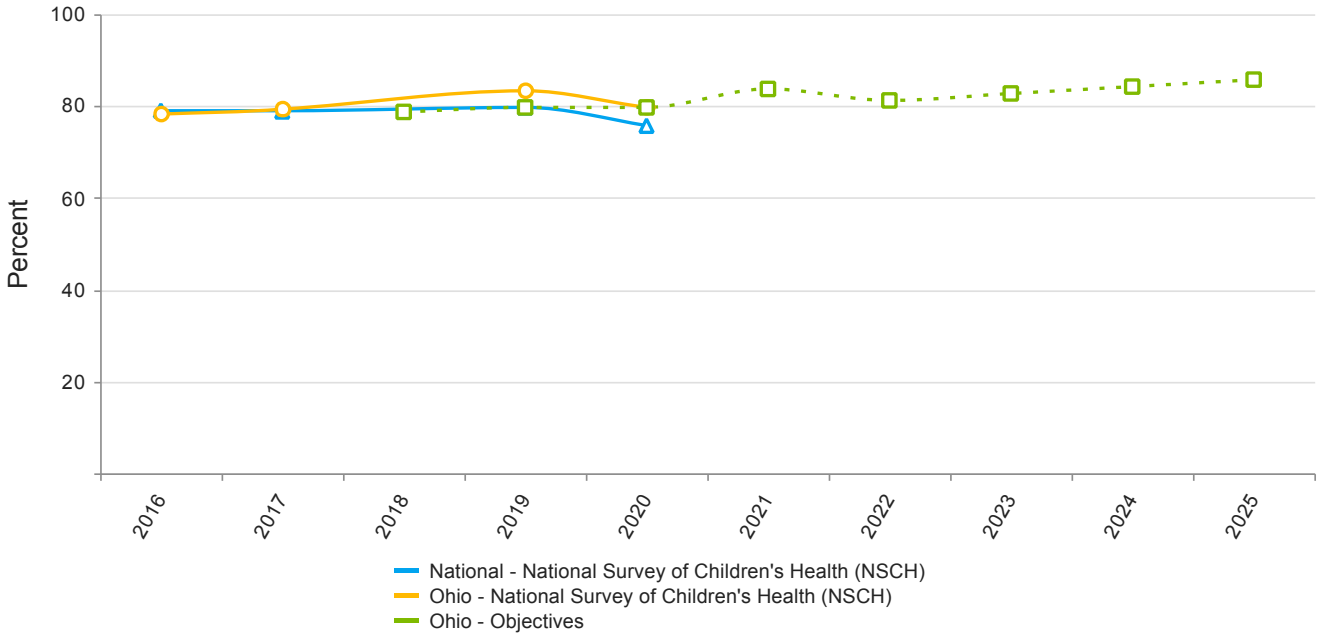
Ohio Healthy Homes and Lead Poisoning Prevention Program

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

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		78.6	79.6	79.6	83.6
Annual Indicator	78.1	79.1	79.1	83.1	79.6
Numerator	694,854	708,785	708,785	747,153	712,653
Denominator	889,704	895,626	895,626	899,030	895,368
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		78.6	79.6	79.6	83.6
Annual Indicator	43.9	44.3			
Numerator	144,230	140,942			
Denominator	328,769	318,477			
Data Source	Ohio Medicaid	Ohio Medicaid			
Data Source Year	SFY 17	SFY 18			
Provisional or Final ?	Final	Final			

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	81.1	82.6	84.1	85.6

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit

Measure Status:	Inactive - We are replacing this ESM with one that measures a strategy, rather than an outcome.

State Provided Data			
	2019	2020	2021
Annual Objective			45.3
Annual Indicator	48	44.4	46.5
Numerator	149,363	139,489	169,947
Denominator	311,048	313,853	365,250
Data Source	Ohio Department of Medicaid	Ohio Department of Medicaid	Ohio Department of Medicaid
Data Source Year	SFY 2019	SFY 2020	SFY 2021
Provisional or Final ?	Final	Final	Final

ESM 10.2 - Percent of middle and high schools with a school-based health center that offers health services to students

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	18.9	19.5	20.1

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	2021
Annual Objective			453.7
Annual Indicator	489.2	465.9	424.1
Numerator	3,727	3,521	3,162
Denominator	761,856	755,742	745,614
Data Source	Ohio Hospital Association	Ohio Hospital Association	Ohio Hospital Association
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	441.5	429.3	417.1	404.9

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	2021
Annual Objective			24.9
Annual Indicator	25.9	25.9	25.9
Numerator	104,317	104,317	104,317
Denominator	402,688	402,688	402,688
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.4	23.9	23.4	22.9

SOM 5 - Percent of high school students who have used marijuana within the past 30 days

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			14.8
Annual Indicator	15.8	15.8	15.8
Numerator	65,023	65,023	65,023
Denominator	410,565	410,565	410,565
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	14.3	13.8	13.3	12.8

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	2021
Annual Objective			34.5
Annual Indicator	36.7	36.7	36.7
Numerator	155,186	155,186	155,186
Denominator	422,534	422,534	422,534
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	34.0	33.4	32.9	32.3

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	
Increase access to school-based health centers	
ESMs	**Status**
ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit	Inactive
ESM 10.2 - Percent of middle and high schools with a school-based health center that offers health services to students	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)

FY21 Annual Report: Adolescent Health

The annual report is organized by the two priorities identified through the needs assessment process to address adolescent suicide and substance use.

After an extended period without an Adolescent Health Coordinator, an Adolescent Health Coordinator was hired from within MCH in February 2021. The Adolescent Health Coordinator is responsible for coordinating MCH priorities and oversees the ODH youth homelessness initiative.

Priority: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate

Measures

The State Performance Measure (SPM) was selected to track intentional self-harm, an important indicator for the National Outcome Measure (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. Evidence-based Strategy Measures (ESM) development for this SPM will be explored during FY 22.

- NOM 16.3- Adolescent suicide rate ages 15-19 per 100,000
  - According to Federally Available Data (FAD), data from the National Vital Statistics System show that the suicide rate among adolescents aged 15-19 was 11.3 per 100,000 during 2018-2020. This is a significant increase from 2013-2015, when the rate was 8 per 100,000.
- SPM- Rate of nonfatal intentional self-harm ED visits and hospitalizations ages 15-19, per 100,000 (VIPS)
  - According to data from Ohio Hospital Association, the self-harm related ED visits and hospitalizations among youth 15-19 years in Ohio was 465.9 per 100,000 in 2019. The rate decreased to 424.1 per 100,000 in 2020.
- ESM: None developed at this time.

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.

As part of the needs assessment process for the five-year Title V adolescent health action plan, Ohio prioritized adolescent mental health and suicide for the first time. While mental health and suicide are essential topics for adolescent health, Title V staff have historically supported ODH and state agency partners' work in these areas. These priorities were determined prior to the COVID-19 pandemic, which drastically highlighted the need to address mental health concerns among adolescents and young adults. Reducing risk factors and increasing protective factors are supported through ODH programs including the Maternal and Child Health Program (MP); through participation in existing workgroups such as Ohio's Anti-Harassment, Intimidation and Bullying (HIB) initiative; Ohio Interagency Council for Youth; Whole Child Advisory Group; participation in the ASPIRE learning collaborative; trainings by School Nursing and Early Childhood Programs and the work of the Sexual Assault and Domestic

Violence Prevention Program (SADVPP).

MP Adolescent Resiliency

Adolescents (10-17) and young adults (18-25) make up 22% of the United States population. The behavioral patterns established during these developmental periods help determine young people's current health status and risk for developing chronic diseases during adulthood.

Although adolescence and young adulthood are generally healthy times of life, some important health and social problems either start or peak during these years. Examples include mental disorders, substance use, tobacco use, nutrition and weight conditions, sexually transmitted infections, including human immunodeficiency virus (HIV), teen and unintended pregnancy, homelessness, academic problems, homicide, suicide, and motor vehicle collisions. Because they are in developmental transition, adolescents and young adults are particularly sensitive to influences from their social environments. Their families, peer groups, schools and neighborhoods can either support or threaten young people's health and well-being. Societal policies and cues, such as structural racism and media messages, can do the same. Older adolescents and young adults, including those with chronic health conditions, may face challenges as they transition from the child to the adult health care system, such as changes in their insurance coverage and legal status and decreased attention to their developmental and behavioral needs. Bolstering the positive development of young people facilitates their adoption of healthy behaviors and helps ensure a healthy and productive adult population.

The Adolescent Health Evidence-based Resiliency projects 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 learners, ACES, violence prevention/Safe Space, nutrition, and /or physical activity for years 1-3.

The following 12 counties are participating in the Adolescent Health Projects: Athens County Health Department, Belmont County General Health District, Clark County Combined Health District, Hamilton County Health Department, Highland County Community Action Organization, Lawrence County Health Department, Mahoning County District Board of Health, Medina County Health Department, Meigs County Health Department, Stark County Health Department, Trumbull County Health Department and Williams County Combined Health District.

The purpose of the MP Adolescent Health Evidence-Based Resiliency Projects is to reduce the rate of adolescent obesity by increasing access to physical activity and nutrition; prevent adolescent substance abuse by improving access to community mental health services; and to improve the identification and coordination of local community resources that support adolescent well-being.

The first year of funding for the grant program focused on planning and implementation, including staffing, development of a workplan, identification of an evaluation plan and development of an advisory committee to guide the work and submission of a final report detailing the population served and demographics.

Years two and three of the program will continue with implementation of the identified program. Staffing, work plan with evaluation and logic model, quarterly outcome reports and a final report are all requirements of the subgrantees. During FY21, the program served 754 adolescents, with 741 completing their respective program. Overall, 72% of participants reported being satisfied with the program. Additionally, the program results showed that 83.9% of participants increased skills and confidence, 75.2% participants increased knowledge, and 70.8% of participants with positive behavior change.

Partnership on Workgroups and Coalitions

MCH staff participate on a wide variety of workgroups and coalitions that support adolescent health initiatives. The Anti-Harassment, Intimidation and Bullying Initiative, led by the Ohio Department of Education (ODE), was initially developed as part of legislation in Ohio that requires Ohio schools to have a bullying policy. The group has expanded its focus beyond bullying and harassment to prevention work, including focusing on mental health and suicide, violence prevention, substance use prevention, human trafficking prevention and related topics. ODH

BMCFH staff that represent include the Adolescent Health Coordinator, School Nurse Consultant and YRBS/YTS Coordinator. Additionally, ODH Violence and Injury Prevention Section (VIPS) staff, including Sexual Assault and Domestic Violence Prevention Program (SADVPP) staff and Youth Suicide Consultant also participate. Other agencies represented include the Ohio Department of Mental Health and Addiction Services (OhioMHAS), Ohio Department of Public Safety, the Ohio Domestic Violence Network, Ohio Center for Autism and Low-Incidence (OCALI) and other state and local organizations, including universities. FY21 activities for the group included aligning group priorities with ODE's Whole Child Framework and exploring data from Ohio's YRBS and Ohio Healthy Youth Environment Survey (OHYES) surveys. During FY21, YRBS and OHYES staff began monthly and provided topical presentations on relevant data to the group to guide activities.

Another workgroup that supports this strategy is the Ohio Department of Education's Whole Child Advisory Group (WCAG). The WCAG is a diverse group of Ohio stakeholders focused on supporting the whole child. The group's role is to guide, promote and support the adoption and implementation of Ohio's Whole Child Framework throughout the state. Members also will help the ODE establish best practices and develop and identify resources that school districts can use to implement the framework. School Nursing program staff were also recruited to participate in the group's School and Student Health Problem of Practice to identify ways to promote physical health of students.

The Ohio Interagency Council for Youth (OICY) is another group focused on youth behavioral health. OICY was established to serve as the advisory body to the state and support the creation and maintenance of a comprehensive continuum of care for timely access to appropriate services among youth and young adults with behavioral health needs. The purpose of the group is to advise state agencies and promote evidence-based and promise practices related to behavioral health programming. The over-arching goals of the group are to increase access to behavioral health services for children and youth 0-25 and to reduce behavioral health disparities among children and youth 0-25. Workgroups focus on policy development affecting youth in behavioral health; workforce development; justice, equity, diversity, and inclusion; funding for youth behavioral health services; and data and evaluation. Youth and family with lived experience are present at each meeting and are also represented on OICY's steering committee. OYIC was created by the OhioMHAS through funding from Substance Abuse Mental Health Services Administration (SAMSHA.) OhioMHAS continues to provide backbone funding for the group. 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.

A new initiative for FY21 was the ASPIRE Learning Collaborative. Ohio VIPS led an interagency Ohio team in the learning collaborative through UNC Chapel Hill, which focused on youth suicide and Adverse Childhood Experiences (ACEs) prevention. Ohio's core team included ODH VIPS section administrator, BMCFH Adolescent Health Coordinator, and staff from ODE, Health Policy Institute of Ohio, OhioMHAS and Ohio Children's Trust Fund. The six-month collaborative walked the group through identification of an ACE or youth suicide as the focus and prioritization of risk and protective factors associated. Due to the unique nature of having a state-level team, the Ohio team identified three ACEs and then mapped out related risk and protective factors. The mapping and prioritization activities were beneficial for the core team in identifying program activities that have an impact on ACEs prevention. MCH and VIPS staff met regularly to reflect on the ACEs work and are working towards establishing an interagency ACEs workgroup.

School Nursing

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_M1HGGIK0N0JO00QO9DDDDM300bf86c00c-1003-4c77-85fc-fbefc48500d9-mMqOoKq). Many 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. It is planned for spring of 2022.

Despite the challenges of the ongoing 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. They have provided significant public health support by conducting COVID-19 contact tracing case investigation for students. 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 conferences (all held virtually since March 2020) 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, the 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, support 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 ongoing pandemic, all conferences were held in a live virtual format via Microsoft Teams.

The three 2021 Regional School Nurse Conferences were held in the spring, providing 5.25 CNEs for topics including mental health and Covid-19: behavior of students and staff; school nurse resilience; health equity; confidentiality; and infection control in the school clinic to 821 nurses over the three days. All these topics support MCH goals of integrative services, reducing barriers/improving access, and care of CSHCN. Summative evaluations for the conference were excellent.

The conference in the summer of 2021 addressed Health and Education Equity, including national speakers on level setting, nursing practices to address inequity, and more; 127 nurses attended, earning 6.4 CNEs. Summative evaluations for the conference were excellent.

The New School Nurse Orientation in August 2021 was again held on three successive Fridays. Registration for this virtual format was higher than previous years with 206 nurses earning up to 19.65 CNEs. While all the topics

supported 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 CSHCN, medical home, reducing barriers/improving access); chronic disease management, autism, special education services, anti-harassment, intimidation, and bullying; vision and hearing screening; management of food allergies; and more topics (CSHCN, 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, 1,831 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 CSHCN, removing barriers/improving access, confidentiality, homelessness, self-harm and cutting, opioids, child abuse and neglect, 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.

Another resource is 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 1,542 school nurses are enrolled in the Bulletin Board; 162 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 49.9% open rated and 17.4% click rate—both above industry average.

With funds from Title V, the School Nursing Program was able to contract with an external evaluator (Philliber Research Group) to conduct an evaluation of the program with the overarching goal to use a mixed methods approach, drawing from both existing and new data, to measure the impact the School Nursing Program has had on school nurses throughout Ohio as they provide care to students, families, staff, and the school community. During this year, the evaluators developed an evaluation plan and implemented data collection using the State-level School Health Infrastructure Measure (SSHIM); interviewing key state level stakeholders; surveying and interviewing participants in the 2021 Orientation for Nurses New to Ohio Schools and independent study courses; and conducting analysis of data in OhioTRAIN, Constant Contact, and the 2017 Survey of Health Services in Ohio Schools. The final report is expected in the winter of 2022.

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, 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 convened an interdisciplinary team to update and revise the document. While the goal was to have the revisions completed in 2022, competing priorities related to the pandemic have delayed the final formatting and production of this resource.

