

# Maternal and Child Health Block Grant

## National Performance Measures

### Table of Contents

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.	3
NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey).	4
NPM 03 - The percent of children with special health care needs age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.	6
NPM 04 - The percent of children with special health care needs age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.	7
NPM 05 - The percent of children with special health care needs age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.	9
NPM 06 - The percent of children with special health care needs age 0 to 18 years who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.	11
NPM 07 - The percent of 19-35 month olds who have received full schedule of immunizations.	13
NPM 08 – Birth Rate for teenagers 15-17 years.	14
NPM 09 – Percent of 3rd graders who have received protective sealants on at least 1 permanent molar tooth.	16
NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.	18
NPM 11: The percentage of mothers who breastfeed their infants at 6 months of age.	20
NPM 12 - Percent of newborns screened for hearing before hospital discharge.	22
NPM 13 - Percent of children without health insurance.	25
NPM 14 - Percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.	28

NPM 15: Percentage of women who smoked in the last trimester of pregnancy.	30
NPM 16 – Suicide deaths among youths 15-19.	32
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	34
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	35

**MCH National Performance Measure 01: The percent of screen positive newborns who receive timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening program.**

**Accomplishment Report Annual Plan for FFY 10/1/12 – 09/30/13**

Strategy A: Prepare report of genetic center cases that match with Newborn Screening Lab cases. Present this information to the Genetic Center Directors.

**Report of Accomplishment:** The epidemiologist supported by the genetics program was re-assigned to other MCH block grant activities. The Genetics Program staff are exploring other options to complete this activity.

Strategy B: Continue participation in the Region 4 Genetics Collaborative.

**Report of Accomplishment:** Approximately 10 ODH staff from the newborn screening laboratory, BCMH, Genetics, Sickle Cell, and Early Intervention Programs participate in the Region 4 Genetics Collaborative. Anna Starr, Genetics Section Administrator is the state lead for Ohio. In addition, approximately 8 parents of children with special health care needs also participate in the collaborative. Staff participate on the following work groups: Secretary's Advisory Committee for Heritable Disorders (SACHDNC); Newborn Screening Long Term Follow-up; Hemoglobinopathies; and Congenital Hypothyroidism 3-year follow up study. Each work group has a workplan, timeline and product(s) for accomplishment. The SACHDNC workgroup is currently working on best practices among states for newborn screening for critical congenital heart disease follow up.

Strategy C: Explore newborn screening for cardiac defects, and develop plan for ODH's role in assuring universal screening and appropriate follow up.

**Report of Accomplishment:** Senate Bill 4, which mandates all birth hospitals to screen babies for critical congenital heart disease (CCHD) was signed by Gov. Kasich in July, 2013. The legislation required ODH to develop administrative rules to define how the screenings shall be implemented, and how hospitals shall report screening data to ODH. ODH is currently in the rule-making process. An ad hoc workgroup of pediatric cardiologists, nursery nurse managers, advocates, March of Dimes, American Heart Association, neonatologists and pediatricians are providing guidance to the ODH on rules, procedures, etc.

Strategy D: Continue collaboration with Medicaid, WIC and BCMH regarding the provision of special formulas for children who participate in multiple programs.

**Report of Accomplishment:** Staff in the Bureau for Children with Developmental & Special Needs developed a proposal for consideration by the Governor's Office of Health Transformation (OHT) for consolidating the authorization and provision of metabolic formula for individuals who participate in one of multiple public payors (Medicaid; BCMH; Metabolic Formula Program; and WIC). The concept is to streamline state agency procedures and collaborate to reduce inefficiencies, save money and improve health outcomes. The proposal has been submitted to the Medical Director of the Ohio Department of Medicaid for review.

**Strategies for the Current FFY 10/1/12 – 09/30/13**

1. Improve the matching of data from Life Cycle, Genetics and Metabolic Formula data systems.

**Activity:** This strategy has been eliminated from this performance measure due to lack of dedicated researcher time to match data between the multiple systems.

2. Continue participation in the Region 4 Genetics Collaborative. on track and remain unchanged

3. Implement newborn screening for CCHD.

**Activity:**

- a. Promulgate rules
- b. Develop data collection mechanism
- c. Hire staff to manage data
- d. Train hospitals on screening/reporting
- e. Provide data reports as part of Ohio's infant mortality initiative

4. Implement OHT Medicaid project for metabolic formula authorization/distribution, and/or re-assess the Metabolic Formula Program's role in distributing formula for Medicaid recipients. on track and remain unchanged

**Plan for Next FFY 10/1/2014 – 9/30/2015**

1. Match data of genetics-related confirmed newborn screening cases with genetics and metabolic formula data systems to determine proportion of cases seen in Genetics and for long term follow-up.

2. Build relationship with new newborn screening laboratory staff nurses by providing orientation on programs and identifying gaps in Ohio's newborn screening short term to long term continuum.

3. Continue participation in the Region 4 Genetics Collaborative workgroups.

4. Monitor implementation of newborn screening for critical congenital heart disease through hospital screening data and other data sets such as OCCSN and BCMH.

5. Transition patients from Metabolic Formula Program to Medicaid/Medicaid Managed Care.

**MCH National Performance Measure 02: The percent of children with special health care needs age 0-18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CYSHCN survey)**

**Accomplishment Report Annual Plan for FFY 10/1/12 – 09/30/13**

Strategy A: Empower families to work in partnership with providers in decision making.

**Report of Accomplishment:** Ohio's CYSHCN program continued partnership with Dr. Pam Oatis and Mercy St. Vincent Medical Center and Family Voices of Ohio on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN. Training in Medical Home/Listening with connection was expanded and enhanced to include four parts; two in person trainings, videos completed independently and follow up mentoring calls. The enhanced training has been provided to 34 Ohio Help Me Grow Early Intervention and Home Visiting providers. Train the trainer sessions have also been completed (18 individuals trained to date) to continue to build the capacity to reach local communities to ensure sustainability and regional accessibility of this training/information.

Collaboration continues around development of a web-based, customizable, care notebook tool that will be useful for a wide range of families including families with children and youth with special health care needs in Ohio.

The BCMH Parent Consultant and Medicaid Liaison have been coordinating with Ohio's five new Medicaid Managed Care plans to provide education and linkage to Ohio's CYSHCN and their families through activities such as linking families to local Consumer Care Councils.

Strategy B: Enhance family partnerships and strengthen regional family activities

**Report of Accomplishment:** The BCMH Parent Advisory Council (PAC) membership and agency/stakeholder participation has continued to grow and diversify and includes family leaders and parents from geographically diverse locations who are representative of each CYSHCN programmatic area. The PAC meetings provide a forum for identification of gaps and barriers for families seeking services for their CYSHCN. The PAC also facilitates planning and coordination of efforts related to informing and empowering parents. This forum is critical for conversation and coordination related to changes in managed care and health care reform and impact on families of CYSHCN in Ohio. The web-based, customizable, care notebook project is a collaboration between parent leadership from two HRSA grants, the "Ohio Statewide Medical Home Project for CYSHCN" and "REAL Action in Ohio: Resources, Education, Alignment and Linkages" and represent organizations including the UCEDD programs at the Ohio State University and University of Cincinnati, the Autism Treatment Network at Nationwide Children's Hospital and Family Voices of Ohio strengthening connections between these diverse family leaders.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

1. Empower families to work in partnership with providers in decision making.

**Activities:**

- a. Ohio CYSHCN program is the Title V partner on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation grant.
- b. The training has been spread to include Public Health Nurses, Help Me Grow EI and Home Visiting program.
- c. A family survey assessing family knowledge and understanding of Medical Home was piloted and will be sustained.
- d. Support of diverse team of parent leaders who are collaborating to develop and complete a web-based, customizable Care Notebook tool that will be useful for a range of families of CYSHCN in Ohio.
- e. Linkage of Ohio's CYSHCN and their families to local Consumer Care Councils for Ohio's five Medicaid Managed Care plans.

2. Enhance family partnerships and strengthen regional family activities

**Activities:**

- a. Family Voices of Ohio leadership and Family to Family Health Information Specialists continue to attend our Parent Advisory Council (PAC) meetings.
- b. Parent Consultant exploring different models of parent support programming.
- c. Continued enhancement of BCMH Parent Advisory Committee to ensure diverse representation.

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

Strategy A: Empower families to work in partnership with providers in decision making.

**Activity:** Complete work with the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN, and use the grant evaluation to help determine future directions. Plan to explore potential connections for sustainability with other systems work related to family engagement and empowerment such as the work of the Ohio Early Childhood Advisory Councils committee on Family Engagement. Evaluate the survey assessing family knowledge and understanding of medical home which was implemented statewide as part of the family assessment completed by the BCMH public health nurses. Based upon survey analysis, we will consider implementing the survey through our BCMH program on an ongoing basis to improve our ability to promote medical home with our families. Continue to facilitate the partnership between the team of family leaders who are collaborating to develop and complete a web-based, customizable

Care Notebook tool that will be useful for a wide range of families of children and youth with special health care needs in Ohio. Continue to connect families with important opportunities to influence health care systems change such as the Medicaid Managed Care Consumer Councils.

Strategy B: Enhance family partnerships and strengthen regional family activities.

**Activity:** Continue to leverage the leadership of our Parent Consultant, to enhance family leadership role/presence throughout the various programs in the Bureau for Children with Developmental and Special Health Needs which houses our CYSHCN programs. Continue to explore parent support models with local parent to parent matches. We will support our BCMH Parent Advisory Council to ensure continued diverse representation and participation of a range of special needs and geographical/regional representation. We continue to work closely with Family Voices of Ohio leadership and Family to Family Health Information Specialists through attendance at our Parent Advisory Council (PAC) meetings. This connection allows for identification of gaps and barriers for families seeking services for their CYSHCN and provides a forum to plan and coordinate efforts related to informing and empowering parents. We also plan to develop a closer connection with VOICES for Ohio's Children, an organization committed to promoting the health of all Ohio children including children and youth with special health care needs.

**MCH National Performance Measure 03: The percent of children with special health care needs age 0-18 years who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN survey)**

#### **Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Strengthen medical home, particularly in the area of coordination of services for families and providers

**Report of Accomplishment:** Continue to connect with medical home initiatives in our state including Ohio's Patient Centered Medical Home Education Pilot Project and the Ohio Patient-Centered Primary Care Collaborative (PCPCC). This collaborative is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals working together to support and promote the Patient-Centered Medical Home model of healthcare delivery in Ohio. The focus on PCMH in Ohio has supported dramatic growth of practices now certified as medical homes in Ohio. An internal ODH team developed a proposal based upon the success of Ohio's PCMH work which would target pediatric practice transformation. As currently conceptualized, the project would use lessons learned from the PCMH project and would apply quality improvement methodology to transform pediatric practices into recognized medical homes. The proposal is currently being considered by state leadership.

Strategy B: Increase demand for quality pediatric medical home services by improving knowledge and understanding of medical home among families and professionals.

**Report of Accomplishment:** The "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN, includes training in local communities in the principles and practice of medical home as well as "Listening with Connection" a communication skill building program. This project also launched a survey assessing family knowledge and understanding of medical home as part of the family assessment completed annually by the BCMH public health nurses. To date, 1038 surveys have been received and are being analyzed. Survey collection will continue through June 30, 2014. Preliminary results indicate that 45% of BCMH children met the criteria for medical home. Only 43% of caregivers were able to correctly define a medical home. This data will help guide further efforts in this area.

### Strategies for the Current FFY 10/1/12 – 09/30/13

1. Strengthen medical home, particularly in the area of coordination of services for families and providers

**Activities:**

- a. We will continue to work collaboratively with medical home initiatives in our state including Ohio's Patient Centered Medical Home Education Pilot Project and the Ohio Patient-Centered Primary Care Collaborative (PCPCC). This collaborative is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals working together to support and promote the Patient-Centered Medical Home model of healthcare delivery in Ohio.
- b. ODH has proposed a project to the Office of Health Transformation to expand pediatric medical homes in Ohio.

