



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Ohio**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The assurance and certifications for Ohio can be made available by contacting

Karen Hughes, MPH, Chief
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Ohio Department of Health
246 North High Street
Columbus, OH 43215
(614) 466-3263

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The Ohio Department of Health made the MCH BG application, including the Needs Assessment, available for public input by placing it on the ODH webpage. Notification of such was sent to the MCH Advisory Committee and MCH Needs Assessment stakeholders. Stakeholders represented DFCHS grantees, other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers.

The current application will be available on the ODH website at
<http://www2.odh.ohio.gov/Resources/repts1.htm>

We received comments from 3 interested parties: 1) Prevent Blindness Ohio; 2) the ODH Division of Prevention, Healthy Ohioans Initiative; and 3) March of Dimes, Ohio Chapter.

/2007/The MCH BG application was made available for public comment on the ODH website at <http://www.odh.ohio.gov/healthresources/reports/healthReports.aspx>. Notification was sent via e-mail to stakeholder groups, local health departments/health agencies, and all local agencies/programs funded through the ODH DFCHS. Notice was also sent via a weekly ODH conference call with all local health departments on 2 separate occasions.

We received comments from 5 interested parties: 1) Prevent Blindness Ohio; 2) Morrow County HD (need for speech therapy services); 3) Huron County HD (need to retain specialty clinics); 4) Trumbull County Child and Family Health Services Prenatal Program (need to retain direct care prenatal care services); and 5) Montgomery County Health District (need for funding to assure access for uninsured, undocumented and working poor; also positive comments on data use

activities and women's health services).//2007//

/2008/ The MCH BG application was made available for public comment on the ODH website at <http://www.odh.ohio.gov/healthStats/data/MCHBG08.aspx>. Notification of the request for comments was sent via e-mail to stakeholder groups, local health departments and health agencies, and all local agencies and programs funded through the ODH DFCHS. Notice was also sent via a weekly ODH conference call with all local health departments. Response could be provided to ODH via an on-line survey, e-mail, in writing or by telephone.

We received 16 comments from 14 interested parties. See attachment for specific comments and ODH's response. Comments specific to a performance measure are included as an attachment to that performance measure. ODH has responded to all comments where contact information was available. All comments and responses are posted with the MCH Block Grant Application and Annual Report on the ODH website. //2008//

/2009/The MCH BG application was made available for public comment on the ODH website during a 3-week period in June. Notification of the request for comments was sent via e-mail to stakeholder groups, local health departments/health agencies, and all local agencies and programs funded through the ODH DFCHS. Notice was also sent via a weekly ODH conference call with all local health departments. Response could be provided to ODH via an on-line survey, e-mail, in writing or by telephone. Because no comments were received, recipients of the announcement were contacted. It was determined that the link did not work correctly. Corrections are being made; comments will be solicited throughout July. We received 3 comments.//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Needs Assessment Summary

See Supporting Documents -- Form 14 and Section IV A and B. -- Priorities, Performance and Program Activities.

The process for creating the 10 Title V priority needs for Ohio's FFY 2006 MCH Block Grant application was based on the process used to identify the 10 priority needs for the FFY 2001 application. The 2000 needs assessment (NA) used a community health assessment (CHA) model developed by ODH through collaboration with local health departments. The 9-step process, which was documented in Ohio's Public Health Plan (1997), is illustrated as a CHA "wheel." Steps 1 - 6 represent the NA phase, steps 7 and 8 are the planning phase, and step 9 is evaluation. Participants in the 2000 NA included ODH staff as well as outside stakeholders. The 10 priority needs identified in 2000 were 1) reduce child/ adolescent mortality; 2) reduce LBW; 3) reduce infant mortality; 4) reduce child/adolescent overweight; 5) reduce percent of teens in grades 9-12 who have sexual intercourse; 6) implement policies/strategies to facilitate coordination of services for CSHCN; 7) eliminate gaps in services for CSHCN; 8) reduce percent of children/adolescents who require oral health care and do not receive it; 9) reduce teen tobacco use; and 10) establish/maintain population-based data for CSHCN.

To improve the NA process for 2005, ODH MCH program staff reviewed the process/ results of the 2000 NA. An evaluation of the prior NA resulted in the decision to include more outside partners; to improve the priority-setting process; and to allow more time for intervention/implementation planning. Secondary data from the previous five-year NA were updated and primary data were collected through a survey of local public health providers and focus groups of families of CSHCN. Priority recommendations from 4 external stakeholder groups: Women's Health, Birth Outcomes, and Infant Health; Early Childhood ; School Age and Adolescents; and CSHCN were the basis for discussion and selection of the final 10 priority needs. The new priority needs are as follows: 1)improve birth outcomes; 2) assure quality screening, identification, intervention, care coordination and medical home; 3) assure access to comprehensive preventive/treatment services for individuals/families, including CSHCN; 4) promote age-appropriate nutrition/ physical activity; 5)improve oral health/ access to dental care; 6) enhance social/emotional strengths of families; 7) increase collaboration/coordination of programs for families through partnerships and data integration; 8) incorporate racial/ethnic/cultural health equity in all activities; 9) decrease substance abuse/addiction including tobacco; and 10) promote sexual responsibility/ reproductive health.

Several of the needs identified as priority areas for the 2000 NA continue to be priorities. Birth outcomes, including infant mortality and LBW; coordination of services for CSHCN; gaps in services for CSHCN; and access to oral health services for children/ adolescents remain as important focus areas. Improving birth outcomes is a higher priority than ever, as Ohio's infant mortality and LBW rates have increased and are worse than the nation. Ohio continues to see large disparities in birth outcomes between the white and black populations. Services for CSHCN that are coordinated/ comprehensive remain a challenge in a climate of decreased funding, inadequate insurance coverage, provider shortages and access to care issues. Continuing access problems for children in need of oral health care services keep this issue a high priority.

Other needs that were high priority in the last NA continue to be priority needs, but were replaced with broader needs statements. Instead of overweight as a priority, age-appropriate nutrition/physical activity is the new priority. Instead of reducing teen smoking, the new priority was broadened to decrease substance abuse/addiction, including tobacco. Instead of reducing percent of teens in grades 9-12 who have sexual intercourse, the new priority is to promote sexual responsibility/ reproductive health; and instead of reducing LBW and infant mortality, the new priority is to improve birth outcomes. Instead of implementing policies/strategies to facilitate coordination of services for CSHCN, the new priority is to increase collaboration/coordination of programs for families through partnerships and data integration.

Two priorities were replaced. Reducing overall child/adolescent mortality is being addressed through Ohio's mandated CFR program. The program has a full-time coordinator and epidemiology support. There is a local CFR team in each of Ohio's 88 counties. These teams are required to review all child deaths to children under the age of 18 years and to make recommendations to prevent subsequent deaths. Population-based data for CSHCN was replaced as a priority because the data needs are met by the National CSHCN Survey and by the OFHS, which has added questions related to CSHCN concerns.

Several new areas have emerged as priorities. Across all population groups, access to care and insurance was the highest need, thus the priorities to assure quality screening, identification, intervention, care coordination/medical home; and to assure access to comprehensive preventive/treatment services for individuals/families, including CSHCN. Concerns about mental/social/emotional health of the MCH population arose in all discussions of unmet need. This resulted in the priority to enhance social/emotional strengths of families. This priority will be addressed in strong partnership with the Ohio Department of Mental Health. All stakeholder groups emphasized the importance of reducing disparities, thus the priority to incorporate racial/ethnic/cultural health equity in all activities.

/2008/ There are no changes to the needs discussed above and no changes in the State capacity to meet those needs. Section D. Outcome Measures - Federal and State- is attached. //2008//

/2009/ There are no changes to the needs discussed above and no changes in the State capacity to meet those needs. Section D. Outcome Measures - Federal and State- is attached. The Ohio Title V program has begun active planning for the next Five Year Needs Assessment. //2009//

III. State Overview

A. Overview

The Health of Ohio

In comparison with other states, Ohioans' health status is about average. Ohio does very well on some measures: mortality from motor vehicle injuries; HIV, and insurance rates. However, Ohio does poorly on measures of birth outcomes such as infant mortality and low birth weight; on measures of health behaviors such as smoking, obesity, diet and physical activity; and on rates of mortality associated with those behaviors: heart disease, stroke and cancer. Disparities, particularly those among blacks and in Appalachia, contribute heavily to poor indicators that diminish Ohio's overall health status. /2008/ According to the United Health Foundation's America's Health Rankings, in 2006 Ohio ranked 25th among the 50 states on a variety of health status measures; this is up from 27th in 2005. While strengths and challenges remain similar to past years, Ohio has seen a decrease in smoking rates and an increase in the rate of the uninsured.//2008// **/2009/ According to the United Health Foundation's America's Health Rankings in 2006, Ohio's rank fell to 29th. Significant changes include increases in prevalence of obesity and in prevalence of poor mental health days per month. On the other hand, Ohio saw decreases in the incidence of infectious diseases and in the rate of deaths from cardiovascular diseases. In regard to health disparities, blacks in Ohio experience 64 percent more premature deaths than whites.//2009//**

Demographics

Ohio ranks seventh in the nation in population, with an estimated 11,435,789 people, including 3.5 million children under the age of 22. In the year 2003, there were approximately 2.4 million women in Ohio who were of childbearing age (15 to 44 years). In recent years, Ohio has averaged about 150,000 live births annually. The birth rate has been relatively stable for the last five years. According to the 2002 National Survey of Children with Special Health Care Needs (CSHCN), the total number of CSHCN in Ohio was 402,800 children or 13.9 percent of children under 18 years of age. The survey identified 338,550 Ohio households with CSHCN or 22 percent of the state's households. In comparison, the survey identified 9.4 million CSHCN nationally or 12.8 percent of children under 18 years of age. Nationally, 20 percent of all households had a CSHCN.//2009/ **According to the 2005/2006 National Survey of CSHCN, the total number of CSHCN in Ohio was 445,205 or 16.2 percent of children under 18 years of age. The survey identified 381,667 Ohio households with CSHCN or 23.9 percent of the state's households. In comparison, the survey identified 10.2 million CSHCN nationally or 13.9 percent of children under 18 years of age. Nationally, 21.8 percent of all households had a CSHCN.//2009//**

Ohio has a land area of 40,953 square miles and is divided into 88 counties. An estimated 81 percent of the population in Ohio resides in metropolitan areas. The ten counties with the largest populations are Cuyahoga (includes Cleveland), Franklin (Columbus), Hamilton (Cincinnati), Montgomery (Dayton), Summit (Akron), Lucas Toledo, Stark (Canton), Butler (Middletown), Lorain (Lorain), and Mahoning (Youngstown). The Ohio Family Health Survey categorized the 88 counties as metropolitan (12), suburban (17), rural non-Appalachian (30) and Appalachian (29).

Ohio has no geographic barriers. However, while Ohio has a highway system that connects most parts of the state very efficiently, the southeast region of the state, including most of Ohio's Appalachian counties, lacks a good highway system, creating a lack of accessibility to both jobs and health care. Pockets of inner city poor and the 19 percent of the population living in rural areas lack access to primary health care services. Access to specialists often requires travel to urban areas of the state. Ohio has seventy-six federally designated health professional shortage areas distributed within 51 of its 88 counties. The greatest areas of unmet need are in metropolitan and Appalachian counties. The designated primary care HPSAs in Ohio are more prevalent in urban areas than rural areas; 71 percent are located in urban areas and 29 percent are in rural areas.

/2007/ Ohio has 102 federally designated health professional shortage areas distributed within 54

of its 88 counties. However, the 48 dental HPSAS (in 41 counties) are more evenly distributed with 24 located in urban areas and 24 located in rural areas. In Ohio, disparities in oral health and access to care have been linked to low family income, residence in an Appalachian county, and race.//2007//

Since 1990, Ohio has had an increase in ethnic and racial minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origins, accounted for 15 percent of Ohio's net growth since 1990. Likewise, the black population accounted for 29 percent of Ohio's net growth since 1990. The three largest groups of Asian populations in Ohio are of Indian, Chinese and Korean origin. In 2003, 85.4 percent of the population was white, 11.7 percent was black, 1.4 percent was Asian or Pacific Islander, and 0.2 percent was Native American and Alaskan Native. These groups may also include Hispanics, who make up two percent of the population. In 2000, 2.2 percent of Ohio's population was composed of persons identifying themselves as being of two or more races.

/2008/ According to the 2005 U.S. Census estimates, the minority population in Ohio increased between 2000 and 2004. At 16%, the Asian/Pacific Islander growth rate was the highest in the state. The Hispanic/Latino population increased by 15%, while the African American population grew by 4%. There are several special populations of note in Ohio. The migrant population continues to slowly increase. Between 2003 and 2004, this population increased by 4%. Ohio is also home to the nation's largest concentration of Amish, with about 40,000 residing in a five-county rural area. Holmes County alone is home to 19,000 Amish. Ohio has also experienced an influx of immigrants, both from primary resettlement of refugees as well as secondary migration from other states. //2008//

/2008/ Ohio's per capita income is currently \$23,322 and median household income is currently \$43,493 compared to the national average of \$46,242. The average civilian labor force unemployment rate for 2005 was 5.9% in Ohio compared to 5.1% for the nation. Ohio has the 7th highest unemployment rate in the nation. //2008//

Health Priorities for Ohio

Of the five priorities established by Governor Bob Taft for his administration, three are directly related to improving and protecting the health of Ohioans: Enabling every child to succeed; caring for those not able to care for themselves; and promoting public health and safety.

/2008/ In November 2006, Ohio elected a new governor, Ted Strickland. Governor Strickland, previously a U.S. Congressman from Ohio, took office on January 8, 2007. As part of the Governor's Turnaround Ohio Initiatives, the Ohio Department of Health will focus on 1) improving the management and prioritization of prevention programming, improving health outcomes, and reducing health disparities through the Healthy Ohio program; and 2) expanding the Help Me Grow program. //2008//

The Ohio Department of Health (ODH) is the agency charged with protecting and improving the health of all Ohioans. In order to carry out this mission, ODH has adopted a strategic plan based on the concept of Healthy Ohioans in Healthy Communities. Title V and other programs in the department are guided by the following core values in this plan: leadership, excellence, accountability, partnership and citizenship. Leadership within the Ohio Department of Health produced a set of priorities for 2005 that remained the same as for 2004. The Director's Performance Goals 2005 (with a listing of MCH-related objectives) are as follows (see entire list in the attachment in Section IV: Priorities, Performance and Program Activities.).

* Encourage healthy choices

- Establish baseline number of overweight Ohio children

* Prevent chronic, environmental, genetic, and infectious diseases

- Increase immunization rates of two year olds

* Eliminate health disparities

- Improve access to dental care for vulnerable Ohioans through dental workforce
- Increase coordination of programs for families and children under age 6
- Develop and implement a Birth Defects pilot program in two areas of the state
- Expand participation of local health departments in Medicaid Administrative Claiming (MAC)

- Establish a baseline number of minority physicians needed to match racial and ethnic composition of Ohio's urban health professional shortage areas
- Increase the number of medical homes for CSHCN
- * Assure public health preparedness and security
- * Assure quality and safety of health care services
- * Improve business performance
- * Improve access to dental care for vulnerable Ohioans through dental workforce

/2007/ The Director's Performance Goals for 2006 are attached in Section IV: Priorities, Performance and Program Activities. Priorities are virtually the same as 2005, with minor updates.//2007//

/2008/ Effective 6/4/07 Alvin D. Jackson, M.D., replaced J. Nick Baird, M.D., ODH Director. It is expected that until Dr. Jackson has the opportunity to review and comment on draft changes to current ODH priorities and performance goals, they will remain similar to the performance goals for 2006.//2008//

/2009/ The ODH is in the process of conducting a strategic planning process that will result in a set of priorities with associated performance goals and measures.//2009//

Process to Establish Title V Needs and Priorities

During 2004 and 2005, in anticipation of the FY2006 MCH Block Grant application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions, and professional judgment from those working in the field. The needs assessment process and resulting priorities are more fully described in other sections and have been used to guide Ohio's MCH Block Grant-funded activities and grant applications for 2005-2006. Ohio utilizes the Community Health Improvement Cycle model that can be found in the attachments.

The MCH Advisory Council assists DFCHS by advising on block grant funded programs and the population served by the Title V Program. Representatives from the Council served on each of the Needs Assessment stakeholder groups. The Council is composed of maternal and child health professionals in both the public and private sectors, clinicians, administrators, policy makers, MCH advocates, consumers, state agency representatives, academicians and state legislators. They are appointed by the Director of Health and meet at least once a year. The most important health care needs and issues identified by the comprehensive assessment of the state's maternal and child health population can be considered by population group:

Women's Health, Birth Outcomes and Newborn Health

- * Access to Adequate Prenatal Care/Health Insurance
- * Preterm Births/LBW
- * Preconception/Family Planning/Unintended Pregnancy/Genetics Referrals and Services
- * Neonatal/Perinatal Mortality
- * STDs/HIV/Hepatitis
- * Overweight/Nutrition
- * Smoking
- * Interconceptional Care
- * Mental Health/Postpartum and Perinatal Depression

Early Childhood

- * Health Coverage and Access to Care
- * Access to Comprehensive Services including: Immunizations, Oral Health, Vision, Hearing, Lead Screening, Behavioral and Mental Screening
- * Infant Mortality

- * Child Care and Development
- * Child Injury
- * Child Death
- * Overweight
- * Social/emotional Health Issues
- * Environmental Issues

School Age and Adolescents

- * Insurance/Health Care Access and Use
- * Chronic Disease Prevention
- * Screenings (includes Oral Health, Vision, Hearing , and BMI)
- * Mental Health Issues
- * Sexual Behaviors
- * Substance Abuse Issues
- * Suicide
- * Motor Vehicle Issues

Children with Special Health Care Needs

- * Insurance/Access/Payment Issues
- * Care Coordination: Medical Home/Community
- * Services for Congenital and Genetic Conditions
- Transition
- * Access to Specialty and Specific Health Care Services
- * Mental Health
- * Medical Condition and Services
- * Impact on Family

The considerable overlap of issues among these population groups was taken into consideration by the DFCHS chiefs in their deliberations in making recommendations on the top ten priorities for the MCH Block Grant.

The top ten priorities (in no priority order) are listed below:

- * Improve birth outcomes
- * Assure quality screening, identification, intervention, care coordination and medical home
- * Assure access to comprehensive preventive and treatment services for individuals and families, including Children with Special Health Care Needs
- * Promote age-appropriate nutrition and physical activity
- * Improve oral health and access to dental care
- * Enhance social/emotional strengths of families
- * Increase collaboration and coordination of programs for families through partnerships and data integration
- * Incorporate racial/ethnic/cultural health equity in all activities
- * Decrease substance abuse and addiction, including tobacco
- * Promote sexual responsibility and reproductive health

Ohio Health Care Systems to Deal with Identified Need

Health Care Delivery Environment: Medicaid

The Medicaid program is the most significant source of payment for health care services for low-income Ohioans. The Ohio Department of Job and Family Services (ODJFS) is the single state agency in Ohio with responsibility for administering the health care needs of Medicaid eligible persons including the health care needs of childbearing women, infants, and children. As in other parts of the country, Ohio's Medicaid program is undergoing major changes as Medicaid spending out paces the growth of state revenues.

In SFY 2004, Ohio Medicaid provided comprehensive health care coverage to:

- * 1 million children, including 45 percent of children under age 5;
- * 265,000 non-elderly adults and children with disabilities;
- * Over 490,000 low income parents

The Ohio Medicaid program offers two delivery systems: the Fee-For-Service (FFS) and Managed Health Care System via the Managed Care Plans (MCP). The FFS system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is delivered. Medicaid MCPs operate in 15 Ohio counties for the Healthy Start and Healthy Families population.

One of Medicaid's program categories is the Covered Families and Children (CFC) category of Healthy Start/Healthy Families that provide health care coverage for pregnant women and children who are not eligible for other Medicaid programs but meet the income guidelines for Healthy Families. Healthy Families allows up to 12 months of coverage for families who would lose coverage because of an increase in income (Transitional Medicaid) It can provide assistance to pregnant women at any age, and infants, children and teens up to age 18.

Pregnant women: Provides time-limited health care coverage to low-income pregnant women with family incomes at or below 150% of poverty. Coverage begins following confirmation of pregnancy and ends two months following birth. In SFY03, 30.1 percent (42,759) of the Ohio's total births were covered by Medicaid.

Infants and Children: Healthy Start provides health care coverage for children from birth through age 18 in families with incomes up to 200 percent FPL. Children in families with incomes at or below 150 percent PFL are eligible regardless of other health coverage. Children in families with incomes at 151-200 percent FPL are eligible only if they do not have creditable health coverage. Newborns are deemed eligible for 12 months if the mother was eligible for Medicaid at the time of birth, regardless of subsequent changes in the mother's income.

Ohio's State Health Insurance Plan for Children (SCHIP): As part of the Medicaid expansion of the Healthy Start program, Medicaid eligibility was increased for children up to 150 percent of FPL on January 1, 1998. In July 2000, Ohio further expanded Healthy Start under SCHIP. This expansion raised the income limit for eligibility up to 200 percent FPL. For this second SCHIP expansion, there was no complementary Medicaid expansion for the under-insured children, so children in this income range (151-200 percent FPL) are only eligible if they are uninsured. Healthy Families previously known as Low Income Families provides health care coverage to families (parents and children). The majority of families receiving Healthy Families coverage are working families. A smaller group receives Ohio Works First (OWF) cash assistance. On July 1, 2000, Healthy Families coverage was expanded to families earning up to 100 percent of the Federal Poverty Level (FPL).

Medicaid Managed Care

Medicaid Managed Care operates in 15 counties. There are three (3) categories of Managed Care counties: four counties are mandatory for Healthy Start eligibles; six counties are preferred options which means that Healthy Start eligibles are automatically enrolled in a managed care plan unless they choose to be in the FFS program; and five counties are voluntary counties which means that a Healthy Start eligible may choose to be in a MCP or in the FFS program. Those eligible through the aged, blind, and disabled categories remained on the FFS program.

In March 2005, Medicaid managed care enrollment was 525,699 as compared to an enrollment of 252,902 in September 1999. Historically, 1997 through 2000 was a time when cash assistance and Medicaid eligibility were delinked as a result of welfare reform.

As a result many lost their eligibility for cash assistance and were disconnected from Medicaid coverage. Between July 1997 and September 1999, the number of families eligible for Medicaid/Healthy Start dropped from 651,651 to 546,405, a decrease of 16 percent. This now compares to a total statewide Medicaid eligibles (MCP and FFS) of 895,215 with 45 percent HF/HS eligibles enrolled in MCPs.

/2007/ Based on a recommendation from the Ohio Commission to Reform Medicaid and Ohio's 2006-2007 Budget mandate, by December 2006 Medicaid Managed Care (MCP) will expand statewide for approximately 1.2 million Covered Families and Children (CFC) and a specific portion of the Aged, Blind, and Disabled (ABD) population. The Ohio Department of Job and

Family Services (ODJFS) is implementing the legislature's directive by dividing the state into 8 regions, each of which will be serviced by at least two Medicaid HMOs. The managed care plans must provide all Medicaid-covered services. Medicaid consumers will be placed in a managed care program which bases the delivery of health care services on a "medical home" model that focuses on care coordination and preventive services, including advice and direction for medical issues via a 24/7 medical advice hotline; help in accessing services with a dedicated call center for members and a provider directory listing primary care physicians, hospitals, and specialists; and special services for consumers with special health care needs including case management.

However, mandatory enrollment only affects a specific portion of the ABD population. It does not affect consumers who are covered under both the Medicaid and Medicare programs or who receive Medicaid services through a home and community based waiver. In addition, MCP membership is not required for children under nineteen years of age who are: eligible for Social Security Income (SSI); receiving adoption assistance, in foster care, or removed from the parent or guardian's home due to a legal change in custody; or receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh).

Due to state budgetary constraints, the Ohio legislature approved reductions to the dental benefits in the state Medicaid program. A fee reduction for all Medicaid dental services of 2% for children and adults, was implemented January 1, 2006. Additional reductions were made to selected adult benefits. //2007//

/2008/ As a result of the Deficit Reduction Act of 2005, effective September 25, 2006, U.S. citizens who applied for Ohio Medicaid's program were required to provide proof of their U.S. citizenship. The intent of this legislation is to ensure that those getting public assistance are documented citizens. There are a few exceptions such as those who are on Medicare, SSI or applying for Disability Medical Assistance or Alien Emergency Medical Assistance. Prior to this time, U.S. citizens could self-declare their citizenship verbally or in writing to meet this requirement. It appears that an unintended consequence has been a decrease in Medicaid recipients.

The managed care expansion for Covered Families and Children (CFC) was completed by December 2006.

Mandatory managed care covers the Healthy Start/Family population.

In May 2005 ODJFS released a RFP to seek potential Managed Care Plans to serve the ABD population with a target date to begin enrollment in December 2006. In October, the Ohio Association of Health Plans, Association of Ohio Health Commissioners, the Ohio Department of Job and Family Services and ODH sponsored a forum for local public health departments as potential providers of services. The MCPs are being phased in the 8 MCP regions with enrollments to be completed by May 2007. There are about 440,000 ABD Medicaid eligibles currently on the fee-for-service system, but only about 125,000 elderly or disabled will be transitioned into the MCPs. The exceptions are in the previous 2007 section.

Strategies to improve coverage for children who are potentially eligible for Medicaid put forth by the new administration in the executive budget includes presumptive eligibility, continuous enrollment for 12 months and expansion of SCHIP to 300% pending federal reauthorization; also expand Medicaid coverage to pregnant women from 150% of FPL to 200% of FPL; and restore Medicaid to working parents from 91% FPL to 100% FPL. Create Medicaid buy-in with people with disabilities up to 200% of FPL (Ticket to Work program). //2008//

Medicaid Administrative Claiming

ODH has been working with ODJFS and more recently with the Centers for Medicare and Medicaid Services (CMS) to implement the Medicaid Administrative Claiming (MAC) program. Activities reimbursed as Medicaid administrative costs are not subject to the same rules and regulations that drive the delivery and reimbursement of Medicaid services. MAC in federal regulation is defined as activities that are "necessary for efficient administration of the State Plan" Historically, federal reimbursement has been provided for activities that increase access to

Medicaid and that assist in improving the quality, appropriate usage, and effectiveness of services. These activities include outreach; referral, coordination and monitoring of Medicaid Services; and program planning, development and interagency coordination of medical services. Thus, Medicaid administrative claiming opportunities are logically focused in communities and among populations with the greatest disparity in health outcomes. MAC will allow ODH and its local partners to reinvest its reimbursements in community-based health-related programs.

//2007/ The Ohio MAC Methodology Guide was submitted to ODJFS and the Center for Medicare and Medicaid Services (CMS) for approval. It is anticipated that the ODH MAC Methodology will be approved by CMS. Quarterly MAC time studies have been conducted to document the percentage of time that staff spends on MAC and Non-MAC activities. Based upon these MAC activities, ODH and its partners have submitted placeholder claims and the federal financial participation will be finalized once ODJFS and CMS approves the MAC methodology. The potential recoupable revenue is significant.//2007// /2008/ Both ODJFS and our local partners have approved agreements; CMS has approved our Methodology Guide. //2008// ***/2009/ODH is now in an expansion phase for Medicaid Administrative Claiming (MAC). To facilitate the expansion we developed a MAC web site:***

<http://www.odh.ohio.gov/about/finmgmt/mac.aspx> . ODH has currently expanded Medicaid Administrative Claiming to seven of our 130 Local Public Health Departments. We anticipate that 60 agencies will end up participating in the program generating a projected revenue of over \$4,000,000 annually.//2009//

Health Care Delivery Environment: Title V

Ohio's Title V Program provides the linkage among the many constructs that impact programs for the maternal and child population. Required MCH core performance measures are evaluated against the results of the state's needs assessment priority areas; State Child Health Insurance Program and other welfare reform programs are directly related to the health care services provided by the Title V Program. Initiatives such as Ohio Family and Children First and the Ohio Department of Health's Strategic Planning Priorities also must inter-relate with the activities funded through the MCH Block Grant.

Ohio's Title V Program is able to work within these programs and initiatives and has become more efficient and responsive to the needs of the MCH population. For example, within the Child and Family Health Services program, local programs that receive Title V funds are familiar with MCH Block Grant performance measures and prepare their grant applications to ODH by population group and level of the MCH service pyramid, based upon their own county-level needs assessment. Title V dollars expended on direct service at the local level are used to augment the publicly-funded safety net. Medicaid and other third party payers are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services.

With the exception of vision and hearing screening, all primary and preventive care services in Ohio's Title V program are provided by grantees of the Ohio Department of Health's Division of Family and Community Health Services. These grantees are often local health departments, but they may also be hospitals, community action agencies, and other non-profit community agencies.

Overview of the Child and Family Health Services Program (CFHS)

CFHS is not only a network of clinical service providers, but also local consortiums of health and social services agencies that identify the health needs, service gaps, and barriers to care for families and children and then plan clinical and community public health services to meet those needs. It also assures clinical child and adolescent health, prenatal, and family planning services for some low income families and children (e.g., legal immigrant children, ineligible for Medicaid by federal mandate even if otherwise meeting family income guidelines), Funding of 79 local sub-grantees is done with a with a combination of Title V and state dollars. CFHS consortiums are also linked to the county Family and Children First Councils, Medicaid, and the Help Me Grow program. The program is more thoroughly described in Section B.

CFHS Projects are necessary even though Medicaid provides substantial funding of health care for the MCH population, including children with special health care needs. For those children

residing in Medicaid mandatory managed care counties, the CFHS clinics would be one of the choices that the family would have for a child health care provider. In many rural counties however, the CFHS clinic may be the only provider in the community who will accept Medicaid eligible clients, and those with no ability to pay for services.