The School Nursing Program supports the work of the Adolescent work group by participating in the Ohio Department of Education Anti-Harassment, Intimidation, and Bullying group as well as the state level Trauma Informed Schools Committee. The resources developed by these workgroups are shared with school nurses across the state via the School Nurse Bulletin Board and during professional development opportunities. MCH funds are also being used to provide schools employing school nurses for the first time with a School Nurse Clinic Starter Kit, which will provide the basic supplies to equip a space in the school for a school nurse. In addition, MCH funds will be used to contract with a facilitator to convene an interdisciplinary, state level group to identify ways to diversify the population of school nurses in the state of Ohio.

Collaboration between the ODH School Nursing Program and BMCFH team have strengthened, with the departments collaborating more closely on their work. As an example, School Nursing Program staff are heavily involved in the American Rescue Plan Act funded work to support school-based health with School-Based Health Centers. In addition to that work, new ongoing school-based health meetings have been created to improve collaboration between the agencies.

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 2022. Title V funding supports the contract for statistical services to draw a weighted sample and clean and weight the data after collection.

Sexual Assault and Domestic Violence Prevention Program
According to CDC, *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence* (Wilkins, Tsao, Hertz, Davis & Klevens, 2014), suicide, teen dating violence, sexual violence and bullying share the same risk and protective factors. ODH is pooling resources to prevent multiple forms of violence at once by working on strategies that address shared risk and protective factors.
The Sexual Assault and Domestic Violence Prevention Program (SADVPP) at ODH funds eleven rape prevention education programs in local communities, some of which reach multiple counties, such that a total of seventeen of Ohio's 88 counties receive some programming. Funded primarily through the Center for Disease Control and Prevention (CDC) and Prevention's Rape Education Program, with some additional support through the Public Health and Health Services Block grant, these programs are focused on the primary prevention of sexual violence with a focus on community and societal change.
Programs worked together to select risk and protective factors of focus for Ohio. These are reducing the risk factors of lack of non-violent problem solving skills, cultural norms supporting aggression, harmful norms around masculinity and femininity, societal norms that support sexual violence, and weak health, educational, economic and social policies and laws, and supporting the protective factors of association with pro-social peers, connection/commitment to school, connecting with a caring adult, community support and connectedness, and coordination of resources and services among community agencies.
Strategies for implementation are selected from or aligned with the CDC technical assistance package to prevent

sexual violence, STOP SV. These strategies include to prevent social norms that protect against violence, teach skills to prevent sexual violence, provide opportunities to empower and support girls and women, and to create protective environments. A recent area of focus for this work has been to complete these strategies within a community mobilization framework, ensuring participation at every stage of implementation from the community to be reached by the strategy.

Some of these programs are part of Ohio's Youth Led Prevention Network and county Alcohol, Drug Addiction and Mental Health Boards. Youth led programming trains youth to recognize when peers are struggling with substance use, physical violence or mental health issues and refer them to the appropriate adults. Youth leaders also encourage their peers to join them in making their schools a safe place to learn. The eleven funded rape prevention programs work collaboratively on awareness month activities (e.g., teen dating violence, suicide prevention). This is evident in cross posting social media messaging. (See below an example of a graphic for a Youth Led Message from the Teen Alliance Council in Warren County).

During the height of the COVID epidemic, the ODH SADVPP program sponsored six community led workgroups for Rape Prevention Education (RPE) funded and non-funded programs. The workgroups centered on areas of interest to explore best practices and strategies to implement in Ohio. Two of the workgroups (Youth Led Social Marketing Practices and Curriculum Adaptation & Preventionist Training) identified youth mental health as a top concern.

The Social Marketing Practices workgroup conducted a survey of youth leaders and identified the need to strengthen ties with local county Alcohol, Drug Addiction and Mental Health Boards. Youth leaders identified mental health issues (i.e., depression and anxiety) and the lack of an adult to turn to as risk indicators. In the white paper being drafted, this workgroup is recommending the need for joint social marketing campaigns.

The Curriculum Adaptation & Preventionist Training workgroup identified the need for creating safe and trauma free spaces on-line. They also identified that many in-class teachers were relying on the preventionist to help with referral not only for teen dating violence and bullying survivors, but those youth who are experiencing mental health challenges. The white paper this workgroup is developing has identified the need for preventionists to be trained in 1) trauma practices and 2) creating trauma free spaces for programming on-line. Additionally, the workgroup will be providing outlines for school personnel and staff training around trauma.

Other work groups were a School Policy work group, which is working to create a rubric of best practices for related school policy, and a work group on evaluation.

Ohio Department of Health staff, including staff in positions in the Bureau of Health Improvement and Wellness partially funded through the MCH Block Grant, support these efforts in partnership with the state sexual assault coalition, the Ohio Alliance to End Sexual Violence (OAESV), which is also a recipient of the Rape Prevention Education funding. Support included:

- Meeting with and providing resources to the local funded projects and the community led statewide work groups.
- Providing a training on community mobilization

- Providing input and recommendations for the OAESV annual conference, held annually each June

Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute. Retrieved from https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

Sexual Risk Avoidance Education

While not funded by Title V, the Sexual Risk Avoidance Program provides resources to support the objective and partners with other Title V funded programs to reduce risk and increase protective factors for youth.

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.

The Sexual Risk Avoidance Program reflects the commitment of 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 reduce births among teens.

The Sexual Risk Avoidance (SRA) Program currently funds organizations that oversee and facilitate Sexual Risk Avoidance Education programming across four geographical regions. The Ridge Project is Ohio's subrecipient in Region 1, which covers northwest Ohio cities and communities. Relationships Under Construction is Ohio's second subrecipient and they reach Regions 2, 3 and 4, which covers the remainder of the state.

Currently, each region is awarded upward of $500,000 through the Sexual Risk Avoidance grant. 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. Subgrantees also utilize student led initiatives such as Ohio Youth Council, advisory groups and teen led podcasts to encourage youth leadership in initiatives. They also offer parent classes and resources, both in person and virtually.

Each agency focuses 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 2021 Ohio's SRA program served 37,331 students. The program targets middle school students, and 80% of those served in FY21 were middle school students. This was a 7% increase from last fiscal year in reaching middle school audience. Although there was a decline in general numbers last year because of COVID, the sub recipients were creative in attempts to continue class instruction and developed online/distance learning modules to modify the current curricula to allow for continued programming. Schools often canceled, prohibited outside guest speakers, or simply ran out of time because of reduced class time.

Moving forward, the program will aim for a return to pre-pandemic levels of engagement, reaching upward of 100,000 students in Ohio schools. The focus will continue to be 11–14-year-olds and priority counties where higher birth rates are present.

In addition to the strategies listed above, training and resources related to ACEs, risk and resiliency and other mental health topics addressing children under the age of 10 are included in the child section of the report. School nurse trainings and other school-based trainings and programs cover both the child and adolescent population, as school staff can work with preschool-aged children up to twelfth grade. There is ongoing collaboration between child and adolescent workgroups to coordinate strategies included in each action plan, including co-leading of the two workgroups by three MCH staff (Adolescent Health Coordinator, Early Childhood Health staff and Parent Consultant). The groups meet each meet separately, bi-monthly, as there are many MCH staff who sit on both workgroups. The workgroups meet as a large group to share updates and discuss coordination twice a year.

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.

According to the Ohio Department of Health, Suicide Demographics and Trends, Ohio 2018 report, suicide is the leading cause of death for Ohioans 10-14 years of age and the second-leading cause of death for Ohioans who are 15-24 years old. From 2007-2018, the rate of youth suicide (10-24 years) increased 64.4% from 7.3 to 12.0 deaths per 100,000. Youth suicide prevention is a state-level priority. MCH and VIPS representation for the Ohio Suicide Prevention Plan will help coordinate services and resources to make the most significant impact on preventing youth suicides.

VIPS contributed to the Ohio Suicide Prevention plan and is responsible for the youth component of the plan. The ODH-funded Child Injury Action Group (CIAG) created a youth suicide subcommittee to address youth specifically. This subcommittee went through the strategic planning process with the Ohio State University College of Public Health and produced a plan that is currently under review. With this plan, ODH can align and coordinate youth suicide prevention efforts for the state. This plan aligns with The Suicide Prevention Plan for Ohio.

The CIAG Youth Suicide Subcommittee started strategic planning with an environmental scan of existing youth suicide resources and services in December 2020. The short-term outcomes were the creation of the subcommittee, including networking and collaboration to create a National Suicide Prevention Month resource guide and Governor's Proclamation for partners. The long-term outcome will be the implementation of the strategic plan. The strategic planning committee met 15 times between August 2020 until April 2021, when the strategic plan was completed. The group accumulate attendance was 288. The group produced an environmental scan and a strategic plan that is currently being reviewed.

VIPS was the funder and lead of the project and MCH was a collaborative partner. MCH Adolescent Health staff participated throughout the strategic planning process and participated on the youth suicide subcommittee. Stark County Health Department was awarded funding to facilitate the strategic planning and environmental scan. ODH worked to draft the plan by identifying priorities, strategies and activities that align with the state suicide prevention plan. Additional partners include Ohio Mental Health and Addiction Services (OMHAS), Ohio Chapter of Mental Health America of Ohio, local health departments, Ohio Suicide Prevention Foundation, local mental health boards and mental health agencies, National Alliance on Mental Illness (NAMI) and other CIAG members.

To further support mental health and suicide work, Ohio was invited to participate in the Adolescent and Young Adult Behavioral Health CoIIN facilitated by AMCHP and NIPN. The Ohio team is led by the BMCFH Adolescent Health

Coordinator and includes team members from ODH BMCFH and VIPS; ODE; the Ohio Department of Mental Health and Addiction Services (OhioMHAS); Ohio Association of Community Health Centers (OAHC); the Ohio Chapter of American Academy of Pediatrics (AAP) and Nationwide Children's Hospital (NCH). ODH VIPS already had a contract in place with Ohio AAP to complete a Quality Improvement project around depression screenings in primary care, so the Ohio CoIIN team decided to utilize School-Based Health Centers (SBHC) for the QI arm of the project. The CoIIN kicked off in July 2021, with Ohio's team meeting monthly. The first sessions of the CoIIN focused on mapping out existing initiatives in Ohio to help determine CoIIN activities. The QI arm work will help inform the activities of the public health arm. The CoIIN ran through December 2021.

Priority: Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use

Measures

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 measures continued efforts to increase rates of adolescents served by Medicaid with well visits.

- SOM- Percent of high school students who have used alcohol within the past 30 days (YRBS)
    - According to the 2019 Ohio YRBS/YTS, 25.9% of Ohio high school students drank alcohol during the 30 days before the survey.
- SOM- Percent of high school students who have used marijuana within the past 30 days (YRBS)
    - According to the 2019 Ohio YRBS/YTS, 15.8% of Ohio high school students used marijuana during the 30 days before the survey.
- 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)
    - According to the 2019 Ohio YRBS/YTS, 35.6% of Ohio high school students used cigarettes, smokeless tobacco (i.e., chewing tobacco, snuff, or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes, or other vaping products during the 30 days before the survey.
- NPM 10: Percent of adolescents (12-17) with a preventive medical visit in the past year
    - According to the Federally Available Data (FAD), data from the 2019-2020 National Survey of Children's Health show that 80.2% of adolescents aged 12-17 years had a preventive well-visit in the past year. Changes to the filter question in the 2018 survey year mean that we cannot compare this value to 2018 data, but it is similar to the percent of adolescents with a preventive well-visit reported in the 2016-2017 NSCH (78.1%).
- ESM: Percent of adolescents (12-17) served by Medicaid with adolescent well visits
    - In State Fiscal Year (SFY) 2021, 46.5% of Ohio's eligible Medicaid youth, ages 12-17, received a well-care visit. Female adolescents were slightly more likely to have had a well visit than male adolescents (48.1% versus 45.0%). Black adolescents were slightly more likely to have had a well visit than white adolescents (49% versus 45%). These numbers are consistent with years past: the overall percent of adolescents served by Medicaid with a well visit was 44.4% in SFY 2020 and 48% in SFY 2019.

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.

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.

The COVID-19 pandemic has further highlighted the importance of prioritizing well-visits for the adolescent population. As part of the Ohio Adolescent Health Partnership, data was shared from Merck regarding national child and adolescent well-visits during the COVID-19 pandemic. MCH staff met with Merck staff, and the data was shared throughout the bureau and agency to elevate the need to address well-visits, particularly for adolescents. This led to a social media campaign during National Immunization Awareness Month in August 2021, which included input from MCH and ODH Immunizations program. ODH Communications staff created a toolkit of social media posts that was shared with stakeholders. The campaign and toolkit included messages related to the importance of well-visits and immunizations, with specific images and messages focused on adolescents.

In addition, ODH received funding through CDC's Workforce Development Grant in July 2021. MCH staff have been leading the development of a funding process to support creation or expansion of School-Based Health Centers (SBHC). The large project braids multiple funding streams and involves internal ODH partners from the Offices of Rural Health and of Health Opportunity and the Ohio Department of Education. Funded projects were awarded in 2022. A SBHC Coordinator will be hired within MCH and will manage the project, along with SBHC initiatives and workgroups with stakeholders. Additional SBHC work includes work within the Office of Rural Health to support expansion of mental-health services in rural SBHCs.

To further support initiatives related to increasing well-visits and supporting comprehensive well-visits, MCH developed a contract with Ohio AAP during FY21. The contract deliverables address multiple priorities across the bureau. The contract was developed during the summer of 2021 and awarded in October 2021. The first year of the contract will offer monthly webinars on a variety of topics, including adolescent immunizations and well-child visits, behavioral health, and other related topics. Resources for physicians and handouts for families on various topics will also be created. Focus groups with families and physicians will also be conducted to inform the creation of materials to ensure they speak to a diverse audience.

Cross-program partnerships and coordination will benefit strategies focused on both adolescent well-visits and school-based health centers. Internally, capacity issues have continued to occur due to the COVID-19 pandemic. The ODH Immunizations program has been primarily focused on the COVID-19 response, but MCH plans to coordinate work as the pandemic needs decrease and staff can return to normal duties.

Oral Health Program

Furthering supporting access to clinical services in schools, the Oral Health Program funds 12 subrecipients for the School-Based Dental Sealant Program. The 12 programs provide dental sealants to students in 33 counties in Ohio. Qualifying schools have at least 40% of the students eligible for the Free and/or Reduced-Price Meal Program. Students in these schools are at higher risk for tooth decay because of poorer access to preventive dental care due to lower family income, lack of dental insurance, or barriers to finding a dentist who accepts Medicaid.

The sealant programs primarily target students in 2nd, 3rd, 6th, and 7th grades. The School-Based Dental Sealant Program experienced similar challenges as other school-based programs, due to COVID-19. During FY21, 3,207 students received dental sealants, a significant decrease from the 18,793 students in ODH funded programs who received sealants in 2019. During the last quarter of 2020, only two of the subrecipient programs were back in the schools. Currently, 10 of the 12 dental sealant programs are back in the schools.

RHWP

The Reproductive Health and Wellness Program (RHWP) provides monitoring and support to its Title X family planning clinics. The 43 subrecipients provide direct healthcare services in their county. All clinics are adolescent friendly. In state fiscal year (SFY) 2021, RHWP clinics reported 61,582 visits, and of those 5,018 (8%) were adolescent visits (i.e., 12 – 17 years old) Most clinics offer telehealth visits, which allowed adolescents the ability to have a visit without transportation. In SFY 2021, 186 adolescents used telehealth for their visit. Beginning in April, most clinics offered incentives to help offset costs of going to an appointment (e.g., transportation passes, gift cards).