2. Increase demand for quality pediatric medical home services by improving knowledge and understanding of medical home among families and professionals.

**Activity:**

- a. Consider sustaining the work of the "Ohio Statewide Medical Home Project for CYSHCN" in local communities in the principles and practice of medical home and "Listening with Connection" a communication skill building program, and follow up on survey results assessing family knowledge and understanding of medical home to drive next steps.

### Plan for Next FFY 10/1/2014 – 9/30/2015

Strategy A: Strengthen medical home, particularly in the area of coordination of services for families and providers

**Activity:** Continue to work collaboratively with medical home initiatives in our state including Ohio's Patient Centered Medical Home Education Pilot Project and the Ohio Patient-Centered Primary Care Collaborative (PCPCC). A team at ODH anticipates initiating a project which is currently under development to expand pediatric medical homes in Ohio. This project would use quality improvement methodology to transform pediatric practices into recognized medical homes. We will continue to provide representation as appropriate on committees for Ohio Medicaid related to Primary Care Health Homes.

Strategy B: Increase demand for quality pediatric medical home services by improving knowledge and understanding of medical home among families and professionals.

**Activity:** Consider sustaining the work of the "Ohio Statewide Medical Home Project for CYSHCN" by providing on-going training in the principles and practice of medical home as well as "Listening with Connection". We plan to use the grant evaluation and data from the medical home survey being completed by June 30, 2014 to drive next steps. Additionally, we will consider adding this survey to the BCMH public health nurse annual assessment on a permanent basis.

**MCH National Performance Measure 04: The percent of children with special health care needs age 0-18 years whose families have adequate private and/or public insurance to pay for the services they need. (CYSHCN survey)**

### Accomplishment Report for FFY 10/01/2012 – 09/30/2013

Strategy A: Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

**Report of Accomplishments:** The "ABD population" was transitioned into Medicaid Managed Care in Ohio on 7/1/13. The Children with Medical Handicaps program (BCMh) collaborated with Medicaid to assist with communication to families and providers about this change. Presentations were also prepared and given to the 5 new Medicaid Managed Care plans regarding our Title V CYSHCN programs and issues impacting Ohio's CYSHCN. BCMh continues to provide updates and guidance to local health departments, public health nurses, and hospital based service coordinators on state and federal changes during weekly

LHD calls, conference opportunities and quarterly regional meetings with local public health nurses and hospital based service coordinators. Our Parent Consultant and our Medicaid Liaison continue active promotion of family participation in regional Medicaid Managed Care community advisory groups. Internal workgroups were convened to provide evaluation and planning for our programs related to continued implementation of the Affordable Care Act. Formal evaluation of a range of MCH programs and potential impact of the ACA is planned using an external vendor.

BCMh continues to interact directly with families on a daily basis informing them of programs for which their child may be eligible including Medicaid/SCHIP, providing guidance and direction regarding the transition to Medicaid Managed Care in Ohio and, once enrolled in the BCMh program, help with coordination of benefits.

**Strategy B:** Maintain CYSHCN data capacity; include questions in the Ohio Medicaid Assessment Survey (OMAS) relative to CYSHCN.

**Report of Accomplishments:** The Ohio Department of Health supported the 2012 Ohio Medicaid Assessment Survey (OMAS) which was a cross-sectional telephone survey (cell phone and landline) which included elements related to CYSHCN. Our CYSHCN team participated on the review team throughout the analysis and report development. The policy brief titled, "Emerging Challenges of Serving Ohio's Children with Special Health Care Needs" was published in June 2013 highlighting challenges such as a growing CSHCN population in Ohio, worse health status and greater unmet needs compared to children without special health care needs.

Collaborative work between epidemiologists and program staff is underway to develop an Ohio CYSHCN data book which will take advantage of data from the NS-CYSHCN 09-10 and will incorporate local data sources such as the OMAS.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

**Strategy A:** Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

**Activities:**

- a. During the transition of the ABD population into Medicaid Managed Care (MMC) in OH we are collaborating with Medicaid on communications to families and providers. We are providing presentations for the 5 new MMC plans regarding our programs & issues impacting Ohio's CYSHCN.
- b. We were also actively engaged on a committee examining eligibility across health & human services programs.
- c. Work collaboratively on internal workgroups related to analysis of the impact of ACA on our programs including work with vendor on generating a formal report regarding impact of ACA on public health programs in OH
- d. BCMh continues to interact directly with families on a daily basis informing them of programs that their child may be eligible including Medicaid/SCHIP, providing guidance and direction regarding transition to MMC in OH & once enrolled in the BCMh program help with coordination of benefits. BCMh continues to contract with 315 public health nurses in 117 LHDs to provide local support for families.

**Strategy B:** Maintain CYSHCN data capacity; include questions in the OH Medicaid Assessment Survey (OMAS) relative to CYSHCN.

**Activities:**

- a. Collaborative work is underway between epidemiologists and program staff to develop an Ohio CYSHCN data book which will take advantage of data from the NS-CYSHCN 09-10 and will incorporate local data sources such as the OMAS.

### Plan for Next FFY 10/1/2014 – 9/30/2015

Strategy A: Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

**Activities:** As ACA implementation continues, health care reform will continue to be a critical area of focus. We will continue work on internal ACA workgroups related to our programs and the impact of the ACA as determined by the Ohio Department of Health. We will also assist ODH with next steps as the Mathematica report on impact of the ACA on ODH public health programs is finalized and shared as deemed appropriate. We will continue to collaborate closely with Medicaid regarding the CYSHCN population and experience with Medicaid Managed Care. We will continue to take advantage of opportunities to serve on workgroups and present information regarding our experience with Ohio's CYSHCN and barriers to needed services. We will also continue to provide updates and guidance to local health departments, public health nurses, and hospital based service coordinators on state and federal changes during weekly LHD calls, conference opportunities and quarterly regional meetings with local public health nurses and hospital based service coordinators. We will continue to promote the critical involvement of Ohio's family leaders through the work of our Parent Consultant and our Medicaid liaison. We will continue to work, through ODH, with the Governor's Office of Health Transformation (OHT) team as appropriate related to Ohio's CYSHCN.

Strategy B: Maintain CYSHCN data capacity; include questions in the Ohio Medicaid Assessment Survey (OMAS) relative to CYSHCN.

**Activities:** The Ohio Department of Health will continue to support the Ohio Medicaid Assessment Survey (OMAS) which was a cross-sectional telephone survey (cell phone and landline). We will promote and utilize the survey analysis related to CYSHCN. We will complete and publish an Ohio CYSHCN data book which will take advantage of data from the NS-CYSHCN 09-10 and will incorporate local data sources such as the OMAS data described. This data book will be used with policy makers and key stakeholders to better describe CYSHCN in Ohio and the disparities faced by this important, vulnerable population.

**MCH National Performance Measure 05: The percent of children with special health care needs age 0-18 years whose families report the community-based service systems are organized so they can use them easily. (CSHCN survey)**

### Accomplishment Report for FFY 10/01/2012 – 09/30/2013

Strategy A: Promote organization of community-based services so that CSHCN families report they can use them easily.

**Report of Accomplishment:** Staff from BCMH and HMG (early intervention and home visiting) continued collaboration on Ohio's early childhood care coordination pilot project which utilizes the HUB/Pathways model of care coordination in Southeast Ohio. The work was expanded through HUB innovation grants to two HUB sites in Ohio to demonstrate models of connection and collaboration between the HUB and HMG.

- Our staff also continued to serve in an advisory role in the development, implementation and evaluation of Project LAUNCH, which is located in southeast Ohio.
- BCMH staff continued work with Ohio Medicaid to improve ease of access to special formulas for our children with special nutritional needs. Work this year focused on individuals with metabolic disorders and improving coordination between systems to ensure simple and timely access to lifesaving formula for this special group. Work with leadership from Ohio Medicaid and Ohio WIC with the goal of improved ease of acquisition of medically necessary formulas for Ohio children and families continues.

Strategy B: Partner in development of innovative strategies to enhance ease of use of systems in Ohio.

**Report of Accomplishment:** HMG and BCMH staff are serving in an advisory capacity to the "Ohio Statewide System of Services for Early Intervention: Bridging the Gaps in Ohio Part C Service Delivery" project sponsored by Ohio's DD Council. The project has identified target communities in the state needing

assistance to improve delivery of early intervention services. Telehealth technology is being used in these communities to engage families, Help Me Grow service providers and primary care providers in early interventions services promoting improved coordination of systems and promoting the medical home model.

- ODH continues to serve as a state sponsor and provides leadership advisory to the Building Mental Wellness (BMW) Learning Collaborative which is currently in Wave 3 of implementation. This project is supported by Ohio Colleges of Medicine Government Resource Center and funded by the Ohio Department of Health and the Ohio Department of Medicaid. The project, being led by the Ohio Chapter of the American Academy of Pediatrics is designed to improve the delivery of children's mental health services, including anticipatory guidance, screening, early diagnosis and management of social-emotional problems in primary care, while integrating resources from Ohio's Pediatric Psychiatry Network (PPN).
- HMG Home Visiting collaborated with the Ohio Chapter of the American Academy of Pediatrics, as part of a "Building Bridges Among Health and Early Childhood Systems" grant award, to revise the materials and messages developed in the BMW project to reach providers in our HMG Home Visiting program. Home Visiting providers were engaged in training about putting early childhood brain development science, toxic stress and the message of resiliency into practice with their families. Survey results from participating providers are being reviewed to guide planning for potential future spread in early childhood.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

1. Promote organization of community-based services so that CSHCN families report they can use them easily.

#### **Activities:**

- a. Review outcomes of the HUB pilot and explore linkage to Help Me Grow and BCMH programs.
- b. Continue to engage with Ohio Medicaid related to access to enteral nutrition with the goal of improved ease of access to special formulas for Ohio Children.
- c. Continue to work with Ohio Family Voices and other parent groups to address community-based weaknesses by exploring and potentially implementing a new regional parent support model with local parent to parent matches.

2. Partner in development of innovative strategies to enhance ease of use of systems in Ohio.

#### **Activities:**

- a. HMG and BCMH staff are serving in an advisory capacity to the "Ohio Statewide System of Services for Early Intervention: Bridging the Gaps in Ohio Part C Service Delivery" project sponsored by Ohio's DD Council.
- b. Ohio's CYSHCN program is also providing leadership advisory to the Building Mental Wellness (BMW) Learning Collaborative.
- c. We are building on learnings from collaboration with the Ohio Chapter of the American Academy of Pediatrics as part of the "Building Bridges Among Health and Early Childhood Systems" grant as we collaborate with the Early Childhood Advisory Council in Ohio to implement the Early Childhood Comprehensive Systems grant focused on toxic stress.

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

Strategy A: Promote organization of community-based services so that CSHCN families report they can use them easily.

**Activities:** Review outcomes of the HUB pilot and explore linkage to Help Me Grow and BCMH programs. Continue to engage with Ohio Medicaid related to access to enteral nutrition with the goal of improved ease of access to special formulas for Ohio children. Continue work with Ohio Family Voices and other parent groups

to address community-based weaknesses by exploring and potentially implementing a new regional parent support model with local parent to parent matches.

Strategy B: Partner in development of innovative strategies to enhance ease of use of systems in Ohio.