/2007/ Overview of Oral Health Program

The Bureau of Oral Health Services seeks to promote and improve the oral health of Ohioans, especially those with limited access to oral health care. The Bureau provides grants to school-based dental sealant programs, the OPTIONS (statewide dental treatment referral network) program and to community agencies for the operation and expansion of safety net dental clinics. Consultation for community development and coalition building is provided to local agencies and organizations actively engaged to address oral health issues. The bureau offers training and technical assistance on community-based prevention programs such as water fluoridation and school-based fluoride mouthrinse programs and provides web-based resources to support community action and public policy development. The bureau is working with home visiting programs and primary health care providers for very young children to increase the number of children 0-2 years old (and their families) receiving oral health assessments, anticipatory guidance and referrals for dental care. The system is described in more detail in Section B.//2007//

Overview of Children with Special Health Care Needs (CSHCN)

The Title V CSHCN Program is facing the challenge of decreased funding and increasing need by increasing coordination with Medicaid and private insurance payers, reducing the scope of clinical services, and reducing the number of children whose families remain financially eligible. In the past year the program has increased its commitment to service coordination by supporting team service coordination for children with hemophilia and other clotting disorders. The program is supporting the Medical Home for all children and especially CSHCN. The CSHCN program continues to network closely with the Medicaid and Early Intervention programs. The Title 5 program for CSHCN is developing a new electronic medical record system which will aid greatly in the matching of CSHCN with the services they need. /2007/ The Title V CSHCN Program continues to face the challenge of decreased funding and increasing case loads. The Program is meeting this challenge by increasing its coordination with Medicaid and private insurance payers. The CSHCN program has increased its collaboration with the Early Intervention Program. This collaboration will decrease duplication of services and increase family satisfaction. There is a Legislative mandate to look for stable funding for the CSHCN program. The Legislature has formed a Bureau for Children with Medical handicaps (BCMh) Funding Committee to investigate and recommend both short term and long term solutions to funding the BCMh program. This committee will report in the next few months.

The program continues to support the Medical Home for all children and especially children and youth with special health care needs(C&YSHCN). The program has developed youth advisory councils in three locations around the state to advise the program on issues around transition from being a youth with special needs to the adult world. The program has implemented and electronic medical record system which will greatly improve its ability to match C&YSHCN with the services they need.//2007//

/2008/ The Title V CSHCN program continues to face the challenge of increasing need and limited resources. However with the change in administration the program has been recommended for an increase in its state funding and this is supported both in the Governor's office and in the legislature. The increase in state funding was included in the State Biennium Budget and will allow the Title V CSHCN Program to continue to serve the families eligible for the program and continue to support the present clinical package of services. There continue to be challenges in the state on the interpretation of EPSDT and payment for Habilitative Services and a larger load may move to the CSHCN Program. The CSHCN program continues to coordinate closely with the state Medicaid program, both fee for service and Managed Care. The CSHCN program continues its strong support of Hospital Based Team Coordination by supporting hospital based teams for the care of hemophilia, cerebral palsy, spina bifida, and cleft lip and palate. The

program continues to support the Medical Home for all children and especially children and youth with special needs. The program's youth advisory councils are active and the program plans on adding a fourth regional council this year. The program has implemented its electronic medical record system and is now working with local health departments on both our collaboration with the Help Me Grow program and the electronic medical record. //2008//

//2009/ The CSHCN Program in Ohio (Bureau for Children with Medical Handicaps {BCMh}) works closely with a wide variety of Parent/Family Organizations. BCMh has a parent on staff, Kathy Bachmann, whose role is to work with families and the Bureau to insure that families are innnvolved at all levels. The Bureau has a very active Parent Advisory Committee. The members of this group are chosen from around the state and we strive to have as much diversity as possible. The members are paid for attending the meetings and for other activities they do for CSHCN in Ohio. BCMh also works with parents at the state DD Council, Family Voices of Ohio, ARC, MRDD, and other local organizations.

A comment related to CSHCN was received in response to a request for public comments on the FFY 09 Application: a superintendent of a county board of MRDD suggested that the Block Grant should include activities specific to children who are on the Autism Spectrum and their families. While Autism is not a condition eligible for the CSHCN treatment program, the condition is eligible for diagnostic services.

As part of a state-funded Autism Diagnosis Education Pilot Project, focus groups are being conducted in 5 counties which reflect the diverse population of Ohio. Multiple focus groups are being conducted in the target communities, and stakeholders such as local public health and private medical providers, families and educators. //2009//

Overview of Help Me Grow

Help Me Grow is an innovative statewide program for mothers-to-be and their young children. The program was started in 1995 by the Ohio Family and Children First Initiative within the Governor's office in consultation with the state's health care, public health, social service and business communities. It is a comprehensive system of services administered through local councils for Ohio families. These services include information about pregnancy, voluntary home visits by to newborns and their parents by a registered nurse to families with infants and toddlers who are extremely vulnerable because of environment, family, or health circumstances and services and supports and services for children who have developmental disabilities (Part C of IDEA). The system is described in more detail in Section B.

Regional Perinatal Center Program (RPC)

Since 1977, Ohio has been divided into six perinatal regions based on the adoption of the State Perinatal Guidelines in response to the national recommendations for the Regional Development of Maternal and Perinatal Health Services (Toward Improving the Outcome of Pregnancy I). These regional designations were based on established referral patterns among hospitals and professionals capable of providing varying levels of maternity and newborn care. ODH further determined that at least one entity would be available within each region to serve as a hub for the Regional Perinatal Center Program. This population based Regional Perinatal Center Program is designed to promote access to evidence-based and risk-appropriate perinatal care to women and their infants through regional activities with the goal of reducing perinatal mortality and morbidity. The system is described in more detail in Section B.

Health Care Delivery Environment: Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Centers also play a vital role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, adolescents, and CSHCN. Financial resources are distributed to provide improved access to health care for the Maternal and Child population. From October 1, 2003 through September 30, 2004, Health Priority Trust (tobacco settlement) and funds and state funds were distributed to pay for health services for uninsured women, pregnant women and children. A total of 88,897 unduplicated patients (pregnant women,

children less than 1 year old and children 1-18 years old) received care in Federally Qualified Health Centers or in the free clinics throughout the state. /2007/ In 2005 133,292 uninsured pregnant women and children received care paid in part with \$5 million from the Health Priority Trust Funds and state funds.//2007//

Ohio has 76 federally designated health professional shortage areas distributed within 51 of its 88 counties. An additional 153 physicians are needed to serve the 1.6 million Ohioans residing in these shortage areas. The Division of Family and Community Health Services has six programs to recruit physicians, both primary care and sub-specialty trained, to work in underserved areas. These programs include a federal scholarship program, two federal, and one state loan repayment program (for American physicians) and the J1 Visa and National Interest Waiver programs for the placement of foreign born physicians. In 2004 Ohio placed 4 pediatricians, 1 OB/GYN, 1 Nurse Practitioner, 4 psychiatrists, and 1 social worker through these programs.

/2007/ Ohio has 102 federally designated health professional shortage areas distributed within 54 of its 88 counties. An additional 139 physicians are needed to serve the 1.6 million Ohioans residing in these shortage areas. In addition, there are 48 non-institutional dental HPSAs distributed within 41 Ohio counties. A new state dentist loan repayment program, implemented in 2005, provided incentive for six dentists to work in underserved areas in Ohio

In 2005, HPSA designations included 16 primary care, 12 dental and 4 mental health. In 2005 Primary Care and Rural Health recruitment programs placed 84 providers in 34 counties in Ohio. The new Minority and Appalachian loan repayment program was implemented in 2005 and 51 participants in the first year of the SEARCH program (Student/ resident Experiences and Rotations in Community Health) were placed in clinical rotations designed to promote long term professional commitments to practice in community health settings. In 2006 a new program to reimburse Free Clinics for medical liability insurance premiums was implemented to improve access to health care for vulnerable populations.//2007//

/2008/ In 2006, Primary Care assisted communities to receive federal approval for 50 HPSA designations in Ohio: 20 Primary Care, 25 dental and 5 mental health. Fifty six health care providers were placed through Primary Care recruitment and retention programs and two providers were placed through the new Minority and Appalachian loan repayment initiative funded by the Tobacco settlement Health Priority Trust Fund. Five million dollars from Health Priority Trust and state general revenue funds were distributed to provide medical care for 149,833 uninsured pregnant women and children. //2008// **/2009/ As of July 1, 2008, Health Priority Trust Fund dollars are no longer available.//2009//**

/2009/ The State Office of Rural Health (SORH) and the Primary Care Office received a site visit from HRSA Office of Performance Review in June 2007. The final report included 4 performance measures to increase the number of Rural Health Clinics, track and evaluate technical assistance from SORH to communities, increase the number of mental health shortage area designations and increase the number of mental health providers placed.//2009//

The Primary Care and Rural Health section in the Division of Family and Community Health Services provides CFHS program coordinators information about physicians who are placed in health professional shortage and medically underserved areas (HPSAs, MUAs) of the state via six different physician placement programs. All of these physicians are Medicaid providers and most accept uninsured clients using a sliding fee scale based on 200% FPL.

The Primary Care Section in the Division compiled the Statewide Assessment of Unmet Need (SAUN) to identify areas of the state with the greatest health care needs, disparities and workforce shortages. The analysis looks at health status indicators, the existence and utilization of primary care resources, and over-utilization of non-primary care resources recognized for their relationship to health care access. Resulting county profiles (modeled on the FQHC Need for Assistance criteria) serve as a useful resource tool for communities seeking FQHC and other funding and are posted on the ODH web site.

/2007/ Based on the DFCHS recent analyses of the disparities, contributing factors, and opportunities for improvement in birth outcomes, a Division-wide Birth Outcomes Improvement Initiative (BOII) has been developed. This Initiative is about refining the message of pre/interconception care in DFCHS maternal and child health serving programs. The initiative will

focus on a few really important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to improve birth outcomes. This initiative brings together Ohio's Maternal and Child Health programs, Early Intervention, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies. New approaches include conducting focus groups of women of childbearing age to assess their attitudes toward preconception and interconception interventions; partnering with Ohio Section of the American College of Obstetricians and Gynecologists to develop or modify and implement Preconception/Interconception service protocols; partnering with the Ohio Department of Mental Health to assess the physical and mental health of women during the postpartum period; and adding preconception and interconception content to care coordination and home visiting programs. The BOII will continue to support the 5 A's Prenatal Smoking Cessation Program and the Ohio Partners for Birth Defects Prevention; and advance the use of the Perinatal Data Use Consortium. //2007//

/2008/ In response to CDC's recent guidance about prenatal HIV testing, a collaborative group including representatives from the Ryan White Part B program (formerly Title II program), CDC funded HIV counseling and testing program and MCHBG programs have begun initial discussion to explore issues associated with the option to move Ohio from an "opt-in" to an "opt-out" state for HIV prenatal testing.//2008//

Health Care Delivery Environment: Local Health Departments

There are 136 local health departments in Ohio. Sixty-one of Ohio's 88 counties have one health department. The other 27 counties contain 75 departments, an average of nearly three per county. Ohio is a "home rule" state; the state health department does not have authority over local health departments except through some statutory requirements for environmental health and subsidy. /2008/ There are currently 135 local health departments in Ohio.//2008// **/2009/ There are currently 130 local health departments in Ohio.//2009//**

In 2005 ODH implemented Local Health Department Improvement standards which are available at <http://www.odh.ohio.gov/LHD/PSWstan.pdf> which do not represent an increase in the number of standards pertaining to subsidy, but they do represent a change toward a continuous quality improvement approach taking into consideration Ohio's first Public Health Standards, the current ODH goals, the Core Public Health Functions, and the National Public Health Performance Standards based on the ten Essential Services.

A Performance Standards Work group (PSW) developed Goals, Standards and Measures. There are 6 goals and 25 standards and a compendium of optional public health measures associated with the standards.

The goals are:

- 1) Protect People from Disease and Injury (includes 5 standards)
- 2) Monitor Health Status (includes 3 standards)
- 3) Assure a Safe and Healthy Environment (includes 5 standards)
- 4) Promote Healthy Lifestyles (includes 3 standards)
- 5) Address the Need for Personal Health Services (includes 4 standards)
- 6) Administer the Health District (includes 5 standards)

In order to receive the yearly subsidy payment, each local health departments submits an application reporting on how it meets the Improvement Goals and Standards. The intended goal is a continuous quality improvement approach.

All ODH grants programs must state which of the Local Health District Improvement Goals will be addressed; all applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards.

/2009/ /ODH received a grant for public health performance standards improvement: Lead States in Public Health Accreditation and Quality Improvement: A Multi-State Learning Collaborative. (MLC) is a three year project funded by the Robert Wood Johnson Foundation and managed by NNPHI and the Public Health Leadership Society. NNPHI facilitates the networking and collaborative efforts of sixteen states as they prepare public

health departments for national accreditation and improve public health practice through the use of quality improvement methods The Ohio Voluntary Accreditation Team (OVAT) was established through the work of the MLC-2 grant. This team is comprised of member associations of the Ohio Public Health Partnership, the Ohio Department of Health and representatives from public health professions and state-wide geography. Infrastructure developed because of the MLC-2 grant funds has changed public health discussion in Ohio. Much progress has been made toward the revision of the LHD Improvement Standards and their migration into common state and local health department standards. The LHD Improvement Standards draft has increased from the initial 25 to 37 standards. Standards work was heavily based on other MLC state examples, the Operational Definition of a Functional Local Public Health Agency, and applicability to both state and local public health. //2009//

Other Issues that Impact Health in Ohio

The ODH strategic priorities, described earlier, have been set for each of the last several years based on annual assessments of needs, wants, and resources. With significant reductions in state public health funding combined with potential or proposed cuts in federal funding, this process is producing significant shifts in current and planned funding for maternal and child health. The department decided against across-the-board cuts at the time of earlier reductions, with priority to activities designed to stop disease spread. Over the past five years Title V and other federally funded initiatives have supported efforts to transform funded projects from direct care to other efforts designed to strengthen community resources for treatment, including local needs assessments, linkages with safety net providers, and targeting of health care provider placement programs. The Legislature has proposed a study commission to address the need for a comprehensive long-term funding solution to support treatment services for children with special health care needs.

//2007//The DFCHS has been involved in many aspects of the ODH Disaster Preparedness efforts. Dr. Mark Siegal, chief of DFCHS's Bureau of Oral Health Services, was Planning Team leader for preparation of the Ohio Pandemic Influenza Preparedness Plan. Many other DFCHS staff members participated on teams during pan flu planning including: medical surge, triage and pre-hospital treatment, volunteer and donation management, citizen preparedness, as well as citizen protection/mass care, which continues to meet and to plan for 'Special Populations' in Ohio under the leadership of Dr. James Bryant, Chief, Bureau for Children with Medical Handicaps and Dr. Virginia Haller, DFCHS Medical Adviser. During the ODH ICS response to Hurricanes Katrina and Rita, Jamie Blair, chief of DFCHS's Bureau of Community Health Services and Systems Development (BCHSSD), served as the Operations Chief, and members of the Primary Care Section formed a primary care response team to assist in local planning necessary to receive the anticipated FEMA flights from Louisiana at locations in three Ohio cities. DFCHS staff has also participated on the Public Health Medical Committee, which reports to the Bioterrorism (BT) Steering Committee on Medical Issues. The Division sits on the BT Steering Committee and the chief of BCHSSD has been involved at the Leadership level. DFCHS has a team working on ODH business resumption and disaster preparedness planning to ensure business continuity in the event of a local disaster.//2007//

//2008//DFCHS leadership participates with DOP in Bioterrorism/Pandemic influenza emergency preparation activities. Two division leaders were tapped to complete the Planning Chief complement of the ICS table of organization for Pan Influenza. CDC funds support 1 FTE school nurse consultant in BCHSSD who co-chairs the special population work group with the BCMH bureau chief as part of the ESF#6 Mass Care activities of the agency.

The MCH BG funded School and Adolescent section successfully negotiated for some CDC funding to prepare and distribute the School Emergency Model "To Go" bags to every school (n=5000) in Ohio as one strategy to assure Public Health Preparedness and Security for the school aged population. The School Nursing program also distributed a training DVD about sheltering in place and prepared a pandemic influenza toolkit for schools which will be distributed in early 2007. //2008// ***2009/ The School Nursing Unit's To Go bags were recognized by***

ASTHO last year in their call for abstracts of best practice. In addition, the ODH school nurse bulletin board is an agency #2 priority process for communicating important public health messages to school nurses in communities.//2009//

Economic Issues that Impact Health In Ohio

Ohio Commission to Reform Medicaid

Ohio's budget bill (House Bill 95) called for the creation of the Ohio Commission to Reform Medicaid to evaluate the Medicaid program and make recommendations to Governor Bob Taft, the Speaker of the House, and the Senate President about reform and cost containment initiatives by January, 2005.

The Commission recently completed its tasks and provided recommendations with action steps to reform Medicaid. The commission recommended that Ohio's current Medicaid eligibility standards for low-income families and children, who represent 74 percent of the covered lives, but only 24 percent of costs, should be maintained.

Budget Cuts to CSHCN

The Ohio CSHCN Program (BCMh) had funding partially restored in the State GRF Budget for SFY 06/07. This will enable the BCMh Treatment Program to restore the Financial Eligibility Criteria to its previous level. This has the potential of restoring financial eligibility for many middle income families (\$35,000 to \$55,000). Many of these families have health insurance, but BCMh assists with payment for co-pays, medications, and treatments not covered by their insurance plans. While the BCMh Treatment Program is able to increase eligibility for this population the legislature removed the religious exemption for application to the Medicaid Program. This will largely affect Ohio's large Amish population. BCMh is working closely with the Amish Community and the Children's Hospitals to find ways to address this need.

/2008/ With the partial restoration of funding in the state GRF Budget for the CSHCN Program BCMh was able to increase enrollment in its Treatment Program and many middle income families (\$35,000 to \$55,000/year) were again eligible for the BCMh Treatment Program. The BCMh Program continues to work closely with the Amish Population and the state's children's hospitals to address the needs of that community.//2008//

Other Concerns:

Prenatal care providers, particularly obstetricians, have expressed concerns about rising malpractice rates, and we have heard occasional reports from local grant recipients about difficulties in finding providers. Legislation is pending that would cap damages; another proposal would extend liability protection to those providing free care.

In Ohio, 81 percent of the population lives in metropolitan areas. Pockets of inner city poor and the 19 percent of the population living in rural areas lack access to primary health care services. Access to specialists is often non-existent. Ohio's MCH Block Grant application is focused on assuring that services are available and accessible to women and children. As part of a department-wide strategic plan, the MCH Block Grant will be joining efforts to reduce health disparities and promote access to primary health care services. Activities to assist eligible women and children in the enrollment of expanded Medicaid programs will be supported. Providers will be recruited to become Medicaid providers, especially dentists. Primary prevention activities will be conducted. And, outreach workers will be provided to work within high-risk neighborhoods to identify and assist pregnant women and mothers. There is a concerted effort to integrate priorities identified through the needs assessment with priorities determined by the state agency and collaborative intervention efforts.

/2007/ Ohio will elect a new governor in November 2006. This new governor will lead a state that historically has been fiscally and socially conservative, and will face the challenge of making tax and spending decisions in a state that is changing in its social make up. Ohio's population is aging, and that requires social and health services that are different than in states with increasing birth rates. In addition, social indicators for the MCH population that have not met state goals, such as the high school graduation rate, families in poverty, youths with substance abuse, and families needing child care subsidies help to define and frame the issues that must be considered by a new administration to meet the needs of Ohio's youngest as well as its oldest

citizens.//2007//

/2008/ In November 2006, Ohio elected a new governor, Ted Strickland. Governor Strickland, previously a U.S. Congressman from Ohio, took office on January 8, 2007. The Governor's budget recommendations for State Fiscal Years 2008/2009 reflect the priorities of his plan to Turnaround Ohio: lifelong learning, access to health care, investments in Ohio's strengths, and accountable government. The Executive Budget included the following recommendations that directly or indirectly affect the MCH population and the Title V program:

- 1) Health care access for all children and low income parents, through expansion of Medicaid and the state SCHIP program
- 2) Increased school funding
- 3) Access to high quality early care and education
- 4) Increased funding for the Help Me Grow Program

In addition, the governor proposed to securitize Ohio's tobacco settlement monies. These funds would be used to pay for Ohio's school construction program and provide property tax relief for senior citizens. ***/2009/ In May, 2008, Governor Strickland signed into law a bill that dissolved the Ohio Tobacco Prevention Foundation and diverted \$230 million of its \$270 million endowment to a statewide economic development package. The \$40 million balance was to be transferred to ODH. Also transferred to ODH was the rights, duties and responsibilities of the Ohio Tobacco Prevention Foundation. The new law charges ODH with developing a statewide tobacco use reduction plan for all Ohioans with emphasis on youth, minorities, regional populations, pregnant women, and others who might be disproportionately affected by tobacco use.//2009//***

The budget, as signed by the Governor on June 30, 2007, includes the following items of importance to the MCH and Title V programs:

- 1) Expands Medicaid eligibility for pregnant women from 150 to 200 percent of the Federal Poverty Level.
- 2) Expands Medicaid health insurance access to children in families earning up to 300 percent of the Federal Poverty Level.
- 3) Restores Medicaid to working parents from 90 to 100 percent of the Federal Poverty Level
- 4) Allows parents earning more than 300 percent of the Federal Poverty Level to buy Medicaid if a child has a pre-existing condition or catastrophic illness that makes private insurance too expensive or impossible to obtain.
- 5) Expands Medicaid coverage to those age 18-20 who are released from foster care.
- 6) Establishes a pilot program to train physicians and others in early detection of autism
- 7) Provides nearly \$30 million to expand early childhood education for children ages 3 and 4.
- 8) Makes it easier to qualify for the Early Learning Initiative, which provides preschool funding for low-income parents.
- 9) Adds \$23 million for Help Me Grow so that an additional 6,000 more children can be served.
- 10) Appropriates \$500,000 for Abstinence and Adoption Education. The Director of Health shall develop guidelines for the establishment of abstinence and adoption education programs in the context of comprehensive sex education that is developmentally appropriate for grades K through 12 with the purpose of decreasing unplanned pregnancies and abortion. //2008//

/2009/ The State of Ohio was selected by the national Academy for State Health Policy (NASHP) to participate in the ABCD Screening Academy to improve the statewide use of structured developmental screening and assessment for care for children on Medicaid ages birth through 6.

Governor Strickland created the Executive Medicaid Management Administration (EMMA) by Executive Order 36S in December 2007. Medicaid is one of the largest programs in Ohio in terms of its budget and the number of Ohioans it serves. Because of the scope and magnitude of Ohio's Medicaid Program, responsibility for its administration has been shared by multiple state departments, resulting in fragmentation of Medicaid policies, processes, and accountability. The EMMA is Ohio's solution to this problem, and serves as the central coordinating body for Ohio's

Medicaid program to maximize efficient and effective delivery of health care to Ohioans who rely upon Medicaid services. EMMA consists of all the state agencies with responsibility for Medicaid funded programs or budget responsibility. EMMA coordinates Medicaid policies and functions across agencies; promotes the efficient and effective delivery of Medicaid-funded services; eliminates duplication in Medicaid operations; and protects federal matching funds.

EMMA works in partnership to unify and build consistency in Medicaid policy and harmonize operations across all state agencies. It will not substitute for the operations of agencies with responsibilities for, and closest to, specific constituencies such as the aged, those with disabilities, mental illness or problems with substance abuse. As such, EMMA will focus on issues that impact multiple agencies

B. Agency Capacity

The State of Ohio has the capacity to provide comprehensive quality care to pregnant women/mothers/ infants/children/adolescents/children with special health care needs (CSHCN), as well as women/men in need of reproductive health care through services administered in the Ohio Department of Health (ODH). ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCH BG) and has established the Division of Family and Community Health Services (DFCHS) for this purpose and for the purpose of ensuring the provision of MCH programs at the state/local level.

DFCHS is also responsible for implementation of the following state statutes that impact the Title V program: 1) Birth Defects Information System (BDIS): authorizes identification of children with birth defects; ensures they are linked with medical/support services; educates Ohioans on prevention; 2) Child Fatality Review (CFR): establishes a CFR board in each county; establishes rules/procedures for CFR: maintaining a comprehensive database, materials, and training to members of CFR boards; prepare/ publish annually a report organizing and setting forth the data; recommend any changes to law/policy that might prevent future deaths; 3) Lead Poisoning: requires that each child at risk of lead poisoning undergo a blood lead test in accordance with guidelines established by the CDC. In the event that a child is identified with lead poisoning, the source of the lead must be identified/abated; 4) Save Our Sight Program: created public donation supported children's vision conservation program to ensure that children in Ohio have good vision/ healthy eyes; 5) Sudden Infant Death Program: requires the reporting of sudden unexpected deaths of children under the age of two, and the provision of counseling/supportive services; 6) Universal Newborn Hearing Screening: requires that every newborn receive a physiologic hearing screening prior to hospital discharge; 7) Vision/Hearing Screening: requires ODH to establish methods/procedures for school hearing/vision screening; allows for screening data collection; 8) Women's Health Services (WHS) Program: established to improve the health and well-being of women, infants, children and families by assuring health care access for a vulnerable population of low-income women. **/2009/ 9) Shaken Baby Syndrome Education Program became law 11/07. Requires ODH to develop and disseminate educational materials; evaluate program effectiveness; report number of SBS child abuse cases (ODJFS);. 10) College Pregnancy/Parenting Offices Pilot Program became law with SFY08/09 biennial budget. This grant program provides funding to 4 institutions of higher learning to establish offices to improve health/well-being of women/infants/ children/families by providing support to pregnant college students or parents/legal guardians of one/more minors./2009//**

PROGRAM CAPACITY

The following is a description of preventive/primary health care services for reproductive age women/ men/pregnant women/mothers/infants/children/adolescents/and CSHCN provided through Ohio's Title V agency. Since bureaus within DFCHS are responsible for administering most of these MCH-related programs, close coordination with non-MCH BG programs occurs. DFCHS has approximately 60 different funding sources supporting its many public health service programs.

Child and Family Health Services Program (CFHS): ODH Title V administers a number of programs to improve the health status of reproductive age/pregnant women/infants/children/CSHCN including direct care/enabling/population-based/infrastructure services. CFHS is a community based program that uses a combination of federal/state/local monies to provide public health programs/services, including safety net clinical services to low-income un/underinsured families/children in Ohio. The program is designed to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants/ children. Currently 79 agencies in 80 counties (local health departments/hospitals/community action agencies/other nonprofit agencies) hold CFHS grants. There are 5 components in the CFHS Program: Community Health Assessment (required); Child Health; Family Planning; Prenatal Health; OIMRI. The maximum funding a county can apply for is determined by a formula similar to the one used to allocate funds for the MCH BG. The Ohio MCH BG process will be used to narrow the focus of the CFHS areas of investment. Applicant agencies are limited to strategies that address the MCH BG priority topics. Applicant agencies must develop strategies based on best practices research with clear, measurable benchmarks for each strategy. CFHS projects have been asked to re-evaluate their need to provide direct care services. DFCHS collaborated with the OSU School of Public Health and the National Association of City/County Health Officials to provide regional strategic decision making process workshops for CFHS projects. /2007/ 73 agencies in 74 counties hold CFHS grants. /2007// /2008/72 agencies in 73 counties hold CFHS grants. DFCHS collaborated with OSU School of Public Health to provide intensive TA for CHA and the strategic decision making process in 19 counties. /2008// **/2009/72 agencies in 73 counties hold CFHS grants. CFHS expanded use of the IPHIS data system to include all CFHS perinatal care providers. /2009//**

Preconceptional and Interconceptional Health Services

Family Planning (FP): Ohio Title V has 2 programs that address the improvement of preconceptional/interconceptional health at the direct service/enabling/population levels. The first is FP. The ODH FP Program uses a combination of federal (Title X and Title V), state/local monies to offer women's health services including contraceptive/gynecologic health care; breast/cervical cancer screening; STDs, including HIV/AIDS information, screening/treatment; and other health screenings (e.g., hypertension/smoking/health risk behaviors). The FP projects also provide community education/infertility information. The goal of the FP program is to improve the health/well-being of women, infants, children/families by assuring health care access for a vulnerable population of low-income women. Programs are focused on clients who are at the greatest risk for poor health outcomes. /2007/13 agencies in 12 counties are providing CFHS (Title V) FP direct care services. /2007// /2008/ 45 agencies in 63 counties provide ODH FP direct care services. /2008// **/2009/Program was awarded funds in 2008 to provide integration of HIV/AIDS Testing/Prevention Services; collaborates with the ODH STD/HIV program to provide HIV/AIDS testing in FP programs. 42 agencies in 50 sites in 53 counties provide ODH FP direct care services; 13 agencies in 12 counties provide CFHS (Title V) FP direct care. /2009//**

Women's Health Services Program (WHSP): The second program that addresses preconceptional/ interconceptional health is the WHSP, established by state law in 2003, and funded with dollars formerly utilized by FP delegate agencies that received federal Title X FP funds. Services program are limited to: pelvic exams/lab testing; breast exams/patient education on breast cancer; screening for cervical cancer; screening/treatment for STDs; HIV screening; voluntary choice of contraception, including abstinence/natural family planning; patient education/pre-pregnancy counseling on the dangers of smoking/alcohol/drug use during pregnancy; education on sexual coercion/violence in relationships; and prenatal care/referral for prenatal care. Priority services are clients who have incomes at or below 100% of the FPL and who are un/underinsured. Consideration for funding was given to provision of services in underserved areas or expansion of existing programs to achieve a balance of services/address health disparities. 20 local health departments were funded in CY2004 to provide services with these funds; 9 programs were funded to local health departments that had not previously provided this range of services. 3 of the funded agencies new to these services are located in

urban areas and are serving a disparate population of low-income, African-American clients. Other programs used to improve preconceptional health are described in the CSHCN section on genetics. /2007/22 local health departments are funded to provide WHS.//2007// //2008/21 local health departments are funded to provide WHS //2008//

Services to Promote Improved Pregnancy Outcomes

Child and Family Health Services Program (CFHS):The prenatal health component of the CFHS program (described above) provides direct/enabling/population/infrastructure services to low income un/underinsured pregnant women.