At a visit in a RHWP Title X clinic, all adolescents receive screenings and referral, if necessary. In SFY 2021, the number of referrals reported in Ahlers Software for adolescents were 260 for victimization/domestic violence, 103 for mental health, 152 for immunizations, 554 for nutrition, and 13 for substance use. Involvement of family is encouraged and methods to resist sexual coercion are presented. When appropriate, counseling and education are provided. For example, in SFY 2021, the number of counseling services provided to adolescents were 3,601 for contraception, 2,486 for reproductive life plans, 1,928 for sexual risk avoidance, 1,090 for abstinence, 2,868 for sexually transmitted infections, and 2,445 for healthy relationships. In calendar year 2020, through counseling, education, and contraceptives, it is estimated that 496 births, 520 abortions, 150 miscarriages, and 1,166 unintended pregnancies were averted in clients 19 years and younger.

The RHWP Title X clinics that participate in the special populations or faith-based organizations deliverables receive additional funding to provide enhanced services. One of the categories for the special population deliverable is adolescents. The clinics with the faith-based organization funding are required to offer educational programming to adolescents geared toward life planning, goal setting and healthy life choices.

The RHWP usually provides one webinar on adolescent health annually. The webinars are intended for healthcare providers. Recent topics include adolescent education and counseling; connecting with teens; communication strategies and considerations; and outreach and special populations. Over 100 healthcare workers were on the most recent training. After listening to the adolescent health presentation, 67% of participants indicated the clinic would have more adolescent outreach, 56% reported an expected increase in adolescent visits, 78% predicted an increase in adolescent patient satisfaction, and 56% believed the clinic would provide higher quality care to adolescents. Furthermore, all Title X clinic staff, including doctors and nurses, must take annual required training on adolescents and mandated reporting. This is monitored annually with technical assistance visits/calls and comprehensive reviews.

The RHWP encourages the subrecipients to prioritize youth voice. For example, all Title X clinics are required to have an advisory committee, and it is expected that adolescents are included as members on these committees. Additionally, clinics are to have patient satisfaction surveys at least twice per year. Both actions provide an opportunity to receive feedback from adolescents. Some changes clinics have incorporated from these activities include offering specific teen clinic hours, having electronic forms and check-in, and providing chargers or wi-fi in

waiting rooms.

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.

Title V has supported the Ohio Adolescent Health Partnership (OAHP) 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 serve adolescents more effectively and positively. With a vacancy in adolescent health at ODH and the shift to all virtual meetings, OAHP has been challenged with membership engagement and meeting attendance since 2020, yet the group continued to meet quarterly, and long-time members remain committed to OAHP's vision. When the Adolescent Health Coordinator position was filled, focus groups were held with long-time members of OAHP to obtain feedback on experiences and recommendations on future strategies and structure. In addition, the OAHP strategic plan expired in 2020. Due to limited adolescent health capacity and based on recommendations from the focus groups, ODH MCH developed an RFP to contract with an individual to act as the OAHP Coordinator during FY21. An individual with many years of experience with OAHP was awarded the contract, which was fully executed in FY22. The OAHP Coordinator will oversee administrative duties of the OAHP and create orientation materials, communication plan and increase youth engagement in OAHP. MCH is also supporting an RFP for a facilitator for a strategic planning process for OAHP, to take place in FY22. The strategic plan will be aligned with MCH priorities, the ODH State Health Improvement Plan along with other stakeholder plans, such as the Ohio Suicide Prevention Plan and the strategic plans of partner agencies such as ODE and OhioMHAS. The strategic planning process will also include youth engagement.

As mentioned previously, the youth suicide subcommittee of the CIAG conducted an environmental scan specific to youth suicide resources as part of the strategic planning process. In addition, the Ohio Department of Education conducted a survey of Ohio schools to assess the number and type of prevention programming that was occurring throughout the state. The results from that survey were expected to be released in July 2021, but ODE continues to analyze the results. Once the data is released, MCH will examine the results from both of those scans to determine if there is a need to conduct any further scans related to prevention activities. Any assessments will be coordinated with OAHP strategic planning development as well.

TUPCP

While not funded by Title V, the Tobacco Use Prevention and Cessation Program provides resources to support the objective and partners with other Title V funded programs.

Youth Engagement Subcommittee

Youth engagement has become an important component of the MCH block grant work, and a strategy was added for

FY22 to engage youth. During FY21, an internal ODH workgroup was convened as a subcommittee of the adolescent workgroup to examine how youth-serving programs utilize youth voice or engage youth in programming. The workgroup included active participation from all MCH youth-serving programs in addition to youth-serving programs from other bureaus, including VIPS, TUPCP, and HIV Prevention Program. FY21 activities included mapping out how programs currently engage youth, discussing ideas for strengthening youth voice and researching best practices and evidence-based youth engagement programs. FY22 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), as mentioned previously.

Ohio Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)

The Ohio YRBS is a CDC-supported, representative, 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 as a state representative sample survey, provides valuable data for the state to inform statewide 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. Administration began with the start of the school year in 2021. COVID-19 added additional barriers to school participation this year, including school staff reporting they were overwhelmed with contact tracing and other COVID-19 related activities, and an increase in parental pushback. This is similar to what other states' YRBS Coordinators reported experiencing during their 2021 survey administration. If weighted data is achieved, it is expected to be received in Spring 2022 and will be examined and disseminated internally and publicly.

Coordination with state partners on youth data collection continues. In December 2020, Youth Survey Coordinator presented to the Ohio Board of Education with staff from ODE and OhioMHAS. The presentation shared information from YRBS and OHYES, the importance of collecting youth behavior data and how schools and communities can use local and state data. In addition, ODH YRBS staff, OHYES staff and ODE staff meet regularly to discuss youth data and co-presented numerous times during FY21, including for the Anti-HIB meetings and for the 2021 All Ohio Counselor's Conference. (Note: OHYES is a school building convenience sample survey administered by Ohio MHAS.)

In addition, MCH staff continue to participate on interagency discussions around youth survey coordination. Staff from OhioMHAS, ODE and ODM have been involved in the process since 2019 and the workgroup has evolved over time. In late FY21, a project director was assigned to facilitate the workgroup, including identifying shared goals. A small workgroup meets weekly to identify goals and a workplan to enhance coordination across surveys.

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.

Youth Homelessness

State Fiscal Year 2020 marked the first time ODH received funds through the state budget (the General Revenue

Fund, GRF) to address youth homelessness. The budget line item was specific to addressing homelessness in individuals aged 14-24, with particular emphasis on homeless youth who are pregnant. Funding was continued through the GRF for SFY22 and 23, which will result in continued funding for the 13 agencies who currently receive funding. Title V does not currently fund this initiative, but the Adolescent Health Coordinator oversees the youth homelessness grants. 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 can be used for services not typically covered by traditional federal funding for homelessness. In FY21, ODH contracted with the Coalition on Homelessness and Housing in Ohio (COHHIO) for technical assistance with the program. The aim of the contract 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. In addition, COHHIO provides ODH guidance on program planning and technical assistance and training opportunities for the funded agencies.

Children's Hearing and Vision Programs

The Ohio Department of Health (ODH) Children's Hearing and Vision Program sets the screening requirements and guidelines for school-based preschool and K-12 schools. These requirements include grades that are to be routinely screened each year; equipment that is acceptable to use; specific hearing and vision tests needed to perform the screenings; and the referral criteria. Schools providing medical services are required to screen school-aged students for vision screenings. Regular school hearing and vision screenings are important methods for identifying children who are at risk for hearing and/or vision loss. In addition to establishing school screening requirements, the program conducts annual reporting of hearing and vision screening data to determine compliance with screening requirements, plan statewide vision screening trainings, establish, and revise Ohio hearing and vision screening guidelines and provide resources for Ohio's schools. During the 2019-2020 school year, the program was greatly impacted due to the COVID-19 pandemic and schools opting for remote learning. Due to this shift, it did not allow for schools to complete the hearing and/or vision screenings in a timely fashion. Schools were encouraged to inform parents and caregivers to their child's primary care providers to receive hearing and vision screenings as part of the annual well child visit schedule.

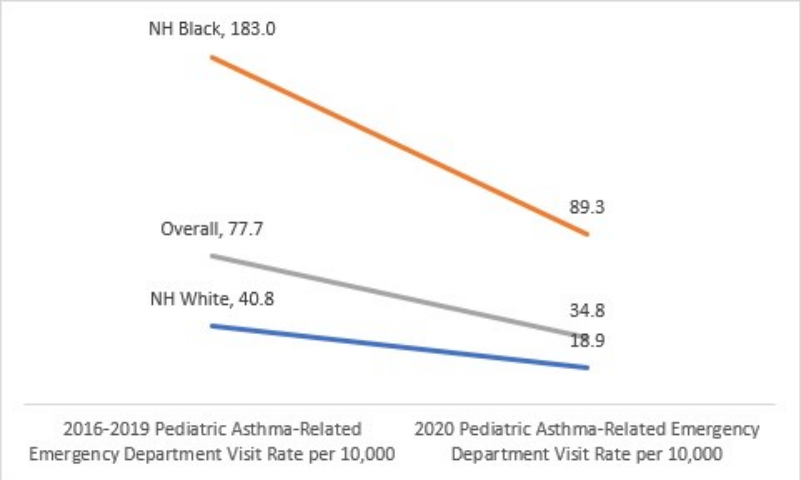
According to the preliminary data from the 2020-2021 Annual Vision Screening Report, the highest percentage of students who were screened in a required grade was preschool (64.42%) followed by kindergarten (57.19%), first grade (51.16%), third grade (50.42%), fifth grade (46.77%), seventh grade (42.28%), ninth grade (34.60%), and eleventh grade (28.45%). The 2020-2021 Annual Vision Screening Report also identified the highest percentage of a required grade to complete follow up after a referral was Kindergarten (24.57%) followed by third grade (23.44%), first grade (22.25%), preschool (21.15%), fifth grade (19.42%), seventh grade (15.50%), ninth grade (10.32%), and eleventh grade (8.99%).

According to the preliminary data from the 2020-2021 Annual Hearing Screening Report, the highest percentage of students who were screened in a required grade was kindergarten (55.8%) followed by preschool (51.00%), first grade (49.0%), third grade (48.0%), fifth grade (45.3%), ninth grade (32.1%), and eleventh grade (27.6%). The 2020-2021 Annual Hearing Screening Report also identified the highest percentage of a required grade to complete follow up after a referral was kindergarten (22.2 percent) followed by first grade (18.3percent), followed by followed by third grade (18.7 percent), preschool (14.9 percent), followed by fifth grade (14.2 percent), then ninth grade (11.1 percent) and eleventh grade (8.5 percent).

Asthma Program (AP)

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, there are racial, educational, and economic disparities in asthma prevalence. Non-Hispanic Black children in Ohio visit the emergency room for asthma at a rate more than 4 times that of non-Hispanic white children. Hispanic children visit

the emergency room for asthma at a rate nearly double that of non-Hispanic white children. Non-Hispanic Black children are hospitalized for asthma at a rate more than 6 times that of white children. Hispanic children are hospitalized for asthma at a rate double that of non-Hispanic white children (OHA 2019). 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 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.



Sources: Ohio Hospital Association Clinical Financial Database 2016-2020
Bridged-Race Population Estimates on CDC WONDER On-line Database 2016-2020

For Hispanic children, their pediatric asthma-related ED visit rates were:
2016-2019: 67.8 per 10,000
2020: 33.2 per 10,000

Adolescent Health, Application Year FY 2023

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 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 the impact these factors had on adolescents, as school and community activities largely returned in-person. While well-child visits decreased across all age groups, adolescents experienced the largest drop in visits. In addition, serious mental health concerns among youth continue. In early 2022, the Surgeon General released a report highlighting the urgent need to address adolescent mental health. The needs related to adolescent mental health and adolescent well-visits remain and will continue to be the key focus areas for Ohio's FY23 block grant strategies.

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 23.

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 23 and beyond. Adolescent resiliency projects through the Maternal and Child Health (MP) program grantees moved to the implementation phase in FY22, 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. FY23 is the final of the three-year funding cycle for the current grant. The MP program is utilizing Results-Based Accountability to ensure programs are measuring progress. The data will be reviewed by ODH staff during the final year to plan for the next iteration of the work. The MP program was moved from the Maternal and Infant Wellness Section to the Women and Family Health Section in April 2022, to better align adolescent health programming within the MCH work.

In addition, MCH staff will continue to participation in existing statewide coalitions and workgroups. Workgroups include the Ohio Anti-Harassment, Intimidating, and Bullying group, which is led by ODE, the Ohio Prevention Partnership (which includes both the Child Injury Action Group and Youth Suicide Subcommittee), ODE's Whole Child Advisory Group, the Ohio Interagency Council for Youth (OICY) and Linking Systems of Care for Ohio Youth. MCH Adolescent Health Coordinator will serve as co-chair of OICY during FY23. 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). In FY22, ODH assembled an internal ACEs workgroup during FY22 and will continue to focus on imbedding ACEs work into existing programs.

The external stakeholder group for this work has been the Ohio Adolescent Health Partnership (OAHP). Historically, ODH provided staff support for OAHP. In FY22, after an extended vacancy in the adolescent health coordinator position, MCH contracted with an individual to serve as the OAHP Coordinator. The contract includes managing communications, creating orientation materials, securing speakers, engaging youth and continued education materials, and managing workgroups. In addition, MCH funds were used to contract with Measurement Resources Company (MRC) to facilitate a strategic planning process with OAHP. The strategic planning contract will go through 2022, resulting in a new OAHP strategic plan. Active youth engagement in the strategic planning process is included as a requirement of the contract.

Additional agency work for FY23 includes addressing risk and protective factors including school nurse and early childhood training, continued community-level work by Sexual Assault and Domestic Violence Prevention Program (SADVPP) and work from the Reproductive Health and Wellness Program, as well as Sexual Risk Avoidance Program.

The topics for regional conferences for school nurses are not yet determined for FY23, but typically reflect emerging and relevant issues facing school nurses and have recently included topics on self-harm, suicide, and mental health, including post-COVID considerations. 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 August.

The School Nursing program is utilizing federal COVID ARPA funding to hire 5 regional and one state School Nurse Consultant through June 2023. These additional staff members will allow the program to provide more support at the regional level, with much greater emphasis on local resources. These nurses will be working with schools, local health departments, educational service centers and other community groups such as alcohol, drug, and mental health (ADAMH) boards to identify needed resources, foster community connections and provide or support professional development, technical assistance and other support for students and their families.

SADVPP will continue to implement strategies to end sexual violence including changes to school and workplace policies, social marketing campaigns, community mobilization efforts, and educational programming - In partnership

with the Ohio Alliance to End Sexual Violence and eleven local sexual violence prevention programs.

FY23 activities include supporting survivors of sexual violence by updating, maintaining, distributing, and educating users about the protocol for sexual assault evidence collection; supporting crisis services in six agencies in order to provide services to African/African American/Black, Asian/Asian American, and Latinx survivors of sexual violence and providing technical assistance and training opportunities for rape crisis centers and others who work with survivors on ways to increase effectiveness in working with survivors from specific communities.

In addition, SADVPP will 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. For FY23, Reproductive Health program awarded additional funding for special populations, which can include adolescents, for 15 subrecipients and the faith-based deliverable to five subrecipients. The Sexual Risk Avoidance Program began 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.

The selection of reducing youth suicide as a priority 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 2022 and MCH will continue to support and align with the strategies in the plan. FY21 and FY22 have been planning years for MCH to identify where gaps exist, and support could be used. MCH is working on finalizing a plan to support the implementation of the Ohio Suicide Prevention plan, including all the collaborative work that has been done throughout the first two years of this grant cycle.

A large part of this work has centered around the Adolescent and Young Adult Behavioral Health (AYA-BH) CoIIN. ODH was invited by AMHCP to participate in the CoIIN after identifying reducing youth suicide as a priority in the action plan. The Ohio team is led by ODH MCH Adolescent Health Coordinator and includes MCH and VIPS staff, along with ODE, OhioMHAS, Ohio AAP, the Ohio Association of Community Health Centers, and Nationwide Children's Hospital, who asks as the recruitment partners for the practices involved in the QI/clinical arm of the project. The team has spent much of FY22 mapping out adolescent behavioral health and suicide prevention activities and discussing gaps and barriers. Ohio has a robust mental health system, with great partnerships occurring at the school and community level. Knowing this and due to the partners on the team, the Ohio CoIIN team chose to focus on partnerships with pediatricians or clinical providers. The project will officially end at the conclusion of 2022, but the Ohio CoIIN team has already decided to continue to meet monthly. Many team members have identified potential resources to support projects to support this connection between schools, communities, and

clinical providers.