**Activities:** HMG and BCMH staff will continue to serve in an advisory capacity to the “Ohio Statewide System of Services for Early Intervention: Bridging the Gaps in Ohio Part C Service Delivery” project sponsored by Ohio’s DD Council. The project is implementing “Tele-EI” using telehealth technology in targeted areas of the state which were identified by needs assessment. Ohio’s CYSHCN program will continue to provide leadership advisory to the Building Mental Wellness (BMW) Learning Collaborative during its final year. The project, being led by the Ohio Chapter of the American Academy of Pediatrics is designed to improve the delivery of children’s mental health services, including anticipatory guidance, screening, early diagnosis and management of social-emotional problems in primary care, while integrating resources from Ohio’s Pediatric Psychiatry Network (PPN). Continue building on learnings from collaboration with the Ohio Chapter of the American Academy of Pediatrics as part of the “Building Bridges Among Health and Early Childhood Systems” grant. We are using the Early Childhood Comprehensive Systems grant focused on toxic stress with the Ohio Early Childhood Advisory Council as key collaborators to accomplish this goal. We are continuing promotion of the Building Piece of Mind materials and plan to spread these materials through Ohio’s early childhood community promoting consistent messaging of early childhood brain development science, toxic stress and resiliency in Ohio.

**MCH National Performance Measure 06: The percent of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

#### **Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Convene a workgroup/sub-committee to address the significant gap in access to transition to adult health care for CYSHCN in Ohio.

**Report of Accomplishment:** BCMH leadership has initiated discussion with members of the Ohio AAP Chapter, Children with Disabilities Committee and has connected with Adolescent Health leadership at ODH. Together a formal stakeholder group is being developed to move work forward. The ODH, with leadership from Ohio’s Title V CYSHCN program and Ohio’s Adolescent Health program, are participating in a State Title V Transition Planning Group which will greatly assist our state in accomplishing this goal. This collaborative is being convened by the Got Transition/Center for Health Care Transition Improvement which is sponsored by The National Alliance to Advance Adolescent Health. This partnership will allow Ohio to draw on a range of existing stakeholders, partners and initiatives to drive improvement in transition in health care for the youth of Ohio, both with and without special health care needs.

Strategy B: Revitalize youth advisory component of the Children with Medical Handicaps program.

**Report of Accomplishment:** Young adult representation has been added to the active BCMH Parent Advisory Council and re-visioning of a youth advisory component for the program has begun. Implementation of the youth advisory component is a goal being carried forward for this coming year. Our Parent Advisor has engaged our BCMH Parent Advisory Council and is working with this group to develop a strategy to move this work forward.

Strategy C: Educate policy makers on insurance coverage needs for young adults with medical needs.

**Report of Accomplishment:** BCMH will continue to work with Medicaid and the Medicaid Managed Care plans regarding the special needs, characteristics, service needs and care coordination strategies for CYSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system. An Ohio CYSHCN data book utilizing the NS-CYSHCN as well as state data sources to highlight areas of need for Ohio’s CYSHCNs will be developed to use as a communication tool with policy makers.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

1. Convene a workgroup/sub-committee to address the significant gap in access to transition to adult health care for CYSHCN in Ohio.

**Activities:**

- a. BCMH leadership has initiated discussion with members of the Ohio AAP Chapter, Children with Disabilities Committee and has connected with Adolescent Health leadership at ODH. Together a formal stakeholder group is being developed to move work forward.

2. Revitalize youth advisory component of the Children with Medical Handicaps program.

**Activities:**

- a. The Parent Advisor is working with our BCMH Parent Advisory Council to develop a strategy to move this work forward.

3. Educate policy makers on insurance coverage needs for young adults with medical needs.

**Activities:**

- a. BCMH continues to represent ODH by providing input to Ohio Medicaid and the Ohio Medicaid Managed Care plans regarding the special needs, characteristics, service needs and care coordination strategies for CYSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system.
- b. BCMH is in the planning stages of an Ohio CYSHCN data book which will utilize the NS-CYSHCN as well as state data sources to highlight areas of need for Ohio's CYSHCNs and can be used with Ohio policy makers.

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

Strategy A: Convene a workgroup/sub-committee to address the significant gap in access to transition to adult health care for CYSHCN in Ohio.

**Activities:** BCMH leadership has initiated discussion with members of the Ohio AAP Chapter, Children with Disabilities Committee and has connected with Adolescent Health leadership at ODH. Together a formal stakeholder group is being developed to move work forward. The ODH, with leadership from Ohio's Title V CYSHCN program and Ohio's Adolescent Health program, are participating in a State Title V Transition Planning Group which will greatly assist our state in accomplishing this goal. This collaborative is being convened by the Got Transition/Center for Health Care Transition Improvement which is sponsored by The National Alliance to Advance Adolescent Health. This partnership will allow Ohio to draw on a range of existing stakeholders, partners and initiatives to drive improvement in transition in health care for the youth of Ohio, both with and without special health care needs.

Strategy B: Revitalize youth advisory component of the Children with Medical Handicaps program.

**Activities:** Young adult representation has been added to the active BCMH Parent Advisory Council and re-visioning of a youth advisory component for the program has begun. Implementation of the youth advisory component is a goal being carried forward for this coming year. Our Parent Advisor has engaged our BCMH Parent Advisory Council and is working with this group to develop a strategy to move this work forward.

Strategy C: Educate policy makers on insurance coverage needs for young adults with medical needs.

**Activities:** BCMH will continue to work with Medicaid and the Medicaid Managed Care plans regarding the special needs, characteristics, service needs and care coordination strategies for CYSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system.

**MCH National Performance Measure 07: The percent of 19-35 month olds who have received full schedule of immunizations**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

**Report of Accomplishment:** Overall, Ohio's 4:3:1:3:3 coverage rate was 74.7%.

A. Monitor immunization data from DCFHS funded programs

**Report of Accomplishment:** WIC continues to require and utilize the IPMACTSIIS (statewide immunization information management system) program in local agencies which was implemented in 2011. For FY 2012, WIC worked on a small pilot of 3 counties who only received WIC coupons one month at a time if the participant's shot record was incomplete at the time of the visit. The pilot program was intended to figure out if this improves immunization rates. If the program was successful WIC would use the information to write recommendations in their policy. Update for FY 13: At this time, the pilot is too short and it will take a year or two to recognize any change. All three of the pilot projects plan to continue the project The Child and Family Health Services program saw a client total of 870 children. 738 (85%) client's immunizations were complete for age. 73(8%) client's immunizations are in progress.

B. Promote the use of the statewide immunization by DFCHS funded programs

**Report of Accomplishment:** BCFHS Hearing and Vision Screening Program (formerly Specialty Services) partnered with the Division of Prevention to create hearing and vision screening tabs in IMPACT SIIS, the statewide immunization information management system. This project resulted in a universal location for hearing/vision screening information and allows two programs, immunizations and hearing/vision to cross outreach. By the end of FY 12, new users were entering or transferring data to IMPACT SIIS. The teams collaborated in developing training sessions. The ODH school and adolescent health school nurse program has been very active with promoting and administering ImpactSIIS access. In collaboration with BCFHS, WIC and the ODH Division of Prevention, a comprehensive training was developed for school nurses and others entering data into ImpactSIIS. The training became available in FY13 on OhioTrain and 186 nurses and 20 school nurses have completed the training.

C. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs

**Report of Accomplishment:** Of the 57 subgrantees funded by the CFHS Grant, 20 provide child and adolescent direct health care. Standards for this program require immunizations to be provided and tracked. For this year accomplishments: Child and Family Services has revised the RFP to require their subgrantee agencies who provide direct health care to increase the number of well-child visits for 19-35 month olds to see if this increases the number of children receiving immunizations. Immunization information to be added to Rural Health Newsletter  
Health Information Exchange are transmitting data between states for clinical purposes (for example Michigan and CliniSync have been doing this for about a year). HealthBridge also covers parts of 3 states. Immunization information is received from 3 or 4 practices through HealthBridge. Other practices are in process, working to try to send through HealthBridge or CliniSync. It is occurring with syndromic via BioSense and other methods.

D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

**Report of Accomplishment:** This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 accomplishments.

## Strategies for the Current FFY 10/1/12 – 09/30/13

### Activities:

- A. Monitor immunization data from DCFHS funded programs. This will be accomplished by analyzing data from the following sources: CFHS program (MATCH) and WIC program. **(Infrastructure)**.
- B. Promote the use of the statewide immunization registry by DCFHS funded programs. This will be accomplished by: monitoring those CFHS sub grantees providing child health service; working through the ODH School Nurse program to promote an awareness campaign within schools that have school-based clinics; and working with the Rural Health program to promote provider awareness at the annual Rural Health Conference. **(Infrastructure)**
- C. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs. This will be accomplished by collaborating with Ohio Health Plans (Medicaid) and other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services. **(Infrastructure)**.
- D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

## Plan for Next FFY 10/1/2014 – 9/30/2015

### A. Monitor immunization data from DCFHS funded programs. **(Infrastructure)**

**Activity:** Analyze data regarding the percentage of 19-35 month olds who have received full immunizations from the following sources: CFHS program (MATCH) and WIC program (data retrieved from CDC National Immunization Survey).

### B. Promote the use of the statewide immunization registry by DCFHS funded programs **(Infrastructure)**

#### Activities:

- Monitor CFHS sub grantees providing child health service.
- Work through the ODH School Nurse program to promote an awareness campaign within schools that have school-based clinics.
- Work with the Rural Health program to promote provider awareness at the annual Rural Health Conference.

### C. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs. **(Infrastructure)**

**Activity:** Collaborate with the Ohio Department of Medicaid and other stakeholder groups; including working with local WIC projects to ensure that children are referred for immunization services.

### D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

**Activity:** Refer to activities in State Performance Measure 04

## **MCH National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

### **Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Ensure that all Reproductive Health and Wellness Program (RHWP) patients complete a Reproductive Life Plan (RLP) **(Infrastructure)**

**Report of Accomplishment:** Of all patients served, 51% have completed a Reproductive Life Plan. This represents an increase of 31% from 2012. Last year was the first year for this objective and it was optional for RHWP sub-grantees to participate. Beginning in 2013 it is a mandatory objective for all RHWP sub-

grantees but it has taken time for each program to adopt a template and train staff in assisting the patient to complete.

Strategy B: Increase the number of patients aged 15 through 17 years in RHWP (Direct Care)

**Report of Accomplishment:** Patients aged 15 through 17 decreased from 2902 to 2814. This decrease reflects a continuing decline in enrollment. ODH collaborates with the Ohio Collaborative to Prevent Infant Mortality, local health departments, Planned Parenthood, community action agencies, Federally Qualified Health Centers, and local nonprofits to provide strategies and services to reduce the risk of pregnancies for 15-17 year olds. The major cities in Ohio have all recently launched initiatives to attract more teens to their clinics.

Strategy C: Provide evidence based comprehensive reproductive health and wellness education to persons under age 18 through RHWP (Enabling Services)

**Report of Accomplishment:** Four RHWP agencies chose to use enhanced services money to provide evidence based comprehensive reproductive health and wellness education to teens. Three of the agencies chose Reducing the Risk and one chose Becoming A Responsible Teen. A total of 65 presentations were given with over 1000 teens participating in these four agencies..

Strategy D: Train frontline staff in foster care and juvenile justice settings in *Reducing the Risk* through the Personal Responsibility and Education Program (PREP) (Infrastructure)

**Report of Accomplishment:** PREP has trained 563 staff at 162 agencies and 1600 youth. This represents an increase of approximately 300 staff, 55 agencies and 1000 youth from last year. This statewide program is reaching Ohio's most vulnerable youth. It is being incorporated into the professional development and training of direct care staff ensuring sustainability of the project. The goal of reducing unwanted teen pregnancy as well as preparing youth for future as productive adults is a focus of this program.

### Strategies for the Current FFY 10/1/12 – 09/30/13

A. Ensure that all ODH-funded Reproductive Health and Wellness Program (RHWP) patients complete a Reproductive Life Plan (RLP).