Ohio Infant Mortality Reduction Initiative Program (OIMRI): OIMRI is an enabling service that will be incorporated into the CFHS program for FY2006. Currently the program funds 12 OIMRI projects that target those census tracts or neighborhoods with high-risk, low-income pregnant women for 1st trimester prenatal care. The OIMRI Program utilizes the community care coordination model to empower communities to eliminate disparities. The community care coordination model supports employing individuals from the community as trained advocates (Community Care Coordinators {CCC}) who empower individuals to access resources. The services focus on achieving success in health/education/ self-sufficiency. The CCC makes home visits on a regular basis during pregnancy and through the baby's 2nd year of life; identifies/reinforces risk reduction behaviors; collaborates with other agencies in making appropriate referrals when necessary to assure positive pregnancy/infant health outcomes. While Ohio has a safety net system of health care for un/underinsured and Medicaid consumers, significant barriers to pregnant women/children accessing those services remain. The OIMRI Program addresses the barriers (e.g., financial/geographic/cultural) that women/children experience and improves their access to/utilization of health care./2007//As of 2006, OIMRI is not a separate program but a component of the CFHS Program. There are now 13 funded OIMRI components.//2007// /2008/ The focus of OIMRI changed in 2006 to address disparity in infant mortality in Ohio's African American community. //2008// **/2009/Ohio began a data needs assessment for OIMRI.//2009//**

Prenatal Smoking Cessation Services Program (PSCP): PSCP was created in response to the high rates of smoking among pregnant women in Ohio and is a partnership with the March of Dimes; American Cancer Society; the Smoke-Free Families National Dissemination Office; and ACOG. As an infrastructure service, PSCP has provided training to more than 500 prenatal care providers on an evidence-based intervention, the "5 A's" (Ask/Advise/Assess/Assist/Arrange). PSCP is focusing its efforts to design/build client/provider systems necessary to support both prenatal care providers and pregnant/postpartum women to make changes which are critical to reducing smoking rates. WIC and HMG will provide PSCP access to their existing system/services/materials for prenatal/postpartum tobacco treatment. /2007/ The Client/Systems Level Tobacco Treatment project is being piloted in 4 counties. See Section IV C, NPM 15, for a discussion of this project and other prenatal smoking cessation activities.//2007//**/2009/ PSCP expanded the Ohio Partners for Smoke-Free Families 5 A's evidence-based systems approach for treating tobacco use/dependence in the WIC system (60 projects).//2009//**

Regional Perinatal Services Program (RPC): Since 1977, Ohio has been divided into 6 perinatal regions based on the adoption of the State Perinatal Guidelines in response to the national recommendations outlined in Toward Improving the Outcome of Pregnancy I. ODH determined that at least 1 entity would be available within each region to serve as a hub for the RPC Program. This population based RPC Program is designed to promote access to evidence-based/risk-appropriate perinatal care to women/their infants through regional activities with the goal of reducing perinatal mortality/morbidity. Since 2002 the program has been in the process of moving from outreach education toward data driven performance monitoring/quality improvement. The program is using the perinatal Data Use Consortium approach (based on CityMatCH and CDC) to engage health professionals from medicine/public health into a regional team to advance data-driven projects/activities. All maternity/newborn care hospitals/local health departments/other public health entities are assisted by the RPC program. /2007/ Corrected:

Regional Perinatal Centers (RPC) Program; not Regional Perinatal Services Program.//2007//
/2009/ODH has an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative. Most of this support will be provided by RPC programs facilitating local access for quality initiatives./2009//

/2007/ See Section A: Overview, for a discussion of the Birth Outcomes Improvement Initiative, a DFCHS-wide initiative that will focus on evidence-based strategies to improve birth outcomes.
/2007//2009/ODH and ODADAS entered into an interagency agreement to provide a 3 day Women's Wellness Symposium in May 2008 addressing improvement of the health of women over the lifespan. //2009//

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): The DFCHS Bureau of Nutrition Services (BNS) administers the Ohio WIC program and the Farmers Market Nutrition Program. WIC is 100 percent federally funded through the U. S. Department of Agriculture. BNS administers the WIC program through 75 local agencies with 230 clinics throughout Ohio's 88 counties. Ohio is among the 10 largest WIC programs in the U.S. and one of the largest in the Midwest. The Ohio WIC program provides highly nutritious foods, nutrition/breastfeeding education/support/immunization screening/ health care referral through local agencies to eligible individuals. The WIC program coordinates with BCFHS for smoking cessation/lead prevention awareness.

Help Me Grow (HMG: DFCHS Bureau of Early Intervention Services (BEIS) administers a birth to 3 program serving pregnant women/newborns/infants/toddlers/their families. HMG includes enabling/ population based services including home visits to pregnant women/first time/teen moms/infants/toddlers at risk for/with DD/disabilities. See further description of HMG below.

Services for Infants/Young Children

Child and Family Health Services Program (CFHS):The child health services component of the CFHS program (described above) provides direct/enabling/population/infrastructure services to low income un/underinsured infants/children.

Help Me Grow (HMG):BEIS administers programs to promote early identification/intervention services for young children. Most of the programs are funded through sources other than the MCH BG, such as state General Revenue Funds, U.S. Department of Education, TANF. and other federal grants from U.S. DHHS. ODH is lead agency for Ohio's Part C Early Intervention Program, which has been integrated into a larger initiative called the HMG Program which includes services for at-risk families with infants/toddlers/ newborn visitation program. HMG will continue to provide important information on prenatal/infant care/development/positive parenting/safety/abuse prevention. In SFY 2004, HMG program visited over 31,000 newborns/their families; and provided supports/services to over 34,000 infants/toddlers at-risk for/with developmental disabilities./2008/In SFY 2006, the HMG program visited over 33,000 newborns/their families; and provided supports/services to over 21,000 infants/toddlers at-risk for/with developmental disabilities./2008//

Healthy Child Care Ohio (HCCO):BEIS also administers the HCCO project in partnership with the Ohio Child Care Resource and Referral Association. Registered nurses provide health/safety consultation/ training to child care providers, screen pre-school children for vision problems, and work in partnership with the Bureau of Child Care and Development at the ODJFS as a resource to child care providers as they implement quality improvement activities to achieve a higher ranking in a newly created tiered rating system for child care providers.

Universal Newborn Hearing Screening/Infant Hearing Program: In July 2004, the birthing hospitals in Ohio began screening all newborns for hearing loss prior to hospital discharge. Each newborn is screened using a physiologic test; results are reported to the parents/newborn's primary care provider. Babies who do not pass the 2-part screen are referred to the regional infant hearing program (9 regional projects) for follow-up/referral to the HMG program if a hearing loss is confirmed. Ohio anticipates that about 400-500 infants with hearing loss will be identified each year.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): WIC provides the enabling services of nutritional help during critical times of growth/development to prevent health problems and improve the health status of eligible individuals. WIC takes the lead in DFCHS in promoting breastfeeding. WIC has partnered with ODE and Ohio Head Start to distribute 2,000 Ohio WIC Healthy Heroes videos to promote child wellness. The videos provide 5 messages on healthy eating/oral health/ safety/physical activity. WIC also has implemented the WIC Healthy Children Ready to Read Initiative: To facilitate/encourage reading readiness among WIC children while teaching children about good nutrition, 30,000 "Give Me 5 a Day" books are being distributed. /2008/Healthy Heroes has been discontinued.//2008//

Oral Health Services: The DFCHS Bureau of Oral Health Services (BOHS) provides population/ infrastructure activities to improve the oral health of young children. BOHS provided leadership to the development of a statewide Head Start Oral Health Strategic Plan. BOHS collaborated with the Ohio Head Start Association and others on this project and continues to convene/support a steering committee focused on implementing the plan. BOHS has 3 separate contracts with local agencies/organizations to develop models for Head Start oral health TA and for increasing the number of primary care dentists willing to treat Head Start children. BOHS has contracts with 2 universities to train safety net dental clinic staff on providing dental care for young children and training home visitors on oral health needs and establishing linkages to dental homes for young children. The latter pilot program is called "Help Me Smile." It interfaces with the HMG program/WIC clinics/Community Health Care Worker programs. The purpose of the project is to train home visitors, WIC health professionals/others who work with families of very young children. /2007/ BOHS has a contract with Columbus Children's Hospital to train safety net dental clinic staff on providing dental care for young children in their clinics. BOHS is working with home visiting programs for very young children to integrate oral health into existing home visiting/service coordination systems. The training for implementing oral health assessment, anticipatory guidance/referrals for children ages 0- 3 was developed/pilot tested in 2005 and will be conducted for these home visiting systems in 2006. A training program for physicians who will conduct oral assessments, provide anticipatory guidance and apply preventive fluoride varnish to the teeth of 0-2 year-olds under new Ohio Medicaid rules was developed and piloted and will be conducted in 2006/2007.//2007// /2008/See attached Oral Health Access report.//2008//

Ohio Childhood Lead Poisoning Prevention Program (OCLPPP): The CDC-supported OCLPPP is a comprehensive population based lead poisoning prevention program. OCLPPP is the collection point for all blood lead (BL) analysis performed on Ohio residents. The data are reported weekly in an electronic format and either held in this program or forwarded to the ABLES program (Surveillance). The OCLPPP is required by statute to complete public health lead investigations on all children in its jurisdiction who have a confirmed BL level of 10 mcg/dl of whole blood or greater. The OCLPPP provides lead poisoning prevention education to medical and public health providers through the Pediatric Lead Assessment Network Education Training program.

//2008//The OCLPPP funds its 4 Regional Resource Centers by using Title V funds for TA to local providers/families on the importance of screening/public awareness/maintenance of local collaboratives to prevent lead poisoning of children. The OCLPPP funds 5 local jurisdictions to facilitate comprehensive Childhood Lead Programs in their local communities. //2008//

Sudden Infant Death Program (SID): The SID Program supports population based activities that assure compliance with an Ohio statute related to reporting of SID and the provision of support/bereavement services. Through a grant, ODH partners with the SID Network of Ohio to be the state's agent for the SID program. The SID Network is responsible for receiving from coroners the Notification of Infant Death. The SID Network notifies the local health district; mails a packet of SID information/bereavement resources to the family; notifies the local network support affiliate; provides training to public health nurses on making a home visit to families; and serves as a resource for SID/risk reduction information for local health departments/other agencies/individuals. Since 2002 the SID Network of Ohio has implemented a community-based African American outreach campaign to reduce the risk of SID in the minority population.

/2008//An evaluation of the SID Program was conducted in 2006-07.//2008//**2009/Per the 2007 evaluation, the SID Risk Reduction component was removed from the competitive grant.//2009//**

Save Our Sight Program (SOS): The population based SOS Program is a state statute to ensure that children in Ohio have good vision/healthy eyes. The SOS Fund was created with the purpose of providing funding, technical assistance/support to 501(c) organizations delivering children's vision services in all Ohio counties. The funds are generated by voluntary contributions by citizens of Ohio registering their motor vehicle and/or renewing their license plate(s) and are administered by ODH. These funds support organizations to provide training/certification/equipment for voluntary children's vision screeners; provide protective eyewear for youth sports/school activities; develop/provide eye health/safety programs in schools; implement an Amblyope Registry. ***/2009/Competitive grant application in SFY 2009 was streamlined to match Ohio Revised Code with emphasis on importance of ongoing evaluation, measuring impact of current SOS eye health/safety programs in Ohio, and strengthening outcome measures/reporting requirements. //2009//***

Services for School-Aged Children/Adolescents

Child and Family Health Services Program (CFHS): The child health services component of the CFHS program (described above) provides direct/enabling/population/infrastructure services to low income un/underinsured children/adolescents.

Save Our Sight Program (SOS): See description above.

School Nursing (SN) Consultation: DFCHS SN consultants provide infrastructure services: consultation/ TA/continuing education for SN. The SN consultants provide assistance to the ODE on accreditation requirements for SN and offer direction for state policies related to the SN care of CSHCN. Various TA documents/guidelines have been created for SN issues to assist in developing standards for school screenings, delegation of medication, management of school health records and management of chronic illness of school students. Regional trainings to all SN in Ohio are provided on topics such as HIPPA, Bioterrorism, SARS/current school based mental health programs. Additional TA/training is delivered to SN through the development of web based continuing education modules. ODH "Guidelines on BMI for Age" were developed to help local health departments/schools collect this information accurately. DFCHS collaborated with ODH Homeland Security Program and received funds to develop school based training for emergency preparedness in schools. ***/2009/ The 2006 SN Survey results are published at <http://www.odh.ohio.gov/odhPrograms/chss/schnurs/schnurs1.aspx> and indicate that 1 FTE RN SN to student ratio in Ohio public schools is 1:1396. The ratio recommended in HP 2010 and by the National Association of SN is 1:750. SN participated in a table top exercise for school closure as a community mediation strategy in response to pandemic flu. SN unit developed a CD for SN about MRSA. //2009//***

Adolescent Health Programs (AHP): DFCHS provides population-based/infrastructure services to improve the health of adolescents through its AHP. A statewide adolescent health advisory committee comprised of physicians/university personnel/adolescent wellness coordinators/interested parents/teens help to direct the program efforts of the adolescent program. The adolescent health coordinator develops TA materials for local health departments/funded grantees who work with adolescents. Regional trainings for local health care providers on adolescent development is an ongoing training program. Other efforts include training health care staff in identifying mental health resources for referral/treatment of adolescents who present with depression/anxiety disorders.

In an effort to improve health of the school aged child, the DFCHS School/Adolescent Health (SAH) program, in collaboration with the ODH Division of Prevention developed the Healthy Ohioan's-Governor's Buckeye Best (BB) Healthy School Awards Program which recognizes schools whose programs/policies reflect a high priority on nutrition/physical activity/tobacco education programs. The BB program assists local schools in assessing their school environment and provides TA to schools to improve the health of the students/staff. Programs focus on improving school nutrition, adding more physical activity and tobacco education. The AHP coordinates implementation of the YRBS in Ohio. In collaboration with the DFCHS Research/Evaluation Section, the AHP developed a report entitled "The Health of Ohio's

Adolescents, 21 Critical Indicators". This report, framed after the national adolescent health initiative, presents Ohio/national data on the 21 critical indicators identified by the nation's adolescent health experts that critically impact the health of adolescents. /2007/ More than 900 schools participated in the BB program in 2005. Baseline BMI data for 3rd grade students in Ohio was collected. Ohio collected weighted YRBS data in 2005. Over 200 SN attended 4 new Emergency Preparedness Trainings in 2005. The SN unit placed more than 2000 AEDs in schools. SN consultants worked with schools on issues related to mandatory reporting of Varicella in schools and other legislative issues (e.g. epipens in schools) that impact health/safety of students. //2007// /2008/A report of the 2004/5 state/local BMI survey of Ohio's 3rd graders, which indicated that 18.9 percent are overweight and 16.7 percent are at risk for overweight, was distributed; the annual BMI sentinel survey is underway. The 2005 YRBS Executive Summary was completed/distributed; data collection for the 2007 YRBS was expanded to provide data by county/race. An additional 2000 AEDs were placed in schools. >1900 schools participated in the Buckeye Best program; \$400,000 in stipends were distributed to 750 schools to help schools support wellness policies. About 600 SN attended regional continuing education conferences hosted by the SN program; 400 school nurses attended emergency preparedness pre-conferences focused on pandemic influenza education; 100 SN were trained through the AAP Pediatric Education for Pre-hospital Professionals curriculum for first responders. The SN Program developed a PowerPoint presentation for SN to train school personnel about bloodborne pathogens and distributed copies of the NASN manual "Occupational Exposure to Bloodborne Pathogens: Implementing OSHA Standards in a School Setting to about 1000 SN. The state Adolescent Health Coordinator developed a Youth Speakers Bureau in partnership with other agencies to address teen suicide prevention/bullying prevention/mental health issues.//2008// /2009/ **Abstinence Only Education program was moved to DFCHS in BCHSSD and now has a more comprehensive/developmentally focused approach which includes Abstinence/Adoption education. SAH received CDC funding for YRBS, HIV education and Coordinated School Health. SAH Section Administrator is chair of CDC's National Association of Chronic Disease Directors- School Health Council. SAH oversees the 7th grade BMI surveillance, physical activity/nutrition grant application activity. //2009//**

Services for Children with Special Health Care Needs

Overview of Title V CSHCN Program: The Bureau for Children with Medical Handicaps (BCMh) has 5 programs that provide direct/enabling/population based/infrastructure services to CSHCN. 1) The Diagnostic Program serves children from birth to 21 to rule out a medically handicapping condition, to diagnose a condition, and to develop a plan of treatment for the child. There is no financial eligibility for this program; 2) The Treatment Program provides ongoing treatment services for eligible children. It serves children from birth to the age of 21 who have a chronic medically handicapping condition for which there is a medical treatment. Families must also meet the financial eligibility for this program; 3) The Hospital Based Service Coordination (SC) Program supports team based service coordination for conditions such as Spina Bifida/Hemophilia. There is no financial eligibility test for this program. The purpose of the program is to link families to services in the tertiary center and to link them back to their community; 4) Community Based SC Program supports Public Health Nurses in the Local Health Departments who assist families in linking to local resources and help families navigate the complex health care system; 5) Medical Home for CSHCN Program supports the efforts of local physicians to be Medical Homes for CSHCN. This is accomplished by reimbursing for care coordination codes/supporting office based SC. The Title V CSHCN Program also houses 4 genetics programs.

The Title V CSHCN program is continuing to face the challenge of decreasing funding/increasing need. Ohio is now in its Biennium Budget process, the legislature may make changes to the program through the budget process. In the past year the program has increased its commitment to SC by supporting SC for children with sickle cell anemia and for young adults transitioning from pediatric to adult health care systems. The program is supporting the medical home for all children, especially CSHCN. The Title V program continues to closely network with the Medicaid and Early Intervention programs. BCMh and the Bureau for Managed Health Care co-sponsored 6 regional meetings with emphasis on Transition Issues, Medical Home, and CSHCN Survey

results. The Title V program for CSHCN is implementing a new electronic medical record system which will aid greatly in the matching of CSHCN with services. /2007/ The Ohio Legislature formed a Funding Commission to look at future funding for the Title V CSHCN Program. The Commission will report back to the Legislature and Governor by 12/31/2006. Ohio is implementing statewide Medicaid Managed Care; the Title V Program is working closely with Medicaid and EI programs in the implementation of the system for CSHCN.//2007// /2008/ The Title V CSHCN program has achieved stable funding in the current recommendations for the Biennium Budget and has increased enrollment of children. With stable funding the BCMH will be considering revisions/additions to its program as recommended by the Legislative Funding Commission.

The collaboration between the Part C/HMG (0 to 3) Program and the BCMH program is increasing the number of children identified with special needs and getting them into services earlier. The Title V Program continues to work closely with Ohio Medicaid and is facing new challenges with the conversion to Managed Health Care in Ohio.//2008// **/2009/ Title V CSHCN program expanded role of parent participation in all programs; supports role of parents in the medical home. Title V CSHCN program is involved in statewide planning for developmental/autism screening; is an active partner with the Ohio Autism Interagency Workgroup.//2009//**

Genetic Services (GS) Program: ODH provides funding to 8 Regional Comprehensive Genetic Centers (RCGC) to ensure/enhance the accessibility/availability of quality, comprehensive GS to all Ohioans. Services include genetic counseling/education/diagnosis/treatment for individuals of all ages. The GS Program is striving to integrate genetics in public health programs through activities conducted through the ODH grants each year. Currently RCGCs focus activities on educating primary care providers about newborn screening and working with local cancer centers/chapters of the American Cancer Society. /2007/ The Genetics Program is working with ODH Cardiovascular Health Programs; promoting the US Surgeon General's Family History Tool; and Ohio's BDIS. //2007// **//2009// Due to a hospital closing, ODH provides funding to 7 RCGC. Priority areas for funded projects for 2008-2009 include education of health professionals about birth defects (BD); how women can reduce their risk of having a baby with a BD; collaborating on hereditary cancer education, clinical services/research projects; collaborating with ODH cardiovascular health project on family history/CVH risk factors; working with children with BD; and assisting in the validation of BD diagnoses reported to the surveillance system. //2009//**

Sickle Cell (SC) Services Program: ODH funds 2 SC initiatives: Regional SC Services Projects (RSCSP) and Statewide SC Family Support Initiative SSCFSI). ODH funds 6 RSCSP throughout the state to ensure/enhance the availability/accessibility of quality, comprehensive services for newborns/children/ adults with/at risk for SC disease, SC trait and related hemoglobin disorders in Ohio. Services include newborn hemoglobin screening follow-up; hemoglobin counseling; outreach education; adolescent to adult care transition; referral services for diagnosis, treatment and management. ODH funds 1 SSCFSI to support statewide family education/training programs; patient/client advocacy; supportive interventions; referral services; and public awareness/media campaigns. Projects provided services to residents of 73 of Ohio's 88 counties. /2007/ Projects provided services to residents of nearly all of Ohio's 88 counties. //2007// **//2009/ODH SC grant funded projects promote minority blood donation and the matching of phenotypically matched blood for SC patients needing transfusions. Ohio has the largest number of phenotypically matched SC patients in the country.//2009//**

Metabolic Formula (MF) Program: ODH provides MF to individuals of all ages in Ohio with phenylketonuria/homocystinuria who are under the care of an approved metabolic specialist. ODH provides MF to approximately 260 individuals each year. MF is very expensive and many pharmacies will not order it for patients who need it. In addition, less than 25 percent of insurance plans in Ohio will cover MF. **/2009/ In January 2008, the MF Program began providing formula to infants with other metabolic disorders such as maple syrup urine disease, propionic academia and tyrosinemia. Program staff efforts to recoup third party**

reimbursement for MF has enabled this expansion to take place. //2009//

Birth Defects (BD) Information System (BDIS): Ohio has legislation authorizing the ODH to develop/implement a BDIS. With the award of CDC funding in 2003, plans for development of the system began. In Ohio, the BDIS is named the Ohio Connections for Children with Special Needs. Administrative rules were approved and a data collection pilot project will take place in 2005. The goal of the project is to design/implement a system for reporting children 0-5 years with identified BD and make referrals to services for the families to ensure they are aware of services available that may improve their child's quality of life or outcome. There is a partnership agreement between ODH and the March of Dimes (MOD) to reduce the burden of BD in Ohio./2007/ Administrative rules have been approved; implementation of a data collection pilot project will take place in 4 counties in 2006 representing 17% of Ohio's births. External partners participate on an advisory council/prevention committee, Ohio Partners for BD Prevention. A partnership agreement between ODH and the MOD exists to reduce the burden of BD in Ohio./2007// ***//2009/ In 9/2007, all hospitals in the state were mandated to report children with BD to ODH. In 4/2008, a 5-county pilot to test the referral mechanism was implemented. Early results are positive/promising and show local collaboration between Help Me Grow (early intervention), local health departments, and BCMH (Title V CSHCN). In addition, 2 prevention education documents were developed: a BD Causes and Prevention Strategies Handbook for health professionals; and a Healthy Steps bookmark that gives women's health tips for those desiring to become pregnant, and those not interested in getting pregnant. Ohio was nominated for a national BD prevention education award from CDC for these resources.//2009//***

Specialty Medical Services Program (SMSP): The SMSP provides clinical services for children in 52 counties in Ohio. The 5 types of clinics, Developmental, Hearing, Neurology, Orthopedic and Vision, improve access for low-income children to pediatric specialists in medically underserved areas. Both diagnosis/treatment services are provided through these itinerant clinics. These "safety net" clinics supplement the private practice system in providing access points for patients. The clinical services are provided through a contractual arrangement with providers and ODH. The itinerant clinics are based primarily in local health departments through a contractual agreement. Local Public Health Nurses assist families in applying for Medicaid and BCMH and help families make follow-up appointments for other testing/surgery. The majority of the clinics are provided in Rural-Appalachian counties located in the SEheastern region of the state due to lack of specialty providers./2007/ The SMSP provides clinical services for children in 43 counties in Ohio through 4 types of clinics: Hearing, Neurology, Orthopedic and Vision (Developmental is deleted). The program has recently restored cardiology services in SE Ohio through a partnership with Cincinnati Children's Hospital and a local health department, offering services without providing financial support to clinic operations./2007// ***//2009/ Almost 5,000 individual children and 6,000 visits to clinics 7/05-- 6/06 (2006-2007data not analyzed). //2009//***

Other Infrastructure Activities.

Data Collection/Analysis: See Section F: HSCIs 09A/B.

Capacity to Provide Culturally Competent Care for Ohio's MCH Population: All CFHS, WHS, FP, and OIMRI grantees must complete the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards self-assessment tool, based on the 14 national CLAS standards. See Section IV D: SPM 04, for DFCHS plans to improve culturally competent care. //2007// //2008//All ODH staff administering MCH grants continue to be offered trainings to improve their ability to provide cultural competency TA./2008//

C. Organizational Structure

The Ohio Department of Health (ODH) is designated as the State agency responsible for administration of the Title V Maternal and Child Health Block Grant (MCH BG).

ODH Director J. Nick Baird, M.D. is one of 26 directors or appointees who serve at the pleasure of Governor Bob Taft. Governor Taft is currently in the 3rd year of his 2nd term as Governor of Ohio. Dr. Baird, an OB/GYN who has been with the ODH since 1999, has extensive experience working as an administrator within a large health care system./2007/Governor Taft is currently in the 4th and final year of his 2nd term as Governor of Ohio. A new governor will be elected in the general election in November//2007//

/2008/Effective 4/1/07 Alvin D. Jackson, M.D., replaced J. Nick Baird, M.D., ODH Director. Dr. Jackson is a Family Physician, and most recently was Medical Director of Community Health Services, a neighborhood clinic in Fremont, Ohio. In November 2006, Ohio elected a new governor, Ted Strickland. Governor Strickland, previously a U.S. Congressman from Ohio, took office on 1/8/07.//2008//

ODH is organized by function with nearly all programs housed within 3 divisions (Organizational charts for ODH and for each Division can be found at: <http://odhorgchart.odh.ohio.gov/OPE/WebApp/Modules/Chart/Chart.aspx>. Organizational charts for the ODH and for the Division of Family and Community Health Services (DFCHS), which administers the MCH BG, are attached to this document.) All 3 divisions within ODH are under the supervision of Anne Harnish, the Assistant Director of Health who has in the past worked with the administration of the MCH BG, served as Chief of the Bureau of WIC and as an advocate with the Ohio Office of the Children's Defense Fund./2009/Anne Harnish left ODH 7/07. **The new Assistant Director for ODH programs is Michele Shipp, MD, MPH, DrPH Dr. Shipp started at ODH 4/08. Prior to joining ODH, Dr. Shipp was Research Assistant Professor, Division of Health Behavior and Health Promotion in the Ohio State University College of Public Health. The current organizational chart for the Title V program (DFCHS) is attached.//2009//**

Nearly all Title V MCH BG funded programs and positions (including the state's CSHCN Program) are under the supervision of the Ohio Title V Director, David P. Schor, MD, MPH, FAAP, Chief of DFCHS. Some Title V MCH BG dollars are transferred to the Division of Prevention, one of the other 2 divisions within ODH, for administration of the Women's Health Program. The Abstinence Only Education Program is administered in the ODH Director's office./2007/Dr. Schor left ODH in February 2006. Karen Hughes, MPH, the former Chief of the Bureau of Child and Family Health Services, has been appointed Chief of the DFCHS.//2007///2008/The Abstinence Only Education Program is administered by DFCHS,//2008//

Dr. Schor directs the work of the following 7 bureaus in DFCHS: Bureau of Child and Family Health Services (BCFHS), Bureau for Children with Medical Handicaps (BCMh), Bureau of Community Health Services and Systems Development (BCHSSD), Bureau of Early Intervention Services (BEIS), Bureau of Health Services Information and Operational Support (BHSIOS), Bureau of Nutrition Services (BNS), and Bureau of Oral Health Services (BOHS)./2007/As of 2/2006, Karen Hughes directs the work of the 7 bureaus in DFCHS.//2007//
Dr. Schor is assisted by a Medical Advisor, Virginia Haller, M.D. Dr. Haller is a pediatrician and formulates medical policy as advisor to the DFCHS Chief, and represents DFCHS and ODH on issues related to family/community services. She lectures on pediatric/public health topics, serves as DFCHS liaison with ODH Prevention Injury Program and ODH liaison to the state Trauma Committee, and coordinates medical resident/student rotations./2007/ Dr. Haller continues as Medical Advisor to DFCHS, and as assistant to Karen Hughes, Chief of DFCHS. //2007// /2008/ The ODH Medical Advisor is now the ODH Medical Director.//2008// **/2009/ Dr. Haller is now DFCHS Medical Advisor.//2009//**

Bureaus in the DFCHS

BCFHS is responsible for administering the following programs: Title X Family Planning (FP);

Women's Health Services Program, Child and Family Health Services (FP, perinatal, well child services, and infant mortality reduction); lead poisoning prevention; prenatal tobacco cessation; pediatric specialty services; Regional Perinatal Centers; Save Our Sight Vision Programs; vision/hearing screening programs; Child Fatality Review; and Sudden Infant Death Program. /2008/Title X FP Program is now ODH FP Program.//2008// **/2009/In FFY08, BCFHS received funds through US EPA for a program to provide risk assessment screening services to women of reproductive age. Programs/Initiatives added to BCFHS include: Shaken Baby Syndrome Education Program, College Pregnancy & Parenting Offices Pilot Program, Neonatal Outcomes Improvement Project (collaboration with ODJFS, OPQC, and RPCs). //2009//**

/2007/The Birth Outcomes Improvement Initiative, as discussed in Section B, was implemented in 2005. Jo Bouchard, MPH, former Assistant Bureau Chief, was named Acting Chief of BCFHS.//2007//

BCFHS has a contract with Cynthia Shellhaas, M.D., MPH to provide medical consultation to bureau program areas serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN.