In FY22, ODH MCH contracted with the Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) to address many health topics for children and adolescents. FY22 activities have included holding focus groups with parents and providers to get feedback on resources on a variety of topics. In addition, AAP offered monthly webinars which have included adolescent mental health, immunizations, ACEs, and other topics. FY23 activities for the grant include Quality Improvement (QI) projects. Ohio AAP will recruit practices to participate in a QI project and the practices will choose from a variety of topics for the QI, including ACEs and adolescent depression screenings. Quarterly trainings will also be offered during FY23.

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 schools in Ohio that have a School-Based Health Center that offer health services to students.

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 prior ESM measure monitored rates of adolescents served by Medicaid with well visits, which is important measure for this work. However, it was replaced with the new ESM, which measures schools in Ohio that have a School-Based Health Center (SBHC). SBHCs are an evidence-based strategy to increase access to care for students, particularly low-income students.

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.
4. Increase the number of schools in Ohio with School-Based Health Centers.

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. In FY22, ODH partnered with the Ohio Department of Education and leveraged CDC Workforce Development funds with ODE funds to offer $26 million dollars to fund fourteen school-based health center projects across Ohio. These one-time funds were to expand existing or create new school-based health centers in priority counties and school districts in Ohio. While MCH funds are not used to fund the initiative, MCH staff participated in the planning and development of the request for proposals and participate in program discussions. In addition to funding SBHCs, funds were used to contract with Nationwide Children's Hospital, through a competitive application process, to implement a training academy for the

SBHC funded agencies. Finally, funds are also planned to contract with the Ohio School-Based Health Alliance. The Alliance provides important opportunities for training, technical assistance, and collaboration among school-based health centers across Ohio.

Because the SBHC projects will end June 30, 2023, FY23 activities for MCH will include monitoring the SBHC project and determining how MCH can be used to increase sustainability of the project and support future SBHC work in Ohio.

ODH's office of Rural Health also provides support for SBHCs in rural areas through a contract with Nationwide Children's Hospital. In addition, the AYA-BH CoIIN team chose to focus on SBHCs for the clinical/QI arm of the project, which focused on increasing depression screenings. Nationwide Children's Hospital serves as the recruitment partner for the work and participates on the public health arm of the project. Partnering with SBHCs for the CoIIN helps facilitate connections between MCH staff and schools and guide further work. FY23 activities will be to review the data from the QI project and determine how the CoIIN team can provide connections for clinical providers, including SBHCs. This collaboration will include MCH's SBHC Coordinator, who joined the CoIIN team as well.

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 continues to be primarily focused on the COVID-19 response, but MCH plans to coordinate work as the pandemic needs decrease and staff can return to normal duties. One coordinated project is a planned media campaign addressing immunizations and well-child visits.

In addition, the previously mentioned contract with Ohio AAP is working to address needs around provider education and quality improvement from many ODH programs.
MCH adolescent health staff have participated on the advisory board for the Midwest Adolescent Health Project from the Adolescent Health Initiative since round one in 2019. For round three, which kicked off in March 2022, three Ohio sites are participating, including two SBHCs. One of the identified priority areas for the Ohio sites are adolescent well-visits.

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.

During FY21, the Ohio Department of Education conducted a survey of all schools in Ohio to determine what prevention activities were occurring in schools, and who was providing the programs or curriculum. The report was released in late 2021. In addition, as part of the Youth Suicide Prevention Plan, a survey of suicide prevention work was conducted. MCH will continue to review these reports, in lieu of conducting a separate environmental scan. The OAHP Strategic Plan will also include reviewing data and existing state plans to align and coordinate activities. 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.

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 several youth-focused tobacco prevention initiatives- such as passing local youth-focused prevention policies, improving, or adopting tobacco-free policies in schools and public spaces, tobacco/nicotine prevention and education efforts, and promotion of the youth-centered cessation program, My Life My Quit. In addition, the program will be funding additional subgrantees as tier 1, who will focus on building capacity for tobacco and nicotine prevention in their area. The new Tier 1 and 2 grant cycle will begin July 1.

FY 23 activities include further examination of 2019 YRBS data on disparities, especially related to mental health and suicide. Ohio has not yet received confirmation of 2021 YRBS weighted data, but if data is received, that will be an important activity for FY23.

Youth engagement has become an important component of the MCH block grant work, which is why a strategy was added to engage youth. During FY22, the internal ODH youth engagement workgroup created a proposal for leadership that recommended ODH replicate the youth advocacy fellowship component of the Providers and Teens Communicating Health (PATCH) Program, which is a promising practice in AMCHP's Innovation Hub. MCH signed an agreement with PATCH to replicate the program and six ODH staff, along with the contracted facilitator of the Ohio Adolescent Health Partnership (OAHP), which is a stakeholder group for the adolescent work. The PATCH replication will be a partnership between ODH MCH and OAHP and the OAHP facilitator and MCH Adolescent Health Coordinator will co-lead the group.

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, representative sample, 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, representative of the state, to inform program and policy decisions on many health behaviors of Ohio adolescents.

The 2021 YRBS/YTS included 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. The 2023 YRBS/YTS will also include the 16 ACEs questions and will be administered during the fall of 2023. FY23 activities will include questionnaire development through the YRBS/YTS advisory committee.

MCH staff have also participated on a multi-agency workgroup around coordinating youth survey work across the state. In FY22, a project manager was identified through the state and has guided the multiagency group through planning and timeline development. The group is currently focused on developing a shared website and have released an RFP for a vendor to develop the website. The focus for FY23 will be getting the website created and published.

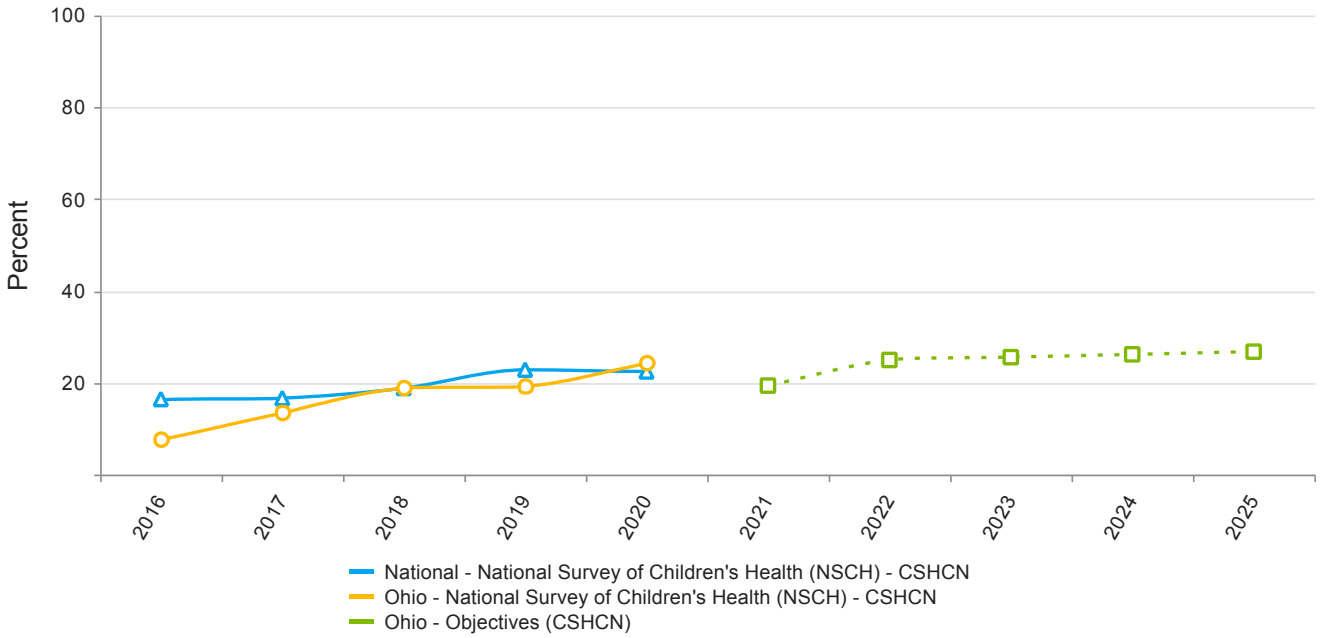
Youth Homelessness

State Fiscal Year 2020 marked the first time ODH received funds in the General Revenue Fund (GRF, aka state budget) to address youth homelessness. The budget line item was specific to addressing homelessness in individuals aged 14-24, with particular emphasis on homeless youth who are pregnant. ODH funds 13 agencies through two different grant programs, and FY23 will be the third year of programming for the agencies. The MCH Adolescent Health Coordinator manages the youth homelessness grants, in addition to adolescent health work. 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 can be used for services not typically covered by traditional federal funding for homelessness. In addition, ODH contracted with the Coalition on Homelessness and Housing in Ohio (COHHIO) in FY21/22 to enhance the data collection to obtain more details about the youth experiencing homelessness who are being served, what services are being provided, and program outcomes. Coordination with state and local stakeholders who also serve youth experiencing homelessness or similar populations has increased since ODH received the funding and further coordination with internal and external partners will be examined in FY23.

Children with Special Health Care Needs

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**	**2021**
Annual Objective			19.4
Annual Indicator	18.9	19.1	24.4
Numerator	48,775	51,261	62,281
Denominator	257,717	268,951	255,707
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.0	25.6	26.2	26.8

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

State Provided Data			
	2019	2020	2021
Annual Objective			22
Annual Indicator			16
Numerator			
Denominator			
Data Source			CMH program records
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	28.0	31.0	33.0

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

Children and Youth with Special Health Care Needs (CYSHCN), Annual Report FY 2021 (October 1, 2020 – September 30, 2021)

Priority: Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services.

Measures:
The state needs assessment data and stakeholders recommended the priority to increase the prevalence of children with special health care needs to receive integrated services. 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 helps to measure progress in ensuring young adults transition into being able to participate as the primary decisionmaker more fully in their care moving forward.

- NOM 17.2: Percent of children with special health care needs (0-17) who receive care in a well-functioning system
    - According to 2019-2020 National Survey of Children's Health, 20.1% of children with special healthcare needs in Ohio received care in a well-functioning system. This is an increase from the 2018-2019 estimate of 15.2%, though not statistically significant.
- NPM 12: Percent of adolescents (12-17) who received services necessary to make transitions to adult health care
    - According to the 2019-2020 National Survey of Children's Health, 24.4% of CSHCN ages 12-17 received services necessary to make transitions to adult care. This is an increase from 2018-2019 (19.1%) and a statistically significant increase from 2016-2017 (13.6%).
- ESM: Percent of CYSHCN ages 12-17 and older enrolled in CMH with a transition plan in place.
    - Utilizing the CMH Service Coordination Program as a proxy, the baseline for this is 16%. This percentage is likely to grow/improve incrementally each year as the transition focus kicks in.

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 and other hemoglobinopathies, 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, 112 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.

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 patient-centered medical home (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 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., diagnostic testing, 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 convening the team 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 2020 and 2021, CMH Nurse supervisor, Jennifer Warfel, worked closely with Ohio's children's hospitals providing technical assistance as they imported 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.

CMH continued enhanced, regular interaction with our peers at the Ohio Department of Medicaid (ODM) and Ohio Department of Developmental Disabilities (DODD). These interactions serve 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 misunderstandings that sometimes occur through the service authorization process, particularly in serving children with medical complexities. This process also provides ODM with needed information to ensure the managed care plans are providing the appropriate care and supports to their clients. 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.

The Ohio Developmental Disabilities Council (ODDC) is a planning and advocacy body committed to community inclusion for people with disabilities. ODDC is funded under the Developmental Disabilities Assistance and Bill of Rights Act, Public Law 106-402. ODDC is a partner within the Ohio DD Network which includes Ohio's Protection & Advocacy System (Disability Rights Ohio) and Ohio's two University Centers for Excellence in Developmental Disabilities: The Nisonger Center of The Ohio State University and the Cincinnati Children's Medical Center of the University of Cincinnati.

The Ohio Developmental Disabilities (DD) Council is made up of over 30 members, with the majority being individuals with developmental disabilities, and parents and guardians of people with developmental disabilities who are appointed by the Governor of Ohio. By the direction of members, the Ohio DD Council funds grant projects that aim to enrich the lives of people with developmental disabilities with an emphasis on self-determination, diversity, and inclusion. Our mission is to create change that improves independence, productivity, and inclusion for people with developmental disabilities and their families in community life.

The CMH Medical Advisory Council (MAC) continues to be a strong support to the CMH program. This council consists of medical professionals who are CMH providers. The council is established by state law. The MAC met quarterly during FY 21 and helped to provide guidance for services related to the CMH program. Members of the MAC onboarded to the CYSHCN BG workgroups to help bring a provider/physician perspective. The MAC oversees two active committees CMH Parent Advisory Committee and Infant Hearing Screening Subcommittee.

The Infant Hearing Screening Subcommittee is a standing committee of the CMH MAC. Committees of the MAC address specific issues, policies and procedures and standards of care relating to children with hearing-related special healthcare needs. 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 (under sections 3701.503 to 3701.509 of the Revised Code). 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. Membership for this subcommittee continues to grow and provide representation from the Deaf/Hard of Hearing community. During FY 21, the IHSS met quarterly and focused on increasing membership of individuals who are Deaf/Hard of Hearing as well as increasing membership of parents and caregivers of infants and toddlers who are Deaf/Hard of Hearing.

During FY 21, the Children with Medical Handicaps Parent Advisory Committee (PAC) continued to grow in racial and ethnic diversity, representing a diverse number of genetic disease and diagnoses, and a robust geographic representation across the state of Ohio. Work continued through the PAC related to the transition of CYSHCN to adult providers, educational settings, adult community services/supports. The PAC provides direct parent and family feedback to the ODH. The CMH PAC continued this year with offerings to participate in Health Equity/Implicit Bias trainings. PAC members often report the experience is valuable and they will apply the information they learn as they interact with other CYSHCN families and care teams. PAC members regularly raise awareness for the CMH program within their regional and disease communities. Multiple members of the PAC have directly engaged within the ODH CYSHCN Block Grant workgroups. Members of the PAC are also involved within other interagency workgroups (when public members are included) and serve on hospital-based family advisory committees.

During this FY, the two full-time Parent Consultants continued to bring a deep family focus within the ODH. They work within the bureau, as well as throughout the department to build strength in collaborating program to program. They both serve on the Bureau Health Equity Action Team and co-lead BG workgroups related to children and CYSHCN. They also serve as members on all the BG workgroups. They connect 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 network with bureau colleagues to bring more awareness of the needs of families of CYSHCN within ODH programs and with a variety of state agencies. During this FY, the Parent Consultants were asked to present in a variety of state and national virtual meetings hosted by national, community-based organizations and sister state 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. One of the Parent Consultants partnered with Ohio Family 2 Family to convene family learning sessions as a follow-up presentation focusing on Emergency Preparedness and helping to understand the importance of following COVID guidance. This workshop was held virtually. One Parent Consultant also completed training to become an Ohio Family 2 Family Peer Mentor and served parents who reached out to Ohio Family 2 Family requesting a mentor. This work continues to support the strong collaboration between the Ohio Department of Health and the Ohio Family 2 Family organization. The parent consultants continue to attend virtual meetings with CMH Field Nurse Supervisors and Managers when they met virtually with local public health nurses (due to COVID) to provide quarterly updates. The 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. The Parent Consultants also had several opportunities to meet with many of the children's hospitals within Ohio and share about the CMH program and other BMCFH programs to help strengthen knowledge so families can be made aware of programs their children/family may be eligible for to help meet their needs. The Parent Consultants continued to publish an ODH Parent 2 Parent

newsletter – February 2021 and September 2021. The Parent Consultants were trained by a Charting the LifeCourse (CtLC) Nexus national team and became Ohio Ambassadors. In their ambassador roles, they help families and support teams understand how the CtLC tools can empower families voice to bring positive results related to services/supports to help meet their child's needs. The ODH Parent Consultants serve on various boards and workgroups, including: Ohio's Interagency Workgroup on Autism (IWGA); DODD Ohio Employment First Task Force; DODD Family Organization Forum; Ohio Adolescent Health Partnership (OAHP); OSU Nisonger Center Family Resource Network Stakeholder Charting the LifeCourse Team; 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).