**Activities:**

- Webinar to train RHWP and the Child Family Health Services (CFHS) staff and sub grantees about RLP will be made available. *Completed*
- Information about importance and how to complete RLP will be provided at annual project directors meeting. *Completed*

B. Increase the number of patients aged 15 through 17 years in RHWP.

C. Ensure that all RHWP projects are providing evidence-based comprehensive reproductive health and wellness education (EBCRHWE) to clients under age 18.

**Activities:**

- ODH will identify EBCRHWE resources for RHWP projects.
- Ensure that 14 Ohio Infant Mortality Reduction Initiative Programs (OIMRI) receive RLP training.

D. Train frontline staff in foster care and juvenile justice settings in Reducing the Risk along with adulthood topics on healthy relationships, financial literacy and educational and career success incorporated into the Personal Responsibility and Education Program (PREP) curriculum.

**Activities:**

- Provide continuation funding for PREP statewide through 9 regional subgrants
- Conduct at least one coalition meeting in 9 regions
- Increase training to Community Correctional Facility staff in 9 regions

## Plan for Next FFY 10/1/2014 – 9/30/2015

A. Encourage women's health clients to complete a Life Plan, Family Plan or Reproductive Life Plan (RLP). *(Enabling)*

### Activities:

- Maintain RLP webinar for Reproductive Health and Wellness Program (RHWP) and the Child Family Health Services (CFHS) sub grantees on ODH website.
- Investigate use of Life planning with other ODH funded programs (e.g., Ohio Infant Mortality Reduction Initiative (OIMRI), WIC, School Nurses, Domestic Violence, Adolescent Health).
- Conduct chart audits during technical and comprehensive visits to ensure all ODH funded RHWP patients complete a RLP.
- Develop one hour module on life course planning for inclusion in School and Adolescent Health public health /school nurse training series.

B. Increase the number of patients aged 15 through 17 years in RHWP. *(Enabling)*

### Activities:

- Ensure that the importance of adolescent well-visits in RHWP clinics is communicated at annual project directors meetings and during comprehensive and technical assistance visits.
- Use Ahlers (FP database) to monitor the number of adolescents utilizing RHWP clinics.

C. Ensure that all RHWP projects are providing evidence-based comprehensive reproductive health and wellness education (EBCRHWE) to clients under age 18. *(Infrastructure)*

### Activities:

- Provide RHWP subgrantees the opportunity to apply for enhanced funds to provide EBCRHWE to reproductive aged males and females in the FY15 continuation grant.
- Monitor use of EBCRHWE through chart audits and observation during comprehensive and technical assistance visits.

D. Train frontline staff in foster care and juvenile justice settings in Reducing the Risk along with adulthood topics on healthy relationships, financial literacy and educational and career success incorporated into the Personal Responsibility and Education Program (PREP) curriculum. *(Infrastructure)*

### Activities:

- Provide continuation funding for PREP statewide through 9 regional sub grants.
- Conduct a minimum of one coalition meeting in each of the 9 regions.
- Increase training to Community Correctional Facility staff in each of the 9 regions.
- Provide trauma training to sub grantees and front line staff.

## MCH National Performance Measure 09: Percent of 3rd graders who have received protective sealants on at least 1 permanent molar tooth

### Accomplishment Report for FFY 10/01/2012 – 09/30/2013

A. Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.  
1) Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs.

**Report of Accomplishment:** ODH continued to promote expansion of existing programs, as budgets permitted, through a continuation RFP based on ODH's dental sealant program expansion plan.

ODH received funding from HRSA, Bureau of Health Professions in FY13 to increase the number of high-risk students receiving sealants through school-based sealant programs. In FY13, this additional funding continued to support the 18 dental sealant programs to provide dental sealants to high risk students in 51 of Ohio's 88 counties. In FY13, 788 (52.8%) of the 1,492 eligible schools participated in a school-based dental sealant program.

The Ohio School-Based Dental Sealant Program map and summary data were updated and are posted on the ODH Web site at:

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/ohs/oral%20health/2013%20DS%20map%20rev%203-13.ashx>

In an effort to increase participation and understanding for schools and parents, two ODH sealant programs coordinated activities with one school-based safety net dental care program in Northeast Ohio (NEO) - Ronald McDonald Care Van at University Hospitals in Cleveland. The pilot project for the NEO Collaboration will be tested in late Fall 2013. After evaluating the pilot, plans are to collaborate in a similar fashion with the Humility of Mary Health Partners Foundation- Smile Station in Youngstown, Ohio with 1-2 school-based dental sealant programs in FFY2014.

Program quality assurance, based on the School-based Dental Sealant Program manual and Performance Improvement Plan, continued by monitoring subgrantees' quarterly program and expenditure reports; and, 5 programs received a comprehensive site visit and formal report.

Data from the 2009-10 statewide survey of Ohio third graders show that Ohio attained the Healthy People 2010 National Objective for the percentage (50%) of children with one or more sealants.

2) Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visits. **Report of Accomplishment:** The School-based Dental Sealant Program Manual will be updated in January 2014 to reflect a change to general supervision for Registered Dental Hygienists working in Ohio school-based dental sealant programs - they are no longer required to have dentists do screenings prior to sealant placement. Changes in the ODH Performance Improvement Plan for the statewide sealant program were proposed and updates completed.

Program reports were reviewed and technical assistance provided to programs where concerns were identified. Training and technical assistance continue to be provided for all programs on program operations, accuracy of program reports and utilization of ODH's electronic grant reporting system.

3) Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff. **Report of Accomplishment:** The on-line distance learning curriculum will be updated in January 2014 to reflect the change to general supervision of Registered Dental Hygienists working in school-based dental sealant programs

#### **Strategies for the Current FFY 10/1/12 – 09/30/13**

Strategy A: Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs.

Strategy B: Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation and site visits.

Strategy C: Update as appropriate the on-line distance learning curriculum for school-based sealant program staff.

#### **Plan for Next FFY 10/1/2014 – 9/30/2015**

Strategy A: Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.

##### **Activities:**

1. Fund school-based dental sealant programs;
2. Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan as appropriate. Evaluation will be based on an analysis of report data, site visits and other documentation;
3. Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff.

Strategy B: Improve the oral health of higher-risk children through effective school-based oral health services (e.g., dental sealants, follow-up treatment).

**Activity:**

1. Identify and collaborate with two safety net dental care programs in Northeast Ohio that will provide follow-up dental treatment to children served by SBSPs in selected schools. This collaboration is called "The Northeast Ohio (NEO) School-based Dental Program"

**MCH National Performance Measure 10: The rate of deaths to children aged 14 years & younger caused by motor vehicle crashes per 100,000 children.**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Use Vital Statistics data to monitor rate of MV deaths to children 1-14 years old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among all deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths.

**Report of Accomplishment:** Rate of deaths analyzed using provisional VS data. Rate of 1.9 approaches objective of 1.5. Contributing factors of motor vehicle crash (MVC) fatalities for children were monitored & analyzed via child fatality review (CFR) data. 323 deaths in 2011 to 1-14 year olds were reviewed; 13% (41) were MVC deaths. This is 49% of all MVC deaths reviewed for ages 0-17 years, similar to 50% in 2010. The 41 MVC deaths represent 27% of all non-natural deaths (152), similar to 29% in 2010.

Strategy B: Analyze factors that contribute to MV deaths of children 1-14 years old using CFR data & crash report data from ODPS. Share information broadly.

**Report of Accomplishment:** Analysis of 41 MVC deaths: 19 passengers, 4 drivers, & 18 cyclists or pedestrians. Of 17 MVC deaths to black children, 9 (53%) were 1-14, & 6 were cyclists or pedestrians. Of 16 deaths to 1-14 year olds in vehicles where restraint use is required by law, 8 (50%) were properly restrained. Observed restraint use highest in NE region & lowest in SE region of state. CFR report & data shared at division meetings & overlapping work groups; CFR trainings; Ohio Adolescent Health Partnership; Ohio Injury Prevention Partnership & CFR Advisory Committee & subgroup meetings. Report announced through media releases & posted on ODH Website. Copies distributed throughout ODH & to elected officials, local CFR boards, Family & Children First Councils, & State Library system.

Strategy C: Encourage local CFR Boards to share information & recommendations about prevention of MV deaths of children 1-14 years old with local partners who can reach families & children.

**Report of Accomplishment:** CFR boards encouraged to seek collaboration from community agencies to develop activities & initiatives in response to CFR findings. TA provided to CFR boards regarding effective ways to solicit & communicate with partners. Local boards found partners to provide bike & pedestrian safety events, free bike helmets & seat belt use incentives. Cooperation with law enforcement & traffic engineers resulted in roadway improvements, media messages re: driveway safety & targeted passenger restraint education. CFR boards active in broadcasting changes in Ohio's booster seat law and advocating strict enforcement. CFHS projects encouraged to include local CFR findings in community assessments & program planning.

Strategy D: Collaborate with injury programs at ODH & other state agencies, to develop strategies to decrease MV injuries & deaths among children.

**Report of Accomplishment:** ODH Injury Prevention (IP) program works with ODPS/Ohio Traffic Safety Office (ODPS/OTSO) to address child passenger safety (CPS) issues. ODH purchases safety seats to distribute through Ohio Buckles Buckeyes (OBB). Each county has designated agency to provide education & distribute CPS seats at no cost to financially eligible families. ODPS/OTSO grant supports these activities. ODH is responsible for Occupant Protection Regional Coordinator (OPRC) Program to provide training & TA to local OBB sites. OPRCs

plan & coordinate other occupant protection activities including CPS check-up events & fitting stations. Grant funds are used to purchase & print CPS educational materials, including materials to promote Ohio's booster seat law. Website is maintained with booster seat information & resources. Memorandum of Understanding allows ODPS to share with ODH raw data from Trauma & EMS Registries. IP coordinates multi-disciplinary, statewide injury prevention coalition (OIPP) with a child injury action subgroup (CIAG). OIPP resource guide for policy makers delivered to key decision makers in Ohio. Guide included story of family whose child was saved by safety seat after a crash. CIAG set review & revision of child restraint law as a priority. Objectives include pilot training with state Highway Patrol regarding enforcement of child restraint law; and develop online training module to educate law enforcement agencies to increase enforcement of current law.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

Strategy A: Use Vital Statistics data to monitor rate of MV deaths to children 1-14 years old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among all deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths.

Strategy B: Analyze factors that contribute to MV deaths of children 1-14 years old using CFR data & crash report data from ODPS. Share information with ODH programs, other state agencies, local health departments, child health partners & policymakers/legislators.

Strategy C: Encourage local CFR Boards to share information & recommendations about prevention of MV deaths of children 1-14 years old with local partners who can reach families & children, such as local media, Help Me Grow, county Family & Children First, Ohio Buckles Buckeyes, school nurse groups, service agencies & clubs, child care providers & legislators.

Strategy D: Collaborate with injury programs at ODH & other state agencies, to develop strategies to decrease MV injuries & deaths among children, including proper use of safety devices & increasing pedestrian safety.

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

A. Use Vital Statistics data to monitor rate of Motor Vehicle (MV) deaths to children 1-14 years old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among all deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths.

#### **Activities:**

- Be alert to possible data quality issues.
- Access additional data sources that include injury data to provide a more comprehensive look at the impact of MV crashes for 1-14 year olds.

B. Analyze factors that contribute to MV deaths of children 1-14 years old using CFR data & crash report data from ODPS. Share information with ODH programs, other state agencies, local health departments, child health partners & policymakers/legislators. Use data analysis to identify groups with increased risks across the age group.

#### **Activities:**

- Include injury data for more comprehensive perspective.
- Continue MV focus section in CFR annual report.
- Use strategy workgroup plus other external partners to review data & give input.
- Use multiple venues to communicate findings, such as ODH Website, e-mails, local health department conference calls, school nurse groups, conference exhibits & presentations.