BCHSSD administers programs designed to improve access to health care services for vulnerable populations. Primary Care/Rural Health Program (PC/RH) provides funding for primary care services for uninsured populations of children/pregnant women, places health care providers via 7 placement programs in underserved areas, submits Health Professional Shortage designation applications for primary care/mental/dental health underserved areas of Ohio, provides funds to support rural hospitals to achieve Critical Access designation and provides 30 small rural hospitals infrastructure building support for quality improvement/networking systems development. BCHSSD provides community assessment data including 88 county profiles of a statewide analysis of primary care unmet need, the 21+ Critical Indicators of Adolescent Health in collaboration with BHSIOS and is gathering baseline data to establish county level BMI data for 3rd graders to assist communities to measure the impact of their efforts to prevent the consequences of the obesity epidemic. The School/Adolescent Health (SAH) program funded by Title V orients, provides regional annual trainings/consultation for about 1200 school nurses in the state and implements the Governor's Buckeye Best schools awards program which recognizes schools that promote physical activity/nutrition/tobacco prevention. BCHSSD manages the Black Lung Disease Program; the SEARCH program that recruits health care provider students to work in underserved areas; and the Ryan White Title II Program which provides funding for health care, medications/support systems to about 7,500 HIV+ Ohioans. /2007/The PC/RH provides 34 small rural hospitals infrastructure building support for quality improvement/networking systems development. BCHSSD Adolescent Health program gathered baseline BMI data from 3rd graders to monitor trends in child overweight.//2007// /2008/Primary Care recruitment and retention programs placed 56 providers in 2006. Ohio received (new or renewed) 50 HPSA designations: 20 Primary Care, 25 Dental and 5 Mental Health. See Section III B for a discussion of SAH activities.//2008//

BCMH administers 5 programs to serve CSHCN: Diagnostic Program; Treatment Program; Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida/Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and help families navigate the complex health care system; Medical Home for CSHCN, supporting the efforts of local physicians to be Medical Homes for CSHCN. Title V CSHCN Program also houses 4 programs in the Genetics Section: Genetic Services Program, Sickle Cell Services Program, Metabolic Formula, and Birth Defects Information System. /2008/ Also see Section III B //2008//

BEIS is responsible for the administration of several programs serving young children (primarily birth to 3) and their families. The Help Me Grow program provides information, services and

supports to pregnant women/new parents/and infants/toddlers at risk for or with developmental disabilities and their families. BEIS also administers the Healthy Child Care Ohio project which provides for health/safety consultation by registered nurses to child care providers; the Infant Hearing Program, to include Universal Newborn Hearing Screening; and the Early Childhood Comprehensive Systems project which requires states to develop intersystem coordination of issues related to early care/education, family support/parenting education/medical home, and social/ emotional development of children birth to age 6. While most funding for these programs comes from sources other than the MCH BG, all of these programs work collaboratively with Title V funded programs to improve the health of infants/young children/their families.

BNS is responsible for administration of the USDA funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as a Farmer's Market Nutrition program. The Ohio WIC program provides highly nutritious foods, nutrition/breastfeeding education/support, immunization screening/health care referral through local agencies to eligible individuals. WIC helps income-eligible pregnant/postpartum/breastfeeding women/infants/children who are at special risk with respect to physical/mental health due to inadequate nutrition, health care, or both. WIC works collaboratively on Title V initiatives for improving the health status of pregnant and breastfeeding women, infants/young children.

BOHS supports local agencies with grant funding to provide dental care services (primary care/dental sealants) to high risk children/women of childbearing age. BOHS also develops program/ training materials and provides TA/monitoring to other DFCHS programs such as BCFHS clinics/BNS/Head Start/ local schools/other public health related programs. Communities are assisted in conducting oral health needs assessments/developing sites for providing primary dental care services. This assistance includes making application for federal designation as a Dental Health Professional Shortage Area. The BOHS improves access to dental health care through the OPTIONS Program (Ohio Partnership to Improve Oral Health through access to Needed Services). The program links uninsured/low income patients with safety net dental programs, or a network of dentists who agree to either donate or significantly discount their fees. /2007/BOHS assistance to communities includes a new state dentist loan repayment program for dentists willing to work in underserved areas. See Section B for more detail on programs/training developed by the bureau. //2007//

BHSIOS is responsible for the provision of support services to all program areas within DFCHS. The Research/Evaluation Section provides data analysis/program planning/evaluation assistance through the utilization of epidemiologists/researchers. Other sections within the BHSIOS provide grants processing support/purchasing/fiscal support to Division programs as well as coordination with the computer-based technological support services in the department. The State Systems Development Initiative and Pregnancy Risk Assessment Monitoring System are administered in BHSIOS. 3 researchers from the ODH Center for Vital/Health Statistics joined the BHSIOS in 2005. This enhanced research capacity will be used to increase analytical capacity in the areas of minority health data gaps, Medicaid data analysis, and the analysis of the 2004 Ohio Family Health Survey.

Title V Support in the ODH Division of Prevention

In the ODH Division of Prevention (DOP), Bureau of Infection Control, the Immunization Unit serves as lead for statewide immunization services and develops the State Immunization Action Plan. The Injury Prevention Program in the Bureau of Health Promotion/Risk Reduction serves as lead for injury programming. The ODH Laboratory, responsible for Newborn Metabolic Screening/ follow up, is also housed in DOP. /2008/ The Bureau of Health Promotion/Risk Reduction is now part of the Office of Healthy Ohio.//2008//

/2007/The DOP's Women's Health Program (WHP) receives MCH BG funding for 3 part time staff positions and various women's health activities. The purpose of the WHP is to improve the health of Ohio's women. Main objectives are: identify issues that affect women's health; develop/ implement programs to address identified issues; serve as a source of information about women's health; and act as an advocate for women's health concerns within state government

and throughout the state. These objectives are achieved through projects of the WHP which include Women's Health Month (WHM), newsletters, fact sheets, and an email discussion group, as well as participation by staff in related committees/work groups./2008/ WHM is now Women's Health Week./2008//

The Title V program coordinates with the all areas described above to implement MCH BG strategies related to immunization, deaths due to motor vehicle crashes, and women's health issues, including domestic violence activities. The Title V program coordinates activities with DOP related to primary/ secondary prevention of chronic diseases (e.g., asthma/diabetes/heart disease) in school settings./2007///2008/Childhood Obesity Surveillance and some school based nutrition/physical activity TA have been the work of the MCH funded SAH section. The 3rd grade BMI surveillance project brought other program areas from the DOP together with the MCH funded programs to develop a state plan for child obesity. Over the last year the MCH funded work of school nursing/school health collaborated with DOP in planning educational training and materials for Asthma/Diabetes/Pandemic Flu. A joint collaborative of Prevention and MCH was formed to become the Childhood Obesity Committee, an outgrowth of a professional development project: Ohio Public Health Leadership Institute. The committee is identifying gaps in services for families/children as well as developing recommendations for the state to reduce Child Obesity in Ohio./2008// **/2009/The Title V program continues work with DOP on asthma/ immunization. School nurses have access to the DOP's immunization registry/associated training to prevent school absence due to immunization non-compliance. The Title V program continues collaborative work on obesity, including writing an application for a CDC grant on nutrition/ physical activity, with the Office of Healthy Ohio's Bureau of Health Promotion./2009//**

/2008/DFCHS leadership participates with DOP in Bioterrorism/Pandemic influenza emergency preparation activities. 2 division leaders were tapped to complete the Planning Chief complement of the ICS table of organization for Pan Influenza. CDC funds support 1 FTE school nurse consultant in BCHSSD who co-chairs the special population work group with the BCMH bureau chief as part of the ESF#6 Mass Care activities of the agency./2008// **/2009/ Primary Care and Rural Health (PC/RH) successfully wrote a proposal to hire a human service program consultant to provide TA to communities participating in emergency preparedness.The hiring freeze has delayed hiring this position but existing PC/RH staff and leadership have provided episodic TA. DFCHS actively participates in the continuity of operations (COOP) activities as part of the executive branch's emergency preparedness effort./2009//**

An attachment is included in this section.

D. Other MCH Capacity

Just over 200 positions within ODH are either fully or partially supported by the MCH Block Grant (MCH BG). Sixteen of these positions are housed in ODH District Offices; the rest are Central Office-based in Columbus.

/2007/ Fifteen MCH BG positions are housed in the ODH District Offices./2007//

/2008/ 198 positions within ODH are either fully or partially supported by the MCH BG; sixteen are housed in the ODH District Offices./2008//

/2009/ There are 194 positions that are funded by the MCH-BG; 15 are housed in the ODH District Offices./2009//

The BCMH employs a Parent Advocate, Kathy Bachmann, who works closely with the BCMH Parent Advisory Council and is involved in all Bureau decision making. She works as a liaison between families and BCMH. She provides information about BCMH to families, and brings the family perspective to BCMH Program leadership. Parents are involved on most Bureau committees. BCMH has developed regional youth advisory councils which advise the Bureau on how to address the transition from youth to young adult. In addition, the BEIS provides funding through Part C of IDEA to establish family support activities within the Help Me Grow (Birth to Three Program).

Ruth Shock is the MCH BG and Needs Assessment Coordinator; the SSDI Coordinator, and the Data Contact for all MCH BG issues. MCH Block Grant Coordinator activities are incorporated into the position description of the Research and Evaluation Section Administrator, DFCHS Bureau of Health Services Information and Operational Support. Responsibilities include coordinating the various aspects of the MCH BG application, coordinating the Need Assessment, as well as provide training on MCH issues such as program planning and evaluation.
/2007/ Ruth Shrock, who now reports directly to the DFCHS Chief as coordinator for the MCH BG and the Needs Assessment, is also the Data Contact for all MCH BG issues. The SSDI Coordinator is now Bill Ramsini, Chief of the DFCHS Bureau of Health Services Information and Operational Support

/2007/ In July 2005 Elizabeth Conrey, Ph.D., was assigned to the Ohio Department of Health through the Center for Disease Control and Prevention, Division of Reproductive Health's Maternal and Child Health Epidemiology program. Dr. Conrey is a registered dietitian with a doctorate in community nutrition and an epidemiology minor from Cornell University. As a CDC assignee to the Ohio Department of Health, Dr. Conrey serves as the state's MCH Epidemiologist. Her duties revolve around capacity building in ODH MCH epidemiological studies.//2007//

Brief biographies of Division of Family and Community Health Services leadership:

David P. Schor
Division Chief

M.D., M.P.H., F.A.A.P.

Experience: Dr Schor is a board-certified pediatrician with training and experience in developmental and behavioral pediatrics who joined the Ohio Department of Health as division chief in January, 2002. He formerly served as MCH director, medical adviser, and director of health promotion with the Nebraska Department of Health and Human Services (1991-2001) Prior to his tenure with the department of health, Dr. Schor served on the staff of the department of pediatrics for both Temple University School of Medicine (1987-1991) and the University of Iowa School of Medicine (1980-1987). Dr. Schor received his bachelors degree in biology from the California Institute of Technology and graduated from medical school at Case Western Reserve University in Cleveland. He received a masters of public health from the University of Michigan in 1994.

Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and other State agencies; and manages the daily operation of the Division. He is a former regional counselor for AMCHP, served on the ASTHO committee that produced the Genomics Toolkit for Public Health published in June, 2003, and is currently a member of the Committee on Poison Prevention and Control (Institute of Medicine, National Academies).

/2007/Dr. Schor left ODH in February 2006. Karen Hughes, MPH, the former chief of the Bureau of Child and Family Health Services, has been appointed Chief of the Division of Family and Community Health Services.//2007//

/2007/Karen Hughes

Division Chief

B.S. Education; R.D.H.; M.P.H.

Experience: 15 years BCFHS Chief

Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and other State agencies; and manages the daily operation of the Division. Karen is the current Region V Director for AMCHP and is involved in lead prevention, birth outcomes and other MCH-related work groups.

//2007//

Virginia A. Haller

Medical Adviser, ODH (changed to reflect the arrival of Dr. Schor as Division Chief and the role Dr. Haller plays outside the Division of Family and Community Health Services)

B.A. Biology, Music; M.D., F.A.A.P.

Experience: 3 years Medical Adviser, DFCHS; 13 years Clinical Associate Professor of Pediatrics, OSU; 3 years Medical Director DFCHS; 1.5 years Medical Director, Ohio Department of Health; 2.5 years Medical Director, United Health Care of Ohio, Inc.; 7 year member of the Franklin County Alcohol, Drug Addiction and Mental Health Services Board; 7 years, Chief and Medical Consultant, Bureau of Maternal and Child Health; 1 year Chair, Ohio Task Force on Drug-Exposed Infants; 2 years Chair, Ohio Compassionate Care Task Force.

Duties: Formulates medical policy as adviser to the Division Chief, represents the Division and the Department on issues related to family and community services.

Lectures on pediatric and public health topics; serves as Divisional liaison with ODH Prevention Injury Program and Departmental liaison to the state Trauma Committee, coordinates medical resident and student rotations.

/2007/ No longer serves as Divisional liaison with ODH Prevention Injury program; active in several aspects of Disaster Preparedness.//2007///2008/The ODH Medical Adviser is now the DFCHS Medical Director.//2008//

Bureau of Child and Family Health Services

Karen Hughes, Bureau Chief

B.S. Education; R.D.H.; M.P.H.

Experience: 14 years BCFHS Chief

Duties: Directs the Bureau of Child and Family Health Services programs, including Child and Family Health Services; Family Planning; Women's Health Services; Ohio Infant Mortality Reduction Initiative; Prenatal Smoking Cessation; Regional Perinatal Centers Program; Ohio Childhood Lead Poisoning Prevention; Save Our Sight; Pediatric Specialty Clinics (Developmental, Hearing, Neurology, Orthopedic, Plastic, Vision); Child Fatality Review; Sudden Infant Death (SID). Co-directs Community Access and Medicaid Administrative Match Programs.

/2007/Bureau of Child and Family Health Services

Jo Bouchard, Acting Bureau Chief

B.S. Health Care Mgmt., R.D.H., M.P.H.

Experience: Over 20 years public health experience, including 4 years BCFHS Assistant Chief; 6 years as Health Planning Administrator, BCFHS; 10 years in program administrator supervisory positions in Bureau of Oral Health Services.

Duties: Directs the Bureau of Child and Family Health Services programs, including Child and Family Health Services; Family Planning; Women's Health Services; Ohio Infant Mortality Reduction Initiative; Prenatal Smoking Cessation; Regional Perinatal Centers Program; Ohio Childhood Lead Poisoning Prevention; Save Our Sight; Pediatric Specialty Clinics (Hearing, Neurology, Orthopedic, Vision); Child Fatality Review; Sudden Infant Death (SID), and DFCHS Birth Outcomes Improvement Initiative. //2007// **/2009/College Pregnancy and Parenting Pilot Office Program; Shaken Baby Syndrome Education Program; Building Capacity to Address Environmental Health Issues during Preconception and Pregnancy Pilot Project (EPA funded) //2009//**

Bureau for Children with Medical Handicaps

James Bryant

Bureau Chief and Medical Director

B.S. Biology; M.D.; F.A.A.P.; Pursuing Masters degree in medical management

Experience: 29 years general practice of pediatric medicine with emphasis on CSHCN; 10 years Chief and Medical Director of BCMH; Associate Professor of Pediatrics, Wright State University School of Medicine; Director at Large of AMCHP.

Duties: Develop standards, implement programs and direct the CSHCN program; supervise state

CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues.

Bureau of Community Health Services and Systems Development

Jamie M. Blair

Bureau Chief

B.S. Nursing; M.S. Psychiatric and Mental Health Nursing; APRN BC

Experience: 9 years BCHSSD Chief; 10 years Certified Community Health Nursing Specialist, 17 years certified in pediatrics and 8 years certified as nurse case manager; 5 years certified in school nursing; 32 years of progressive experience including: program development, strategic planning, health care delivery, patient assessment, case management, research and evaluation, patient advocacy, standards development and training.

Duties: Directs the assessment, planning, implementation, policy development and evaluation of statewide programs including the offices of Primary Care and Rural Health (including 6 health care provider recruitment and retention programs), Black Lung, Part B of Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, School and Adolescent Health Services, and collaborative initiatives to improve health care access for underserved populations.

//2007/ Provides oversight to programs including statewide school nursing consultation and contributes community health nursing expertise to emergency preparedness efforts.//2007//

Bureau of Early Intervention Services

Debra Wright

Bureau Chief

BS Nursing; MS Nursing Administration; Pursuing MS degree in Family Nurse Practitioner program

Experience: 6.5 years as bureau chief; 4.5 years as program administrator; 2 years as genetics nurse consultant; 2 years in public health nursing; and 11 years experience in obstetrical, neonatal and pediatric nursing.

Duties: Directs the planning, development, implementation and evaluation of Bureau programs which focus on families with infants and toddlers (Help Me Grow program to include Part C of IDEA; Infant Hearing Screening program; and Healthy Child Care Ohio program); and coordinating interagency efforts around a state plan for Early Childhood systems which address medical home, family support, parent education and social-emotional development of young children.

Bureau of Health Services Information and Operational Support

Bill Ramsini

Bureau Chief

Ph.D. Agricultural Education

Experience: 19 years of experience in the area of health care data collection and analysis. Chief, Center for Vital and Health Statistics; Bureau Chief, Division of Family and Community Health Services.

Duties: Directs the work of BHSIOS which provides support to all other DFCHS bureaus in research and evaluation, information systems and operational support. Oversees the State Systems Development Initiative, the Pregnancy Risk Assessment Monitoring System (PRAMS), and coordinates the data cooperation between, ODH, Ohio Department of Job and Family Services, and Ohio Hospital Association.

Bureau of Nutrition Services

Michele A. Frizzell

Bureau Chief

BS in Dietetics; Registered Dietitian; Master in Business Administration

Effective April 4, 2005, Michele Frizzell is Chief of the Bureau of Nutrition Services. Experience: Over 20 years of diverse public service experience, most recently at the Ohio Department of

Alcohol and Drug Addiction Services (ODADAS), where she managed the quality improvement initiatives for a number of ODADAS statewide programs. For the ten years prior to her work at ODADAS, she held a number of positions in the ODH WIC Program, including program consultant, administrator of program support, and system redesign project manager.

Bureau of Oral Health Services

Mark Siegal

Bureau Chief

D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health; Diplomate of the American Board of Dental Public Health and a past-president of the Ohio Academy of Pediatric Dentistry.

Experience: 18 years Chief; 2 years Columbus City Health Department Dental Director; 4 years Hospital Director for Pediatric Dental Services; 4 years New Mexico Health District Dental Director.

Duties: Directs the Bureau of Oral Health Services' activities toward improving the oral health of Ohioans by assessing needs, implementing community-based disease prevention and health promotion and increasing access to dental care. Maintains a liaison role with professional associations and other agencies on policy development and other collaborative efforts.

E. State Agency Coordination

The Ohio Title V Program, administered entirely within the ODH, has strong collaborative relationships with other state agencies, local health departments (LHD), local public health agencies, academic programs/professional associations to improve the health of the MCH and CSHCN population.

Collaborations with Other State Agencies

Ohio Family and Children First (OFCF): OFCF is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. This partnership is critical because no single state system has the resources or capacity to meet this goal alone. Oversight of the initiative is provided by the OFCF Cabinet Council. Members of the Cabinet Council include agency directors of ODE; ODADAS; OBM; ODH; ODJFS; ODMH; ODMRDD; ODA; and ODYS. The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities./2008/ DFCHS data staff serves on the OFCF Data Committee to develop a set of child well-being indicators./2008//

Each of Ohio's 88 counties has created an OFCF Council. Local council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness and to address a shared commitment to child well-being which include: expectant parents and newborns thrive, infants and toddlers thrive, children are ready for school, children and youth succeed in school, youth choose healthy behaviors, and youth successfully transition into adulthood.

/2009/ Other Multiple State Agency Collaborations: Executive Medicaid Management Administration (EMMA): An independent state office that will coordinate the management and implementation of the Ohio Medicaid program across state agencies -- Governor's Office, ODH, ODMH, ODJFS, ODMR/DD, Aging, OBM, ODADAS.

NASHP (National Academy for State Health Policy): A Grant to increase developmental assessments of children -- ODH, ODJFS, ODMH, ODADAS, ODMR/DD.

VCHIP: A Grant to build state and regional capacity for enhancing developmental and preventive services for young children -- ODH, ODMH, ODADAS, ODMR/DD./2009//

Ohio Department of Job and Family Services (ODJFS): ODJFS develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children. ODJFS also administers the Medicaid program. Ohio's Title V program has 9 MCH/CSHCN-related interagency agreements with ODJFS as follows:

- 1) An agreement links Title V and Title XIX services for the purpose of coordinating health services and conducting outreach, program eligibility and payment for services for Ohio mothers and children as defined and specified in 42 USC section 701, et. al., and 7 CFR Part 246. The agreement coordinates the exchange of information and referral among the local Child and Family Health Services projects (CFHS), WIC, Help Me Grow (HMG), Ryan White programs, Offices of Primary Care and Rural Health (PCRH), and the Ohio Medicaid programs.
- 2) An agreement on environmental lead risk assessment done in homes of Medicaid-eligible children with blood lead levels (BBL) > or equal to 15 ug/dL includes the provision of written recommendations to HEALTHCHEK (EPSDT) Coordinators who request assistance with housing relocation./2007/Amended to change BBL to > or equal to 10ug/dL./2007//
- 3) An agreement on the relationship and responsibility for data sharing and analysis on blood lead screening on Medicaid-eligible children and other lead-related information is used to enhance services, and give county coordinators better information./2007/ This agreement was folded into the MMIS/Immunization Registry agreement.(#7)./2007//
- 4) An agreement reimburses ODH for a portion of the administrative costs of TA/training of local providers of the HMG program. A large portion of funding for the statewide program is provided through TANF dollars.
- 5) An agreement reimburses ODH for the costs associated with developmental evaluations conducted by HMG providers as a result of new federal requirements in "The Keeping Children and Families Safe Act of 2003" which requires all children under the age of three who are involved in a substantiated report of child abuse and/or neglect to be referred to early intervention services provided by ODH through the HMG program.
- 6) An agreement reimbursing ODH for costs associated with the development of brochures/materials, and training on communicable diseases/first aid/medication administration/back-to-sleep/developmental screening/inclusive child care as part of a health/safety training curriculum for child care providers/ trainers.
- 7) An agreement on a statewide immunization and MMIS interface creates an interface between ODJFS and ODH to share immunization records./2007/ Sharing of blood lead testing was added to this agreement./2007// **/2009/This agreement will provide Medicaid funds for development of a new lead poisoning surveillance system./2009//**
- 8) An agreement defines relationships/responsibilities between ODJFS and ODH for the conduct of desk reviews/interim settlements/field audits/and final settlements for ODH's Bureau for Children with Medical Handicaps (BCMH). The agreement meets the requirements of Title V for financial accountability and administration of BCMH.
- 9) An agreement provides funding for an annual training session required for members of Child Fatality Review Boards (CFR). BCFHS coordinates with the ODJFS Children's Trust Fund Board on activities related to the CFR program, including the preparation/publishing of the CFR annual state report./2008/This is an informal agreement//2008 **/2009/An Interagency Agreement is being developed to formalize the collaboration with OCTF./2009//**
- 10) An agreement for data sharing and research projects of mutual interest related to the administration of Medicaid and the State Children's Health Insurance Program produced

information needed for MCH policy decisions.

In 2005 the Community Access Program funded by the Primary Care Bureau of HRSA provided the infrastructure to develop and pilot a Medicaid Administrative Claiming (MAC) plan for the state which will provide a sustainable funding source for local health departments to continue to provide enabling services to vulnerable MCH populations. /2007/HCAP funding ended 5/05; MAC unit transitioned to the ODH Office of Financial Affairs. State plan for MAC was submitted and is under review by CMS. //2007//

Bureau of Early Intervention Services (BEIS) collaborates with the ODJFS Bureau of Child Care and the Child Care Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health/safety information to licensed child care providers. The ODH Healthy Child Care Ohio coordinator serves as an ex-officio member on the ODJFS Day Care Advisory Council, a legislatively mandated body that advises ODJFS on child care policy and implementation of child care law.

The DFCHS Medical Director sits on the Medicaid Medical Advisory Committee for the ODHS, and serves on the Executive Committee for that group.

ODH and ODJFS collaborated on the implementation of the 2nd round of the Family Health Survey (OFHS) to address data gaps. ODJFS funded the project and ODH provided TA. Approximately 40,000 telephone interviews were conducted in 2004 to gather data on risk factors/health status/unmet need/ access to care/health insurance status. The data are currently being analyzed./2008/BHSIOS is involved in planning for the 3rd round of OFHS. BHSIOS chief is a member of OFHS advisory committee. ODJFS is expected to fund the project. BHSIOS goal is to meet some unmet data needs.//2008//**2009/ A major goal of the 2008 OFHS is to provide data that will be comparable to 2004 data for trend and "change over time" analysis. The 2008 OFHS will help policymakers assess impact of recent changes in the health care market place and government programs, such as Medicaid eligibility expansions. The OFHS will also help policymakers evaluate claims that individuals or groups make about continuing needs/problems/solutions. //2009//**

The DFCHS Chief serves on the ODJFS Children's Trust Fund Board; BCFHS coordinates with the Trust Fund on activities related to the CFR program, including preparation and publishing of the CFR annual state report.

/2007/The Primary Care and Rural Health section worked with the ODJFS State Refugee Coordinator to apply for Refugee Preventive Health Discretionary funding for refugee services.//2007//

//2008//ODJFS participates with the ODH Perinatal Data Use Consortium. //2008//**2009/ ODH entered into an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative. Most of this support is provided by the Regional Perinatal Center Program facilitating local access for quality improvement initiatives. //2009//**

//2008//ODH and ODJFS work together to assist in implementation/coordination of the Ohio mandated Medicaid Managed Care Program. BCFHS provided teleconferences and meetings for LHD to meet with ODJFS Medicaid and Managed Care Plan personnel to implement managed care contracts between the plans/health agencies.//2008// **/2009/ ODH collaborated with ODJFS to write a grant application to CMS for coordinating efforts among pilot hospital sites and FQHCs for an ER diversion project. //2009//**

Ohio Department of Education (ODE): TA and training are provided by DFCHS nutrition/oral health/ nursing/hearing/vision consultants to state Head Start Programs in collaboration with Ohio Head Start Association, Inc. (OHSAI) and ODE. At the request of OHSAI and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration

between the 2 programs in the areas of nutrition screening/assessment/education/referral/recruitment was signed. The Bureau of Nutrition Services (BNS) coordinates with ODE and with the Head Start Program for sharing WIC Ohio Healthy Heroes videos. ***/2009/This is no longer an active coordination. Videos were provided a few years ago./2009//***

Bureau of Community Health Services and Systems Development (BCHSSD) provides TA to approximately 1,200 school nurses as they assist families/students to access primary care/mental health/ dental health safety net services identified by the Primary Care Program to address unmet health care needs and to eliminate health disparities. BCHSSD successfully applied for Bioterrorism funding to add a 2nd school nurse consultant to assist school with emergency preparedness for the school aged population.

BCHSSD School and Adolescent Health (SAH) program helps ODE improve nutrition messages for school aged children/families/teachers with the expertise of a public health nutritionist funded by the MCH BG. The SAH program also works with randomly selected local school districts to administer the YRBS. In collaboration with the Ohio Chapter of the American Cancer Society, SAH administers the Governor's Buckeye Best School awards program which recognizes schools for achievements in the areas of increasing physical activity, improving nutrition and preventing tobacco use. The school nursing supervisor in SAH worked collaboratively with ODE department of special education services to revise rules for providing clinical services to students with special health care needs. ***/2009/SAH section collaborated with ODE to write a grant application to CDC that funds support for YRBS, Coordinated School Health and HIV education./2009//***

HMG program in BEIS collaborates with the Part B Special Education and 619 (Preschool) programs at ODE to assure that training/information to local programs/school districts are coordinated where necessary.

ODE sits on the ODH Lead Advisory Council, which is adding requirements for child care's school facilities to ensure lead safe environments.

Ohio Department of Alcohol and Drug Addiction Services (ODADAS)

An interagency steering committee (including parents/private organizations/ODADAS) co-chaired by the Title V director as ODH's representative, produced a "town meeting" discussing family impact of Fetal Alcohol Spectrum Disorders (FASD). The initiative, supported by the Office of the First Lady of Ohio, received SAMHSA funding to produce a strategic plan for enhanced prevention/recognition/intervention services. A conference including keynotes from other states' programs is set for 8/2005. ***/2007/SAH is represented on the Interagency Prevention Partnership which looks at ways to coordinate efforts to prevent substance abuse./2007// 2008/ODH shares the leadership of the state's FASD initiative with 2 other state agencies. A steering committee comprised of 9 state agencies, 2 colleges/universities, providers/parents guides the initiative through components including primary/secondary prevention services for those affected and data collection. The charge to the steering committee is to integrate FASD activities in state/local agencies through existing programs/systems, not relying on dedicated funding. Through the partnership, a state website was launched, www.notasingledrop.org which provides information about FASD to health care professionals, families and the general public. The state agency leadership group meets monthly; the statewide steering committee meets quarterly.2009/ ODH and ODADAS entered into an interagency agreement to provide a 3 day Women's Wellness Symposium in May 2008./2009//***

Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD): An agreement between ODH and ODMRDD confirms their intent to assist jointly in comprehensive planning/coordination for a statewide HMG system to include infants/toddlers with developmental delays/disabilities, as defined in Part C of the Individuals with Disabilities Act, and their families. DFCHS staff serves on several interagency committees and the BCMH chief was the ODH representative on the Ohio Autism Taskforce which was staffed by ODMRDD./2008/See ODADAS/2008//

Ohio Department of Mental Health (ODMH): Collaboration with ODMH happens on 2 levels: BEIS is working closely with the early childhood mental health initiative (MHI) at ODMH on projects addressing early identification and referral of new mothers with postpartum depression and young children with potential social/emotional needs; and training providers on ways to work with families with young children with challenging behavior. BCHSSD continues to work on school based MHIs by representing the school nurse perspective and has co-sponsored a statewide strategic planning session to develop a plan for increasing school based mental health programs in Ohio schools. Currently there are 4 pilot programs in 4 area school districts using the "Columbia Teen Screen" - Depression Screening Program./2008/See ODADAS//2008//

Ohio Department of Rehabilitation and Correction (ODRC): BNS continues coordination with ODRC for the Prison Nursery Program.