During FY 21 work continued to support pediatric cancer, which has objectives in Ohio's State Cancer Plan. ODH created a webpage - https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/childhood-cancer/welcome. The Parent Consultants led a workgroup of individuals from a variety of backgrounds (state staff, community-based organization leaders, medical professionals, advocates, and parents of pediatric cancer patients). Their efforts centered around successfully hosting the first annual (virtual) Childhood Cancer Summit. Over 700 families, physicians, nurses, community-based organizations, and others registered for the event. The summit was a 2-day event held virtually focusing on topics to address the medical, emotional, and financial toll cancer brings, while increasing awareness, and targeting major pain points, such as helping families alleviate the long-lasting, devastating effects of childhood cancer. Topics included: PTSD and anxiety, financial help and community supports, palliative care and symptom management, how to live with grief, clinical trials, transitioning to adult care, and survivorship. Both Parent Consultants serve on this team with one helping to lead the workgroup.

Related to the CYSHCN Block Grant work, ODH 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 meet at the least bi-monthly to ensure the projects within the workplan is followed.

1. Family Engagement
    - CMH PAC Members
2. Physician Work Group/Provider Outreach
    - Co-chairs: Katie Bach, CMH Field Nurse Supervisor East Ohio and Dr. Laura Hart, Nationwide Children's Hospital
3. Care Coordination
    - Co-chairs: Patrick Kilbane, CMH PAC Co-Chair & Amy Clawson, Ohio Family to Family Northern Ohio Family Support Specialist
4. Transition Health Care
    - Co-chairs: Jennifer Warfel, CMH Field Nurse Supervisor West Ohio & Annie Ross-Womack, Ohio Sickle Cell Association Executive Director
5. Transition Non-Health Care
    - Sue Smith, CMH Internal RN Supervisor & Lynne Fogel, Ohio Family to Family Central Ohio Family Support Specialist and CMH PAC Member

ODH onboarded many partners to the CYSHCN work team during this time. Meetings occurred to identify and outline work already occurring to support the objectives/strategies. The workgroup members from both the external partners and internal partners were asked to select a sub workgroup. Co-chairs were assigned (see above) for each sub workgroup. In September 2021, ODH hosted a Co-chair orientation to share information about how sub workgroups will progress in the workplan (co-chairs will participate in 30-minute quarterly meetings with Allyson and Kim, all

members will attend quarterly large workgroup meetings. Members who have agreed to join a sub workgroup will meet as a team at least two times October 2021 – January 2022, then meet at least quarterly following. Pilot projects to support the below Objectives/Strategies are due by April 2022 from each sub workgroup. Members of the workgroups and collaborative partners include: ODH staff members; UCEDD (University Centers for Excellence in Developmental Disabilities); DODD (Department of Developmental Disabilities); ODM (Ohio Dept. of Medicaid); ODE (Ohio Dept. of Education); OOD (Opportunities for Ohioans with Disabilities); IWGA (Ohio's Interagency Work Group on Autism); DD Council (Ohio Developmental Disabilities Council); OAHP (Ohio Assn. of Health Plans); Ohio F2F (Family to Family); Ohio DDC Clinic; multiple Ohio Children's Hospital providers and staff members; Ohio adult hospitals serving CYSHCN; several community-based organizations; CMH PAC/MAC members; and individuals and families with lived experiences (including adult patients).

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%.

External and internal partners convened during the year to discuss and capture the current state of medical transition services as it related to medical pediatric providers, adult medical providers, hospital systems and family involvement. Social determinant barriers to medical transition were also discussed and captured. This information will be utilized by the co-chairs in the sub workgroups for possible pilot project ideas, including medical provider education, family education and medical transition resources.

Strategies:

1. Work with adult and pediatric medical providers to assure knowledge and awareness of transition.
2. Work with partners to increase the number of adult providers that serve CYSHCN population and participate in transition planning.
3. Work with partners to assure family and teen knowledge and support regarding transition.
4. Support children's and adult hospital systems in the same geographic area to conduct pilot transition projects.
5. Identify social determinant barriers in medical transition and require transition planning model to address.

Partnership Development and Transition Non-Health Care Workgroup

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.

External partners shared resources they are working on or reviewing related to transition for non-health care resources. This information is being utilized by the co-chairs in the sub workgroups for possible pilot project ideas, including Charting the LifeCourse (CtLC), DODD Part C and Ohio Department of Education Part B services.
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).
2. Explore mechanisms for automatic referrals for children at certain age to those other programs that would help transition to other supports/systems.

Partnership Development and Transition Non-Health Care Workgroup

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%.

External and internal partners convened during the year to discuss and capture the current state of care coordination in clinical and non-clinical settings. Resources and care coordination templates were shared amongst partners that highlight the diversity of coordination services and resources that are available based upon clinical and non-clinical settings. This information will be utilized by the co-chairs in the sub workgroups for possible pilot project ideas.

In addition to partner discussions, CMH partnered with Nationwide Children's Hospital's Partners for Kids Service Coordination to integrate the CMH Hospital Based Service Coordination (HBSC) Service Plan into their system wide electronic medical records (EMR). This collaboration will encourage existing CMH HBSC programs to integrate CMH HBSC Service Plan into their existing EMRs by 2025. CMH is working to partner with tertiary care facilities within Ohio to establish their own or integrate the CMH HBSC Service Plan format into existing EMRs for all CYSHCN regardless of CMH status. MetroHealth Hospital in Cleveland, Ohio provides HBSC to all individuals in the Comp Care Center regardless of CMH coverage. The Comp Care Center provides care to individuals with complex medical needs throughout the lifespan and services do not end at 21.

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).
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.
3. Seek ways to expand HBSC for CYSHCN not enrolled in CMH.
4. Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems.
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.

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 a program funded through an earmark in the Mothers and Children's Safety Net state budget line item 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; hearing loss diagnosis; and family income 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 identified by newborn bloodspot screening. 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.

Children with Special Health Care Needs

Action Plan

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 CSHCN ages 12-17 enrolled in CMH with a transition plan in place.

1. 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%.
   a. Work with adult and pediatric medical providers to assure knowledge and awareness of transition
   b. Work with partners to increase the number of adult providers that serve CSHCN population and participate in transition planning
   c. Work with partners to assure family and teen knowledge and support regarding transition
   d. Support children's and adult hospital systems in the same geographic area to conduct pilot transition projects
   e. Identify social determinant barriers in medical transition and require transition planning model to address

2. 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
   a. 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)
   b. Explore mechanisms for automatic referrals for children at certain age to those other programs that would help transition to other supports/ systems

3. 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%.
   a. 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)
   b. 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.
   c. Seek ways to expand HBSC for CSHCN not enrolled in CMH.
   d. Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems
   e. 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.

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	2021
Annual Objective			19.9
Annual Indicator	23.5	20.4	20.4
Numerator	594,643	515,502	517,182
Denominator	2,531,859	2,526,971	2,535,206
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	19.4	18.9	18.4	17.9

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	2021
Annual Objective			50
Annual Indicator	40	50	50
Numerator	4	5	5
Denominator	10	10	10
Data Source	Action Plan	Action Plan	Action Plan
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.0	80.0	90.0	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

FY21 Annual Report: Cross-Cutting/Systems Building

From the comprehensive needs assessment, two cross-cutting priorities were identified – Adverse Childhood Experiences (ACES) and health equity. These cross-cutting priorities are also included within each population domain workgroup for integration into their Action Plans, and cross-cutting priority strategies are incorporated throughout the population domain annual reports.

Priority: Prevent and mitigate the effects of adverse childhood experiences.

Measures

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.

- SPM: Percent of children, ages 0 through 17, who have experienced two or more adverse childhood experiences. (NSCH)
- ESM: None developed at this time.

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 ACEs questions to the Youth Risk Behavior Survey (YRBS). Ohio's YRBS is combined with Ohio's Youth Tobacco Survey (YTS) and coordinated with the Ohio Department of Mental Health and Addiction Services' OHYes survey collection efforts. The 2021 YRBS/YTS includes 16 new ACEs questions. Due to COVID-19, the survey administration was moved from Spring 2021 to Fall of 2021. Survey results are expected to be received Spring/Summer 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).

Strategies A--E within this objective are included in the other population domain Action Plans and activities for the FY 2021 year and are reported within those annual reports.

Update on Strategy F – the Bureau Health Equity Committee (since renamed to the Bureau Health Equity Action Team in FFY22) works to develop and create opportunities for BMCFH staff and staff of the local programs funded by BMCFH programs to learn more about ACEs and other concepts to institutionalize and center health equity in Ohio's MCH work. During FFY21, BMCFH programs offering subgrants to local entities were encouraged to include a deliverable on community engagement in their solicitation requests for FY22. The Wisconsin Community Engagement Assessment Tool (CEAT) was recommended and staff from the Wisconsin Department of Health generously shared their training videos and offered to provide technical assistance to ODH staff.

ACEs and Health Equity Integration

ACEs

A review was conducted in each population domain action plan for primary, secondary, and tertiary activities associated with ACEs. The review used CDC's Prevent ACE's Technical Package and Social Ecological Model as review tools. Findings included:

- All action plans are addressing ACEs, resiliency, and trauma practices with varying degrees. However, the term "ACEs" may not be associated with the activities.
- Activities focus more on secondary and tertiary prevention.
- A need for more community and societal prevention level work. An excellent example of community level activities is from WIC and their breastfeeding in the workplace policy. Research is needed on what other states are doing at this level.
- A need for better coordination between action plans. One example could be to create one "parenting" or "provider" social marketing campaign rather than several.
- A need for coordination with other ODH programs doing similar work.

These results were shared with each population action plan.

An all-bureau staff learning session was provided on ACEs and health equity, and foundational resources were provided as part of the onboarding of new employees. Additional training is being planned for 2023. As part of BMCFH's contract with the Ohio Chapter of the American Academy of Pediatrics, an educational session was held in spring 2022 for local primary care providers and public health program staff on ACES.

Reference:

Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

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 and

ended in January 2021. 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: decreasing economic stress, decreasing the stigma associated with seeking help, and increasing association with a caring adult.

Three major outcomes from the ASPIRE projected included: 1) identified 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.) 2) Better coordination across ODH bureaus addressing primary, secondary and tertiary prevention of ACEs. 3) Supporting the Ohio Children's Trust Fund Primary Prevention Application to the US Department of Health and Human Services to continue a statewide partnership on ACEs.

Based on the outcomes from the ASPIRE project and the review of the Block Grant population domain activity plans, it was agreed that an agency-wide workgroup would be created in a sister bureau, Health Improvement & Wellness. The workgroup would focus on primary, secondary and tertiary prevention across the social ecological model. The workgroup includes a framework of health equity, social determinants of health, and trauma practice. Initially, the stakeholders will be made up of ODH staff. Primary and secondary stakeholders, and key/influencer stakeholders will be invited to the workgroup in the future. Core members of the workgroup agreed that a Community of Practice Model would be used for operation of the workgroup because it engages people in the process of collective learning from each other; and that everyone brings their talents, knowledge, and experiences to help make needed changes.

A state-by-state ACEs and Trauma Action review began in August 2021 by ODH MPH/MSW student Intern Elizabeth Kleinhenz. Specifically, Ms. Kleinhenz's review identified model states for prevention and trauma activities and identified planning considerations to inform the workgroup.

Priority: Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

Measures

SOMs from the Women and Infant population domain groups are relevant to this health equity priority. In addition, the childhood lead poisoning SOM from the Child population domain is also relevant to reducing environmental hazards. The SPM reflects the commitment to incorporating the priority into each population. ESM development will continue to be considered during activity planning and implementation.

SOM: (Women/Maternal) Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations.

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

SOM: (Perinatal/Infant) Black infant mortality rate per 1,000 live births.

- Objective: 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.)

- Examine data on causes of infant death by race and ethnicity to inform data to action.

SOM: (Child) Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl)
- 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.

To reduce the percent of children with a confirmed elevated blood lead levels in the state as a whole and in the high-risk areas of the state identified by ODH, are the two outcomes Ohio is measuring.

Objective: By 2025, implement plan developed by the bureau health equity committee (now renamed the Health Equity Action Team) to build a 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 the Children with Medical Handicaps (CMH) Parent Advisory Committee (PAC).

Equity Integration
The SPM provides an indicator of the integration of the equity priority within each of the priority population domain 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.

The Bureau of Maternal Child and Family Health created a Health Equity Committee in 2020. 2021 Activities included:
- Monthly Meetings were held.
- Convened sub workgroups to enable staff with subject matter expertise to have dedicated time to explore specific concepts and come back to the larger bureau group with recommendations for implementation.
- Staff from the Bureau Chief's Office participated in all groups, and updates were routinely provided to the Medical Director's Office (up chain leadership of the bureau). Additionally, the bureau equity group worked in tandem with the ODH Office of Health Opportunity to align activities, provide feedback and avoid duplication.
- Program Review of 4 programs as a pilot – an intensive review of the internal and external equity issues of certain (volunteer) program staff provided important information. Staff were more forthcoming without supervisors in the group and expressed their interest in centering equity in their daily work.

Four Sub Workgroups of the bureau group were developed:

1. **Data Workgroup**

- Staff Health Equity Survey
- BMCFH Program Inventory

- Data Stewardship Policy Review

2. **Onboarding & Participation Workgroup**

- Onboarding Teams channel with resources and materials
- 21-Day Equity Challenge
- 4 Month Onboarding Plan
- Provided resources for a weekly bureau email on health equity topics

3. **RFP Workgroup**

- Participated in the AMCHP MCH Workforce Development National Cohort
- Several presentations were made to bureau staff on health equity, and on the Wisconsin Community Engagement Assessment Tool (Components include Community Partnership, Culture of Inclusion, and Equity, Program Environment, Program Leadership, Professional Development and Continuous Improvement)
    - Encouraged centering Health Equity in Subgrants- provided List of Ideas for BMCFH Collaboration with OHO (RFP)

4. **Training Workgroup**

- Microsoft teams - Training Hub
- Coordination OHO & BMCFH
- Equity Resources Library
- ODH Leadership Informed

During FY21 the cross-cutting co-leads presented to each population domain action team on the cross-cutting priorities to set the stage for further integration during FY22. 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. Activities planned for FY22 will focus on working with the population domain action teams for the populations without specific equity strategies associated with their performance measures. 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.

MCH Workforce Development (WFD) Cohort

- The RFP workgroup participated in the AMCHP workforce development cohort to work toward consensus on a strategy for centering equity in subgrants BMCFH funds. Through the tools and coaching, we determined to utilize the Wisconsin Community Engagement Assessment Tool as a starting point for local subgrantees to begin assessing where they are and develop a plan for improvement. One program is piloting the Wisconsin tool, and several programs are utilizing other engagement and equity strategies.
- Staff from the bureau equity committee worked closely with staff from the ODH Office of Health Equity on developing revised language on equity in the ODH subgrant template.

Children with Medical Handicaps Parent Advisory Committee (PAC)

In FY21, the Bureau Parent Consultants worked to diversify the membership of the PAC related to geography, race, and gender (recruited more fathers' participation) and provided training to PAC members to improve their knowledge about centering equity in the work and feedback they provide to the CMH Program.