C. Encourage local CFR Boards to share information & recommendations about prevention of MV deaths of children 1-14 years old with local partners who can reach families & children, such as local media, Help Me

Grow, county Family & Children First, Ohio Buckles Buckeyes, school nurse groups, service agencies & clubs, child care providers & legislators.

**Activities:**

- Provide TA, training & tools to local CFR boards re: ways to present & share information to audiences, including use of CFR data for funding applications.
- Encourage cultural & linguistic competency in development of activities to prevent deaths & injuries from MV crashes, especially for pedestrian safety in urban areas & for educating public about child booster seat law.
- Respond to requests for population-specific reports to encourage the sharing of information & recommendations.
- Prepare fact sheets from data for MV deaths to 1-14 year olds & risk factors unique to age group. Use fact sheets & data briefs to engage community groups & schools.

D. Collaborate with injury programs at ODH & other state agencies, to develop strategies to decrease MV injuries & deaths among children, including proper use of safety devices & increasing pedestrian safety. **Activities:**

- Educate partners regarding issues, priorities & need to collaborate for solutions.
- Use CFR Advisory Committee, strategy workgroup, other ODH stakeholder groups & Ohio Injury Prevention Partnership to engage partners, leverage influence & coordinate efforts to identify & implement changes to policy, practice or legislation to reduce child MV deaths.

**MCH National Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.**

Strategy A: Support breastfeeding (BF) objectives of the Ohio Collaborative to Prevent Infant Mortality (OCPIM) and Ohio Perinatal Quality Collaborative (OPQC). (Infrastructure)

**Report of Accomplishment:** BF objectives are included in the *Preventing Infant Mortality in Ohio: Task Force Report*. At least one workgroup member attended all OCPIM meetings. A presentation on BF was given during at least one OCPIM meeting. OCPIM sent bi-weekly list-serve topics and updates which included BF information. To reduce late bacterial infection in infants born 22-29 weeks gestation, OPQC participating hospitals strive to get >80% of these infants fed any human milk within the first 72 hours of life.

Strategy B: Promote and support BF throughout the State of Ohio. (Population-Based)

**Report of Accomplishment:** The Child and Family Health Services (CFHS) program hosted a *Business Case for Breastfeeding* training webinar. At least fifteen CFHS agencies are using this training to educate businesses within their community. Creating Healthy Communities program also promotes the *Business Case for BF* to subgrantees.

Ohio continues to implement Healthy Ohio Breastfeeding Friendly Awards. In 2012, there were 21 BF worksite awards and in 2013, there were 22 BF worksite awards. This award recognizes BF friendly employers who create a supportive environment for their employees and/or clients/customers who wish to breastfeed onsite.

WIC staff continues to be trained on BF promotion and support. The "Grow and Glow: Using Loving Support To Grow and Glow in WIC - Breastfeeding Training for Local WIC Staff" is an online training used to ensure WIC staff attain a level of skill proficiency required to promote and support BF in WIC clinics. WIC hosted a statewide BF Peer Helper Conference and a course on advanced clinical training. WIC determined the IBCLC project in southeast Ohio has been underutilized. WIC BF Peer Helpers are present in all 75 funded projects.

CFHS program has applied the findings from 2011 WIC African American Breastfeeding Focus Group Project to revise a BF curriculum for home-visiting CHWs and AA women. DFCHS is also coordinating with Black Mothers' Breastfeeding Association to provide cultural competence in BF support training to ODH and subgrantees.

Medically fragile infants on the BCMH treatment program were provided donor breast milk at a cost of \$5,205 for FY13. This is significantly less than the previous year (\$14,460) as outpatients are the last priority served and there were significant donor milk shortages during this time frame.

OBA, the State BF Coalition, is working with USBC and is in the process of reorganizing. ODH began hosting bi-monthly BF webinars that includes OBA members.

ODH is working collaboratively with partners across Ohio to customize Text4baby statewide to include information on state and local healthcare services, programs, and resources and integrate Text4baby into existing maternal and child health programs in Ohio, including CFHS, HMG, Home Visiting, Healthy Start, WIC, Medicaid/CHIP.

Strategy C: Review BF data to identify targeted population and intervention for Ohio (e.g., African American (AA), Appalachians, teens) (Infrastructure).

**Report of Accomplishment:** ODH published a BF fact sheet that contains information from NIS and PRAMS about breastfeeding initiation and duration in Ohio. 2008 NIS data indicate that Ohio has the lowest percent of BF initiation of all states in HRSA Region 5. PRAMS data show that BF rates have increased in the last 5 years, with 75 percent of Ohio mothers reporting ever BF in 2010. Preliminary 2012 Vital Statistics data indicate that 67.8% of women were BF at hospital discharge. Other PRAMS data show that women who are less educated, Black, or receiving Medicaid services have lower rates of BF in Ohio. Women with more than 12 years of education and those not on WIC are more likely to continue to BF. However, even within WIC, BF rates continue to rise. Women in southeast Ohio lag behind the rest of Ohio. Based on BF data and infant mortality data, ODH has created a new policy supporting BF for the first year of life.

#### **Strategies for the Current FFY 10/1/12 – 09/30/13**

Strategy A: Support breastfeeding (BF) objectives of the Ohio Collaborative for Preventing Infant Mortality (OCPIM) and Ohio Perinatal Quality Collaborative (Infrastructure) Status Update: In progress

Strategy B: Promote and support BF throughout the State of Ohio (Population-Based)  
Status Update: In progress

Strategy C: Review BF data to identify target population and intervention for Ohio (e.g. AA, Appalachians, teens, etc.) (Infrastructure) Status Update: In progress

#### **Plan for Next FFY 10/1/2014 – 9/30/2015**

A. Support breastfeeding (BF) objectives of the Ohio Collaborative for Preventing Infant Mortality (OCPIM) and Ohio Perinatal Quality Collaborative (*Infrastructure*)

##### **Activities:**

- Attend all OCPIM meetings and BF subcommittee meetings and provide epidemiology support for BF related Task Force objective. This will be measured through the documentation of meetings attended and ODH staff contribution to BF work of subcommittee.
- Start human milk in 80% of 22-29 week gestational age infants by 72 hours of life and achieve  $\geq 100$  ml/kg/day of human milk by 21 days of life. (Applies to premature babies born in the NICU of participating hospitals). This will be measured through OPQC data reports.

B: Promote and support BF throughout the State of Ohio (*Population-Based*)

**Activities:**

- Continue supporting the *Business Case for BF*. This will be measured through the number of new lactation support programs and policies.
- Continue a BF worksite award in Ohio. This will be measured through the number of awards given.
- Continue to train WIC staff and BF promotion and support. This will be measured through the number of trainings and the number of staff attendees.
- Plan culturally appropriate BF intervention based on findings from 2011 research on WIC AA and Appalachian population. Regional IBCLC project in Appalachian Counties and continue BF Peer Helper in every county. This will be measured through the intervention development and implementation.
- Continue to provide donor breast milk for medically fragile infants on the BCMH Treatment Program. This will be measured through data obtained from BCMH billing records.
- Support Ohio BF coalitions through membership and collaboration. This will be measured through the record of meetings attended, ODH updates provided to coalitions, coalition updates provided to ODH, and collaborative activities.
- Promote Text4Baby throughout Ohio. This will be measured through tracking Text4Baby enrollment.
- Support hospitals participating in evidence-based maternity care practice improvement such as Best Fed Beginnings, the Baby Friendly Hospital Initiative, or the Ten Steps to Successful BF. This will be measured by tracking reports distributed by the monitoring agencies.
- Partner with the Black Mothers' Breastfeeding Association to host regional BF workshops on "Cultural Competence in Breastfeeding Support for African Americans." This will be measured through workshop attendance.

C. Review BF data to identify target population and intervention for Ohio (e.g. AA, Appalachians, teens, etc.) (*Infrastructure*)

**Activities:**

- Compare BF rates in PRAMS and Vital Statistics and NIS in 2006-2011 as available. This will be measured through reports generated and reports shared.
- Identify Ohio population with lowest BF rates using PRAMS or Vital Statistics data. This will be measured through reports generated and reports shared.

**MCH National Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: The goals of the infant hearing program are to ensure universal newborn screening, diagnostic follow-up for infants who do not pass the newborn screening, and early intervention services for infants identified with hearing loss.

**Report of Accomplishment:** In calendar year 2012, 97.1% of all infants born in Ohio were screened. Approximately 57.4% of the infants that did not pass their newborn hearing screening went on to complete a comprehensive diagnostic evaluation by three months of age, while another 11.3% were screened after the 3 month diagnostic milestone. The remainder were lost to follow-up or lost to documentation.

Strategy B: Monitor and provide technical assistance to birthing and children's hospitals to assure all infants receive hearing screenings.

**Report of Accomplishment:** The Consultant Audiologists monitored and provided oversight for about 130 Universal Newborn Hearing Screening (UNHS) programs at hospitals and birthing centers to ensure compliance with UNHS. The Consultant Audiologists utilized hospital reports in the Integrated Perinatal Health Information System (IPHIS; vital statistics birth records) to monitor referral rates and track infants

with missed screenings. Consultants continued to emphasize the importance of communication with families as well as accurate data collection.

Strategy C: Monitor diagnostic reports from Pediatric Audiologists conducting diagnostic evaluations on infants not passing their newborn hearing screenings in order to meet the goal of identifying permanent hearing loss by three months of age.

**Report of Accomplishment:** In 2012, the 3,960 infants who did not pass a newborn hearing screening were referred for comprehensive diagnostic evaluation. The evaluation results were reviewed by the ODH Consultant Audiologists. Diagnostic Reports were then sent to the Regional Infant Hearing Programs (RIHPs) for documentation or follow-up for unconfirmed results. The Consultant Audiologists provided outreach to audiology providers on the importance of submitting the forms when they are not received.

Strategy D: Identify pediatric audiologists providing follow-up diagnostic evaluations and other services for non-pass UNHS infants.

**Report of Accomplishment:** An Audiology Directory of about 100 self-identified pediatric audiologists throughout Ohio is updated and provided to Hospital UNHS Coordinators annually. The Pediatric Audiology Directory is also posted at <http://www.ohiohelpmegrow.org/parents/infantheating/infantheating.aspx>. Parents, professionals, and RIHP staff can search the directory by geographic location to find a provider.

Strategy E: The RIHPs track non pass referrals and provide early intervention services for infants identified with permanent childhood hearing loss.

**Report of Accomplishment:** The number of newborns screened, identified as non-passes, and referred to the RIHPs for follow-up remained nearly constant at 2.9%. About 4.7% of the infants who did not pass newborn hearing screening were diagnosed with a permanent hearing loss. All families eligible for Part C early intervention services for a hearing loss were offered services but only 70% of the families chose to participate in the RIHP program in their county providing support and information for the family raising an infant with a confirmed hearing loss.

Strategy F: The Infant Hearing Program, with input from the Advisory Subcommittee and the Genetics Program, continued participation in collaborative initiatives.

**Report of Accomplishment:** The Infant Hearing Program met quarterly with the UNHS Advisory Subcommittee to obtain stakeholder input. The Subcommittee workgroups assisted with oversight and implementation of limited National Initiative for Children's Health Quality (NICHQ) activities throughout this grant period.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

Strategy A: Monitor birthing hospitals, free standing birthing centers, children's hospitals, and local health departments to ensure that complete and accurate data for newborn hearing screenings are reported to the Ohio Department of Health.

#### **Activities:**

1. Monitor IPHIS and Hi\*Track data for timeliness, accuracy and completeness.
2. Monitor hospital UNHS referral rates and missed screenings.
3. Provide targeted Technical Assistance as needs are identified.
4. Monitor local health department compliance with UNHS requirements.