Ohio Environmental Protection Agency (OEPA): BNS continues coordination with OEPA for the annual Sport Fish Consumption Advisory./2007/ BOHS works with OEPA to maintain current information on the fluoride status of community water systems./2007// /2009/Ohio EPA continues to participate on the Ohio Lead Advisory Council./2009//

Ohio Developmental Disabilities Planning Council (ODDPC): The BCMH Chief represents ODH, DFCHS on the ODDPC, serving on the Children's and the Health Committees.

Collaboration with Social Security Administration (SSA)

An agreement between SSA and ODH, BCMH, establishes conditions under which SSA agrees to disclose information related to eligibility for and payment of Social Security benefits and/or supplemental security income and special veterans benefits, including certain tax return information to ODH, BCMH for use in verifying income/eligibility.

Collaborations with Local Public Health Agencies/Local Health Initiatives

The DFCHS Chief and BCFHS Chief serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB.

/2009/An ODH representative from the OCLPPP serves as an appointed steering committee member of the Greater Cleveland Lead Advisory Council./2009//

BCMh has close working relationships with LHDs throughout the state and a representative from a LHD serves on the BCMH Medical Advisory Council. BCMH has been working with Federally Qualified Health Centers (FQHCs) throughout the state and is strengthening that relationship.

Collaborations with FQHCs

While PCRH programs are administered in ODH by the Title V Director, PCRH programs maintain many collaborative relationships with outside agencies/systems. PCRH programs take the lead for 2 Presidential Initiatives in Ohio: development/expansion of FQHCs, and growth of the National Health Service Corps (NHSC). A coordinated effort is underway with Ohio Primary Care Association (OPCA) to develop FQHCs in medically underserved areas. NHSC Scholarship and Loan Repayment Programs assist in staffing Ohio FQHCs as well as other safety net provider sites located in underserved areas. In 2004, PCP partnered with Ohio Academy of Family Physicians Foundation and Statewide Area Health Education Centers to win the NHSC SEARCH contract for Ohio. The SEARCH program places primary care/dental/mental health students/residents in underserved areas as a long term recruitment strategy. PCP partners with Ohio Board of Regents to operate 2 loan repayment programs that provide incentives for local health care providers to practice in underserved areas. In 2004 Osteopathic Heritage Foundation

joined the partnership by supplying local funds for the retention of a dentist in Appalachian Ohio. Ohio Rural Development Partnership (ORDP) developed a 501c3 organization, Ohio Rural Partners (ORP), which is able to apply for and receive federal/foundation/other funding. Senator Carey and other legislators who sit on the OPDP advisory committee offered to introduce language into the budget corrections bill to move the administration of the OPDP from the BOR to ODH but the outcome is not known yet//2009//

The Division Chief was the governor's appointed representative of ODH on the Ohio Physician Loan Repayment advisory committee which selects applicants who are practicing in underserved parts of Ohio to receive loan repayments funded with money collected with medical license renewals./2009/Dr. James Bryant, BCMH Bureau Chief, became the ODH representative and OPLRP advisory committee chairperson./2009//

Other Partnerships

The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards/committees, and shares some committees with organizations.

Ohio Hospital Association (OHA): OHA is the membership/advocacy organization for most of Ohio's hospitals. OHA has developed a strong interest in its small/and rural hospitals, and has created a Small/ Rural Hospital Committee. In addition, OHA partnered with the State Office of Rural Health (SORH) in the development/implementation of the State Rural Hospital Flexibility Grant Program that enabled Ohio to designate Critical Access Hospitals (CAHs). Early in the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the OPCA, the Ohio State Health Network, Division of EMS, ORDP, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly; since its inception this meeting has been hosted by OHA. A total of 31 CAHs have been designated to date./2007/34 small rural hospitals have achieved CAH designation in Ohio./2007//

A memorandum of understanding for data sharing between ODH and OHA was signed in 2003. ODH developed an agency agenda for data needed from OHA for research/reporting purposes and has received and analyzed OHA data./2008/ ODH staff is currently analyzing hospitalization data dealing with ambulatory sensitive conditions to determine potential access to care issues across Ohio./2008//

Ohio Association of Children's Hospitals (OACH): BCMH collaborates closely with OACH. The Association is a key member of the MCH Advisory Counsel, the Birth Defects Advisory Council, and serves on other advisory groups as requested. OACH is a key partner/advocate for health care issues for all children, especially CSHCN.

Ohio Chapter/American Academy of Pediatrics (OC/AAP): OC/AAP shares the Children with Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. The ODH DFCHS participates with the OC/AAP in development of a long term strategic plan targeting mental health concerns for children/adolescents. The DFCHS Medical Director chairs the physician group which advises ODH on the recruitment of providers to participate in the statewide immunization registry. She also serves as liaison between ODH and OC/AAP in regard to the immunization education program for physicians/nurses./2007/ BOHS works with OC/AAP and American Council of Family Practitioners to develop oral health training for physicians/ pediatricians./2007//

Ohio Section of ACOG: The BCFHS Bureau Chief attends Ohio ACOG quarterly meetings to share information from ODH./2007/Ohio ACOG and other diverse groups are members of the Family Planning (FP) Advisory Council. //2007// /2008//An ACOG representative actively participates on the ODH facilitated Action Learning Lab for Prenatal Smoking Cessation//2008//

/2009/ The Ohio ACOG representative is an invited member of the ODH FP Advisory Council and the FP State-Wide Needs Assessment Stakeholders Workgroup/2009//

Ohio Rural Development Partnership: See discussion under "Collaborations with FQHCs.

Ohio Dental Association (ODA): BOHS partners with ODA to administer a statewide volunteer dental care program called Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services). This dental referral/case management program matches clients with dentists who provide discounted or donated care in their offices. The Bureau Chief is a member of ODA's SubCouncil on Access to Dental Care and Dental Specialty Councils. The SubCouncil successfully put forth resolutions supporting recommendations of the Director's Task Force on Access to Dental Care. /2007//In 9/2005, ODA restructured, eliminating the SubCouncil.//2007//

Ohio Head Start Association, Inc. (OHSAI): BNS has an interagency agreement with OHSAI for the purpose of program coordination. BOHS collaborates closely with the OHSAI and convenes the Head Start Oral Health Steering Committee on a regular basis. Among other agencies/organizations on this group are ODJFS, ODH BEIS, State Head Start Collaboration Office, Ohio Academy of Pediatric Dentistry, ODA, and numerous local groups.

Health Policy Institute of Ohio (HPIO): BOHS collaborates with HPIO to convene the Dental Workforce Roundtable, with representatives from dental schools, organized dentistry, dental hygiene and dental expanded functions: state dental board, PCA, and Association of Ohio Health Commissioners. BOHS is actively represented on Ohio Coalition for Oral Health, with LHDs, FQHCs, and OPCA. /2007/Report of the Roundtable's work/recommendations was released 3/06.//2007//

Ohio Public Health Association (OPHA): BCHSSD assumed the lead to work with OPHA Directors of Nursing Section and Ohio Nurses Foundation (ONF) to develop 17 web based continuing education modules in support of public health nurse (PHN) workforce development. 8 of the modules were based on competencies developed by the Council on Linkages Between Academia and Public Health Practice. 5 of the modules were designed for school nurses; 4 were designed to meet the learning needs of PHNs who supervise a new health care provider role in Ohio, Community Health Worker. All of the modules can be accessed at www.publichealthnurses.com. MCH BG funds supported development of the project./2007/ The modules became self sustaining 7/2005 when registration revenue was able to support maintenance expenses.//2007// /2008/ 8 of the original PHN competency based modules were updated through a 2006/07 HRSA Grant, "Using a Hybrid Education Modality for PHN Workforce Development In Ohio and Pennsylvania" which is a collaborative effort among academic/public health nursing practice partners. The OPHA Directors of Nursing section discussed using the 8 updated competency based modules as prerequisites for the quarterly PHN orientation content presented by ODH. All 17 modules will move to a website supported by the ONF.//2008//

/2007/Ohio Lead Advisory Council (OLAC):In addition to appointed members from ODJFS/ODE/OEPA, these organizations also have members who serve on the OLAC: Ohio Department of Development, Apartment Owner's Association, Help End Lead Poisoning Coalition, Environmental Health Association, National Paint and Coatings Association, and other nonprofit/public health agencies outside of the appointed membership.//2007//

/2007/Ohio Coalition for Oral Health (OCOH):BOHS is actively represented on the OCOH, with LHDs/ FQHCs/OPCA.//2007//

Other: BOHS staff works closely with Anthem Foundation, Osteopathic Heritage Foundations and Sisters of Charity, 3 private foundations which are funding initiatives to increase access to dental care. BOHS staff is involved with over 13 community groups which have identified dental needs as a priority. These groups typically include local agencies such as: LHDs/job and family services/WIC/EI/dental societies, community action agencies/schools. BOHS also collaborates

with Association of State and Territorial Dental Directors, Indian Health Services and local dental clinics to develop a web-based safety net dental clinic manual to provide TA on starting/operating a non-profit clinic. The manual went on-line in 2003.

School and Adolescent Health (SAH) program is involved in the Ohio Action for Healthy Kids Initiative, which builds upon the Healthy Ohioans-Buckeye Best Program by working throughout the state to improve nutrition/physical activity in schools and after school programs. SAH works with the Ohio Parks and Recreation Association to create or strengthen relationships among schools and their local Parks and Recreation entities to encourage more physical activity for school aged youth./2007/ The Governor established the Ohio Physical Fitness and Wellness Advisory Council, charged with creating wellness policy guidelines and resources for schools; ODH's appointed seat on the council was filled by a SAH representative. //2007//

The First Lady's Office created a state task force on Underage Drinking in Ohio. SAH Services Unit was appointed to the task force to represent ODH. The task force is charged with implemented community town hall meetings throughout Ohio to strategize on ways to reduce/prevent underage drinking.

/2007/National Partnership to Help Pregnant Smokers Quit, a coalition of diverse organizations working together to help pregnant smokers quit smoking, selected Ohio as one of 10 states to participate in an Action Learning Lab. Ohio's Partnership includes national organizations as well as other ODH programs and Ohio organizations: Planned Parenthood Affiliates of Ohio, Tobacco Use Prevention and Control Foundation and Ohio ACOG.//2007//

F. Health Systems Capacity Indicators

Introduction

The HSCIs taken as a group are an important set of indicators that act as a catalyst for working with health and social service systems beyond the Title V program. For many of these indicators, the State Systems Development Initiative (SSDI) Grant is the vehicle by which relations with other agencies/organizations e.g., Ohio Medicaid; Ohio Hospital Association, are formed and maintained so that data can be acquired, analyzed and used for further action. For example, all of the Medicaid indicators require interactions with the Ohio Medicaid program that have led to a data sharing agreement, discussions on how to share analytical methodologies, and the beginning of discussions on expanding PPOR analyses to the Medicaid population. In addition, both Medicaid and the Ohio Hospital Association participate in the Perinatal Data Use Consortium, designed to use data to improve birth outcomes in Ohio. Within the Ohio Department of Health, the set of HSCIs strengthens collaborations among the asthma program and the Tobacco Risk Reduction program, in the ODH Bureau of Health Promotion and Risk Reduction in the newly created Office of Healthy Ohio.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	32.9	32.7	33.2	33.4	33.4
Numerator	2924	2392	2428	2456	2456
Denominator	889158	731891	731672	734735	734735
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

2007 data are not available. 2006 data are used to estimate 2007 data

Notes - 2006

Data source: Ohio Hospital Association (OHA) Statewide Clinical and Financial database, 2006.
 Numerator: the number of hospital discharges for Ohio residents age <5 years for 2006.
 Denominator: 2005 U.S. Census population of Ohio children <5 years old. Bridged-race Vintage 2005 postcensal population estimates for July 1, 2000 - July 1, 2006, by county, single-year of age, Hispanic origin, and sex

Notes - 2005

Data source: Ohio Hospital Association (OHA) Statewide Clinical and Financial database, 2005.
 Numerator: the number of hospital discharges for Ohio residents age <5 years for 2005.
 Denominator: 2005 U.S. Census population of Ohio children <5 years old. Bridged-race Vintage 2005 postcensal population estimates for July 1, 2000 - July 1, 2005, by county, single-year of age, Hispanic origin, and sex

Narrative:

According to data from the Ohio Hospital Association, 32.9 percent of children under the age of five years were hospitalized for asthma in 2003, up slightly from 2002.

*/2007/*According to data from the Ohio Hospital Association, 32.7 per 10,000 children under the age of five years were hospitalized for asthma in 2004, nearly the same as 2003, but is lower than it was in 2002 .*//2007//*

/2008/ According to data from the Ohio Hospital Association, there were 33.4 child hospitalizations for asthma per 10,000 children under the age of five years in 2006, nearly the same as 2005.

According to the 2003 National Survey of Children's Health, 9.3 percent of Ohio parents of children aged 0 to 5 years had ever been told their child had asthma. This compares to 8.9 percent for the nation. 7.8 percent of the children ages 0-5 still had asthma at the time of the survey, compared with 8.9 percent in the nation.*//2008//*

/2009/*According to data from the Ohio Hospital Association, there were 33.2 child hospitalizations for asthma per 10,000 children under the age of five years in 2005, slightly higher than in 2004.*//2009//

The DFCHS Bureau for Children with Medical Handicaps (BCMh) works closely with the ODH State Asthma program in assessing and collecting data on children with asthma in Ohio.

*/2008/*As issues arise, BCMh works with the ODH Asthma Program to address concerns. The concentration is on optimizing care and decreasing both ER visits and hospitalizations*//2008//*

DFCHS serves on the Ohio Asthma Council. The BCMh Asthma Pilot is in its second year and in the pilot, pharmacists work with patients to increase medication compliance and to decrease ER visits and hospitalizations. ODH continues to collaborate with the Ohio Hospital Association and the Ohio Association of Children's Hospitals to obtain hospital discharge data on children with asthma.

/2007/ The BCMh Asthma Pilot has been completed and BCMh in collaboration with the ODH Asthma Program is initiating a Medication Therapy Management Services of Children with Asthma and Diabetes. In this program pharmacists work with patients and physicians to increase

medication compliance and to decrease ER visits and hospitalizations. //2007//

/2008/The Asthma Medication Therapy Management Program is being expanded throughout the state and is a national model for improving compliance with medications.//2008//

/2008/ An activity has been added to Ohio's State Performance Measure # 6: Access/Safety Net to look at asthma admissions and other ambulatory sensitive service codes in the Medicaid database as proxy indicators of access.//2008//

/2009/ No changes in program activities.//2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	82.3	88.2	80.4	81.5	80.5
Numerator	111932	62621	58184	61112	61815
Denominator	135992	70997	72334	74970	76800
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2007 Medicaid enrollment and services. Denominator: The number of Medicaid enrollees whose age is less than one year.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Notes - 2006

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2006 Medicaid enrollment and services. A consumer could have been enrolled in both Medicaid and SCHIP during the year and would be counted in both HSCI 02 and HSCI 03.

Notes - 2005

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2005 Medicaid enrollment and services. A consumer could have been enrolled in both Medicaid and SCHIP during the year and would be counted in both HSCI 02 and HSCI 03.

Narrative:

In 2003, 82.3 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, up slightly from 2002.

/2007/ In 2004, 88.8 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, up from 2003. Since 2000, Ohio has seen steady improvements in the

percentage of Medicaid enrollees under the age of one year receiving at least one initial periodic screen.//2007//

NOTE: These data are provided to the Ohio Department of Health (ODH) by the Ohio Department of Job and Family Services (ODJFS), Medicaid Program. Per the Medicaid Program, "in prior years, the data was limited to persons whose age was less than one at any time in the reporting year and included persons who may have turned one in the reporting year. This data reflects persons whose age was less than one for the entire reporting year."//2007//

/2008/ In 2005, 80.4 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, down from 88.8 percent in 2004. Ohio's Medicaid program reports that they have used a different methodology from previous years: only infants who actually received a service in the reporting year were counted; previously they were counted if they were under the age of one year and had ever received a service.//2008//

/2009/In SFY 2006, 81.5 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, up from 80.4 percent in 2005. In SFY 2007, 80.5 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, down from 2006. NOTE that the SFY 2007 report includes only those infants who were in Title XIX; none in SCHIP, as in previous years. Data for SFY 2007 were prepared by ODH,DFCHS.//2009//

The Division of Family and Community Health Services (DFCHS) provides technical assistance in DFCHS funded projects to assist consumers in enrolling in Medicaid Healthy Start/Healthy Families, and accessing safety net services and health care services. As an example, the Division provided technical assistance to Child and Family Health Services projects on removing the major barriers to Medicaid enrollment that included: assisting clients in completing the Medicaid application; following-up to determine Medicaid enrollment status, reminding clients about enrollment before and during appointments; conducting community education on Medicaid enrollment. The Division collaborates with interdepartmental, state, local agencies and initiatives to provide technical assistance publicize and disseminate Healthy Start information to providers, consumers, and employers.

The BCHSSD Primary Care and Rural Health Section collects data about health services provided to children (including <1 year old) women and pregnant women that are funded by earmarked state funds for these populations and funds for the same populations from the Health Priorities Trust Fund (Tobacco Trust). Primary Care and Rural Health also collects data from all primary care and specialist providers who are placed in underserved areas via 6 different provider placement programs including Ohio Physician Loan Repayment program, J1 Visa program, Health Service Corps scholarship program. //2007//

/2008/ The BCHSSD Primary Care and Rural Health Section now has seven provider placement programs with the addition of Minority and Appalachian loan repayment program funded with tobacco trust fund dollars.

Ohio's Title V program continues to work with DFCHS funded projects to provide information, technical assistance, and/or training as appropriate to providers and consumers on how to understand and navigate the health care system.

In FFY 2006 the Ohio WIC program screened all of its over 280,000 applicants and participants were screened and/referred for Healthy Start. 18 site visits to local CFHS agencies were provided technical assistance and information on ensuring CFHS clients understand and navigate the health care system. 13 Ohio Infant Mortality Reduction (OIMRI) projects were funded to provide intensive care coordination to high risk families in counties that have high infant mortality rates. 18 FQHCs in 34 counties and 13 Free Clinics assisted children and families enroll into Healthy Start. BCMH assisted families and providers by helping them navigate the Mandatory Mail Order

rules of insurance and Medicaid; referring clients to all the products of Medicaid; and premium assistance programs. BCMH worked with ODJFS sponsored staff development on Medicaid policies and procedures on Authorizations for DME. BCMH developed literature and training on: Medicaid Managed Care for families and Service Coordinators. Other publications included the Parent to Parent Newsletter, and a flyer on citizenship requirements for application for Medicaid as a result of DRA. BEIS hosted a HMG video teleconference for Project Directors and other local county staff.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	82.1	71.2	64.8	67.0	64.6
Numerator	4795	2919	2696	2902	2676
Denominator	5841	4097	4162	4332	4143
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2007 SCHIP enrollment and services. Denominator: The number of SCHIP enrollees whose age is less than one year.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Notes - 2006

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2006 Medicaid enrollment and services. A consumer could have been enrolled in both Medicaid and SCHIP during the year and would be counted in both HSCI 02 and HSCI 03.

Notes - 2005

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2005 Medicaid enrollment and services. A consumer could have been enrolled in both Medicaid and SCHIP during the year and would be counted in both HSCI 02 and HSCI 03.

Narrative:

In 2003, 82.1 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen, up slightly from 2002.

/2007/ In 2004, 71.2 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen. This is about a 15 percent decrease from levels seen in the last three years.

NOTE: These data are provided to the Ohio Department of Health (ODH) by the Ohio Department of Job and Family Services (ODJFS), Medicaid Program. Per the Medicaid Program, "in prior years, the data was limited to persons whose age was less than one at any time in the reporting

year and included persons who may have turned one in the reporting year. This data reflects persons whose age was less than one for the entire reporting year."//2007//

/2008/ In 2005, 64.8 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen. This is a nine percent decrease from the previous year. Ohio's Medicaid program reports that they have used a different methodology from previous years: only infants who actually received a service in the reporting year were counted; previously they were counted if they were under the age of one year and had ever received a service.//2008//

/2009/ In SFY 2006, 67.0 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen, down from 64.8 percent in 2005. In SFY 2007, 64.6 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen. NOTE that the SFY 2007 report includes only those infants who were in SCHIP; none in Title XIX, as in previous years. Data for SFY 2007 were prepared by ODH,DFCHS.//2009//

Refer to #02 as SCHIP is part of the Medicaid Program in Ohio.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	85.3	86.0	85.9	71.5	71.5
Numerator	120967	113916	111886	76985	76985
Denominator	141857	132507	130193	107631	107631
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

2006 data are not available. 2005 data are used as estimates for 2006

Notes - 2006

Data Source: Ohio Vital Statistics, 2006 final resident birth data, prenatal visits not missing. Calculated using obstetrical estimate of gestational age. NOTE: The switch to the NCHS 2003 birth certificate resulted in many missing values for entry into prenatal care. Substantive changes in both question wording and the sources for this information have resulted in data that are not comparable between revisions.

Notes - 2005

Data Source: Ohio Vital Statistics, 2005 final resident birth data, prenatal visits not missing.

Narrative:

In 2004 (provisional data), 88.5 percent of women with a live birth had a Kotelchuck Index (KI) of at least 80 percent, an increase from 85.3 percent in 2003. /2007/ Per final 2003 Vital Statistics (VS) data, 85.3 percent of women with a live birth had a KI of at least 80 percent, down from 86.5 percent in 2002. 2004 VS data are not yet available. //2007// /2008/ Per final 2005 VS data, 85.9 percent of women with a live birth had a KI of at least 80 percent, down from 86.0 percent in 2004. 2006 data are not yet available. //2008// **/2009/ Per final 2006 VS data, 71.5 percent of women with a live birth had a KI of at least 80 percent. 2007 data are not yet available. Comparisons with previous years cannot be made because the 2003 revisions to the Birth Certificate effective in 2006 required that data be collected using a different methodology. There are also many missing data. //2009//**

The KI combines 2 independent dimensions of prenatal care (PC). It characterizes the timing of PC initiation and frequency of visits received after initiation of PC compared to ACOG recommendations. While KI is a valuable index in measuring adequacy and timing of PC, it does not measure quality of PC. The Division of Family and Community Health Services (DFCHS) recognizes the importance of adequacy of PC and has several program strategies to improve the measure. DFCHS is funding and providing TA to projects that employ community health workers to improve access to care through culturally competent (CC) care coordination. The DFCHS Bureau of Child and Family Health Services is also committed to ensuring that CC care is provided in its CFHS funded perinatal clinics. All CFHS subgrantees are monitored for capacity to provide CC care. An analysis done 2 years ago revealed that many subgrantees do not provide ongoing CC training for their providers and do not have access to training resources. As a result of this analysis, DFCHS is providing TA/training.

/2007/ In 2005, an analysis was completed of the response of CFHS funded agencies to the Culturally and Linguistically Appropriate Services (CLAS) assessment; a grant requirement. Results of assessments demonstrated a need for TA/training related to: diversity education for staff; outreach activities; development of strategic plan to address CC; and evaluating CC activities.

Based on DFCHS' recent analyses of disparities, contributing factors, and opportunities for improvement in birth outcomes, a DFCHS Birth Outcomes Improvement Initiative (BOII) was developed. The initiative is about refining the message of pre/interconception (PI) care in DFCHS MCH-serving programs. The initiative will focus on a few really important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to improve birth outcomes. The initiative brings together Ohio's MCH programs, Early Intervention, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies listed below.

1. Conduct focus groups of women of childbearing age and providers for these women:
2. Partner with Ohio ACOG to develop/modify and implement PI service protocols: Pilot MOM focused interconception visits:
3. Focus all programs on populations at greatest risk:
4. Partner with Ohio Department of Mental Health to conduct a Maternal Depression Screening Pilot Project:
5. Implement 5 A's Prenatal Smoking Cessation Program:
6. Advance use of Perinatal Data Use Consortium:
7. Support Ohio Partners for Birth Defects Prevention:
8. Support Fetal Alcohol Spectrum Disorders Statewide Initiative:
9. Convene Ohio Summit for PI Health:

/2008/ DFCHS, BCFHS contracted with OSU School of Nursing for project to conduct 18 consumer focus groups and 30 provider interviews for SFY 2007; IRB approval was obtained. Report at HSCI 5D.

As part of partnership with Ohio ACOG to develop/modify and implement PI service protocols, ACOG representatives attended DFCHS quarterly meetings; ALL Ohio Team developed a state action plan to address Tobacco Prevention and Cessation for Women of Reproductive Age.

For development of a pilot program, Mom-Focused Interconception Visits, that would include interventions to improve outcome of a subsequent pregnancy in women who previously delivered a LBW baby, literature reviews were completed; a survey to assess Ohio Infant Mortality Reduction Initiative programs was conducted. To focus all programs on populations at greatest risk, results of Perinatal Periods of Risk (PPOR) analysis were used to drive program direction. Ohio's PPOR indicated that the African Americans AA); Teens; AA Teens (15-17) populations are disproportionately affected by poor birth outcomes. A DFCHS survey was conducted to determine programs to target and strengthen their focus on populations at greatest risk.//2008//
/2009/See HSCI 05C re: initiatives to improve birth outcomes./2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	82.4	86.5	86.6	84.7	83.2
Numerator	944752	1002023	1038301	988028	859076
Denominator	1146391	1158606	1198969	1166365	1031971
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2007 Medicaid enrollment and services. Does not include SCHIP participants (198,921) Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid (Title XIX) during SFY 2007. Does not represent the number of children potentially eligible, but who are not enrolled in Medicaid. Does not include SCHIP enrollees (208,067).

Calculations done at Ohio Department of Health, Division of Family and Community Health Services.

Notes - 2006

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2006 Medicaid enrollment and services. Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid during SFY 2006. Does not represent the number of children potentially eligible, but who are not enrolled in Medicaid.

Notes - 2005

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2005 Medicaid enrollment and services. Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid during SFY 2005. Does not represent the number of children potentially eligible, but who are not enrolled in Medicaid.

Narrative:

/2007/ This HSCI was formerly reported as National Performance Measure 14.

In 2004 86.5 percent of potentially Medicaid-eligible children received a service paid by the Medicaid program. This is higher than the 82.4 percent who received a service in 2003. Overall, since 2000, Ohio has seen improvements in the percentage of potentially Medicaid-eligible children receiving a service paid by the Medicaid program. The data for this indicator are provided to the Ohio Department of Health (ODH) by the Ohio Department of Job and Family Services (ODJFS), Medicaid Program.

/2008/In 2005 86.6 percent of potentially Medicaid-eligible children received a service paid by the Medicaid program. This is virtually the same as what was seen in 2004. //2008//.

/2009/In SFY 2006, 84.7 percent of Medicaid-eligible children received a service paid by the Medicaid program, down slightly from the 86.6 in 2005. In SFY 2007 83.2 percent of Medicaid-eligible children received a service paid by the Medicaid program. NOTE that the SFY 2007 report includes only those children who were in Title XIX; none in SCHIP, as in previous years. Data for 2006 were prepared by ODH, DFCHS.//2009//

In an effort to ensure/improve chances that potentially Medicaid eligible children receive services paid by Medicaid, activities include:

- 1) All WIC and BCMH children are screened for potential Healthy Start/Healthy Family eligibility;
- 2) Local Help Me Grow consultants inform families about Healthy Start and referral when appropriate

Local CFHS projects provided over 340 hours of Combined Programs Application assistance and over 5,865 hours of care coordination activities to families in SFY05.

Outreach and collaboration are essential elements in this Health Service Capacity Indicator. This is evidenced by: ODH submitting the Medicaid Administrative Claiming (MAC) Methodology Guide to ODJFS and CMS for public health outreach activities that support the efficient administration of the Medicaid program; BCMH's Medicaid Benefits Coordinator providing technical assistance to Bureau for Children with Medical Handicaps (BCMh) consumers having problems with Medicaid HMO processes; and BCMH having quarterly meeting with ODJFS Medicaid Managed Care Bureau to facilitate communications and service delivery for providers and consumer.

Other DCFHS collaborative efforts included participation in the state/local coalition of the Ohio Children's Defense Fund's Covering Kids and Families Initiative, Medicaid Medical Advisory Committee and local Joint Medicaid/Healthy Start Advisory Councils.//2007//

/2008/The following accomplishments are reported for FFY 2006:

- 1.Per the latest CMS (HCFA)-416 report for FY 2004, 472,785 (47 percent) of 1,014,090 Medicaid eligible children received at least one or periodic HEALTHCHEK screen.
- 2.Per the latest CMS (HCFA)-416 report for FY 2004, 377,907 (37 percent) of 1,014,090 Medicaid eligible children received any dental services.
- 3.Per the latest CMS (HCFA)-416 report for FY 2004, 60,027(16 percent) Medicaid eligible children ages 1-5 of 386,629 were screened for blood lead test.
- 4.All WIC and BCMH children are screened for potential Healthy Start/ Family eligibility.
- 5.Early Intervention System of Payment (EISOP) for families with no other method of paying for needed early intervention services requires the use of the Combined Programs Application (CPA). The CPA is used to apply for Healthy Start (HS) and requires determination of eligibility for HS prior to the use of EI services.
- 6.Local CFHS projects provided over 572 hours of Combined Programs Application assistance and over 4,145 hours of care coordination activities to families in SFY06.