Other Efforts Supported by Title V MCH

BMCFH Parent Consultants

Two full time Parent Consultants were hired in FY20 and are tasked with improving parent/family perspective throughout the bureau. They have presented at multiple state and national conferences on strategies to engage families in MCH work. Additionally, they are both ambassadors of *Charting the LifeCourse* and use the tools regularly as they work with individual families. They participate on nearly every workgroup the bureau convenes, as well as representing BMCFH and families on numerous other state level advisory groups.

FY23 Annual Plan: Cross-Cutting/Systems Building

The current FY21-25 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 included as priorities to address in the Action Plans for each population domain workgroup. 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 spiked in 2019. Ohio Department of Mental Health and Addiction Services (OhioMHAS) believes that the spike has 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 of 2020, stressors such as financial strain and school and childcare closures support the need for building a system in Ohio that prevents, increases 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.

To address the priority of adverse childhood experiences 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).

The ODH applied for and received funding from CDC to add ACEs questions to the Youth Risk Behavior Survey (YRBS). Ohio's YRBS is combined with Ohio's Youth Tobacco Survey (YTS) and coordinated with the Ohio Department of Mental Health and Addiction Services (MHAS) OHYes survey efforts. The 2021 YRBS/YTS included 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 during 2022. Once results have been analyzed, we will use the results to inform strategies moving forward.

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 (HIB) Initiative (Adolescent).
4. Provide resources, technical assistance, and professional development to health professionals working in the school and early childhood level to support resiliency, decrease HIB (Adolescent), and improve clinical experiences for minority and underserved patients.
5. Support programming in local communities and Ohio Health Improvement Zones for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP (Women & Adolescent).
    - Ohio Health Improvement Zones (OHIZ) refer to any community with a US Centers for Disease Control, Agency for Toxic Substance and Disease Registry (CDC/ADSTR) Social Vulnerability Index (SVI) Score of .75 or higher. The SVI measures the socioeconomic and demographic factors that affect the resilience of individuals and communities – the ability to prevent human suffering and financial loss in a disaster. By understanding where these populations are located and what factors contribute to their levels of risk, Ohio Health Improvement Zones can aid in all phases of improving health in communities. Current data tells us that often social determinants of poor health and threats to resilience coexist in communities. For example, the same communities that lack access to healthy food are also likely to face other barriers, such as large numbers of single-parent households, lack of access to high-performing schools, or lack of access to safe and affordable housing and transportation.
    - The SVI uses the most current data available from the US Census Bureau American Community Survey 5-year estimates (2014-2018) to assign each census tract in the nation a score ranging from 0 – 1, detailing areas of high and areas of low SVI. The SVI is comprised of 15 indicators grouped into 4 themes: socioeconomic status, household composition and disability, minority and language, and housing and transportation. Census tracts with scores of .75 and greater are designated as Ohio's Health Improvement Zones. For more information on Ohio's Health Improvement Zones visit: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-improvement-zones.
6. Support MCH programs to further integrate ACEs and Health Equity priorities within each population Action Plan (ADDED for FY 22).
7. Provide resources, technical assistance, and professional development to health professionals working in the school and early childhood level to support resiliency, decrease harassment, intimidation, and bullying (HIB) (Adolescent) and improve clinical experiences for minority and underserved patients.
8. Support programming in local communities and Ohio Health Improvement Zones for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP (Women & Adolescent).
1. 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 domains 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).

A result of Ohio's participation in the ASPIRE (ACEs and Suicide Prevention in Remote Environments) Safe States collaborative learning cohort, state member agency Ohio's Children Trust Fund applied and received federal funds for a five-year grant. The grant supports the development of a comprehensive child and family well-being system, designed to prevent child abuse and neglect. Representatives from both the BMCFH and the Bureau of Health Improvement and Wellness (HIW) are part of the state team to review Ohio's systems: uplift what is working and make recommendations for changes. Any systems changes identified within ODH, the ODH representatives will work with appropriate personnel to adapt and improve the departments' programs. The grant also works to implement community-based pilot programs that partner with people with lived experiences. The results of the pilot programs will help inform how to better partner with people with lived experiences.
ODH, with the help of The Ohio State University MPH/MSW intern conducted a state-by-state review of plans (FY22). This review identified best practices for preventing ACEs and trauma practices at the organization level. In December '21, the results of this state-by-state review were presented to BMCFH, BHIW, and ASPIRE stakeholders. ODH used the review to create the ODH's ACEs community of practice workgroup. The workgroup is open to all ODH staff interested in using a public health approach focusing on primary prevention (before it occurred), strengthening assets (secondary prevention) and healing and community resources (tertiary prevention). The ODH workgroup is using the CDC's ACEs technical package as a foundational resource. The workgroup is also using the frameworks from Tennessee and Oregon to identify where ODH is in the process of adapting ACEs and trauma informed within the organization:

Stage 1	**Stage 2**	**Stage 3**	**Stage 4**
Exploration	Installation	Initial Adaptation	Full Adaptation
Assessment readiness Introductory training SHIP Alignment	Agency infrastructure change and training based on readiness assessment	Agency training and coaching to support adoption: increasing knowledge and skills, building trusting relationships, promote trauma informed practices. Evaluation plan for evaluating process and adoption	Support and sustain practices. Train the trainer model

The workgroup met three times in FY22 and acknowledged there are programs that may be at different stages, but

the organization is at stage 1: exploration. During a brainstorm activity, the workgroup identified training as a high priority for FY 22 and 23. Activities will include information in the ODH employee newsletter (reaching 1200+ staff) and planning a lunch and learn education session for all staff. The workgroup has identified several videos, under 15-minutes in length to share in the newsletters. The first video was shared in the May 11, 2022, newsletter. The first lunch and learn on ACES is being planned for late August or early September 2022.
Referring to the state-by-state review, the workgroup uplifted the concept of having "champions" at ODH. The champions would help plant the seed and encourage within their program areas about ACEs and trauma work. Twenty-five ODH workgroup members and BMCFH consultants registered to take the Tufts University School of Medicine's HOPE training. Participants have been asked to complete a survey and the results will identify how to use the champions during FY23-24.
The workgroup is interested in conducting a readiness assessment and creating a glossary of terms. The workgroup is aware that other statewide and national efforts are working on an organizational assessment tool and developing a glossary. It is our intention to use these tools when published.
Several states have created a logic model showing how their State Health Improvement Plan aligns with ACEs and trauma work. ODH is in the process of updating a new SHIP. A subcommittee will be created to develop a logic model to link health outcomes to the ACEs and trauma work.
Finally, the ODH Sexual Assault/Domestic Violence Prevention Program (SADVPP) is hosting an MPH/MSW intern from The Ohio State University who will conduct a literature review and interview BMCFH-funded home visiting workers and supervisors. The project is focusing on using the ACE and PCE screening tools, the comfort of the clients receiving the tool, the confidence and agency support the home visiting works receive. The results from this project will help the home visiting program. However, other programs within ODH are using ACE and PCE screening tools and this activity will help these programs as well.

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 population domains are relevant to this health equity priority. In addition, the childhood lead poisoning prevention SOM from the Child population domain 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. Develop plan for improving internal MCH organization equity and staff capacity through the Bureau Health

Equity Advancement Team (HEAT).

3. Develop plan to institutionalize health equity in policy, program, grant, and contract administration through the HEAT.
4. Build diversity in the CMH Parent Advisory Committee (PAC).

During FY 22 the Health Equity Committee was renamed to the BMCFH Health Equity Advancement Team (HEAT). The group continues to implement a three-pronged assessment approach (staff survey, pilot program review, and community engagement subgrantee assessment as well as use the results of the assessments to inform efforts of the working groups (Onboarding and Participation, Training and RFP). From Ohio's MCH Block Grant Technical Assistance request in our FFY22 submission, we were referred to the MCH Workforce Development Center to operationalize equity learning & create a support plan for Title V/MCH staff. This single state intensive TA is geared to moving data into action to address gaps identified in the Bureau of Maternal, Child and Family Health (BMCFH) Staff Competency Survey; and Program Review pilots administered by the HEAT.

The SPM provides an indicator of the integration of the equity priority within each of the priority population domain Action Plans. The Action Plan submitted in FY20 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 population domains. Activities planned for FY23 will focus on working with the population domain action teams for the populations without specific equity strategies associated with their performance measures, specifically, the Infant, Child, and Adolescent population domain groups. 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 FY21 the cross-cutting co-leads presented to each population action team on the cross-cutting priorities to set the stage for further integration during F 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.

Other Efforts Supported by Title V MCH

BMCFH Parent Consultants

The bureau Parent Consultants continue to represent and provide technical assistance and guidance on parent and family engagement in all bureau programs. They are both ambassadors for *Charting the LifeCourse* and have presented on how they utilize the tools with families statewide and nationally. They both participate on many work groups and advisory groups at ODH, within the BMCFH, and on groups convened by sister state agencies.

ODH ACES Workgroup (convened by the Bureau of Health Improvement and Wellness)

BMCFH staff participate on the department's ACES workgroup, housed, and convened by the Sexual Assault and Domestic Violence Prevention Program. Jointly, the staff are working on an ACES lunch and learn session to be promoted to all ODH staff.

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 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.

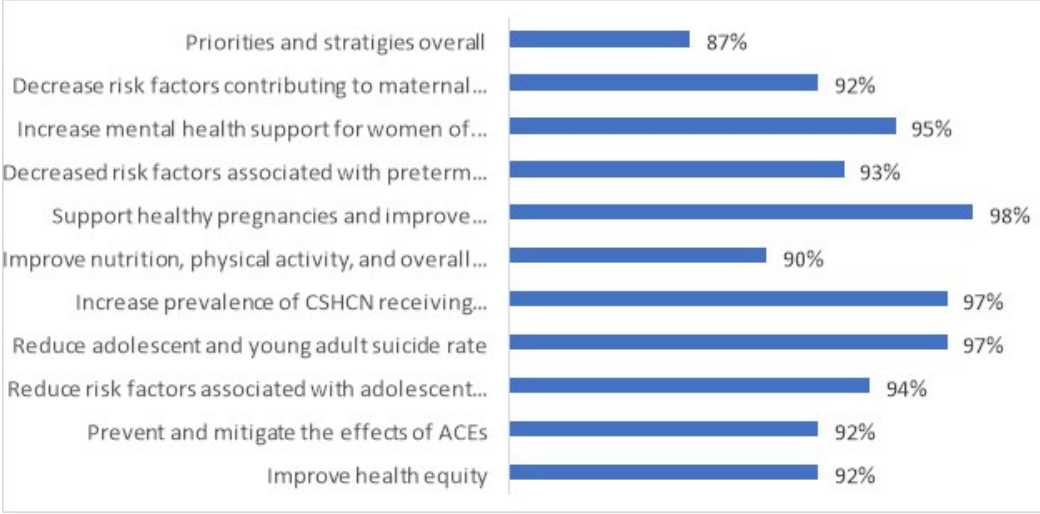
The 2023 Title V MCH Block Grant public comment survey was available for public input from June 6 to July 25, 2021. During the public comment period, invitations to comment were shared by BMCFH staff with their networks of local grantees, stakeholders, consumer groups, parent groups, listservs, and interested 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. Domain 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 represented 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.

Seventy-three individuals responded to the public comment survey. Respondents could select multiple affiliations: most respondents were parents (29), including parents of children with special health care needs (9). This was followed by health care providers (16), representatives of community-based organizations (15) local health departments (11), advocacy organizations (7), state health department (5), and other state agencies (5).

Respondents represented 27 of Ohio's 88 counties, plus 8 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 16 respondents.

Overall respondent feedback indicates that 87% 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 oral health, transition to adult healthcare (especially for children with special healthcare needs), lack of adequate childcare options for children with special health care needs, substance use, and housing insecurity.



Overall, respondents supported the strategies and objectives. For each of the ten priorities, between ninety 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 33 to 48. Respondents were asked to provide suggestions for improving or adding strategies associated with each priority which are summarized below.

Women

- Priority A: Decrease risk factors contributing to maternal morbidity.
  - 92% 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, blood pressure screenings, obesity prevention, bias and racism in healthcare, support for birth centers.
- Priority B: Increase mental health support for women of reproductive age.
  - Yes – 95%
  - Suggestions focused on medication-assisted therapy (MAT), funding for mental health services including reimbursement for depression screening and higher pay and incentives to recruit more providers and addressing mental health across all ages (not just women 18-44).
- Priority C: Decrease risk factors associated with preterm birth.
  - Yes – 93%
  - Suggestions focused on increased home visiting, addressing alcohol consumption and other substance abuse in addition to tobacco, and access to contraception.

Infant

- Priority: Support healthy pregnancies and improve infant and birth outcomes.
  - Yes – 98%
  - Suggestions included breastfeeding support including paid family leave, increased access to breastfeeding supplies, and addressing needs and wellbeing of the mother; increase education of safe sleep to middle and high school students; increase access, including residential treatment, to substance abuse treatment during pregnancy; create a more diversified (i.e., train and recruit) workforce for professions providing perinatal services (e.g., doulas, lactation consultants, minority health care advocates, etc.); address social determinants of health, especially housing.

Children

- Priority: Improve nutrition, physical activity, and overall wellness of children.

    - Yes - 90%
    - Suggestions focused on ACEs and mental health access, “Centering Parenting” programs, obesity prevention and improved nutrition.

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 including better coordinated care and a “go-to” place where parents can find all available resources.

Adolescents

- Priority A: Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate.
    - Yes – 97%
    - Suggestions focused on behavioral and mental health services including increased access and incorporating into schools.
- Priority B: Increase protective factors and improve systems of care to reduce risk factors associated with the prevalence of adolescent substance use.
    - Yes – 94%
    - Suggestions were minimal.

Cross-cutting

- Priority A: Prevent and mitigate the effects of adverse childhood experiences.
    - Yes – 92%
    - Suggestions focused on ACEs including utilizing a more culturally appropriate tool, work with school-based psychology, domestic violence education, and including youth representation.
- Priority B: Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes.
    - Yes – 92%
    - Suggestions focused on equity training healthcare providers and including those with lived experience.

III.G. Technical Assistance

The Title V Program within the Ohio Department of Health (ODH) routinely explores options for technical assistance. In calendar year 2020, the bureau identified a need for assistance moving data to 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 (now re-named to the Health Equity Action Team - HEAT.) Additional information about the survey, work thus far and for FY23 is available in the Cross-Cutting Annual Report and Application narratives.

The staff competency assessment was adapted from the Health Equity Skills for Public Health Professionals survey, which was designed through a partnership between 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 Program Review was adapted from the Massachusetts' internal action steps to develop and implement an operational framework to incorporate health equity principles and lens in all workstreams. BMCFH built the tool using Google Jamboard to facilitate anonymous participation. Findings from both the survey and program review were documented. Ohio's Title V Program made a TA request in the FY22 MCH Block Grant application for more targeted bureau-level training opportunities.