Strategy B: Review diagnostic evaluations for infants who referred on hospital screenings. Identify infants diagnosed by three months of age. Continue to track and monitor all other referred infants to improve diagnostic follow-up rates and to reduce number of infants lost to follow-up before resolution of hearing status.

**Activities:**

1. Review and forward diagnostic audiology reports for non-pass infants to RIHPs.
2. Monitor and educate individual pediatric audiologists and medical providers regarding recommended evaluation protocols and reporting requirements.
3. Monitor RIHP tracking and follow-up to ensure families of non-pass infants are contacted; and receive evaluations and referrals in accordance with protocols.

Strategy C: Promote awareness of early intervention and work collaboratively with professionals to provide early diagnosis (by 3 months of age) and intervention (by 6 months of age) for infants identified with a permanent childhood hearing loss.

**Activities:**

1. Survey pediatric diagnostic audiologists annually and update directory.
2. Support SKI\*HI training for RIHP service providers.
3. Continue outreach to professionals and primary care providers.

Strategy D: Identify program strengths and weaknesses. Utilize public health and professional community resources to assist in addressing identified program weaknesses.

**Activities:**

1. Meet regularly with the UNHS Advisory Subcommittee to identify and address program strengths, weaknesses, and identify resources for improvement.
2. Collaborate with stakeholder groups to improve program outreach, implement collaborative activities, and strengthen loss to follow up initiatives utilizing the National Initiative on Children's Health Quality model.

**Plan for Next FFY 10/1/2014 – 9/30/2015**

A. Monitor birthing hospitals, free standing birthing centers, children's hospitals, and local health departments to ensure that complete and accurate data for newborn hearing screenings are reported to the Ohio Department of Health.

**Activities:**

1. Monitor IPHIS and Hi\*Track data for timeliness, accuracy and completeness.
2. Monitor hospital UNHS referrals and missed screenings.
3. Provide targeted Technical Assistance as needs are identified.
4. Monitor local health department compliance with UNHS requirements.

B. Review diagnostic evaluations for infants who referred on hospital screenings. Track and monitor all referred infants to order to identify infants with permanent hearing loss. Monitor timeliness of diagnostic identification. Increase diagnostic follow-up rates and reduce number of infants lost to follow-up before resolution of hearing status.

**Activities:**

1. Monitor RIHP tracking and follow-up to ensure families of non-pass infants are contacted and receive assistance with evaluations and referrals in accordance with protocols.
2. Monitor and educate individual pediatric audiologists and medical providers regarding recommended evaluation protocols and reporting requirements.
3. Review and forward diagnostic audiology reports for non-pass infants to RIHPs.

- C. Promote awareness of early intervention and work collaboratively with professionals to provide early diagnosis (by 3 months of age) and intervention (by 6 months of age) for infants identified with a permanent childhood hearing loss.

**Activities:**

1. Survey pediatric diagnostic audiologists annually and update directory.
2. Support SKI\*HI training for RIHP service providers.
3. Continue outreach to professionals and primary care providers.

- D. Identify program strengths and weaknesses. Utilize public health and professional community resources to assist in addressing identified program weaknesses.

**Activities:**

1. Meet regularly with the UNHS Advisory Subcommittee to identify and address program strengths, weaknesses, and resources for improvement.
2. Collaborate with key stakeholders to improve program outreach, implement collaborative activities, and support continuous quality assurance initiatives focused on reducing loss to follow-up.

**MCH National Performance Measure 13: Percent of children without health insurance**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Monitor data regarding the rate of uninsured children (infrastructure).

**Report of Accomplishment:** For the two-year average, covering 2011 and 2012, the Current Population Survey (CPS, 2012-2013) has an uninsured status for 7.7 percent of Ohio resident children. The Ohio Medicaid Assessment Survey (OMAS, 2012) estimated uninsured children (0-17 years) at 4.7% (95% C.I.: 4.0%-5.4%). However, the OMAS questionnaire limited the time period of being uninsured to within the week prior of survey administration, unlike CPS which asked within the last 12 months.

In FFY 2013 Child and Family Health Services indicated that 12.5% (232,734) of all visits were with un/underinsured children and 61,837 children were seen in free clinics/community health centers. 17% (477,000) of children were uninsured for dental care (2012 OMAS). The rate has remained between 17 and 19% in the last three Ohio Family Health and OMAS surveys (2008, 2010, and 2012). The OMAS survey is some of the only data the oral health section is able to obtain on adults with dental insurance coverage and unmet dental needs and routinely uses this source for surveillance of the oral health of adults in Ohio.

Strategy B: Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system (population-based & infrastructure).

**Report of Accomplishment:** Information on how to apply for Medicaid/Healthy Start (HS) was provided to low-income families through 196 local WIC clinics; 17 School-Based Dental Sealant Subgrantee Programs working in 46 counties in Ohio and 11 Safety-Net Dental Clinic Subgrantee Programs.

BCDSHN and Ohio Department of Medicaid (ODM) hosted a webinar for public health nurses focused on transitioning CSHCN from Medicaid fee-for-service to the Medicaid managed care delivery system.

BCDSHN delivered presentations to HMG social workers, public health nurses regarding Medicaid covered services and Medicaid programs.

BCDSHN attended training sessions and forums regarding Health Reform which focused on pediatric ACOs, health care for persons with pre-existing medical conditions, and healthcare marketplace.

Medicaid Administrative Claiming (MAC) data indicates that BCDSHN spends almost 57% of their time referring, facilitating, monitoring and coordinating, Medicaid activities for families of children with special health care needs. Promotion of MAC claiming to LHDs was done through the 2013 Sealant Sharing Day/Bidder's Conference presentation for all School-Based Dental Sealant Programs in Ohio.

BCDSHN supported CSHCN families by providing financial assistance to hospitals in coordinating specialty medical care; helping coordinate insurance benefits with providers; and advising parents on how to follow-

up with appealing denials of services; providing information on COBRA plans, Ohio High Risk Pool, Medicaid for the aged blind or disabled, Medicaid Spend down Assistance Program, Medicaid Premium assistance programs, and the Adult Hemophilia insurance Program.

Strategy C: Promote enrollment in SCHIP (Healthy Start) and other policy changes that lead to more kids/families being covered consistently and adequately (i.e., presumptive eligibility for pregnant women and children; family planning eligibility, continuous, express lane eligibility) through public health agencies, schools and school-based programs (enabling).

**Report of Accomplishment:** The interagency, Combined Programs Application form is used to assist families in accessing DFCHS programs. WIC served an average of 263,684 participants in FFY 2013, and screens all applicants for Medicaid Healthy Start participation and enrollment at certification and recertification appointments.

BCDSHN participated in Voices for Ohio's Children coalition to promote simplification of Medicaid enrollment and retention.

BCDSHN attended Medicaid managed care consumer council meetings for the purpose of providing recommendations regarding the medical needs of CSHCN; and conducted quarterly regional meetings with the Parent Advisory Council PAC to receive information on resources and supports

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

A. Monitor data regarding the rate of uninsured children. Infrastructure

**Activities:**

- Report health insurance data from NCPS, OMAS & DFCHS programs.
- Develop communication plan to spread results of OMAS to DFCHS programs.

B. Provide information, TA/training to providers and consumers regarding how to access and navigate public health care system. Population-based & Infrastructure

**Activities:**

- Provide health insurance info to public and private sector providers via DFCHS programs.
- Develop, implement and monitor the SFY 13-15 ODH/Medicaid Interagency Agreement (IAA) deliverables containing provisions regarding Medicaid enrollment, data access, outreach & training activities.
- Promote use of Medicaid Administrative Claiming (MAC) in LHDs for access, use & delivery of Medicaid-covered services.

C. Promote enrollment in Ohio's Medicaid Expansion (ACA) and other policy changes that lead to more kids/families being covered consistently and adequately through public health agencies, schools and other social services agencies. Enabling

**Activities:**

- Participate in ODH meetings to spread ACA-related info via website & other sources. *In Progress*
- Coordinate efforts with Ohio Medicaid to conduct outreach and enrollment in Ohio's Medicaid expansion. *In Progress*
- Provide info about eligibility & enrollment via trainings and conferences. *In Progress*

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

A. Monitor data regarding the rate of uninsured children (infrastructure).

**Activities:** For the two-year average, covering 2011 and 2012, the Current Population Survey (CPS, 2012-2013) has an uninsured status for 7.7 percent of Ohio resident children. The Ohio Medicaid Assessment Survey (OMAS, 2012) estimated uninsured children (0-17 years) at 4.7% (95% C.I.: 4.0%-5.4%). However,

the OMAS questionnaire limited the time period of being uninsured to within the week prior of survey administration, unlike CPS which asked within the last 12 months.

In FFY 2013 Child and Family Health Services indicated that 12.5% (232,734) of all visits were with un/underinsured children and 61,837 children were seen in free clinics/community health centers. 17% (477,000) of children were uninsured for dental care (2012 OMAS). The rate has remained between 17 and 19% in the last three Ohio Family Health and OMAS surveys (2008, 2010, and 2012). The OMAS survey is some of the only data the oral health section is able to obtain on adults with dental insurance coverage and unmet dental needs and routinely uses this source for surveillance of the oral health of adults in Ohio.

- B. Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system (population-based & infrastructure).

**Activities:** Information on how to apply for Medicaid/Healthy Start (HS) was provided to low-income families through 196 local WIC clinics; 17 School-Based Dental Sealant Subgrantee Programs working in 46 counties in Ohio and 11 Safety-Net Dental Clinic Subgrantee Programs.

BCDSHN and Ohio Department of Medicaid (ODM) hosted a webinar for public health nurses focused on transitioning CSHCN from Medicaid fee-for-service to the Medicaid managed care delivery system. BCDSHN delivered presentations to HMG social workers, public health nurses regarding Medicaid covered services and Medicaid programs.

BCDSHN attended training sessions and forums regarding Health Reform which focused on pediatric ACOs, health care for persons with pre-existing medical conditions, and healthcare marketplace.

Medicaid Administrative Claiming (MAC) data indicates that BCDSHN spends almost 57% of their time referring, facilitating, monitoring and coordinating, Medicaid activities for families of children with special health care needs. Promotion of MAC claiming to LHDs was done through the 2013 Sealant Sharing Day/Bidder's Conference presentation for all School-Based Dental Sealant Programs in Ohio.

BCDSHN supported CSHCN families by providing financial assistance to hospitals in coordinating specialty medical care; helping coordinate insurance benefits with providers; and advising parents on how to follow-up with appealing denials of services; providing information on COBRA plans, Ohio High Risk Pool, Medicaid for the aged blind or disabled, Medicaid Spend down Assistance Program, Medicaid Premium assistance programs, and the Adult Hemophilia insurance Program.

- C. Promote enrollment in SCHIP (Healthy Start) and other policy changes that lead to more kids/families being covered consistently and adequately (i.e., presumptive eligibility for pregnant women and children; family planning eligibility, continuous, express lane eligibility) through public health agencies, schools and school-based programs (enabling).

**Activities:** The interagency, Combined Programs Application form is used to assist families in accessing DFCHS programs. WIC served an average of 263,684 participants in FFY 2013, and screens all applicants for Medicaid Healthy Start participation and enrollment at certification and recertification appointments.

BCDSHN participated in Voices for Ohio's Children coalition to promote simplification of Medicaid enrollment and retention.

BCDSHN attended Medicaid managed care consumer council meetings for the purpose of providing recommendations regarding the medical needs of CSHCN; and conducted quarterly regional meetings with the Parent Advisory Council PAC to receive information on resources and supports

**MCH National Performance Measure 14: Percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85<sup>th</sup> percentile.**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Conduct data surveillance and monitoring activities:

**Report of Accomplishment:** Inventory of statewide resources/programs: Collected data from local WIC subgrantees on all new and/or revised referral resources for childhood obesity via the required RFP. Some clinics are referring children with a BMI at or above the 85<sup>th</sup> percentile to in-house wellness programs with a dietitian in addition to physician referrals.