7. BCMH provided TA was provided to Akron City Health Department (credentialing with Managed Care Plans and Lawrence County Educational Services Center to initiate Medicaid billing).
8. BCMH's Medicaid Benefits Coordinator provided TA to BCMH consumers having problems with Medicaid HMO processes.
9. Healthy Child Care Ohio Health Consultants promoted Healthy Start to approximately 30 families. Health Consultants have a lot of "repeat business" and contact with providers who serve ineligible families. There has been a reduction in first time contacts.
10. BCMH met quarterly with ODJFS Medicaid Managed Care Bureau to facilitate communications/service delivery for providers/consumers.//2008//

/2009/Accomplishments for FFY07 are similar to those reported for FFY06. Additions include: BOHS staff met with state Medicaid staff; reps. of all 8 (MMC) health plans/dental grantees for a Q&A session. Medicaid implemented a statewide expansion of mandatory managed care for Medicaid recipients. There was much confusion about implementing the expansion, especially the process of credentialing providers for MMC programs. BOHS staff developed relationships with reps. of the MMC programs and got their assistance when local programs needed help getting reimbursement.//2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	45.6	38.7	48.1	47.3	45.4
Numerator	95529	103372	110765	114182	101048
Denominator	209394	267001	230292	241412	222725
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2007 dates of service. The data only includes Medicaid (Title XIX) recipients who were between 6 through 9 for the entire SFY 2007.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Notes - 2006

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2006 dates of service.

Notes - 2005

Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2005 dates of service.

Narrative:

In 2003, 45.6 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is up from 40.6 percent in 2002.

In 2003 45.6 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is up from 40.6 percent in 2002.

/2007/ In 2004, 38.7 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is down from 45.6 percent in 2003 and is lower than levels seen in 2002 and 2001.//2007//

/2008/ In 2005, 48.1 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is an increase of 24 percent from the previous year, however, according to the Medicaid program, there were some changes in the methodology used in counting which children would be included in a given fiscal year.//2008//

/2009/ In SFY 2006, 47.3 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is down from the 48.1 percent in 2005. In SFY 2007, 45.4 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. NOTE that the SFY 2007 report includes only those children who were in Title XIX; none in SCHIP, as in previous years. Data for SFY 2007 was prepared by ODH, DFCHS.//2009//

ODH and ODJFS work collaboratively to generate an accurate report for this and other access to dental care indicators.

In an effort to improve the health systems capacity, ODH provides MCH BG funds (\$.5M) and tobacco settlement monies (\$1M) to fund the start-up and expansion of twelve local nonprofit dental clinics.

/2007/ BOHS is developing training for school nurses on conducting oral health screenings and making appropriate referrals to dentists.

An additional \$500,000 was made available from Ohio's general revenue funds to support dental safety net programs in SFY 2005. An additional eight programs received grants from ODH to support their operations.

The Ohio Department of Health does not receive the level of funding that would be required to implement programs that would significantly impact the utilization of Medicaid dental services by 6-9 year olds. The previously mentioned activities/programs will help, but won't have a significant impact on statewide utilization of the Medicaid program. //2007//

/2008/ Changes were made to the Ohio Medicaid program in 2006, including decreased reimbursement and a statewide expansion of Medicaid managed care. These changes will likely result in a decrease in the percent of EPSDT eligible children ages 6-9 who received dental services in 2006 and 2007. /2008//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	26.3	39.4	39.4	31.6	43.9
Numerator	9357	8919	8919	9197	16218

Denominator	35544	22648	22648	29096	36942
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2006

This is provisional data, as BCMH is unable to complete the data match with the local SSI data repository located at the Ohio Department of Job and Family Services. The individual who regularly performs data matches has been re-assigned to work on the implementation of the new state electronic accounting system and is unavailable.

The estimate was derived using the average of the last 4 years of data available to ODH/BCMh.

Notes - 2005

2005 data is an estimate based on 2004 data.

Narrative:

The Ohio Department of Health (ODH), Bureau for Children with Medical Handicaps (BCMh) works with the Regional SSI office to determine numbers for this indicator.

In 2003, 26.3 percent of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs Program Ohio Department of Health, BCMh. This is slightly less than the 27 percent who received services in 2002.

/2007/ Based on estimated data for 2005, 39.4 percent of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs Program (BCMh). This is about 33 percent higher than the percent served in 2003.

The BCMh works with the Regional SSI office to determine the compliance with this indicator. BCMh encourages participants in its program to apply for SSI when appropriate. BCMh has had an aggressive public awareness campaign with 105 local health departments, through Public Awareness contracts, to ensure that children with special health care needs are referred to SSI for evaluation of eligibility. In addition, BCMh has provided educational in-services, in partnership with local SSI staff, to field nurse consultants and local public health nurses. BCMh provided copies of the Social Security and SSI Benefits for Children with Disabilities booklet to the local health department nurses who work with the BCMh program.//2007//

/2008/ The data reported are provisional, as BCMh was unable to complete the data match with the local SSI data repository located in the Ohio Department of Job and Family Services (ODJFS). The individual who regularly performs data matches has been reassigned to work on the implementation of the new state electronic accounting system (OAKS) and is unavailable. ODH is working with ODJFS to obtain a timely report, but OAKS is the present priority and we expect assistance later this year. BCMh is looking at a mechanism to screen the SSI referrals and then send them an appropriate referral letter. Many of the SSI referrals are patients with mental health diagnoses and will need referral to that system. Both of these changes will be accomplished by October of this year.//2008//

/2009/ The data reported are provisional, as BCMh was again unable to complete the data match with the local SSI data repository. However, BCMh is receiving notification from SSA on children who have applied for SSI. BCMh then sends the family of the applicant a letter informing them that the child may be eligible for services in the Title V CSHCN

program if the child is determined to have a medically handicapping condition. BCMH will also assist the family in linking to other programs and resources for which the child may be eligible. The estimate reported is based on nine months of referrals from SSA. (9/07 through 4/08). //2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	10.7	7.8	8.8

Notes - 2009

Data Source: Ohio Department of Health, Vital Statistics Resident Birth Files, 2006 final data. Unlike in prior years, Medicaid status taken from Vital Statistics birth records, not from Medicaid matched files. This is the first year payment data has been available from birth files.

Narrative:

In 2004 (provisional data), 88.5 percent of women with a live birth had a Kotelchuck Index (KI) of at least 80 percent, an increase from 85.3 percent in 2003. /2007/ Per final 2003 Vital Statistics (VS) data, 85.3 percent of women with a live birth had a KI of at least 80 percent, down from 86.5 percent in 2002. 2004 VS data are not yet available. //2007// /2008/ Per final 2005 VS data, 85.9 percent of women with a live birth had a KI of at least 80 percent, down from 86.0 percent in 2004. 2006 data are not yet available. //2008//

/2009/ Per final 2006 VS data, 71.5 percent of women with a live birth had a KI of at least 80 percent. 2007 data are not yet available. Comparisons with previous years cannot be made because the 2003 revisions to the Birth Certificate effective in 2006 required that data be collected using a different methodology. There are also many missing data. Data for 2006 were prepared by ODH,DFCHS.//2009//

The KI combines 2 independent dimensions of prenatal care (PC). It characterizes the timing of PC initiation and frequency of visits received after initiation of PC compared to ACOG recommendations. While KI is a valuable index in measuring adequacy and timing of PC, it does not measure quality of PC. The Division of Family and Community Health Services (DFCHS) recognizes the importance of adequacy of PC and has several program strategies to improve the measure. DFCHS is funding and providing TA to projects that employ community health workers to improve access to care through culturally competent (CC) care coordination. The DFCHS Bureau of Child and Family Health Services is also committed to ensuring that CC care is provided in its CFHS funded perinatal clinics. All CFHS subgrantees are monitored for capacity to provide CC care. An analysis done 2 years ago revealed that many subgrantees do not provide ongoing CC training for their providers and do not have access to training resources. As a result of this analysis, DFCHS is providing TA/training.

/2007/ In 2005, an analysis was completed of the response of CFHS funded agencies to the Culturally and Linguistically Appropriate Services (CLAS) assessment; a grant requirement. Results of assessments demonstrated a need for TA/training related to: diversity education for staff; outreach activities; development of strategic plan to address CC: and evaluating CC activities.

Based on DFCHS' recent analyses of disparities, contributing factors, and opportunities for

improvement in birth outcomes, a DFCHS Birth Outcomes Improvement Initiative (BOII) was developed. The initiative is about refining the message of pre/interconception (PI) care in DFCHS MCH-serving programs. The initiative will focus on a few really important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to improve birth outcomes. The initiative brings together Ohio's MCH programs, Early Intervention, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies listed below.

1. Conduct focus groups of women of childbearing age and providers for these women:
2. Partner with Ohio ACOG to develop/modify and implement PI service protocols: Pilot MOM focused interconception visits:
3. Focus all programs on populations at greatest risk:
4. Partner with Ohio Department of Mental Health to conduct a Maternal Depression Screening Pilot Project:
5. Implement 5 A's Prenatal Smoking Cessation Program:
6. Advance use of Perinatal Data Use Consortium:
7. Support Ohio Partners for Birth Defects Prevention:
8. Support Fetal Alcohol Spectrum Disorders Statewide Initiative:
9. Convene Ohio Summit for PI Health:

/2008/ DFCHS, BCFHS contracted with OSU School of Nursing for project to conduct 18 consumer focus groups and 30 provider interviews for SFY 2007; IRB approval was obtained. Report at HSCI 5D.

As part of partnership with Ohio ACOG to develop/modify and implement PI service protocols, ACOG representatives attended DFCHS quarterly meetings; ALL Ohio Team developed a state action plan to address Tobacco Prevention and Cessation for Women of Reproductive Age.

For development of a pilot program, Mom-Focused Interconception Visits, that would include interventions to improve outcome of a subsequent pregnancy in women who previously delivered a LBW baby, literature reviews were completed; a survey to assess Ohio Infant Mortality Reduction Initiative programs was conducted. To focus all programs on populations at greatest risk, results of Perinatal Periods of Risk (PPOR) analysis were used to drive program direction. Ohio's PPOR indicated that the African Americans AA); Teens; AA Teens (15-17) populations are disproportionately affected by poor birth outcomes. A DFCHS survey was conducted to determine programs to target and strengthen their focus on populations at greatest risk.//2008//

/2009/See HSCI 05C re: initiatives to improve

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	matching data files	8.5	7.1	7.7

Notes - 2009

Data field was updated to 2004. No data beyond 2004 for this indicator are available because the matched Medicaid/birth certificate file is not available to link with the infant birth/death file. ODH has begun generating the data for this indicator instead of Medicaid. The data presented is based on adjusted infant mortality rates, which assign the unmatched infant death certificates to Medicaid and non-Medicaid deaths on the basis of each group's proportion of matched live births.

Narrative:

The Ohio Department of Health (ODH) typically receives information from the Medicaid Program in the Ohio Department of Job and Family Services (ODJFS). The Medicaid Program's data that was provided to ODH is 1 year in arrears because of ODH Vital Statistics (VS) delays in processing 2003 birth/death files. As in all prior years, however, outcomes for persons who are on Medicaid are worse than the population as a whole and those not on Medicaid. /2007/Neither 2003/2004 VS data were available to Medicaid, who prepares this report. For 2002, the infant death rate among infants on Medicaid was 12% higher than among infants not on Medicaid.//2007// /2008/ 2003/2004 complete VS data (including the linked infant birth/death files) were not available to Medicaid. For 2003 Medicaid used the following methodology to calculate infant mortality: The Medicaid Infant Mortality Rate is defined as the number of infants born in CY 2003 with a date of death in the Medicaid file within one year of birth, divided by the number of live births in CY 2003. This definition is not the same as the NCHS definition of infant mortality.//2008//

/2009/ No data beyond 2003 for this indicator are available from Medicaid. ODH is in the process of acquiring the matched Medicaid/birth certificate files so that ODH can generate the data in the future. It is anticipated that the data will be available in the fall of 2008. In the meantime, the last available data (2003) are used to estimate 2007.//2009//

The information is used by Title V programs, including the Child and Family Health Services program (CFHS), to identify/target higher risk populations for outreach/services.

/2007/ The Division of Family and Community Health Services (DFCHS) BCFHS, is in the process of contracting with Dartmouth University for Perinatal Data Use Consortium - Phase IV. One deliverable is to collaborate with Ohio Health Plans (Medicaid) in a perinatal data project emphasizing pre/interconception care to produce the following:

- a. A written report on an analysis of data on postpartum visits among women with Medicaid financed births.
- b. A PowerPoint presentation on Medicaid births, LBW births, and trends in service delivery and outcomes (quality improvement and performance focus). //2007//

/2008/ While the contract with Dartmouth for analysis of postpartum visits was not done, Dartmouth did use PRAMS data from Ohio and 3 other states for 2 studies on access to family planning (FP) services. Such access should have an impact on the percent of births with poor outcomes. The first study tested the hypothesis that greater geographical access to FP facilities is associated with lower rates of unintended and teenage pregnancies and found no relationship. The second study sought to determine whether selected structural/organizational characteristics of publicly available FP facilities are associated with greater availability and found that availability varied by these characteristics, many determined by federal/state policies.

DFCHS, BCFHS requested DFCHS data support staff to prepare a report on the percent of women who return for (complete) 1 postpartum visit. This indicator is 1 of a set of performance measures used in the evaluation of Ohio's 6 Regional Perinatal Centers. Analysis was done using Medicaid claims data (the only available data source). The report indicated that less than half of women return for a postpartum visit. Results will assist the state in identifying strategies for assisting women in spacing their pregnancies as a way to reduce the risk of subsequent LBW.//2008//

/2008/See HSCI 04 for a discussion of the ODH Birth Outcomes Improvement Initiative.//2008

The Bureau of Community Health Services and Systems Development (BCHSSD) Primary Care and Rural Health (PC/RH) program will use Medicaid data to verify performance of safety net health care providers placed in underserved areas to assure they are providing health care services in their practice settings in proportions no less than the percent of Medicaid eligibility

rates in their respective health professional shortage areas of placement. /2007/BCHSSD PC/RH program used Medicaid data to verify performance of safety net health care providers placed in underserved areas to assure they are providing health care services in their practice settings in proportions no less than the percent of Medicaid eligibility rates in their respective health professional shortage areas of placement. Based on this analysis the Director sent letters to 2 practice sites identifying deficiencies in providing health services to underserved populations and requesting corrective action plans. //2007// /2008/J1 Visa physician applications continue to provide projections of patients who will be served in comparison to county level rates of Medicaid, Medicare/uninsured populations.//2008//

/2009/ See HSCI 05C re: birth outcome improvement initiatives in Ohio.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	61.2	78.7	72.7

Notes - 2009

Data Source: Ohio Department of Health, Vital Statistics Resident Birth Files, 2006 final data. Unlike in prior years, Medicaid status taken from Vital Statistics birth records, not from Medicaid matched files.

The switch to NCHS 2003 birth certificate standard resulted in many missing values for entry into prenatal care. Prenatal care has 26% missing data.

Narrative:

The Ohio Department of Health (ODH) typically receives information from the Medicaid Program in the Ohio Department of Job and Family Services (ODJFS). The Medicaid Program's data that was provided to ODH is 1 year in arrears because of ODH Vital Statistics delays in processing 2003 birth/death files. As in all prior years, outcomes for persons who are on Medicaid are worse than the population as a whole and those not on Medicaid. /2007/ Neither 2003 nor 2004 data were available to Medicaid, who prepares this report. For 2002, the percent of infants born to pregnant women on Medicaid receiving first trimester prenatal care was 25 percent lower than among infants whose mothers were not on Medicaid.//2007// /2008/ 2004 VS data were not available to Medicaid, who prepares this report. For 2003 the percent of infants born to pregnant women on Medicaid receiving first trimester prenatal care was 16 percent lower than among infants whose mothers were not on Medicaid. This was an improvement from the previous year.//2008// **/2009/ Note that the data source for this indicator is no longer the linked Medicaid/VS birth file, as this was not available from Medicaid. The data source for the reporting year is payment data from Ohio VS birth files. For 2006 the percent of infants born to pregnant women on Medicaid receiving first trimester prenatal care was 61.2, which is 28.6 percent lower than among infants whose mothers were not on Medicaid**

(78.7). 2007 data are not yet available. Comparisons with previous years cannot be made because the 2003 revisions to the Birth Certificate that took effect in 2006 required that data be collected using a different methodology. Data for SFY 2007 were prepared by ODH, DFCHS.//2009//

The information is used by Title V programs, including the Child and Family Health Services program (CFHS), to identify and target higher risk populations for outreach and services. /2007/The Division of Family and Community Health Services (DFCHS),BCFHS, is in the process of contracting with Dartmouth University for Perinatal Data Use Consortium - Phase IV. One of the deliverables is to collaborate with Medicaid in a perinatal data project emphasizing pre/interconception care to produce the following products: A written report on an analysis of data on postpartum visits among women with Medicaid financed births; and A PowerPoint presentation on Medicaid births/LBW births/trends in service delivery and outcomes (quality improvement and performance focus).//2007// /2008/ See HSCI 05A for a discussion of studies done by Dartmouth University and analyses of postpartum visits by women whose births were financed by Medicaid. See HSCI 04 re:the ODH Birth Outcomes Improvement Initiative.//2008//

The Bureau of Community Health Services and Systems Development (BCHSSD) Primary Care and Rural Health (PCRH) program use Medicaid data to verify the performance of safety net health care providers placed in underserved areas to assure they are providing health care services in their practice settings in proportions no less than the percent of Medicaid eligibility rates in their respective health professional shortage areas of placement./2007/ The BCHSSD, PCRH program used Medicaid data to verify the performance of safety net health care providers placed in underserved areas to assure they are providing health care services in their practice settings in proportions no less than the percent of Medicaid eligibility rates in their respective health professional shortage areas of placement. Based on this analysis the Director sent letters to 2 practice sites identifying deficiencies in providing health services to underserved populations and requesting corrective action plans.//2007// /2008/ J1 Visa physician applications continue to provide projections of patients who will be served in comparison to county level rates of Medicaid, Medicare and uninsured populations.//2008//

/2009/ ODH is working with ODJFS to address poor pregnancy outcomes; and is working to increase Medicaid enrollment. An Ohio partnership of state agencies, neonatal/obstetrical providers, professional organizations and a center with expertise in quality improvement aims to improve pregnancy outcomes through a Centers for Medicaid and Medicare Services (CMS) sponsored transformation effort. This partnership, the Ohio Perinatal Quality Collaborative (OPQC), will address issues of prematurity. Through Medicaid Administrative Claiming (MAC) ODH & ODJFS are working to reduce health disparities by assuring the opportunity for eligible clients to obtain Medicaid services. ODH is working with public health and private sector stakeholders to secure approval for a Medicaid waiver to expand eligibility for Medicaid coverage of family planning services. ODH is conducting a statewide needs assessment/ planning process of reproductive health needs that includes participation from almost 100 stakeholders.//2009//

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid,</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	64.5	75.2	71.5

Notes - 2009

Data Source: Ohio Department of Health, Vital Statistics resident Birth Files, 2006 final data. Unlike in prior years, Medicaid status taken from Vital Statistics birth records, not from Medicaid matched files.

The switch to NCHS 2003 birth certificate standard resulted in many missing values for entry into prenatal care. Prenatal care has 26% missing data.

Index calculated using obstetrical estimate of gestational age.

Narrative:

In 2004 (provisional data), 88.5 percent of women with a live birth had a Kotelchuck Index (KI) of at least 80 percent, up from 85.3 percent in 2003. /2007/ Per final 2003 Vital Statistics (VS) data, 85.3 percent of women with a live birth had a KI of at least 80 percent, down from 86.5 percent in 2002. 2004 VS data are not yet available. //2007// /2008/ Per final 2005 VS data, 85.9 percent of women with a live birth had a KI of at least 80 percent, up from 85.3 percent in 2003. 2006 data are not yet available. //2008// **/2009/ In 2006 64.5 percent of women on Medicaid had a KI of at least 80 percent. which is 16.6 percent lower than mothers who were not on Medicaid (75.2). 2007 data are not yet available. Comparisons with previous years cannot be made because the 2003 revisions to the Birth Certificate, effective in 2006, required that data be collected using a different methodology; There was also much missing data in 2006. Data for 2006 were prepared by ODH, DFCHS. //2009//**

The KI combines 2 independent dimensions of prenatal care (PC). It characterizes the timing of PC initiation and frequency of visits received after initiation of PC compared to ACOG recommendations. While KI is a valuable index in measuring adequacy/timing of PC, it does not measure quality of PC. The Division of Family and Community Health Services (DFCHS) recognizes the importance of adequacy of PC and has several program strategies to improve the measure. DFCHS is funding and providing TA to projects that employ community health workers to improve access to care through culturally competent (CC) care coordination. The DFCHS Bureau of Child and Family Health Services is also committed to ensuring that CC care is provided in its CFHS funded perinatal clinics. All CFHS subgrantees are monitored for capacity to provide CC care. An analysis done 2 years ago revealed that many subgrantees do not provide ongoing CC training for their providers and do not have access to training resources. As a result of this analysis, DFCHS is providing TA/training.

/2007/In 2005, an analysis was completed of the response of CFHS funded agencies to the Culturally/ Linguistically Appropriate Services (CLAS) assessment, a grant requirement. Results of assessments demonstrated a need for TA/training related to: staff diversity education; outreach activities; development of strategic plan to address CC: and evaluating CC activities.

Based on DFCHS' recent analyses of disparities, contributing factors, and opportunities for improvement in birth outcomes, a DFCHS Birth Outcomes Improvement Initiative (BOII) was developed. The initiative is about refining the message of pre/interconception (PI) care in DFCHS MCH-serving programs. The initiative will focus on important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to

improve birth outcomes. The initiative brings together Ohio's MCH programs, EI, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies listed below.

1. Conduct focus groups of women of childbearing age and providers for these women;
2. Partner with Ohio ACOG to develop/modify and implement PI service protocols: Pilot MOM focused interconception visits;
3. Focus all programs on populations at greatest risk;
4. Partner with Ohio Department of Mental Health to conduct a Maternal Depression Screening Pilot Project;
5. Implement 5 A's Prenatal Smoking Cessation Program;
6. Advance use of Perinatal Data Use Consortium;
7. Support Ohio Partners for Birth Defects Prevention;
8. Support Fetal Alcohol Spectrum Disorders Statewide Initiative;
9. Convene Ohio Summit for PI Health. /2008/ DFCHS, BCFHS contracted with OSU School of Nursing for the project to conduct 18 consumer focus groups and 30 interviews of providers for SFY 2007; IRB approval obtained. Report attached.

As part of partnership with Ohio ACOG to develop/modify and implement PI service protocols, ACOG representatives attended DFCHS quarterly meetings; ALL Ohio Team developed a state action plan to address Tobacco Prevention and Cessation for Women of Reproductive Age.

For development of a pilot program, Mom-Focused Interconception Visits, that would include interventions to improve outcome of a subsequent pregnancy in women who previously delivered a LBW baby, literature reviews were completed; a survey to assess Ohio Infant Mortality Reduction Initiative programs was conducted. To focus all programs on populations at greatest risk, results of Perinatal Periods of Risk (PPOR) analysis were used to drive program direction. Ohio's PPOR indicated that the African Americans AA); Teens; AA Teens (15-17) populations are disproportionately affected by poor birth outcomes. A DFCHS survey was conducted to determine programs to target and strengthen their focus on populations at greatest risk.//2008// /2009/ See HSCI 05C re: initiatives

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	200

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) is currently 150 percent.

/2007/ For 2004, the percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1) is 150 percent and for SCHIP is 2000 percent. //2007//

/2008/ No changes in the poverty levels.//2008//

The Ohio Department of Job and Family Services, Medicaid Program, provides information on the poverty level for eligibility in the State's Medicaid and SCHIP Programs.

/2007/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying infants, children, and families eligible for Medicaid and SCHIP and assisting them with enrollment. //2007//

/2008/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying infants, children, and families eligible for Medicaid and SCHIP and assisting them with enrollment.//2008//

/2009/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying infants, children, and families eligible for Medicaid and SCHIP and assisting them with enrollment.//2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	200

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for children ages 1 to 19 years is currently 150 percent.

/2007/ For 2004, the percent of poverty level for eligibility in the State's Medicaid programs for children ages 1 to 19 years, was 150 percent; for SCHIP, the poverty level for eligibility for children was 200 percent. //2007//

/2008/ No changes in the poverty levels.//2008//

The Ohio Department of Job and Family Services, Medicaid Program, provides information on the poverty level for eligibility in the State's Medicaid and SCHIP programs.

/2007/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying children eligible for Medicaid and SCHIP and assisting their families with enrollment. //2007//

/2008/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying children eligible for Medicaid and SCHIP and assisting their families with enrollment.//2008//

/2009/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying infants, children, and families eligible for Medicaid and SCHIP and assisting them with enrollment.//2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Notes - 2009

Data Source, Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid)

Not Applicable, as the Ohio SCHIP program does not cover pregnant women as a category (unless they qualify as a child).

Narrative:

The percent of poverty level for eligibility in the State's Medicaid programs for pregnant women is currently 150 percent. Ohio's SCHIP program does not cover pregnant women

/2007/ For 2004, the percent of poverty level for eligibility in the State's Medicaid programs for pregnant women was 150 percent; Ohio's SCHIP program does not cover pregnant women. //2007//

/2008/ No changes in the poverty levels.//2008//

The Ohio Department of Job and Family Services, Medicaid Program, provides information on the poverty level for eligibility in the State's Medicaid and SCHIP programs.

/2007/ See discussion for HSCI 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, for activities related to identifying infants, children, and families eligible for Medicaid and SCHIP and assisting them with enrollment.
//2007//

/2008/ See discussion for HSCI 07A.//2008//

/2009/ See discussion for HSCI 07A.//2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

WIC and birth certificate records are linked on an as-needed basis, not necessarily annually.

ODH does not currently link birth certificates and newborn screening files. ODH has implemented the Integrated Public Health Information System (IPHIS). Phase One involved the collection of Vital Statistics data. This integrated system is expediting the extraction of needed Vital Statistics data and it is also beginning to be used for the collection of other data. Discussions about collecting newborn screening data on the birth certificate are expected to be raised again at some future date.

The MCH program has access to subsets of the Ohio Hospital Association database per a Memorandum of Understanding between the Ohio Department of Health and the Ohio Hospital Association.

The development of Ohio's Birth Defects Surveillance System is in progress. Pilot data collection from several hospitals was completed in 2007. Data collection was expanded statewide in July 2007. Data analysis will begin when sufficient data are available.

The linkage is done at the state Medicaid office in the Ohio Department of Job and Family Services, Ohio Health Plans. Data needed for MCH Block Grant reporting are normally provided to the Ohio Department of Health annually, but were not provided in 2007.

Narrative:

The ability of Ohio to assure that the Maternal and Child Health (MCH) program and Title V agency have access to policy/program relevant information/data is carried out through the State Systems Development Initiative (SSDI) grant. The goal of Ohio's SSDI grant for the period 10/1/2003-9/30/2006 is to assist in building infrastructure for comprehensive, community-based systems of care for all children and their families. This goal will be accomplished through a focus on the Title V MCH Block Grant BG Health Systems Capacity Indicator #9(A), and will be addressed, over the 3-year grant period, through 7 project objectives: 1) improve access to data linkages between Ohio birth records and Medicaid files; 2) create data linkages between Ohio birth records and WIC eligibility files; 3) obtain access to hospital discharge data; 4) increase analyses of data from PRAMS; 5) increase analyses of data from YRBS; 6) monitor opportunities for establishment or improvement in priority data linkages and access to priority data sets that are unable to be addressed in the current project period; 7) provide quality data for MCH BG performance measures and five-year needs assessment.

Access to both Medicaid and Ohio Hospital Association (OHA) data are achieved through an interagency agreement (Medicaid) and a Memorandum of Understanding (MOU). ODH has for the first time linked WIC and birth certificate data. Ohio participates in both the CDC PRAMS and YRBS; SSDI funds pay for a contracted biostatistician to assist with statistical analysis of the data. SSDI staff participated in the MCH Five Year Needs Assessment to provide quality data. /2007/There were no changes in key activities for FFY06.//2007

In regard to coordination of activities, the SSDI Coordinator is also the Title V MCH BG Coordinator, and is housed in the ODH Division of Family and Community Health Services (DFCHS), allowing for integration of Title V BG activities with SSDI activities. /2007 /The new SSDI Coordinator (Bill Ramsini) is involved in Title V BG, allowing for integration of Title V Block Grant activities with SSDI activities.//2007// /2008/Coordination of the MCH BG takes place in the ODH DFCHS; SSDI coordination remains in DFCHS, BHSIOS.//2008//

In regard to experience to date, coordinating committees that involve representatives from ODH (including SSDI), Medicaid, and OHA, were established to oversee interagency agreements. Several Medicaid projects were approved in the DFCHS. ODH received data from OHA; initial analyses were completed. To examine the effect of WIC participation on birth outcomes, Ohio

birth files were linked with prenatal WIC records. Several in-depth analyses of PRAMS data that were done with SSDI resources have been used for YRBS. A process for creating linked infant birth/death files was developed in a previous SSDI budget year.

/2007/ ODH received data from OHA; and some analyses were completed. A list of new projects will be developed in 2006. New WIC linkage projects will be conducted in 2006. The single most significant achievement of the year was progress toward the objective on linking WIC and birth certificate data: To create data linkages between Ohio birth records and WIC eligibility files to assist DFCHS in program planning/policy development. The first project agreed upon was an examination of the effect of prenatal WIC participation on birth outcomes. The SSDI epidemiologist linked Ohio's most recent birth files (2002) with prenatal WIC records for 2001 and 2002. A 90 percent match was achieved. Since Ohio's birth records are geocoded, the matched files were categorized by census block groups into three neighborhood types: low, medium, and high income levels. The outcomes for women on WIC in each neighborhood type were compared with the outcomes for women not on WIC. In low income neighborhoods, outcomes for women in WIC were significantly better than for those not on WIC.//2007//

/2008/SSDI is involved in the following activities: a data linkage training funded by a mini-grant from AMCHP and Title V was conducted in 5/07; assessing need for data linkage among MCH programs; assessed data linkage software; updated PPOR analysis using most recent linked birth and death file; provided assistance in development of a Medicaid RFP for a new data warehouse.//2008//

/2009/The SSDI project successfully extended data sharing agreements with the Ohio Medicaid agency and OHA; analyses were completed using these data sources. The SSDI-funded contract for statistical assistance with OSU was extended for another year. OSU statisticians assisted in sampling design/data weighting in areas such as surveys on WIC, pediatrics, school nurses, vision/hearing. Also assessed a methodology for identifying children at risk for lead poisoning. EI and CSHCN data was linked with Medicaid data. We now receive vital statistics data on a timely basis.//2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Risk Tobacco Survey	3	No

Notes - 2009

The data for the Youth Risk Tobacco Survey are available to the Title V Program from the Ohio Department of Health, Office of Healthy Ohio, Bureau of Health Promotion and Risk Reduction, where the survey is administered

Narrative:

Ohio has been conducting the Youth Risk Behavior Survey (YRBS) since 1993; starting in 2003, the survey has been conducted by ODH, DFCHS. In addition, the ODH Division of Prevention administers the Youth Tobacco Survey (YTS). The data from these surveys on use of tobacco products by youth is used for needs assessments and to monitor tobacco use among youth.