Following HRSA review of Ohio's FY22 MCH Block Grant and technical assistance request, we were referred to the Workforce Development Center at UNC. During SFY22 the Health Equity Action Team began working with the UNC Workforce Development Center to receive Single State Intensive Technical Assistance (TA). The experience has been valuable and continues into the Fall, 2022. We anticipate being able to develop a blueprint for moving forward with meaningful training on centering equity at all levels of the bureau's programs. At this time, we would like to focus on receiving the Single State Intensive TA and working to implement a plan for BMCFH staff. At this time, we do not have a specific TA request for FY23.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - fully signed A-2223-04-0110 ODH with all attachments.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MEDTAPP Multi-Agency Agreement.pdf

Supporting Document #02 - Parent Consultant Flyer.pdf

Supporting Document #03 - Ohio Title V MCH BG Priority Action Plan FY21-FY25 (submitted FY23).pdf

Supporting Document #04 - Program Map copy.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ODH TO_1.5.2022_FY 23.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Ohio

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,427,360	
A. Preventive and Primary Care for Children	$ 8,982,755	(38.3%)
B. Children with Special Health Care Needs	$ 7,886,905	(33.6%)
C. Title V Administrative Costs	$ 557,041	(2.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 17,426,701	
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)	$ 90,849,865	
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)	$ 208,377,378	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 299,227,243	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
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) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 650,000
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	$ 7,711,212
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,007,196
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,040,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 186,799,674
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,072,222
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 22,065,962 (FY 21 Federal Award: $ 22,331,382)		$ 21,462,897	
A. Preventive and Primary Care for Children	$ 7,916,271	(35.9%)	$ 7,533,736	(35.1%)
B. Children with Special Health Care Needs	$ 7,716,077	(35%)	$ 8,592,049	(40%)
C. Title V Administrative Costs	$ 718,531	(3.3%)	$ 431,845	(2.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 16,350,879		$ 16,557,630	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 67,346,423		$ 62,539,649	
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)	$ 67,346,423		$ 62,539,649	
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)	$ 89,412,385		$ 84,002,546	
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)	$ 219,737,929		$ 200,522,371	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 309,150,314		$ 284,524,917	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Asthma Control Program (NACP)	$ 650,000	$ 293,737
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000	$ 480,130
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 125,000	$ 38,599
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,855,181	$ 6,440,766
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,800,000	$ 8,709,323
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 197,154,200	$ 180,047,504
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 246,312
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,134,389	$ 1,926,710
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 99,261
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,219,159	$ 2,240,029

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Ohio's cost for Children with Special Healthcare Needs increase due to direct services and additional staff support in FY21	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Ohio Admin low cost due to loss of a staff person during FY21.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 4,118,924	$ 2,844,230
2. Infants < 1 year	$ 1,855,186	$ 1,997,419
3. Children 1 through 21 Years	$ 8,982,755	$ 7,533,736
4. CSHCN	$ 7,886,905	$ 8,592,049
5. All Others	$ 26,549	$ 63,618
Federal Total of Individuals Served	$ 22,870,319	$ 21,031,052

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 5,886,587	$ 3,282,265
2. Infants < 1 year	$ 5,886,587	$ 3,282,265
3. Children 1 through 21 Years	$ 16,435,205	$ 22,871,669
4. CSHCN	$ 38,850,008	$ 32,900,424
5. All Others	$ 364,119	$ 203,027
Non-Federal Total of Individuals Served	$ 67,422,506	$ 62,539,650
Federal State MCH Block Grant Partnership Total	$ 90,292,825	$ 83,570,702

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 5,400,471	$ 4,085,989
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 3,904,139	$ 2,575,890
B. Preventive and Primary Care Services for Children	$ 1,005,000	$ 584,219
C. Services for CSHCN	$ 491,332	$ 925,880
2. Enabling Services	$ 7,406,874	$ 7,732,577
3. Public Health Services and Systems	$ 10,620,015	$ 9,644,331
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,391,660
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,941,137
Dental Care (Does Not Include Orthodontic Services)		$ 584,219
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 823
Other		
Public Health Nursing and Public Health Dietitia		$ 168,150
Direct Services Line 4 Expended Total		$ 4,085,989
Federal Total	$ 23,427,360	$ 21,462,897

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 38,412,798	$ 28,319,576
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	$ 600,000	$ 178,722
C. Services for CSHCN	$ 37,812,798	$ 28,140,854
2. Enabling Services	$ 11,541,088	$ 4,106,882
3. Public Health Services and Systems	$ 17,468,619	$ 30,113,191
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		$ 11,153,568
Physician/Office Services		$ 1,951,964
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 7,032,236
Dental Care (Does Not Include Orthodontic Services)		$ 610,338
Durable Medical Equipment and Supplies		$ 2,854,876
Laboratory Services		$ 42,456
Other		
Public Health Nursing and Public Health Dietitia		$ 4,674,138
Direct Services Line 4 Expended Total		$ 28,319,576
Non-Federal Total	$ 67,422,505	$ 62,539,649

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: 130,300 **Data Source Year: 2021**

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	129,586 (99.5%)	3,357	199	199 (100.0%)

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	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	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
2-Methylbutyrylglycinuria (2MBG)	129,586 (99.5%)	61	0	0 (0%)
Short Chain Acyl-CoA Dehydrogenase Deficiency (SCAD)	129,586 (99.5%)	77	0	0 (0%)
Carnitine Acylcarnitine Translocase Deficiency (CACT)	129,586 (99.5%)	20	0	0 (0%)
Carnitine Palmitoyltransferase Type II Deficiency (CPT-II)	129,586 (99.5%)	20	0	0 (0%)
Argininemia (ARG)	129,586 (99.5%)	16	0	0 (0%)
Hypermethioninemia (MET)	129,586 (99.5%)	362	0	0 (0%)
Tyrosinemia Type III (TYR III)	129,586 (99.5%)	126	1	1 (100.0%)
Hawkinsinuria	129,586 (99.5%)	126	0	0 (0%)
S,D Disease	129,586 (99.5%)	123	0	0 (0%)
S,E Disease	129,586 (99.5%)	123	0	0 (0%)
C,C Disease	129,586 (99.5%)	123	3	3 (100.0%)
C, Beta-Thalassemia	129,586 (99.5%)	123	1	1 (100.0%)
D,D Disease	129,586 (99.5%)	123	0	0 (0%)
E, Beta-Thalassemia	129,586 (99.5%)	123	0	0 (0%)
E,E Disease	129,586 (99.5%)	123	0	0 (0%)
HyperPhenylalinemia (HPHE sig.)	129,586 (99.5%)	81	5	5 (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	127,825 (98.1%)	68	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:

CCHD data reported is from calendar year 2019. There were 122,644 infants screened with 62 presumptive positive. All babies who fail the 3-screening protocol are referred for additional testing and treatment, often for other cardiac issues, not targeted by newborn pulse oximetry screening.

Hearing Screening Data is from calendar year 2020. There were 122,644 infants screened with 294 presumptive positive. All 294 confirmed cases were referred to Early Intervention for long-term follow up care.

Field Level Notes for Form 4:

None

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 2021

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	10,440	63.5	0.0	28.6	7.9	0.0
2. Infants < 1 Year of Age	12,089	46.8	0.6	48.2	4.4	0.0
3. Children 1 through 21 Years of Age	56,070	58.5	0.0	32.0	9.5	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	40,532	63.8	0.0	31.5	4.7	0.0
4. Others	68,938	28.0	0.0	51.8	20.2	0.0
Total	147,537					

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	129,191	No	128,771	97.8	125,938	10,440
2. Infants < 1 Year of Age	129,730	No	128,771	98.0	126,196	12,089
3. Children 1 through 21 Years of Age	3,036,052	Yes	3,036,052	61.7	1,873,244	56,070
3a. Children with Special Health Care Needs 0 through 21 years of age^	703,378	Yes	703,378	37.5	263,767	40,532
4. Others	8,524,849	Yes	8,524,849	2.4	204,596	68,938

^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:	**2021**
	Field Note: Pregnant women served includes: - Moms and Babies First (home visiting services): 277 pregnant women - Moms Quit for Two (smoking cessation program): 1,153 pregnant women - Appalachian Breastfeeding Network (breastfeeding support hotline): 4,249 calls, this was a new service started in March 2020; therefore the volume increased during FY 2021. - Ohio Equity Institute (support services): 3,983 pregnant women - Reproductive and Health and Wellness (safety net clinical services): 320 pregnant women Total = 10,440 Primary source of insurance coverage for those with unknown insurance status was estimated using Form 5a reference data.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	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): 5,379 - Moms and Babies First (home visiting): 1,102 infants - Infant Hearing Program (infants receiving follow-up services--our most recent data is from the 2020 calendar year): 5,608 Total: 12,089 Primary source of insurance coverage for those with unknown insurance status was estimated using Form 5a reference data.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
In FY 2021, we saw a drop in the number of children served by about 20%. This can largely be attributed to the COVID-19 pandemic which prevented home visiting. Additionally, many children where in a virtual learning environment and therefore did not receive services normally given in the school environment. Number of children served includes:
- Moms and Babies First (home visiting): 212 children
- Oral Health Program (school-based sealants, fluoride mouth rinse, dental safety net program): 5,400 children
- Lead Poisoning Prevention Program (children receiving case management; includes children 0-6 yrs): 3,014
- Hearing/vision screening equipment loans* (children who received these services through loaned equipment): 2,000. Note: these data are from 7/1/20 to 6/30/21
- Hearing Aid Assistance Program: 119. Note, these data are from 7/1/20 to 6/30/21.
- Children with Medical Handicaps Program: 37,399
Total: 56,070
* Primary source of insurance coverage for those with unknown status was estimated using Form 5a reference data.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
There is likely overlap between CMH clients and the other programs listed here, but we could not de-duplicate. Number of CSHCN served includes:
- Hearing Aid Assistance Program (note: these data are for 7/1/2012 to 6/30/2020): 119 children
- Children receiving case management through Lead Poisoning Prevention Program (ages 0-6): 3,014 children.
- Children receiving services through the Children with Medical Handicaps program: 37,399
Total: 40,532

* Primary source of insurance coverage for those with unknown insurance status was estimated using Form 5a reference data.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Number of others served includes:
- Women and men aged 22+ receiving services through the Reproductive Health & Wellness program (clinical services): 27,908
- Those receiving services through the Genetics Services program* (note: these data could not be disaggregated by population group and age): 38,223
- Women and men aged 22+ receiving services through the Oral Health Program (dental safety net program): 1,932
Total: 68,938

*Insurance for those with unknown insurance status was estimated using Form 5a reference data.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

	Field Note: Mothers who received safe sleep education in the hospital	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**
	Field Note: ODH Bureau of Vital Statistics, resident births in FY 21	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: Newborn screening	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: ODH Bureau of Vital Statistics, resident births in FY 21	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Incudes children served by school nurses (4 and up), lead screening program, and breastfeeding and postpartum women under 22 served by WIC	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Includes student with disabilities enrolled in school children receivng case management through lead prevention program	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: Includes family members of newborns receiving safe sleep education, genetic services, reproductive health and wellness program, breastfeeding and postpartum women 22+ receiving services from WIC, Early Childhood Professionals trainings, Parenting at Mealtime and and Playtime trainings, Maternity Staff completing First Steps for Healthy Babies training. School Nursing Program online training attendees, SUID families, Providers trained in maternal telehealth delivery, domestic violence training, Women and men 22+ receiving services through Oral Health safety net program.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Ohio

Annual Report Year 2021

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	130,300	83,699	17,703	8,224	93	3,396	112	3,269	13,804
Title V Served	130,300	83,699	17,703	8,224	93	3,396	112	3,269	13,804
Eligible for Title XIX	51,327	24,528	12,883	4,295	52	1,045	61	1,996	6,467
2. Total Infants in State	129,861	80,654	17,584	8,224	88	3,354	110	3,215	16,632
Title V Served	126,677	80,654	17,584	8,128	88	3,354	110	3,215	13,544
Eligible for Title XIX	51,670	23,950	12,814	4,312	49	1,040	61	1,974	7,470

Form Notes for Form 6:

2021 birth data are preliminary and were pulled from the files last updated on 5/2/2022.

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Ohio

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 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 and 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) 965-2863	(614) 965-2863
5. Number of Calls Received on the State MCH "Hotline"		15,121

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	Children with Medical Handicaps Helpline, Breastfeeding Hotline	Children with Medical Handicaps Helpline, Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		30,213
3. State Title V Program Website Address	https://odh.ohio.gov/about-us/offices-bureaus-and-departments/bmch/welcome-to	https://odh.ohio.gov/about-us/offices-bureaus-and-departments/bmch/welcome-to
4. Number of Hits to the State Title V Program Website		450,722
5. State Title V Social Media Websites	https://www.facebook.com/ODH/MaternalChildFamilyHealth	https://www.facebook.com/ODH/MaternalChildFamilyHealth
6. Number of Hits to the State Title V Program Social Media Websites		3,845,862

Form Notes for Form 7:

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, Childhood Cancer, 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, Reproductive Health and Wellness, Sexual Assault and Domestic Violence Prevention, School Health, School Nursing, Sickle Cell, Shaken Baby, SIDS, YRBS. Social media campaigns and websites include both paid and organic social media. This number is smaller than the previous year due to this being during the height of COVID. The number of calls to "Other" Toll-Free Hotlines include the Children with Medical Handicaps Helpline and the Breastfeeding Hotline. 63% of the incoming calls to the Breastfeeding Hotline occurred between 4:00 and 8:00 p.m.

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	Chief, Bureau of Maternal, Child and Family Health
Address 1	246 North High Street
Address 2	4th floor
City/State/Zip	Columbus / OH / 43215
Telephone	(614) 965-2863
Extension	
Email	dyane.goganturner@odh.ohio.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Patrick Londergan
Title	Administrator, Children with Medical Handicaps Program
Address 1	246 North High Street
Address 2	4th floor
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	Kimberly Matthews
Title	Parent Consultant
Address 1	246 North High Street
Address 2	4th floor
City/State/Zip	Columbus / OH / 43215
Telephone	(740) 334-2355
Extension	
Email	Kimberly.Mathews@odh.ohio.gov

Form Notes for Form 8:

Dyane Gogan Turner
614-752-7464
Patrick Londergan
614-728-7039
Sara Haig
614-728-2957

Form 9
List of MCH Priority Needs

State: Ohio

Application Year 2023

No.	Priority Need
1.	Decrease risk factors contributing to maternal morbidity
2.	Increase mental health support for women of reproductive age
3.	Decrease risk factors associated with preterm births
4.	Support healthy pregnancies and improve birth and infant outcomes
5.	Improve nutrition, physical activity, and overall wellness of children
6.	Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate
7.	Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use
8.	Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services
9.	Prevent and mitigate the effects of adverse childhood experiences
10.	Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes

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 10
National Outcome Measures (NOMs)

State: Ohio

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	77.5 %	0.1 %	99,260	128,131
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
2019	78.4	2.5	1,014	129,307
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
2016_2020	20.6	1.8	139	673,703
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**
2020	8.5 %	0.1 %	10,957	129,085
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**
2020	10.3 %	0.1 %	13,311	129,097
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**
2020	27.6 %	0.1 %	35,653	129,097
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
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	2.0 %			
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
2019	6.7	0.2	905	134,874
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
2019	6.9	0.2	927	134,461
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
2019	4.6	0.2	616	134,461
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**
2019	2.3	0.1	311	134,461
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**
2019	243.9	13.5	328	134,461
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
2019	110.1	9.1	148	134,461
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
2019	9.5	0.3	1,223	128,243
2018	11.7	0.3	1,504	129,075
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
2019_2020	10.9 %	1.3 %	263,559	2,420,503
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
2020	16.5	1.1	208	1,262,783
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
2020	37.7	1.6	555	1,473,356
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
2018_2020	10.0	0.7	227	2,263,277
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
2018_2020	11.3	0.7	255	2,263,277
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
2019_2020	22.2 %	1.5 %	570,936	2,573,903
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
2019_2020	20.1 %	3.1 %	114,552	570,936
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
2019_2020	3.0 %	0.6 %	64,577	2,118,062
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
2019_2020	10.2 %	1.1 %	216,121	2,109,000
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
2019_2020	52.7 %	4.8 %	176,829	335,372
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
2019_2020	91.1 %	1.2 %	2,343,417	2,573,119
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
2019_2020	17.2 %	1.9 %	185,975	1,079,755
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
2017	70.1 %	4.0 %	96,000	137,000
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
2020_2021	60.2 %	1.9 %	1,467,993	2,438,527
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
2020	75.5 %	2.9 %	558,757	739,983
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**
2020	93.4 %	1.4 %	690,924	739,983
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
2020	93.4 %	1.6 %	691,321	739,983
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
2020	17.6	0.2	6,404	364,534
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
2019_2020	4.1 %	0.9 %	106,002	2,568,179
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				75	74.4
Annual Indicator			74.3	73.7	73.1
Numerator			1,442,216	1,438,131	1,436,365
Denominator			1,941,208	1,951,578	1,964,967
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	74.1	75.2	76.2	77.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Adjusted targets to equal intervals between new baseline (73.1%) and 2025 target (77.2%). This is about a 1% absolute annual increase.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	80.9	77.2	84.2	84.4	82.1
Annual Indicator	76.8	81.9	82.8	80.1	82.3
Numerator	101,413	106,884	110,538	101,710	108,381
Denominator	132,017	130,510	133,422	127,037	131,672
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	84.4	86.6	88.7	90.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Adjusted so that annual objectives are equal intervals between new baseline (82.3%) and our 2025 target (90.8%), which is about a 2.1% absolute annual increase.