Work with the ODH Bureau of Prevention in using the inventory data: Not met.

Collect data from the WIC participant survey: Data analysis for 2011 is complete but is not complete for 2012.

Overall participant satisfaction with WIC services was at 84%, down from 84% in 2010.

Help disseminate report on 3<sup>rd</sup> grade obesity to local projects: This is no longer given out to clinics at the directors meeting.

Explore ways to build capacity for data with the discontinuation of PedNSS: This has not been addressed in the last year. WICs primary focus has been working to implement EBT starting in 2015 and has involved all bureau staff.

Strategy B: Increase WIC staff education and involvement in prevention and treatment initiatives.

**Report of Accomplishment:** Continue to distribute educational pieces on topic such as cultural competency and critical thinking to local WIC staff to continue the foundation established with the Value Enhanced Nutrition Assessment (VENA) training: Emails on VENA related topics were distributed. An autumn forum was presented for health professionals on such topics as “Picky versus Problem Eating in children ages 6 months to 5 years.” Provide advanced education topics via the Health Professional newsletter to staff related to new breastfeeding guidelines: HP newsletter provided more in-depth research regarding interconception health and counseling strategies to address these issues.

Strategy C: Explore new opportunities for collaboration.

**Report of Accomplishment:** Continue to serve, as needed, on the Ohio American Academy of Pediatrics advisory committee for the Ounce of Prevention promotion grant: WIC continues to represent as needed.

Seek for partnership and collaboration opportunities by serving on the Supplemental Nutrition Assistance Program for Education committee for partnership, information, and education resources: There has been a lot of turnover on this committee. To date, WIC has reviewed 2 sets of EFNEP and Extension lesson plans for use in the WIC clinics. State WIC has written 2 APLs to encourage WIC local staff to use EFNEP and Extension staff to provide nutrition education for midcertification WIC appointments.

Collaborate with Help Me Grow and Early Care and Education as needed: WIC continues to represent as needed.

Strategy D: Evaluate WIC efforts to impact overweight.

**Report of Accomplishment:** Continue to reevaluate the WIC participant survey to gather data on participant perception of weight, WIC obesity intervention and healthy eating behavior: Survey was not revised this past year due to staffing changes, but the 2014 survey will be updated to correspond with changes to breastfeeding policy and obesity awareness initiatives.

Pending funding availability, begin the planning process for the next phase of the “WIC Activity Box” Pilot aimed to provide education to participants who are at-risk for overweight or are obese: Not met.

Revise the Ohio WIC Nutrition Education plan for addressing childhood overweight: Draft accepted by USDA, not available in published form yet.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

#### **A. Conduct data surveillance and monitoring activities.**

##### **Activities:**

1. Continue to conduct and support the inventory of statewide resources/programs addressing the treatment of childhood obesity. –met
2. Collect data from the WIC participant survey. – not met

#### **B. Increase WIC staff education and involvement in prevention and treatment initiatives.**

##### **Activities:**

1. Continue to distribute educational pieces on topic such as interactions and health care plans for participants at or at risk for obesity.-new
2. Provide advanced education to staff related to new breastfeeding guidelines and GDM treatment guidelines.

#### **C. Explore new opportunities for collaboration.**

##### **Activities:**

1. Continue collaboration with the ODH Bureau of Prevention and Health Promotion obesity coordinator to support the state obesity plan.
2. Continue to serve on the Ohio American Academy of Pediatrics advisory committee for the Ounce of Prevention grant.-met
3. Seek for collaboration opportunities by serving on the SNAP for Education committee.
4. Collaborate within ODH for CHIPRA grant.

#### **D. Evaluate WIC efforts to impact overweight.**

##### **Activities:**

1. Continue to reevaluate the WIC participant survey.-not met
2. With OA funding, use texting as a means to promote nutrition education to participants.
3. Revise the Ohio WIC Nutrition Education plan to follow MyPlate recommendations.

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

#### **A. Conduct data surveillance and monitoring activities. (Infrastructure)**

##### **Activities:**

1. Collect data from the WIC participant survey.
2. Explore ways to build capacity and evaluate data.

#### **B. Increase WIC staff education and involvement in prevention and treatment initiatives. (Infrastructure)**

##### **Activities:**

1. Distribute educational pieces on topic such as critical thinking to local WIC staff to continue the foundation established with the Value Enhanced Nutrition Assessment training.
2. Provide advanced education topics via the Health Professional newsletter and state-wide workshops.

#### **C. Explore new opportunities for collaboration. (Infrastructure)**

##### **Activities:**

1. Continue collaboration with the ODH Bureau of Prevention and Health Promotion obesity coordinator to support the state obesity plan.
2. Serving on the Supplemental Nutrition Assistance Program for Education committee.
3. Collaborate within ODH for CHIPRA grant.

**D. Evaluate WIC efforts to impact overweight. (Infrastructure)**

**Activities:**

1. Continue to reevaluate the WIC participant survey.
2. With OA grant funding, use texting as a means to promote nutrition education to participants.

**MCH National Performance Measure 15: Percent of women who smoked in the last trimester of pregnancy  
Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Build the capacity of MCH healthcare systems to support the 5A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use and Dependence Guidelines). (Infrastructure)

**Report of Accomplishment:** Ohio Partners for Smoke-Free Families (OPSFF) will accomplish this through the following activities: Assess the MCH healthcare systems (i.e. WIC, CFHS) capacity to support evidence-based smoking cessation interventions; ensure that healthcare systems are in place to screen women for tobacco use and offer treatment; ensure that practitioners have the tools, training and technical assistance needed to treat smokers effectively.

With the assistance of the CDC, an Epi-aid was conducted September 2013 to perform a rapid assessment of the MCH healthcare systems (i.e. WIC, CFHS) to understand the risk and protective factors for full, partial or no implementation of the 5A's in perinatal clinics prior to an entire state rollout. Results: Efforts need to be concentrated to strengthen training, provide community resources, documentation, information on the role of pharmacologic therapies, and how to address the use of alternative tobacco products.

Workgroup remains committed to building capacity (i.e., expanding program reach). Two Human Services Program Consultants were hired September of 2013 to concentrate 5A's efforts across the state for the addition of 25 additional WIC, all 14 OIMRI and 25 RHWP programs for expansion of the 5A's in 2014. CFHS perinatal direct care and WIC chart reviews began in October of 2012.

Capacity goal of strategy was met evidenced by maintaining a presence in WIC and CFHS perinatal DC sites. Women continued to be screened in CFHS Direct Care Clinics during FFY 2013 per USPHS Treating Tobacco Use and Dependence Guidelines.

Goals: ensuring practitioners have tools, training were met during FFY 2013. Help Me Grow continues to implement the 5A's in all counties.

Strategy B: Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke.

**Report of Accomplishment:** CFHS will accomplish this through the following activities: Assess the healthcare systems and provider (i.e., CFHS) capacity to support environmental health risk reduction; awareness of environmental health risks; ensure systems in place to screen women for environmental health risks; ensure practitioners have tools, and training; ensure women have access that will help them take action to reduce environmental exposures.

OPSFF will provide information and support for MCH healthcare systems (i.e. WIC, CFHS) to recommend and support patients' efforts to adopt strategies to limit second and third-hand exposure to smoke within their homes (provider recommendation is a recommended evidence-based intervention). Ohio currently has a strong smoke free workplace law, strictly enforced through local public health agencies. Currently, an online training is under development with expected release date end of January, 2014.

Strategy C: Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women.

**Report of Accomplishment:** The PSCP will accomplish this through: Promoting evidence-based cessation interventions; collaborate with partners and leverage resources; use the media effectively; convene and facilitate or participate in workgroups to address tobacco use and dependence: The Infant Mortality

Consortium; MCH BG Performance Measure 15 Workgroup, The Ohio Tobacco Control and Resource Group and Ohio Partners for Birth Defects Prevention.

To address perinatal smoking among low-income women in Ohio, the OPSFF was established in 2006. In July 2013, Ohio's Governor allocated funding to ODH from the state's general fund to address infant mortality, including \$1 million for immediate use. OPSFF workgroup met on a weekly basis as a collaborative effort to address tobacco use and dependence among women of reproductive age, including pregnant women, and develop plans for SFY 2014-2015 with state vitality funds.

Strategy D: Incorporate culturally appropriate activities and interventions.

Refer to activities in State Performance Measure 04.

#### **Strategies for the Current FFY 10/1/12 – 09/30/13**

- A. Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (*USPHS Treating Tobacco Use and Dependence Guidelines*).
- B. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke.
- C. Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women.
- D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

#### **Plan for Next FFY 10/1/2014 – 9/30/2015**

- A. Build the capacity of MCH healthcare systems to support the 5A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (*USPHS Treating Tobacco Use and Dependence Guidelines*). (*Infrastructure*)

##### **Activities:**

- Assess the MCH healthcare systems (i.e., WIC, CFHS,) capacity to support evidence-based smoking cessation intervention.
- Assess provider (i.e., WIC, CFHS,) awareness of evidence-based smoking cessation interventions.
- Ensure that healthcare systems are in place to screen women for tobacco use and offer treatment. Ensure that practitioners have the tools, training and technical assistance needed to treat smokers effectively.
- Ensure that a Quality Improvement (QI) plan is in place throughout the expansion project.

- B. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke. (*Infrastructure*)

##### **Activities:**

- Assess the healthcare systems (i.e., CFHS) capacity to support environmental health risk reduction.
- Assess provider (i.e., CFHS) awareness of environmental health risks.
- Ensure that systems are in place to screen women for environmental health risks.
- Ensure that practitioners have the tools, training and technical assistance.
- Ensure women have access to information that will help them take action to reduce environmental exposures.

- C. Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women. (*Infrastructure*)

##### **Activities:**

- Promote evidence-based smoking cessation interventions.

- Collaborate with partners and leverage resource; use the media effectively.
- Convene and facilitate or participate in the following workgroups to address tobacco use and dependence: OPSFF; Ohio Collaborative to Prevent Infant Mortality; MCHBG NPM 15 Workgroup, Tobacco Free Ohio Alliance and Ohio Partners for Birth Defects Prevention. Current smoking data from Ohio PRAMS and Ohio BRFSS reflecting trends will be shared with these partners.

D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04. *(Infrastructure)*

**Activities:**

- Implement the 5A's program for Ohio's 14 OIMRI programs.
- Implement culturally appropriate media campaign for Appalachian counties.

E. Develop a plan to reach the populations with the highest need. *(Infrastructure)*

**Activity:**

- A four county saturation of the 5A's will be conducted in Gallia, Lawrence, Scioto and Ross counties.

**MCH National Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Use YRBS data to monitor behavioral health issues of Ohio's teen age population.

**Report of Accomplishment:** Ohio YRBS data has been collected for 2013 44 high schools and 1,455 students responded to the survey. Results are currently being analyzed and a full report will be posted in the first quarter of 2014. No significant changes have been noted overall. Data on suicidal behaviors for Ohio's teens is as follows:

In 2013, 14 percent of Ohio high school students reported seriously considering suicide in the past year, a decrease from 1993, but no significant change from 2011.

In 2013, 1 percent of students had to be medically treated following a suicide, no change over time, but a decrease since 2011.

In 2013, 26 percent of students stopped doing usual activities due to being sad, no significant change from 2011.

In 2013, 21 percent of Ohio high school students reported seeing a doctor, nurse, therapist, social worker or counselor for a mental health problem in the past year, no significant change from 2011.