/2007/ The Ohio Department of Health, Bureau of Community Health Services and Systems Development, School and Adolescent Health section, in collaboration with the Bureau of Health

Services Information and Operational Support, collected weighted YRBS data in 2005.

32 percent of adolescents in grades 9 through 12 reported using tobacco products in the past month. This is in comparison to 28 percent in 2003.//2007//

//2008// Data collection for the 2007 YRBS has been completed; weighting and analysis will be done by CDC during the summer of 2007. Response rates were high enough to allow for weighting of the data, and sample size will be sufficient to analyze data by race and by county type, which will assist us to focus appropriate interventions. //2008//

/2008/ According to the 2006 Ohio Youth Risk Tobacco Survey, 11.6 percent of Ohio middle school students and 28.7 percent of Ohio high school students were current users of any form of tobacco products. Among high school students, males were significantly more likely than females to be current tobacco users. In 2006 there were no significant differences between white and black middle school or high school students with respect to rates of tobacco use. Twelfth graders were significantly more likely than ninth or 10th graders to be current tobacco users.//2008//

Most of the youth tobacco activities in the Ohio Department of Health are carried out by the Division of Prevention, Bureau of Health Promotion and Risk Reduction. Their activities include: A grant with ON TASC, Inc., a prevention resource center in Youngstown to provide training in the "Life Skill Training" Curriculum. This is a curriculum for middle school students. More than 90 individuals have been trained.

/2008/The ODH Division of Prevention, Bureau of Health Promotion and Risk Reduction is awaiting numbers from ON TASC for the current fiscal year. The 90 will probably increase to around 140 or more. They are updating their strategic plan and should have that completed by the end of June.//2008//

The Smoke-Free Schools committee was established to encourage schools to have 100% tobacco free campuses.

The Tobacco Use Prevention Strategic Plan was released and baseline data on prevention was started.

/2009/ According to the 2007 Youth Risk Behavior Survey, 27.5 percent of students reported using any tobacco products in the past 30 days. This is in comparison to 32.1 percent in 2005. Ohio Department of Health, Office of Healthy Ohio, Bureau of Health Promotion and Risk Reduction, is in the process of conducting the 2008 Youth Risk Tobacco Survey. They expect the results from CDC by the end of the summer and then will produce a new report. Note that the Bureau of Health Promotion and Risk Reduction has moved from the Division of Prevention to the Office of Healthy Ohio.//2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Ohio Department of Health has recently updated its Strategic Plan and Performance Goals. Please see the attached documents.

Ohio is addressing all the 18 National Performance Measures, and the following ten State Performance Measures:

1. (State 1): Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes
2. (State 2): Percent of low birth weight black births among all live black births
3. (State 3): Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services
4. (State 4): Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions
5. (State 5): Percent of 3rd graders who are overweight
6. (State 6): Increase the state's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services
/2008/ Change in wording: Assess the contribution of safety net providers in meeting the need for primary care, mental health and dental services
7. (State 7): Percentage of 3rd grade children with untreated caries
8. (State 8): Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System
9. (State 9): Increase the proportion of children who receive age- and risk-appropriate screenings for lead, vision, and hearing.
- 10.(State 10): Integrate ODH Maternal and Child Health Information Systems

/2008/ Program activities are listed in Sections III C and D: Discussion of National and State Performance Measures.//2008//

B. State Priorities

Summary of Needs Assessment

The Needs Assessment Team used information about health status of the MCH population gathered as a result of the five-year needs assessment to generate a list of needs organized by the 4 levels of the pyramid.

Direct Health Care Services

1. Access for low-income women/adolescents to perinatal/family planning safety net services
2. Access for low-income children/adolescents to dental care (including dental sealants)
3. Adequate numbers/distribution of providers accepting Medicaid
4. Direct funding of payment for health care services for those portions not covered by other funding sources.
5. Special equipment for CSHCN
6. Home health care for CSHCN
7. Mental health services for the MCH population, including CSHCN
8. Medical homes for CSHCN
9. Community-based care for CSHCN

Enabling Services

1. Assistance in enrollment process for available health insurance plans
2. Targeted outreach efforts to bring high-risk women into early prenatal care
3. Culturally appropriate services for MCH population
4. Prenatal smoking cessation programs
5. Programs that employ community health workers to improve access to care through culturally competent care coordination
6. Effective community-based outreach/enrollment strategies to ensure children receive needed health care services through Medicaid/SCHIP
7. Information for families of CSHCN about available services/resources
8. Assistance with navigating systems for families of CSHCN
9. Transportation/translation services
10. Programs to provide nutrition services for those who are overweight/obese

Population-Based Services

1. Public awareness about reproductive health/family planning services
2. Awareness among low-income women about importance of early/continual prenatal care
3. Understanding among pregnant women of the harmful effects on the fetus from smoking/consuming alcohol during pregnancy
4. Public awareness about the following:
 - * Overweight children and healthy eating/exercise
 - * Health effects of childhood lead poisoning
 - * Importance of early professional vision care for children
 - * Importance of early oral health care for children
 - * Importance of immunization schedule
 - * Postponement of teen sexual activity
 - * Proper use of safety devices to decrease motor vehicle deaths in children
 - * Navigation of the health care system
 - * Adolescent asset building models
 - * Risk factors for adolescent suicide
 - * Risk factors for new adolescent drivers
 - * Mental/behavioral health issues in the MCH population

Infrastructure Building Services

1. Information/training for providers on the following:
 - * Factors contributing to low/very low birth weight
 - * Culturally competent practices
 - * Identifying populations at risk for poor birth outcomes
 - * Identifying populations at risk for mental/behavioral health problems
 - * Pediatric overweight; adult obesity
 - * Oral health status, oral health resources, access to dental care
 - * Blood lead screening policy
 - * Vision assessment
 - * Hearing assessment
 - * Screening/referral
 - * Immunization schedule
 - * Adolescent risk assessment inventories
 - * Adolescent skill building/decision making models
 - * Promotion of motor vehicle safety
 - * Healthy Start/SCHIP information
 - * Risk factors for adolescent suicide
 - * Suicide prevention initiatives
 - * CSHCN in school settings
2. Quality data/information for policy development/program planning on the following:
 - * Smoking/alcohol use among pregnant women

- * Access to early prenatal care, including high-risk
 - * Adequacy of prenatal care
 - * Effective outreach strategies
 - * Education needs of prenatal providers
 - * Low/very low birth weight factors/trends
 - * Breastfeeding rates
 - * Injury prevention
3. Information for legislators/policymakers/MCH stakeholders on risk factors contributing to LBW and effect of prenatal care on birth outcomes
 4. Understanding among prenatal service providers of the barriers to care that pregnant women face.
 5. Capacity building among local public health agencies to conduct a community health assessment/planning process including 88 county profiles of unmet primary care needs
 6. A statewide system for infant/child/adolescent death review
 7. Quality data/information for policy development/program planning on the following:
 - * Childhood lead poisoning prevention
 - * Effective immunization outreach strategies
 - * Contributing factors for teen pregnancy and LBW
 - * Motor vehicle crashes
 - * Rate of uninsured children served through safety net health care programs
 - * Medicaid provider recruitment, training, reimbursement
 - * Uninsured rates for children
 - * Medicaid eligible children receiving services
 - * Barriers to Medicaid enrollment
 - * Placement of primary care providers/board certified pediatric specialists in underserved areas
 9. Coordination/collaboration with state Medicaid program re: enhanced blood lead screening for Medicaid eligible children
 10. Collaboration among public/private agencies to coordinate immunization planning
 11. Information for legislators, policy makers, and MCH stakeholders re: factors contributing to teen births
 12. Coordination among complex government programs.
 13. Access to providers (e.g., increasing the number of Medicaid providers and providers who accept uninsured patients using a sliding fee scale based on 200 percent FPL.
 14. Continuity of care with the established provider for CSHCN
 15. Establishment of a network of providers in both urban/rural areas who are needed to diagnose/treat asthma and pervasive developmental disorders
 16. Availability of community PHN services
 17. Comprehensive population-based data on CSHCN

B. Prioritization of Issues

As described in Ohio's needs assessment methodology, prioritization was accomplished in two phases:

- I. Separately for maternal/infant; early childhood; school-aged child/ adolescent; CSHCN populations (B.1)
- II. Unified for entire MCH population (B.2)

B.1 Issues Ranked in Priority Order in Phase I Needs Assessment Workgroups

Women's Health, Birth Outcomes/Newborn Health Issues Ranking

1. Access to adequate prenatal care/health insurance
2. Preterm Births/LBW
3. Preconception/Family Planning/Unintended pregnancy/genetics referrals/services
4. Neonatal/Perinatal Mortality
5. STDs/HIV/Hepatitis
6. Overweight/Nutrition
7. Smoking
8. Interconceptional Care

9. Mental Health/Postpartum/Perinatal Depression

Early Childhood Health Issues Ranking

1. Health Coverage/Access to Care
2. Access to Comprehensive Services including: Immunizations, Oral Health, Vision, Hearing, Lead Screening, Behavioral/Mental Health Screening
3. Infant Mortality
4. Child Care/Development
5. Child Injury
6. Child Death
7. Overweight/Nutrition
8. Social/Emotional Health Issues
9. Environmental Issues

School-Aged Child/Adolescent Health Issues Ranking

1. Insurance/Health Care Access/Use
2. Chronic Disease Prevention
3. Screenings (Includes Oral Health, Vision, Hearing)
4. Mental Health Issues
5. Sexual Behaviors
6. Substance Abuse Issues
7. Suicide
8. Motor Vehicle Issues

CSHCN Health Issues Ranking

1. Insurance/Access/Payment Issues
2. Care Coordination: Medical Home/Community
3. Services for Congenital/Genetic Conditions
4. Transition
5. Access to specialty and specific health care services
6. Mental Health
7. Medical Condition and Services
8. Impact on Family

B.2. Top Ten MCH Health Issues Identified in the Phase II Process (Unranked)

- * Improve birth outcomes
- * Assure quality screening, identification, intervention, care coordination, medical home
- * Assure access to comprehensive preventive/treatment services for individuals and families, including CSHCN
- * Promote age-appropriate nutrition/physical activity
- * Improve oral health/access to dental care
- * Enhance social/emotional strengths of families
- * Increase collaboration/coordination of programs for families through partnerships and data integration
- * Incorporate racial/ethnic/cultural health equity in all activities
- * Decrease substance abuse/addiction, including tobacco
- * Promote sexual responsibility/reproductive health

Data Analysis/Research Agenda

During the course of reviewing data as part of the needs assessment process, the Needs Assessment Team identified gaps in data and information that would have been helpful to better identify populations at risk and contributing factors toward which interventions could be developed. When such gaps in data were identified, they were noted. They since have been incorporated as strategies in the FFY 2006 MCH BG and thereby represent the continual process of needs assessment that will be undertaken by DFCHS in the coming year. Listed below are

gaps in data identified through that process and will formulate our research agenda for FFY 2006./2007/for FFY2007//2007///2008/for FFY 2008./2008// **/2009/ for FFY 2009./2009//**

/2007/NPM 01: Newborn screening follow-up

Develop data system for Genetics/Sickle Cell for diagnosed cases from NBS Lab; reconcile Metabolic Formula Program records with NBS Lab; implement data system for local subgrantees; evaluate NBS and follow up system to determine where gaps in diagnosed disorders and treatment information occur./2007// /2008/Implement new data system in genetics program to collect identifying and clinical management information on children 0-5 identified with NBS disorders./2008// **/2009/ Participate with staff at ODH Newborn Screening Lab to develop new data system and study its impact on case disposition forms, abnormal results letters, and access to the system by staff from Genetics, Sickle Cell and Metabolic Formula Programs./2009//**

NPM 03: Medical Home

Conduct analyses of the impact of the "Medical Home" on CSHCN using results of the National CSHCN Survey that is now in the field, as well as other National Child Health Surveys./2008/Evaluate family satisfaction portion of BCMH/BEIS pilot./2008/

NPM 04: CSHCN with a Source of Insurance for Primary and Specialty Care

Use results from the Ohio Family Health Survey to describe CSHCN access to Medical Home and source of health insurance./2007/Analysis completed./2007//

/2008/NPM 05: CSHCN whose families report the community-based service systems are organized so they can use them easily.

Measure/evaluate access to Specialty Services at community level./2008//

NPM 07: Immunization

Monitor and analyze DFCHS program immunization data.

NPM 08: Teen Births

Identify and monitor populations and areas at risk for teen pregnancy.

/2008/Analyze PRAMS data to identify issues specific to teens. Evaluate BCFHS programs to determine if they are using evidence-based practices to reduce contributing factors to teen pregnancy./2008//

NPM 09: Dental Sealants

Evaluate effectiveness of BOHS approach to funding school-based sealant programs.

NPM 10: Motor Vehicle Death Rates (children ages 1 through 14)

Assess current literature and available data to identify at-risk populations, gaps in data, and opportunities for future programs. /2007/Monitor MV deaths; analyze contributing factors./2007//

NPM 11: Percent of mothers who breastfeed their infants at hospital discharge.

Identify data sources and methodologies to describe the proportion of Ohio mothers who exclusively breastfeed at hospital discharge and at 6 and 12 months./2007/Old NPM 11 is retired.

New NPM 11: Analyze data on mother's perceptions of maternity care practices related to breastfeeding in Ohio./2007///2008/Analyze newly available 2006 birth certificate breastfeeding data./2008//

NPM 12: Newborn Hearing Screening

Monitor birthing locations to assure that infants receive hearing screenings and that referral rates are acceptable. Monitor tracking/follow-up of UNHS results to reduce rate of loss to follow-up.

/2008/NPM 13: Children without Health Insurance

Monitor impact of Mandatory Managed Care into all counties on DFCHS funded

projects.//2008//

/2007/NPM 14 (new): Childhood Overweight

Conduct data surveillance and monitoring activities.//2007// /2008/ Investigate differences between peer counties that have differing obesity rates based upon 2005 PedNSS data.//2008// **/2009/ Conduct an analysis of Ohio 3rd grade BMI and PedNSS data to explore differences in trends of childhood obesity by county and by race/Hispanic ethnicities.//2009//**

NPM 15: Very Low Birth Weight Live Births

Assess current literature and available data to understand associations of Artificial Reproductive Technology with multiple births and VLBW trends./2007/ Measure retired.

NPM 15 (new): Prenatal Smoking

Assess existing provider systems/services for prenatal/postpartum tobacco treatment in 4 pilot counties. Survey providers to determine provider-level capacity to deliver the 5 A's. Measure health care systems' capacity to institutionalize consistent identification, documentation and treatment of prenatal/postpartum tobacco users; measure the prevalence of smoking among women of reproductive age.//2007 /2008/Conduct process evaluation of pilot activities.//2008//

/2007/NPM 16: Suicide

Describe problems of youth suicide in Ohio.//2007//

NPM 17: Very Low Birth Weight Infants Delivered at Facilities for High-Risk Deliveries and Neonates

Analyze current information regarding newborn survival rates at Level II and Level III hospitals by the following: specific birth weights and gestation; provider criteria for transfer of high-risk pregnancies to Level III facilities (e.g., referrals, use of transport); availability of high-risk services; cost of transport and care; and the impact of insurance/provider referral on transport practices./2007/ An analysis in progress. Additional analysis: Design a study of birth outcomes by hospital level and regional perinatal designation. //2007// /2008/ Continue the analysis; evaluate components of competitive RFP for RPC funding; monitor national/state/local performance measures by ODH and RPC staff.//2008//

NPM 18: Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester

Analyze current information on the women who are not getting care (e.g., defining subpopulations, cultural practices, geographic areas, insurance practices) in order to develop more effective outreach strategies. /2008/ Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. //2008// **/2009/ Examine disparities in prenatal care in first trimester rates re: age, marital status, income, education, parity, payer, race/ethnicity.//2009//**

SPM 01: Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes

Identify characteristics of Ohio women experiencing unintended pregnancy and contributing factors (e.g., use of birth control)./2007/Analysis has been completed; updates based on most recent PRAMS data have been requested.//2007// /2008/ Examine disparities in pregnancy rates re: age, relationship status, income, education, and race/ethnicity.//2008//

Conduct programmatic research, literature reviews, and time-limited demonstration projects to identify evidence based practices that might be best for delaying first pregnancy among those under 18 years, and lengthening birth spacing among the high risk population in Ohio./2007/ Work on this is in progress. Additional analysis: Identify baseline rates of unintended pregnancy in Ohio.//2007//

SPM 02: Percent of low birth weight black births among all live black births

Identify strategies to address subpopulations in the African American population at risk for poor birth outcomes./2008/Survey DFCHS programs interacting with women of childbearing age to determine if services are provided to population of greatest risk based on PPOR data./2008//

/2007/SPM 03: Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services Survey DFCHS Programs to create inventory of current practices related to social emotional health screening and referral in DFCHS Programs) //2007///2008/ Conduct follow-up survey to programs. Survey will identify: protocols, standards/guidelines for screening/referral; screening tools used to assess social/emotional health; training provided to develop skills; data sources/types of data collected on screening/referrals; needs for services by population group; partners/collaborators./2008// **/2009// Conduct focus groups with the state's new 168 mental health consultants to find out extent to which children birth to age 8 are referred for further evaluation of their social emotional health needs. Examine data collected within Ohio's Help Me Grow(HMG) program and NASHP pilot study for the past 12 months on prevalence of physicians and Help Me Grow (HMG) home visitors using social-emotional screening tools./2009//**

SPM 04: Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions

Develop/implement a consumer survey to measure acceptability of health care in relation to cultural sensitivity. /2007/Develop division-wide profile of MCH populations served./2007/

SPM 05: Percent of 3rd graders who are overweight

Conduct data surveillance/monitoring activities: select Sentinel School Sample; collect heights/weights of Sentinel School Sample./2007//

SPM 06: Increase the state's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services /2008/new wording: Assess the contribution of safety net providers in meeting the need for primary care, mental health and dental services//2008// Conduct programmatic research, literature reviews/consumer surveys to develop definitions of access to treatment/preventive services and ways to measure. /2007/In regard to access to care, evaluate degree to which Ohio is doing the right things (per analysis of root causes of poor access); if Ohio is doing the right things, evaluate degree to which they are being done right)./2007/ Assess existing data capacity to measure access: develop/analyze a survey regarding safety net dental clinics to determine capacity; and the potential ability to expand.; assess minority providers in urban areas; identify data gaps to measure access./2007// /2008/ Analyze Ohio Hospital Association data for ambulatory sensitive conditions such as pediatric asthma./2008// **/2009/ Measure gaps in access to primary care/contribution of safety net providers. //2009//**

SPM 08: Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System

Evaluate success/effectiveness of OCCSN to: collect/link birth defects data with other child records; implement parent notification/referral system; describe degree to which coordination between HMG/other CSHCN programs occurs./2007/conduct evaluation on data collection/referral to services implementation that began in FFY06 in 4 counties of the state; expand implementation of birth defects data collection/referral to services system to additional areas of the state./2007// /2008/Build birth defects data system that meets program needs for surveillance/case reporting/data sharing/integration./2008//

SPM 09: Increase the proportion of children who receive age/risk- appropriate screenings for lead/vision/hearing.

Identify data collection methods to measure screening rates./2008/ Measure impact of activities on preschool screening rates; identify barriers to screening in primary care settings./2008// **/2009/ Identify available data sources and/or explore data collection methods to measure impact**

of activities on preschool screening rates for vision/hearing./2009//

SPM 10: Integrate ODH MCH Information Systems
/2007/Assess data integration needs of bureaus./2007/

C. National Performance Measures

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	97.3	78.6	96.2	66.3	66.3
Numerator	144	147	179	4679	4679
Denominator	148	187	186	7052	7052
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

2007 data are not available; 2006 data are used to estimate 2007 data.

Notes - 2006

ODH Newborn Screening Lab does not collect treatment/clinical management information. Currently, ODH Genetics and Sickle Cell programs collect de-identified data. This will change in future years. Given protocol at the Lab, we assume all cases except hemoglobin traits receive confirmation, although Sickle Cell Traits do not require clinical management.

Notes - 2005

Data Source: ODH Newborn Screening Laboratory, 2005.
The laboratory does not routinely collect treatment data. There is no field in the laboratory database to enter the information. Any treatment information that comes in with the diagnostic information is entered into a comment field and cannot be easily recovered by queries. Therefore, these are estimated figures.

Beginning in July 2007, newborn screening treatment information will be collected through the ODH Genetics Program

a. Last Year's Accomplishments

The target for 2006 was 100 percent. The actual percent of newborns that were screened and confirmed with conditions mandated by the state and that received appropriate follow up was xxx percent. Ohio did/ did not meet its goal. Data for 2007 are not available.

A. Develop consensus on the definitions of "timely and appropriate follow-up" for the disorders on

Ohio's newborn screening panel.

Accomplishments: Developing consensus on the definitions of "timely and appropriate follow-up" for the disorders on Ohio's newborn screening panel has been partially completed. Data collected from genetic centers will be analyzed to assist in coming to consensus of definitions. This will occur in FFY08.

B. Explore mechanisms for collecting treatment information.

Accomplishments: Mechanisms for collecting treatment information have been identified. ODH-funded genetics centers began providing data on treatment information for newborn screening cases.

C. Implement the data system that collects treatment information.

Accomplishments: The data system that collects treatment information has been implemented. In FFY07, the data was collected via excel spreadsheet. In FFY08, the data will be completed as part of a newly designed genetics data system.

D. Evaluate system to determine where gaps in diagnosed disorders and treatment information occur.

Accomplishments: The evaluation of the system to determine where gaps in diagnosed disorders and treatment information occur has been partially completed. Data has been collected from genetic centers and is currently under review in FFY08.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop consensus on the definitions of "timely and appropriate follow-up" for the disorders on Ohio's newborn screening panel.				X
2. Request recommendations from the Newborn Screening Advisory Committee.				X
3. Work with Sickle Cell Medical Directors for input on hemoglobinopathies and explore BCMH Treatment Protocols for newborn screening disorders.				X
4. The Genetics Section will work with OMIS on development of a data system for Genetics/Sickle Cell that is able to accept download of diagnosed cases from New Born Screening (NBS) Lab system.				X
5. Routinely reconcile Metabolic Formula Program data records with NBS Lab records.				X
6. Genetics Section staff, in collaboration with OMIS, will implement a data system for local subgrantees.				X
7. Evaluate NBS and follow up system to determine where gaps in diagnosed disorders and treatment information occur.				X
8. Determining strategies to find/follow up on children diagnosed with disorders who are not receiving treatment -- and whether or not the treatment received meets ODH's definition.				X
9.				

10.				
-----	--	--	--	--

b. Current Activities

A. Develop consensus on definitions of "timely and appropriate follow-up" for the disorders on Ohio's newborn screening panel.

This infrastructure-level strategy is being carried out through the following activities: 1) request recommendations from the Newborn Screening Advisory Committee; 2) work with Sickle Cell Medical Directors for input on hemoglobinopathies; 3) explore BCMH Treatment Protocols for newborn screening disorders.

B. Explore mechanisms for collecting treatment information.

This infrastructure-level strategy is being carried out through the following activities that include: 1) the Genetics Section will work with OMIS on development of a data system for Genetics/Sickle Cell that is able to accept download of diagnosed cases from New Born Screening (NBS) Lab system; 2) routinely reconcile Metabolic Formula Program data records with NBS Lab records.

C. Implement the data system that collects treatment information.

This infrastructure-level strategy is being carried out through activities including: Genetics Section staff, in collaboration with OMIS, will implement a data system for local subgrantees.

D. Evaluate NBS and follow up system to determine where gaps in diagnosed disorders and treatment information occur.

Evaluation activities include: 1) assessing gaps; and 2) determining strategies to find/follow up on children diagnosed with disorders who are not receiving treatment -- and whether or not the treatment received meets ODH's definition

c. Plan for the Coming Year

A. Monitor data from regional genetic centers and reconcile with NBS Lab data.

This infrastructure-level strategy will be carried out through the following activities:

1. Monitor data from genetic centers monthly (completeness, timeliness, accuracy)
2. Compare with NBS Lab data quarterly (# children with abnormal NBS results seen by RCGC staff)
3. Report data through Annual Data Report (# children identified through NBS seen in RCGC; # children diagnosed with NBS disorders by type of treatment; analysis of timeline from birth, NBS, diagnosis, and treatment)

B. Implement consistent hemoglobin trait reporting procedures among Regional Sickle Cell Services Projects.

This infrastructure-level strategy will be carried out through the following activities:

1. Review current case closing procedures among projects and identify and implement best practice procedures in all centers
2. Implement use of the trait letter in Regional Sickle Cell Services Projects (from sickle cell project to primary care physician)

C. Work with Medicaid, BCMH and WIC to streamline administrative procedures for the provision of metabolic formula to individuals in Ohio.

D. Participate in Region 4 Genetics Collaborative.

E. Participate with staff at ODH Newborn Screening Lab as they develop a new data system and the impact on case disposition forms, abnormal results letters, and access to the system by staff from Genetics, Sickle Cell and Metabolic Formula Programs.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	60	75	75	75
Annual Indicator	59.3	59.3	59.3	59.3	65.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	75	75	75	75	75

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with data from the 2002 National CSHCN Survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2007 was 75 percent. The actual percent of CSHCN whose families partner in decision making and are satisfied with the services they receive was 65.4 percent. According to the National Children with Special Health Care Needs Survey (2005/2006), Ohio has not met its target.

A. Develop more methods of getting information to parents, in additions to newsletters.

Several key activities were moved to federal fiscal year 2008: 1) evaluating and distributing the family satisfaction portion of the BCMH/BEIS pilot; and 2) distributing results of family satisfaction portion of the BCMH/BEIS pilot. This activity was moved to 2008 due to contract vendor has not finalized the report. Activity 3, working with HMG regarding FIN focus groups data to evaluate family satisfaction and program impact on families for the 0-3 population and Activity 4, distributing results of Family Information Network focus groups data to evaluate family satisfaction and program impact on families for the 0-3 population. Activity 5, printing and distributing handbook on navigating health care systems for parents of CSHCN, has been cancelled due to

lack of funding to print and distribute handbook.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop more methods of getting information to parents.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Develop more methods of getting information to parents, in additions to newsletters.

This population-level strategy is being accomplished by

1. evaluating family satisfaction portion of the BCMH/BEIS pilot;
2. distributing results of family satisfaction portion of the BCMH/BEIS pilot;
3. working with HMG regarding FIN focus groups data to evaluate family satisfaction and program impact on families for 0-3 population;
4. distributing results of Family Information Network focus groups data to evaluate family satisfaction and program impact on families for 0-3 population; and
5. finalizing material and placing on HMG website, the handbook (link to BCMH) on navigating healthcare systems for parents of CSHCN.

c. Plan for the Coming Year

A. Empower families to work in partnership with providers for decision-making.

This infrastructure-level strategy will be carried out through the following activities:

1. Create a "regional page" on BCMH web site and link to regional resource and referral web sites.
2. Partner with Family VOICES of Ohio to strengthen regional family activities.
3. Implement activities related to core component #1 of the Integrated Systems Grant. Core Component #1 is Family/professional partnership at all levels of decision-making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55	56	60	60	60

Annual Indicator	55.9	55.9	55.9	55.9	55.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	60	60	60

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with data from the 2002 National CSHCN Survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2007 was 60 percent. The actual percent of CSHCN who received coordinated, ongoing, comprehensive care within a medical home was 55.6 percent. According to the National Children with Special Health Care Needs Survey (2005/2006), Ohio has not met its target.

A. Develop and implement a Medical Home service coordinator for SCHCN in managed care in collaboration with ODJFS, Bureau of Managed care.

This activity continues to be ongoing but the program has been unable to work with the ODJFS on this project due to several high priority projects of their own at this time.

B. Develop and implement a pilot program for Medical Home office based service coordination. This infrastructure-level strategy is being accomplished by: 1) working with Drs. James Duffee and Ron Levine in development of an office-based service coordination model; and 2) working with advanced practice nurses and social workers in development of the office-based service coordination model.

C. Implement physician CEU program on web regarding CSHCN medical home.

The Bureau for Children with Medical Handicaps continues to work with Drs. James Duffee and Chuck Onufer, in Illinois, in development of a web-based Medical Home CEU program; and 2) working with Dr. Levine and Cincinnati Children's Hospital in placing the CEU Program on line. This is not completed at this time and is on-going.

D. Continue to support Cincinnati Children's Hospital Resource Directory (web-based).

This infrastructure-level strategy has been accomplished by 1) serving on the advisory council for Cincinnati Children's Hospital Resource Directory; and 2) serving on the National AAP Advisory Council for the Medical Home On Line Resource Directories.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Cincinnati Children's Hospital Resource Directory (web-based).				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Develop and implement a Medical Home service coordinator for SCHCN in managed care in collaboration with ODJFS, Bureau of Managed care.

This infrastructure-level strategy is being accomplished by: 1) working with Drs. James Duffee and Ron Levine to develop an office-based service coordination model; and 2) working with advanced practice nurses and social workers to develop an office-based service coordination model.

B. Develop and implement a pilot program for Medical Home office based service coordination.

This infrastructure-level strategy is being accomplished by: 1) working with Drs. James Duffee and Ron Levine in development of an office-based service coordination model; and 2) working with advanced practice nurses and social workers in development of the office-based service coordination model.