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.5	17.2	24.6	28.7	23.3
Annual Indicator	16.7	23.7	26.0	21.6	23.1
Numerator	21,279	30,504	33,213	26,964	29,092
Denominator	127,543	128,458	127,978	124,604	126,012
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	25.1	27.2	29.2	31.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Adjusted so that targets are equal intervals between new baseline (23.1%) and 2025 target (31.2%). This is about a 2% absolute increase per year.	

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	82.5	83.3	90	90.5	91
Annual Indicator	85.5	85.5	85.5	85.5	85.5
Numerator	111,358	111,358	111,358	111,358	111,358
Denominator	130,239	130,239	130,239	130,239	130,239
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2015	2015	2015	2015

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	82.5	83.3	90	90.5	91
Annual Indicator	82.7	85.5	86.6	87.6	89.1
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	90.1	91.1	92.0	93.0

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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/.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Adjusted targets so that there are equal intervals between our new baseline (89.1%) and our 2025 target (93%). This about a 1% absolute increase per year.	

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	2021
Annual Objective			41	44	46.9
Annual Indicator	39	40.4	42.3	45.4	47.8
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.1	50.5	51.8	53.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Targets have been adjusted so that there are equal intervals between the new baseline (47.8%) and our 2025 target (53.1%). This is about a 1.3% absolute increase per year.

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	2021
Annual Objective			54	58	64.5
Annual Indicator	40.9	51.9	57.7	61.5	64.1
Numerator					
Denominator					
Data Source	OPAS	OPAS	OPAS	OPAS	OPAS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.2	70.3	73.4	76.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Targets have been adjusted so that there is an equal interval between our new baseline (64.1%) and the 2025 target (76.5%). This is a 3.1% absolute increase per 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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		41.6	42.1	29	34.9
Annual Indicator	41.1	33.3	28.5	34.3	36.7
Numerator	114,362	95,915	73,603	105,296	129,873
Denominator	278,232	287,752	258,257	306,997	353,406
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	37.6	38.6	39.5	40.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Targets have been adjusted so that they are in equal intervals from our new baseline (36.7%) and 2025 target (40.4%), which is a 10% increase over new baseline. This is about a 0.93% absolute increase per year.

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		78.6	79.6	79.6	83.6
Annual Indicator	78.1	79.1	79.1	83.1	79.6
Numerator	694,854	708,785	708,785	747,153	712,653
Denominator	889,704	895,626	895,626	899,030	895,368
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		78.6	79.6	79.6	83.6
Annual Indicator	43.9	44.3			
Numerator	144,230	140,942			
Denominator	328,769	318,477			
Data Source	Ohio Medicaid	Ohio Medicaid			
Data Source Year	SFY 17	SFY 18			
Provisional or Final ?	Final	Final			

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	81.1	82.6	84.1	85.6

Field Level Notes for Form 10 NPMs:

1.	**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).
2.	**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.
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note:	Annual targets have been readjusted so that there are equal intervals between our new baseline (79.6%) and 2025 target (85.6%). This is a 1.5% increase per year.

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**	**2021**
Annual Objective			19.4
Annual Indicator	18.9	19.1	24.4
Numerator	48,775	51,261	62,281
Denominator	257,717	268,951	255,707
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.0	25.6	26.2	26.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Since we met our target for 2021, the 2025 target was readjusted to be a 10% increase over our new baseline. Annual targets were created to be equal intervals between new baseline (24.4%) the new 2025 target (26.8%). This is an absolute increase of 0.6% per year.

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	2021
Annual Objective			15.2
Annual Indicator	9.4	15.5	15.5
Numerator	173,603	290,381	290,381
Denominator	1,846,840	1,873,426	1,873,426
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	14.7	14.5	14.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
We do not yet have 2021 OMAS data, so 2019 data are still our most recent.

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			21.2
Annual Indicator	22.2	22.1	21.9
Numerator	426,982	414,681	408,790
Denominator	1,922,700	1,879,577	1,864,493
Data Source	Behavioral Health Risk Factor Surveillance System	Behavioral Health Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.1	19.7	19.4	19.0

Field Level Notes for Form 10 SPMs:

None

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	2021
Annual Objective			453.7
Annual Indicator	489.2	465.9	424.1
Numerator	3,727	3,521	3,162
Denominator	761,856	755,742	745,614
Data Source	Ohio Hospital Association	Ohio Hospital Association	Ohio Hospital Association
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	441.5	429.3	417.1	404.9

Field Level Notes for Form 10 SPMs:

None

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	2021
Annual Objective			19.9
Annual Indicator	23.5	20.4	20.4
Numerator	594,643	515,502	517,182
Denominator	2,531,859	2,526,971	2,535,206
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	19.4	18.9	18.4	17.9

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:	**State Provided Data**
	Field Note: State-specific data on adverse childhood experiences were available only as two-year combined estimates.	

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	2021
Annual Objective			50
Annual Indicator	40	50	50
Numerator	4	5	5
Denominator	10	10	10
Data Source	Action Plan	Action Plan	Action Plan
Data Source Year	2020	2021	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.0	80.0	90.0	100.0

Field Level Notes for Form 10 SPMs:

None

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	2021
Annual Objective			121.4
Annual Indicator	118.6	123.9	118.1
Numerator	266	276	270
Denominator	22,422	22,271	22,857
Data Source	HCUP-SID	HCUP-SID	HCUP-SID
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	116.5	114.8	113.2	111.5

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Since we surpassed our 2022 goal we set last year, the 2022-2024 targets have been changed to reflect accelerated change towards our 2025 target, which is an absolute decrease of 1.65 in the rate of SMM per 10,000 delivery hospitalizations.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This 2025 was calculated last year based on a 12% improvement over 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	2021
Annual Objective			10.8
Annual Indicator	8	11	11
Numerator	149,350	209,312	209,312
Denominator	1,866,875	1,902,836	1,902,836
Data Source	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey	Ohio Medicaid Assessment Survey
Data Source Year	2017	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	10.6	10.5	10.3	10.1

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
We do not yet have 2021 OMAS data, so 2019 data are still our most recent.

SOM 3 - Percent of children ages 0-5 with confirmed elevated blood lead levels

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1.8
Annual Indicator	2.3	2.1	1.9
Numerator	3,856	3,533	2,776
Denominator	168,352	165,832	143,705
Data Source	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse	Ohio Public Health Data Warehouse
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.5	1.3	1.2	1.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
No change in targets from last 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	2021
Annual Objective			24.9
Annual Indicator	25.9	25.9	25.9
Numerator	104,317	104,317	104,317
Denominator	402,688	402,688	402,688
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.4	23.9	23.4	22.9

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:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Since we do not have updated data, targets remain the same.	

SOM 5 - Percent of high school students who have used marijuana within the past 30 days

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			14.8
Annual Indicator	15.8	15.8	15.8
Numerator	65,023	65,023	65,023
Denominator	410,565	410,565	410,565
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	14.3	13.8	13.3	12.8

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:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Since we do not have updated data, targets remain the same.	

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	2021
Annual Objective			34.5
Annual Indicator	36.7	36.7	36.7
Numerator	155,186	155,186	155,186
Denominator	422,534	422,534	422,534
Data Source	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey	OH Youth Risk Behavior Survey/Youth Tobacco Survey
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	34.0	33.4	32.9	32.3

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:	**State Provided Data**
	Field Note: We do not yet have updated data for this measure.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Since we do not have updated data, targets remain the same.	

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			15.5	12.9	12.6
Annual Indicator	15.2	15.6	13.9	14.3	13.6
Numerator	369	384	339	356	326
Denominator	24,316	24,542	24,359	24,971	23,941
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	OH Department of Health Bureau of Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	11.7	9.8	7.9	6.0

Field Level Notes for Form 10 SOMs:

1.	**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 are based on equal intervals between the updated baseline (2020 data) and the 2025 target, which comes out to an absolute decrease in the rate of 1.9 deaths per 1,000 live births per year.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Ohio

ESM 1.1 - Percent of birthing hospitals implementing AIM hypertension model

Measure Status:	**Inactive - Replaced with an ESM that is more aligned with our well-woman NPM.**

State Provided Data			
	2019	**2020**	**2021**
Annual Objective			10
Annual Indicator		0	30.9
Numerator		0	30
Denominator		102	97
Data Source		Program data	Program data
Data Source Year		FY 2020	FY 2021
Provisional or Final ?		Final	Final

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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This is the percent of birthing hospitals who participated in wave 1 of the AIM Hypertension Patient Safety Bundle Quality Improvement Project.	

ESM 1.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	32.0	33.0	34.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Targets were set based on equal intervals between baseline (FY 2021) and a 10% improvement by 2025.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This is a 10% improvement over FY 2021 baseline.	

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	66	72.6	82.7	84.5	86.4
Annual Indicator	67.9	77.9	82.5	86.1	90.7
Numerator	72	81	85	87	88
Denominator	106	104	103	101	97
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.3	90.3	92.2	94.2

Field Level Notes for Form 10 ESMs:

None

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	2021
Annual Objective			5,500	5,500	5,750
Annual Indicator			5,961	6,019	5,379
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6,000.0	6,000.0	6,000.0	6,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Due to COVID-19, crib distribution was impacted due to gathering restrictions.

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**	**2021**
Annual Objective			50	70	72
Annual Indicator			70	65.4	65.1
Numerator			5,879	5,251	5,632
Denominator			8,394	8,027	8,652
Data Source			OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys	OH Comprehensive Home Visiting Integrated Data Sys
Data Source Year			FFY 2019	FFY 2020	FFY 2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	74.0	76.0	78.0	80.0

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

ESM 10.1 - Percent of adolescents (12-17) served by Medicaid with adolescent well visit

Measure Status:	Inactive - We are replacing this ESM with one that measures a strategy, rather than an outcome.

State Provided Data			
	2019	2020	2021
Annual Objective			45.3
Annual Indicator	48	44.4	46.5
Numerator	149,363	139,489	169,947
Denominator	311,048	313,853	365,250
Data Source	Ohio Department of Medicaid	Ohio Department of Medicaid	Ohio Department of Medicaid
Data Source Year	SFY 2019	SFY 2020	SFY 2021
Provisional or Final ?	Final	Final	Final

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.

ESM 10.2 - Percent of middle and high schools with a school-based health center that offers health services to students

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	18.9	19.5	20.1

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: 2023 and 2024 targets were identified by using equal intervals from the difference between the FY 21 baseline and the 2025 target. This equates to a 0.6% absolute increase per year.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This is a 10% increase over baseline.	

ESM 12.1 - Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			22
Annual Indicator			16
Numerator			
Denominator			
Data Source			CMH program records
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	28.0	31.0	33.0

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
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

Measure Status:	Active
Goal:	Decrease the percent of women ages 18 to 44 who had unmet mental health care or counseling needs in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 18 to 44 who had an unmet mental health care or counseling need in the past year **Denominator:** Number of women ages 18 to 44
Healthy People 2030 Objective:	n/a
Data Sources and Data Issues:	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.
Significance:	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.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the rate of nonfatal intentional self-harm among adolescents ages 15-19</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents ages 15-19</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related objective: IVP-19 — Reduce emergency department visits for nonfatal intentional self-harm injuries among those aged 10 and up</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 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

Measure Status:	Active
Goal:	Reduce the percent of high school students who use alcohol
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school students who used alcohol in the past 30 days **Denominator:** Number of high school students
Healthy People 2030 Objective:	Related objective: SU-4 — Reduce the proportion of adolescents who drank alcohol in the past month to 6.3% 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:	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.

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>Inactive - Replaced with an ESM that is more aligned with our well-woman NPM.</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 1.2 - Percent of uninsured women ages 18 and older served in Title X Reproductive Health & Wellness clinics who were referred for enrollment or enrolled in health insurance
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 number of women enrolled in health insurance.</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 uninsured women (unduplicated clients) ages 18 and older who are served in Title X Reproductive Health & Wellness clinics and were referred to or enrolled in health insurance ("Medicaid Enroll Assist").</td></tr>
<tr><td>Denominator:</td><td>Number of uninsured women (unduplicated clients) ages 18 and older who are served in a Title X Reproductive Health & Wellness clinic</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ahlers database for Title X clinics</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Our evidence-informed strategy is to utilize certified application counselors (CACs) to refer and/or enroll uninsured women in health insurance. We accessed evidence on expanded insurance coverage through HRSA's MCHBest evidence library. Several studies cited in the evidence library illustrate how increases in insurance coverage (in these cases, via Medicaid expansion) resulted in increased uptake of preventive health services. This strategy influences the percent of women with a preventive health visit by increasing the number of women with health insurance, which covers or greatly offsets the cost of preventive well-visits.</td></tr>
<tr><td>Significance:</td><td>In 2019, more than 1 in 10 women of reproductive age did not have health insurance, and the percent of uninsured women has increased since 2015 (Ohio Medicaid Assessment Survey). Women who were uninsured were more likely to avoid getting needed care than women who had health insurance, and much more likely to avoid getting needed care due to cost. Just over half of uninsured women had a routine healthcare visit within the past year, compared to 75% of their insured counterparts (OMAS). Health insurance coverage provides affordable access to preventive health services, including well visits, that can help women maintain or achieve optimal health before, during, and after pregnancy. This ESM measures the number of women referred to or enrolled by CACs. This is important to measure because it demonstrates the number of women who were uninsured but can now access health care, including no-cost well-visits.</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:	Inactive - We are replacing this ESM with one that measures a strategy, rather than an outcome.
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 10.2 - Percent of middle and high schools with a school-based health center that offers health services to students
NPM 10 – Percent of adolescents, ages 12 through 17, 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 school-based health centers in Ohio.</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>Weighted number of middle and high schools in Ohio with a school-based health center that offers health services to students.</td></tr>
<tr><td>Denominator:</td><td>Number of schools in Ohio eligible to be sampled for the School Health Profiles survey.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data for this measure come from the School Health Profiles survey. The School Health Profiles (Profiles) assists state and local education and health agencies in monitoring and assessing characteristics of school health education; physical education and physical activity; practices related to bullying and sexual harassment; school health policies related to tobacco-use prevention and nutrition; school-based health services; family engagement and community
involvement; and school health coordination. If at least 70% of the principals or lead health education teachers in the sample completed the questionnaire, the data can be weighted to represent the population. If the state does not obtain a 70% response rate, data are not weighted, and unweighted data represent only the schools in which the principals or teachers completed the questionnaire.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This ESM measures our strategy, Increase access to school-based health centers in Ohio. We accessed evidence on school-based health centers and adolescent well-visits on HRSA's MCHBestStrategy database. Specifically, the paper by Allison et al., School-based health centers: improving access and quality of care for low-income adolescents, demonstrated an increase in adolescent well-visits among low-income students who used school-based health centers compared to community clinics. School-based health centers can eliminate many barriers to obtaining care including transportation; parents missing time at work and lack of a provider or medical home. In many cases, they also limit the time out of the classroom. Comprehensive well visits can be provided at school-based health centers, and with expanded access to these clinics, adolescents with a comprehensive well visit may increase as well.</td></tr>
<tr><td>Significance:</td><td>This ESM measures the availability of school-based health centers across Ohio. This is important to measure because it quantifies the potential for access to key health services, including well visits, within schools, which can eliminate a number of obstacles to health care.</td></tr>
</table>

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 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 2021

	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	• Infant Deaths are linked to Medicaid
3) Medicaid	Yes	No	Quarterly	6	Yes	
4) WIC	Yes	Yes	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	No	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	No	
7) Hospital Discharge	Yes	No	Quarterly	4	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	9	Yes	• Medicaid

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None