Data will be shared with Ohio's intra agency team during the first quarter of 2014 with plans to collaborate on data reports and additional analysis as resources allow.

Strategy B: ENGAGE Project, a one year SAMHSA planning grant.

**Report of Accomplishment:** ODH continues to partner with ODJFS and OFCF in the ENGAGE Project. Ohio has received additional funding beyond the planning grant to work on addressing the needs of youth transitioning out of foster care. Many of the youth are involved in multiple systems and have a host of behavioral issues. ENGAGE will work with pilot communities to provide support and help coordination efforts at the local level for transitional youth. In addition ODH has been developing a plan for increasing Trauma training for direct care staff who works with foster care/transitional youth in the PREP program. Approaching behavioral health issues within the transitional youth is a goal of the trauma informed care work. Training will begin in 2014.

Strategy C: Collaborate with Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide school based strategies.

**Report of Accomplishment:** The Ohio Adolescent Health Partnership is a state level committee comprised of adolescent health experts from a variety of settings including but not limited to: medical, community based

agencies, state departments, universities, etc. who have prioritized mental health as a significant issue for Ohio's youth. In the Adolescent Health Strategic Plan, the Partnership has developed the following to address adolescent behavioral health issues in an effort to make a positive impact on the number of teen suicides in the state

- **Goal 1:** Ohio adolescents will recognize the non-use of Alcohol, Tobacco and Other Drugs as the norm.
- **Goal 2:** Behavioral health and physical health services for adolescents will be more fully integrated to impact preventive interventions, increase early detection and increase access to care.

Other behavioral health efforts include a joint initiative with ODH and Ohio American Academy of Pediatrics called The Building Mental Wellness (BMW) Learning Network. This project supports pediatric practices to develop the culture, skills, and collaboration to assure success in serving your patients affected by emotional, developmental or behavioral issues. In addition to the benefits of improving patient care, participants will also receive Part IV MOC, CME and a practice stipend.

In addition the Ohio Suicide Prevention Foundation and ODH are collaborating on a one hour webinar training for school nurses to be offered in last quarter of 2014.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

#### **A.** Use YRBS data to monitor behavioral health issues of Ohio's teen age population

YRBS data for 2013 has been analyzed and reports developed. A fact sheet for behavioral health stressing depression in teens has been developed and will be shared with stakeholders and school personnel. YRBS interagency data meeting is scheduled for first week in April. Educational fact sheets and reports have been developed and can be accessed at ODH YRBS web page.

#### **B.** Partner with and obtain support from the Ohio Adolescent Health Partnership to develop awareness of teen behavior health issues.

Progress:

OAHP continues to meet and develop strategies to address behavioral health for adolescents. Report can be accessed at ODH Adolescent Health web page.

ODH and OSPF continue to work on developing a one hour webinar for school nursing personnel on signs and symptoms of depression and suicide to be taped in December.

#### **C.** Promote the inclusion of behavioral health services as part of the comprehensive health services offered to all students who utilize school based health centers in Ohio.

Progress:

Topic of Behavioral Health was added to the Ohio School Based Health Care Association for next Annual meeting. Plans on developing training materials are under discussion.

Plan for Next FFY 10/1/2014 – 9/30/2015

#### **A.** Use YRBS data to monitor behavioral health issues of Ohio's teen age population

##### **Activities:**

Convene YRBS interagency committee to review data for 2013.

Continue ODH partnership with ODE, OMHAS and various universities and local ADAHM boards to develop new survey for 2015 and discuss integration with local survey efforts..

Develop educational materials to report behavioral health data to schools and other stakeholders.

#### **B.** Partner with and obtain support from the Ohio Adolescent Health Partnership to develop awareness of teen behavior health issues.

**Activities:**

Develop and disseminate position paper on importance of integrating behavioral health into physical health for teen population.

Assess Pediatric and Family Practitioners need for professional development related to teen behavioral health issues related to early detection.

- Promote educational training for Pediatric and/or family practice re: behavioral health issues.
- Partner with OSPF to promote professional development for school personnel on Ohio's Campaign for Hope.

C. Promote the inclusion of behavioral health services as part of the comprehensive health services offered to all students who utilize school based health centers in Ohio.

**Activities:**

- a. Assess the needs for education and training to SBHC staff
- b. Work with local suicide coalitions to facilitate partnerships in counties where SBHC are located.

**MCH National Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.****Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Continue to analyze and identify data trends pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities. (Infrastructure)

**Report of Accomplishment:** Perinatal Periods of Risk Analysis (PPOR) was conducted using birth and death data from the State of Ohio to examine the specific risk factors influencing fetio-infant mortality rates among at-risk populations. The Maternal Health/Prematurity (MHP) period contained all deaths that occurred to infants of very low birth weight and contained the largest proportion of excess mortality. 55 percent of excess mortality among non-Hispanic black teens is attributable to this risk period, the most among any at-risk population examined. The health of women prior to and during pregnancy is the most important contributing factor to the MHP risk period.

Plans were discussed to develop web-based regional perinatal reports that include information about preterm birth and the percent of babies by birth weight born in hospital identified by level designation and work with the Division of Quality Maternity Licensure Unit to use data to strengthen licensure rules and enforcement.

Strategy B: Fund, monitor and evaluate DCFHS programs designed to take data to action. (Infrastructure)

**Report of Accomplishment:** ODH continues to partner with ODJFS to implement quality improvement activities among local maternal and child health providers. A Low Birth Weight Fact Sheet was developed by ODH and highlights the health impact, the cost impact, data on Ohio births and information on what is currently being done in Ohio to prevent LBW births and preterm births.

Ohio's maternity licensure rules were extensively revised and in effect January 1, 2012. Among the many changes in the maternity licensure rules is a requirement to transfer non-emergency obstetrical patients in premature labor to a higher level nursery unless a consulting neonatologist concurs that the infant does not require transfer. A new requirement is to report maternal and newborn deaths.

OIMRI information sheets were developed by ODH to provide history, goals, and IMR of the program.

A new Infant Safe Sleep and Breastfeeding policy was adopted and implemented by ODH in April 2013.

**Strategies for the Current FFY 10/1/12 – 09/30/13**

Strategy A: Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities. (Infrastructure).

Strategy B: Fund, monitor and evaluate DCFHS programs designed to take data to action. **(Infrastructure)**.

**Plan for Next FFY 10/1/2014 – 9/30/2015**

- A. Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities. This infrastructure level strategy will be accomplished by:
- Develop web-based regional perinatal reports that include information about preterm birth and the percent of babies by birth weight born in hospital identified by level designation
  - Disseminate regional profile reports to DCFHS staff
  - Continue to plan a project that would:
    - Identify 2 regions with the highest percentage of VLBW babies born in level I facilities.
    - Perform descriptive analyses to identify the characteristics of VLBW infants who are born in level I facilities in these regions in order to identify why VLBW infants are born in the Level I facilities.
  - Set regular meetings between BCFHS and Maternity Licensure Program to monitor data and discuss needed action concerning Level 1 and Level 2 facilities delivering VLBW infants.
- B. Support the development and implementation of Fetal Infant Mortality Reviews. This infrastructure level will be completed by:
- Fund ODH staff position to provide technical assistance to local FIMRs
  - Provide funding to OEI Teams for startup costs of FIMR implementation
  - Develop a statewide data collection system for FIMR
  - Host quarterly meetings of OEI Teams to discuss/share issues concerns around implementation of FIMR at local level.
- D. Fund, monitor and evaluate DCFHS programs designed to take data to action. This Infrastructure level strategy will be accomplished by:
- Strengthen partnership with Ohio Department of Medicaid to implement quality improvement activities among local maternal and child health providers
  - Align DCFHS programs to implement the recommendations identified in *Preventing Infant Mortality in Ohio: Task Force Report*.

**MCH Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

**Accomplishment Report for FFY 10/01/2012 – 09/30/2013**

Strategy A: Improve the rate of Medicaid coverage for eligible women and men by promoting newly approved presumptive eligibility for pregnant women and the expansion of coverage for family planning services under Medicaid. (Infrastructure).

**Report of Accomplishment:** ODH continues to work with ODJFS, family planning, and prenatal partners to develop and distribute outreach materials statewide. Information and links to Medicaid was posted on the ODH website. In January 2012, Ohio implemented the Medicaid Family Planning State Plan Amendment (SPA), which increased Medicaid eligibility for family planning services to men and women up to 200% of the federal poverty level. As of 9/30/13, 152,706 Ohioans have enrolled and/or obtained services through the SPA. (Related to SPM 01)

Strategy B: Examine disparities in prenatal care in the first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity. (Infrastructure)

**Report of Accomplishment:** The Ohio Department of Health partnered with CityMatch and established the Ohio Institute for Equity (OEI) in Birth Outcomes. ODH is reviewing literature of evidence-based practices on getting women into prenatal care in the first trimester.

Strategy C: Provide training and/or technical assistance to increase strategic plans to increase Cultural Competency in family planning and prenatal care services in DFCHS funded programs. (Infrastructure)

**Report of Accomplishment:** This strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 work plan.

Strategy D: Support the work of the Ohio Collaborative to Prevent Infant Mortality. (Infrastructure)

**Report of Accomplishment:** ODH continues to partner with ODJFS to implement quality improvement activities among local maternal and child health providers and align DFCHS programs to implement the recommendations identified in *Preventing Infant Mortality in Ohio: Task Force Report*. The *Action Learning Collaborative on Infant Mortality and Racism toolkit* was distributed to local public health, private providers and community partners, through OhioTrain and at the Infant Mortality Summit in November 2013. ODH staffs the OCPIM and plans quarterly meetings. OCPIM is a diverse group of public health officials, policy makers, researchers, health advocates, health care providers, and other stakeholders. Meeting attendance is now over 100 members.

### **Strategies for the Current FFY 10/1/12 – 09/30/13**

A. Improve the rate of eligible women and men covered by Medicaid by promoting presumptive eligibility for pregnant women. **(Infrastructure)**.

B. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity. **(Infrastructure)**.

C. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs. **(Infrastructure)**.

D. Support the work of the Ohio Collaborative to Prevent Infant Mortality. **(Infrastructure)**

### **Plan for Next FFY 10/1/2014 – 9/30/2015**

A. Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities. *(Infrastructure)*

**Activities:**

- Develop a report with recommendations for actions based on the analysis and interpretation of referral data and the identifications of trends and opportunities.
- Based on the report recommendations implement pre/interconception service protocols for public health/private providers.

B. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity. *(Population Based)*

**Activities:**

- Gather and analyze data of first trimester entry into prenatal care in BCFHS funded programs and provide technical assistance where needed.
- Review literature of evidence-based practices of prenatal care in the first trimester

C. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs. *(Enabling)*

**Activity:** See SPM 4 work plan.

- E. Work with partners, OPQC & Medicaid to implement the Progesterone Project to reduce the rate of premature births in Ohio <37 weeks by 10% and births <32 weeks by 10% by increasing the screening , identifications and treatment of pregnant women at risk for preterm birth who will benefit from progesterone. *(Infrastructure)*
- Provide funding along with Medicaid via state General Revenue Fund to support implementation of the Progesterone Prevention Project.
  - Actively monitor progress of QI project to:
    - raise awareness about the need for screening and intervention for progesterone
    - provide support to 26 prenatal clinic teams to implement screening, identification, and treatment
    - develop the capacity and capability of skilled ultrasound technicians
    - remove the administrative barriers to administration of progesterone
- F. Support the work of the Ohio Collaborative to Prevent Infant Mortality to address prenatal in the first trimester. *(Infrastructure)*
- Activities:**
- Create and implement an infant mortality awareness media campaign focusing on the disparities in birth outcomes.
  - Convene the Second Ohio Infant Mortality Summit: Turning Up the Volume on Infant Mortality: Every Baby Matters.