C. Implement physician CEU program on web regarding CSHCN medical home.

This infrastructure-level strategy is being accomplished by: 1) working with Drs. James Duffee and Chuck Onufer, in Illinois, in development of a web-based Medical Home CEU program; and 2) working with Dr. Levine and Cincinnati Children's Hospital in placing the CEU Program on line.

c. Plan for the Coming Year

A. Strengthen Medical Home, particularly in the area of coordination of services for families and providers

This infrastructure-level strategy will be carried out through the following activities:

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based)
2. Develop, implement and evaluate a pilot program for Medical home office based service coordination
3. Work with BEIS and ODJFS foster care system to improve the medical home for children in foster care
4. Coordinate with BEIS and Ohio Chapter of AAP on implementation of the ODH Autism grant to

connect medical home to autism services

5. Implement activities related to core component #2 of the Integrated Systems Grant. Core Component #2 is Access to comprehensive health and related services through the medical home.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	75	75	75	75
Annual Indicator	60.8	60.8	60.8	60.8	64.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	75	75	75	75	75

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with data from the 2002 National CSHCN Survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2007 was 75 percent. The actual percent of CSHCN whose families had adequate private and/or public insurance to pay for the services they need was 64.6 percent. According to the National Children with Special Health Care Needs Survey (2005/2006), Ohio has not met its target.

A. Inform providers and families on how to access and use insurance benefits.

The Bureau for Children with Medical Handicaps was unable to host six regional education meetings on "full utilization of insurance benefits" including local public health nurses, HMG service coordinators for families of CSHCN because of major changes that were and are occurring in Ohio's Medicaid program that affects CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inform providers and families on how to access and use insurance benefits.		X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Inform providers and families on how to access and use insurance benefits

This infrastructure-level strategy is being accomplished by holding six regional education meetings on "full utilization of insurance benefits" including local public health nurses and HMG service coordinators for families of CSHCN

B. Enhance efforts to expand children's insurance coverage

This infrastructure-level strategy is being accomplished through the following activities:

1. Work with key stakeholders in expansion of Medicaid for Children/SCHIP or Medicaid; and
2. Work with ODJFS on defining the EPSDT Benefit for Ohio.

c. Plan for the Coming Year

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

This strategy will be accomplished through the following infrastructure- and population- level activities:

1. Work with key stakeholders in expansion of Medicaid for Children/SCHIP and Children Buy-In program.
2. Continue to work with consumers and provides on implementation of new therapy rules.
3. Implement activities related to core component #4 of the Integrated Systems Grant. Core Component #4 is Adequate public and/or private financing of needed services.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	80	81	90	90	90
Annual Indicator	80.2	80.2	80.2	80.2	92.2
Numerator					

Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	95	95	95

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with data from the 2002 National CSHCN Survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2007 was 90 percent. The actual percent of CSHCN whose families report that community-based service systems are organized so they can use them easily was 92.2 percent. According to the National Children with Special Health Care Needs Survey (2005/2006), Ohio has met its target.

A. Inform families of community-based services.

We were unable to host six regional education meetings on "Medicaid Managed Care" including ODJFS, HMG for families of CSHCN because of major changes that were and are occurring in Ohio's Medicaid program that affects CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inform families of community-based services.		X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Inform families of community-based services

This population-level strategy is being accomplished by conducting regional educational meetings with ODJFS, HMG, and BCMH

B. Measure and evaluate access to Specialty Services at the community level

This infrastructure-level strategy is being accomplished through the following activities:

1. Develop a methodology to measure and evaluate the access to Specialty Services at the community level.
2. Measure and evaluate access to specialty care at the community level.

c. Plan for the Coming Year

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

This infrastructure-level strategy will be carried out through the following activities:

1. Work to develop in the Youngstown area to establish a system of care for CSHCN by partnering with Akron Children's and other children's hospitals
2. Work with Ohio Family VOICES and other parent groups to address needs
3. Implement activities related to core component #5 of the Integrated Systems Grant. Core Component #5 is Organization of community services so that families can use them easily.

Performance Measure 06: *The percentage 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10	10	25	25	25
Annual Indicator	5.8	5.8	5.8	5.8	48.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	50	50	50

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with data from the 2002 National CSHCN Survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2007 was 25 percent. The actual percent of CSHCN whose families partner in decision making and are satisfied with the services they receive was 48.5 percent. According to the National Children with Special Health Care Needs Survey (2005/2006), Ohio has met its target.

A. Develop more methods of getting information to parents, in additions to newsletters
 The Title V Children with Special Health Care Needs Program -- ODH Bureau for Children with Medical Handicaps (BCMh) - has maintained the forum for youth with special health care needs in having quarterly regional meeting of the Youth Advisory Councils. These have been held in Marietta, Cleveland, and Dayton. Local experts on Rehab Services, SSI, and Managed Health Care have spoken to the Youth at these meetings. Information from the meetings is shared as appropriate, with other BCMh groups such as the Medical Advisory Council, Parent Advisory Committee, etc.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct quarterly, regional meetings with the Young Adult Advisory Council.		X	X	
2. Inviting pertinent agencies/staff to present at YAAC meetings, i.e. Rehab Services Commission, SSI, Genetic Counselors.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Maintain a forum for youth with special health care needs to discuss needs and receive information on services and supports.

This population-level strategy is being accomplished through the following activities
 1. Conduct quarterly, regional meetings with the Young Adult Advisory Council, including the NW region.
 2. Invite pertinent agencies/staff to present at YAAC meetings, i.e. Rehab Services Commission, SSI, Genetic Counselors.

B. Recruit and Educate Physician Providers for Youth

Dr. James Bryant and the BCMh field nurses is accomplishing this infrastructure-level strategy recruiting physician providers for youth in transition by working with present providers and

medical schools in Ohio. This will be measured by recruiting ten new providers in this category for this year.

C. Educate Policy Makers as to needs for Insurance Coverage for young Adults with Medical Needs

To accomplish this infrastructure-level strategy, BCMH is working with the YAAC and PAC to educate policy makers. This is being done through direct contact with policy makers and legislative contacts

c. Plan for the Coming Year

A. Maintain a forum for youth with special health care needs to discuss needs and receive information on services and supports

This infrastructure-level strategy will be carried out through the following activities:

1. Conduct quarterly, regional meetings with the Young Adult Advisory Council (add NW region).
2. Invite pertinent agencies/staff to present at YAAC meetings, i.e. Rehab Services Commission, SSI, Genetic Counselors.
3. Continue to develop regional transition teams to ensure medical care.

B. Educate Policy Makers as to needs for Insurance Coverage for young Adults with Medical Needs

This infrastructure-level strategy will be carried out through the following activities:

1. Continue to develop regional transition teams to ensure medical care
2. Educate policy makers as to insurance coverage for young adults with medical needs
3. Recruit and Educate Physician Providers for Youth.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79	79	84	84.5	85
Annual Indicator	82.3	79.5	84.1	81.3	81.3
Numerator	188056	176829	187429	180619	180619
Denominator	228501	222427	222864	222163	222163
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	85.5	86	86	86	86

Notes - 2007

2007 data are not available. 2006 data were used to estimate 2007.

Notes - 2006

Data source: Estimated percent of Ohio children 19-35 months of age with vaccination coverage (series 4:3:1:3:3 = 4 doses DTaP or DTP, 3 doses polio, 1 dose MMR, and 3 doses Hib.) from the U.S. National Immunization Survey, (MMWR Q1/2006 - Q4/2006. Percent value is + or - 5.

Data for the denominator from US Census data:2006 - All 2-year-olds and one-half of the 1-year olds.

The numerator was generated by applying Ohio's CDC percentage of vaccination coverage to the denominators.

Notes - 2005

Data source: Estimated percent of Ohio children 19-35 months of age with vaccination coverage (series 4:3:1:3:3 = 4 doses DTaP or DTP, 3 doses polio, 1 dose MMR, and 3 doses Hib.) from the U.S. National Immunization Survey, (MMWR Q1/2004 - Q4/2004. Percent value is + or - 5.

Data for the denominator from Ohio Vital Statistics data:

Live births from Aug 1 of 2003 through Jan 31 of 2005.

The numerator was generated by applying Ohio's CDC percentage of vaccination coverage to the denominators.

a. Last Year's Accomplishments

The target for Calendar Year 2006 for the 4:3:1:3:3: series was 84.5 percent. The actual percent of 19 to 35 month olds who received the full schedule of appropriate immunizations for age was 81.3. Ohio has not met its target for 2006 (Data are not available for 2007).

A. Monitor immunization data from DCFHS funded programs.

Data from the following sources were analyzed: CFHS program (MATCH) and WIC program.

Analysis of WIC data showed that 80 percent of the children in the 19-35 month age range were up to date on their immunizations while 84 percent of CFHS children were fully immunized.

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

This strategy was accomplished 1) monitoring those CFHS subgrantees providing child health services; 2) working with BCHSSD to promote an awareness campaign within schools that have school-based clinics; and 3) working with the Rural Health program to promote provider awareness at the annual Rural Health Conference.

CFHS subgrantees were monitored by assigned program consultants using the program specific data collection systems. Twenty-nine technical assistance and five comprehensive visits were made. BCHSSD promoted immunizations and the statewide immunization registry within schools that have school-based clinics. Because this year's Rural Health Conference focused on rural Health Information Technology (HIT) initiatives provider awareness was not promoted at this conference

C. Collaborate and coordinate immunization planning and programming efforts with national,

state and local health programs

This infrastructure-level strategy will be accomplished by collaborating with the ODJFS Immunization Advisory group and other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services.

Of the 72 subgrantees funded by the CFHS Grant, 50 percent have included immunization strategies in their program plan. Activities included collaboration with local stakeholders and Regional Lead Resource Centers, among others. Children who are enrolled in the Help Me Grow program have their immunization needs addressed in the Individual Family Service Plan. Educational pamphlets on immunizations are dispersed to families during Health Fairs and concentrated campaigns utilizing community health assessment data to determine areas of need.

Health Professionals within the local WIC clinics review both the immunization records of the children being certified/recertified and the schedule of immunizations with parents and guardians.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze data from the following sources: CFHS program (MATCH) and WIC program.				X
2. Work with BCHSSD to promote an awareness campaign within schools that have school-based clinics; and work with the Rural Health program to promote provider awareness at the annual Rural Health Conference.			X	
3. Collaborate with the ODJFS Immunization Advisory group and other stakeholder groups; and work with local WIC projects to ensure that children are referred for immunization services.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor immunization data from DFCHS funded programs.

This infrastructure-level strategy is being accomplished by analyzing data, including trends, from the CFHS program utilizing the MATCH data collection system.

B. Promote the use of the statewide immunization registry by DFCHS funded program

This infrastructure-level strategy is being accomplished through the following activities:

1. Monitor those CFHS subgrantees providing child health services;
2. Work with the Rural Health Program to promote provider awareness at the annual Rural Health

Conference;

3. Monitor immunization status by HMG service providers upon program entry and exit with referral/care coordination.

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

This infrastructure-level strategy is being accomplished through the following activities:

1. Collaborate with the ODJFS Immunization Advisory Group and other stakeholder groups;
2. Collect immunization data on initial WIC certification and subsequent recertification visits (every 6 months) with referral and consistent education for immunizations

c. Plan for the Coming Year

A. Monitor immunization data from DCFHS funded programs.

This infrastructure-level strategy will be accomplished by analyzing data, including trends, from the CFHS program utilizing the MATCH data collection system.

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

This infrastructure-level strategy will be accomplished by 1) monitoring those CFHS subgrantees providing child health services; 2) working with the Rural Health program to promote provider awareness at the annual Rural Health Conference; 3) monitoring of immunization status by HMG service providers upon program entry and exit.

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

This infrastructure-level strategy will be accomplished by collaborating with the ODJFS Immunization Advisory group and other stakeholder groups.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	18	18	18	18	18
Annual Indicator	20.1	19.2	19.6	19.8	19.8

Numerator	4764	4569	4710	4836	4836
Denominator	237328	237738	240837	244467	244467
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	18	18	18	18	18

Notes - 2007

2007 data are not available; 2006 data were used as estimates

Notes - 2006

Data for denominator from US Census Bureau, 2006 population estimates. Numerator from OH resident births, final 2006 Vital Statistics birth file.

Notes - 2005

Data for denominator from US Census Bureau, 2005 population estimates. Numerator from OH resident births, final 2005 Vital Statistics birth file.

a. Last Year's Accomplishments

The target for CY 2006 was 18 births per 1,000 live births to teens 15-17. Ohio's actual rate was 19.8. Ohio did not meet its target (2007 data are not available).

A. Identify and monitor populations and areas at risk for teen pregnancy by analyzing PRAMS (state-level data); YRBS (state- and regional-levels), and Vital Statistics data (state-, county- and regional-levels).

Based on 2004-2006 data for 15-17 year olds live births, the teen birth rate was 19.37. (NOTE: 2006 data were preliminary) An analysis of PRAMS data (2000 to 2003) identified that the birth rate for 15 to 17 year old black teens was about twice that of white teens age 15 to 17 years in Ohio.

B. Identify, summarize, and distribute information to DFCHS funded programs on contributing factors to teen pregnancy; and evidence-based/promising practices to reduce teen pregnancies.

A literature search was conducted of contributing factors to determine what influences a teen's decision to become pregnant. Technical assistance visits with 53 delegate agencies included a review of program requirements regarding prevention of sexual coercion, culture competence, and family/community involvement in teen decision-making about reproductive health. Applying ODH data, efforts to reach at risk populations has focused on building capacity for cultural competency. The ODH family planning project implemented a tool for assessment of cultural competence within delegate agencies (See <http://www.odh.ohio.gov/odhPrograms/cfhs/famx/familyx1.aspx>). The completed assessments have progressed toward implementation of strategic plans to improve culturally competent policies and health services.

C. Collaborating with other programs to implement interventions to reduce teen pregnancy rates including the Family Planning and Abstinence Education programs; and the Birth Outcomes Improvement and Ohio Infant Mortality Reduction Initiatives.

ODH Family Planning Program is collaborating with the ODH Adolescent Health Program and a

local health department to provide an evidence-based teen pregnancy prevention program in an adolescent health clinic that serves primarily African-American adolescents from 11-21. This project is being coordinated by ODH, CityMaTCH, AMCHP and Health Care Education and Training.

BCFHS, in collaboration with internal and external stakeholders has established a Birth Outcomes Initiative to determine and initiate activities to decrease poor birth outcomes in at risk populations and to lessen subsequent poor birth outcomes to women who have already had poor birth outcomes.

The ODH Family Planning Program has initiated a state-wide family planning needs assessment to determine the need for reproductive health services in counties and cities in Ohio. This process has included program project directors, advisory council members and program staff and will continue into 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and monitor populations and areas at risk for teen pregnancy by analyzing PRAMS (state-level data); YRBS (state- and regional-levels), and Vital Statistics data (state-, county- and regional-levels).				X
2. Conduct a literature search of contributing factors to include what influences a teen's decision to become pregnant; reasons why unintended pregnancy occurs; the importance of community support; sexual coercion; and culture influences.				X
3. Conduct a search for evidence-based/promising practices to include the literature, Internet, OSU School of Public Health, and other sources.				X
4. Collaborate with other programs to implement interventions to reduce teen pregnancy rates including the Family Planning and Abstinence Education programs; and the Birth Outcomes Improvement and Ohio Infant Mortality Reduction Initiatives.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Analyze PRAMS data reported by teen mothers to identify issues specific to this population. Examine results to determine next steps and recommendations for further research.

B. Evaluate BCFHS programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy.

This infrastructure-level strategy is being accomplished through the following activities:

1. Conduct a survey to determine the programs in Ohio that are addressing teen pregnancy;
2. Compare those programs to evidence-based practice;
3. Provide technical assistance to improve program quality.

C. Refer to activities for State Performance Measure 02: Strategy C (Ohio Birth Outcomes Improvement Initiative)

c. Plan for the Coming Year

The following infrastructure level strategies will be accomplished through the activities listed.

A. Analyze PRAMS data reported by teen mothers to identify issues specific to this population. Examine results to determine next steps and recommendations for further research.

1. Work with PRAMS coordinator to identify data on teen births.
2. Use Vital Statistics data for prioritizing concerns of stakeholders about the effect of teen pregnancy on birth outcomes in Ohio.
3. Disseminate prioritization results to sub-grantees from stakeholder meeting.
4. Formulate recommendations for best practice strategies by using the prioritization results from the stakeholder's meeting.
5. Monitor program's Culturally and Linguistically Appropriate Services (CLAS) strategic plans to ensure implementation (See Office of Minority Health, DHHS, 2001. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Retrieved February 15, 2008, from <http://www.omhrc.gov/assets/pdf/checked/executive.pdf>).

B. Evaluate BCFHS programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy.

1. Based on previous year's survey to compare programs in Ohio that are addressing teen pregnancy prevention programs, compare these programs to evidence-based practice programs.
2. Provide technical assistance to improve program quality through a statewide education/training meeting.
3. Monitor introduction of standards of practice into community outreach activities.
4. Ensure prevention programs incorporate learning materials appropriate for LEP (i.e. limited English proficiency) clients.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	40	42	44	45	47
Annual Indicator	39.2	39.6	42.7	43.6	42.2
Numerator	461	456	5992	410	53703
Denominator	1175	1152	14029	941	127146
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	48	49	50	51	52

Notes - 2007

Data Source: From the 2006/2007 Annual Sentinel School Survey of 25 schools which provided a population-based estimate for the state. Numerator: Actual number of children in the sample who received protective sealants = 473 (population estimate = 53703). Denominator: Actual number of children in the sample who were screened = 1147 (population estimate = 127146).

Notes - 2006

Data Source: From the 2005/2006 Annual Sentinel School Survey of 25 schools which provided a population-based estimate for the state.

Notes - 2005

Data Source: 2004/2005 fourth statewide oral health survey of schoolchildren.

a. Last Year's Accomplishments

The target for FFY 2007 was 47 percent. The actual percent of children who received protective sealants on at least one permanent molar tooth was 42.2 percent. Ohio did not meet its target.

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

Five programs had modest program expansions by adding qualifying schools. This addition of new schools expanded the program into three counties previously not served by the dental sealant program. 27,091 students were screened and 18,578 students received dental sealants.

Statewide dental sealant program summary information has been updated (including a map). This "At-A-Glance" fact sheet will be posted on the Ohio Department of Health's website.

B. Improve quality in sealant subgrant programs by assuring accurate subgrantee reporting, analyzing quarterly report data and other documentation, conducting site visits and providing technical assistance based on identified program needs.

The process for reviewing quarterly program reports was changed to improve both the timeliness and accuracy of the reports that were being submitted. Technical assistance was provided via email and phone contact regarding inaccurate reporting and in response to inquiries from the local programs. A site visit was made to the Washington County Health Department to observe the program and provide technical assistance.

Statewide expansion of Medicaid managed care in 2007 raised concerns for the dental sealant programs which are required to bill Medicaid for dental sealants (thereby leveraging MCH BG funds). A meeting was held with the sealant programs and all eight managed care plans, providing an opportunity for the managed care plans to respond to questions from the sealant programs and improving communications between the dental sealant programs and Ohio's Medicaid managed care plans.

C. Evaluate the effectiveness of the BOHS approach to funding school-based sealant programs.

A researcher was hired and has conducted a thorough analysis of the data collected by ODH-funded dental sealant programs. The data point to areas requiring technical assistance for the school-based sealant programs. Decreasing participation rates, isolated retention concerns and other issues identified through this analysis of the data are being addressed.

ODH has been in discussions with Susan Griffin and Kari Jones, CDC, about utilizing SEALS, a database developed for states to enter data and evaluate the effectiveness of their school-based dental sealant programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand program to additional qualifying schools as funding and efficient planning permit.				X
2. Update the Ohio School-based Dental Sealant Program fact sheet, including a map showing locations of sealant programs and counties served by each, a current list of funded agencies, and summary data, including the number of students to be served in 2				X
3. Improve quality in sealant programs by assuring accurate reporting, analyzing quarterly report data and other documentation, conducting site visits and providing technical assistance based on identified program needs.				X
4. Evaluate effectiveness of the BOHS approach to funding school-based sealant programs.				X
5. Review funding systems utilized in other states (e.g., NY, IL and TN); and 3) developing a plan for future funding of sealant programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Fund local agencies to operate efficient, high quality school-based dental sealant programs.

This infrastructure-level strategy is being accomplished through the following activities:

1. Expand program to additional qualifying schools via existing subgrantees as funding/efficient planning permit;
2. Update the Ohio School-based Dental Sealant Program fact sheet, including a map showing locations of sealant programs and counties served by each, a current list of funded agencies, and summary data, including number of students to be served in 2006.

B. Improve quality in sealant subgrant programs.

This infrastructure-level strategy is being accomplished by assuring accurate subgrantee reporting, analyzing quarterly report data/other documentation, conducting site visits and providing technical assistance based on identified program needs and conducting Sealant Sharing Day.

C. Evaluate effectiveness of the BOHS approach to funding school-based sealant programs.

This infrastructure-level strategy is being accomplished by developing and implementing a plan for future funding of sealant programs. The plan, to be developed after FY07 activities (analyzing trend data to identify problems and reviewing other states' funding systems) will take into account the effectiveness and equity of changing to another system for reimbursement for sealants provided to students not enrolled in Medicaid (e.g., subsidy agreements that reimburse agencies a flat rate per child sealed).

c. Plan for the Coming Year

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

This infrastructure-level strategy will be accomplished through the following activities: 1) implement plan for expanding the number of schools and children served by ODH-funded sealant programs; 2) update the Ohio School-based Dental Sealant Program At-A-Glance sheet, including a map showing locations of sealant programs and counties served by each, a current list of funded agencies, and summary data, including the number of students to be served in 2009.

B. Improve quality in sealant subgrant programs.

This infrastructure-level strategy will be accomplished by 1) assuring accurate subgrantee reporting, analyzing quarterly report data and other documentation, conducting site visits and providing technical assistance based on identified program needs and 2) evaluating the potential for using CDC's SEALS program with the Ohio dental sealant programs based on an evaluation of a pilot program conducted in 2008.

C. Evaluate effectiveness of the BOHS approach to funding school-based sealant programs.

This infrastructure-level strategy will be accomplished by developing and implementing a plan for future funding of sealant programs. The plan, to be developed after FY2008 activities (analyzing trend data to identifying problems and reviewing other states funding systems) will take into account the effectiveness and equity of changing to another system for reimbursement for sealants provided to students not enrolled in Medicaid (e.g., subsidy agreements that reimburse agencies a flat rate per child sealed).

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.5	2.4	2.4	2.4	2.4
Annual Indicator	3.1	2.9	2.6	2.7	2.7
Numerator	72	66	59	58	58
Denominator	2327236	2293008	2264102	2122965	2122965
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2007

2007 data are not available. 2006 data are used to estimate 2007 data.

Notes - 2006

Data Source:

Numerator: Ohio Vital Statistics 2006 final death file

Denominator: U.S. Census/NCHS Bridged Race, Vintage 2006 Ohio population estimates for 2006

Notes - 2005

Data Source:

Numerator: Ohio Vital Statistics 2005 final death file

Denominator: U.S. Census/NCHS Bridged Race, Vintage 2005 Ohio population estimates for 2005

a. Last Year's Accomplishments

The target for Calendar Year 2006 was 2.4 deaths/100,000. Ohio's actual rate was 2.7. Ohio did not meet its target for 2006. (2007 data not available).

A. Use Vital Statistics data ...Child Fatality Review data ...Ohio Department of Public Safety crash report data ...

The rate of deaths has been analyzed using Vital Statistics data. The contributing factors of motor vehicle crash fatalities for children under 18 years have been monitored and analyzed via child fatality review data. Child fatality review data for children 1-14 years old was further analyzed. 394 deaths in 2005 to children 1-14 years old were reviewed; 56 were vehicular deaths. This represents 43 percent of all vehicular deaths reviewed; 14 percent of all 1-14 year old deaths; and 31 percent of all non-natural deaths (180) to 1-14 year olds.

B. Analyze the factors that contribute to deaths...Share the information...

Analysis of the 56 vehicular deaths reviewed found that 52 percent involved the death of a child passenger in a motor vehicle, and 38 percent involved the death of child pedestrian or biker. The remaining 10 percent involved children on ATVs, watercraft and other types of vehicles. Of the 29 deaths to 1-14 year old passengers of motor vehicles, 19 (66 percent) were not properly restrained. 56% of all child passengers killed were with drivers younger than 18 years old. Of the 10 black child vehicular deaths ages 1-14 years, only two were in a vehicle. The other 8 were pedestrians.

The CFR Annual Report and data were shared at numerous division meetings and overlapping work groups; CFR trainings; the Combined Public Health Conference; the Ohio Public Health Epidemiology Conference; the WIC Symposium; and CFR Advisory Committee and subgroup meetings. The report was announced through media releases to newspapers, television and radio stations. The report was posted on the ODH Website and published copies were distributed throughout ODH and to mandated elected officials, local CFR boards, Family and Children First Councils, and the State Library system.

C. Encourage local Child Fatality Review Boards to share information and recommendations...

CFR boards are encouraged to seek collaboration from other community agencies to develop activities and initiatives in response to CFR findings. Local boards have partnered with schools and service organizations to provide bike safety events, free bike helmets and seat belt use incentives. Cooperation with law enforcement and traffic engineers has resulted in roadway improvements, media messages re: driveway safety and targeted passenger restraint education. Ohio's Graduated Driver License law was strengthened in April, 2007, in large part as a result of grassroots efforts by CFR boards and others with whom CFR data were shared. New revisions

to the law limit the number of child passengers for teen drivers and establish a curfew for young drivers. CFHS projects were encouraged to include local CFR findings in community health assessments and program planning.

D. Collaborate with injury programs...

The ODH Injury Prevention program works closely with the Ohio Department of Public Safety/Governor's Highway Safety Office (ODPS/GHSO) to address child passenger safety (CPS) issues. ODH received a grant from ODPS/GHSO to support these activities. The funds were used to purchase educational materials dealing with child passenger safety. ODH purchases safety seats that are distributed through a network (Ohio Buckles Buckeyes) of child passenger safety programs. Each county has an agency designated to provide education and distribute child passenger safety seats at no cost to families that meet financial eligibility. A Memorandum of Understanding has been signed by the Director of Health and the Director of ODPS for the sharing of data from the Trauma and EMS Registries. An Injury Prevention staff member is a member of the Ohio Child Fatality Review Advisory Committee where death to children resulting from motor vehicle crashes has been a priority. The Injury Prevention Program is developing a multi-disciplinary, statewide injury prevention coalition in which the Child Fatality Review Program, as well as members of the Governor's Highway Safety Office are participating in an effort to improve injury prevention collaboration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor child motor vehicle (MV) crash death data using VS, Child Fatality Review (CFR) data, and Ohio Department of Public Safety (ODPS) crash report data.				X
2. Assess data quality issues; data quality problems that could be remedied; and need for new data sources.				X
3. Analyze factors that contribute to child deaths caused by MV crashes.				X
4. Continue the Vehicular Death special focus section in the CFR annual report.				X
5. Provide TA, training and tools to local CFR boards re: ways to present and share information to various audiences.				X
6. Work with CFHS Program Consultants to strengthen collaborations between local CFR boards and CFHS projects.				X
7. Identify and share best practices for collaborations among CFR boards.				X
8. Use CFR Advisory Committee and workgroup recommendations to engage state partners to coordinate efforts to identify and implement needed changes to policy, practice or legislation to reduce child deaths due to MV crashes.				X
9.				
10.				

b. Current Activities

A. Use VS/CFR/Ohio Department of Public Safety data to monitor MV crash deaths.

1. ID differences in case definition in data sources.
2. ID possible data quality issues.
3. Assess need for more data sources.

B. Analyze factors that contribute to MV deaths in children age 1-14. Share information with ODH

programs, other state agencies, local health departments, child health partners/ policymakers.

1. Continue Vehicular Death special focus section for CFR annual report.
2. Use strategy workgroup/other external partners to review data/give input.
3. Use multiple venues to disperse findings.

C. Encourage local CFR Boards to share information/recommendations re: prevention of MV deaths in children age 1-14 with local partners who can reach families/children.

1. Provide TA/training/tools to local CFR boards re: ways to present/share information to various audiences.
2. Work with CFHS Program Consultants to strengthen collaborations between local CFR boards/CFHS projects.
3. Share best practices for collaborations among CFR boards, especially for pedestrian safety in metro areas.

D. Collaborate with injury programs in ODH/other state agencies, to develop strategies to decrease child MV injuries/deaths, including proper use of safety devices/pedestrian safety.

Use CFR Advisory Committee/strategy workgroup/Injury Community Planning Group recommendations to engage state partners/leverage influence to ID/implement changes to policy/practice/legislation to reduce child MV deaths.

c. Plan for the Coming Year

A. Use VS data to monitor the rate of deaths to children age 1-14 caused by MV crashes. Use Child Fatality Review (CFR) data to monitor the percentage of deaths among all deaths reviewed caused by motor vehicle crashes. Use Ohio Dept.of Public Safety (ODPS) crash report data to monitor county of MV crash deaths.

This infrastructure-level strategy will be accomplished through the following activities:

1. ID differences in case definition among data sources.
2. Continue to be alert to possible data quality issues.
3. Assess need for additional data sources.

B. Analyze factors that contribute to deaths among children age 1- 14 caused by caused by MV crashes using state CFR data/crash report data from the ODPS. Share the information with ODH programs/other state agencies/local health departments/child health partners/ policymakers such as legislators.

This infrastructure-level strategy will be accomplished through the following activities:

1. Continue the Vehicular Death special focus section for the CFR annual report.
2. Use the strategy workgroup plus other external partners to review data/give input.
3. Use multiple venues to disperse findings, such as ODH Website, e-mails, conference exhibits/presentations.

C. Encourage local CFR Boards to share information/recommendations about prevention of MV deaths among children age1-14 with local partners who can reach families/ children, such as local media, Help Me Grow, county Family and Children First, Ohio Buckles Buckeyes, service agencies, and legislators.

This infrastructure-level strategy will be accomplished through the following activities:

- 1.Continue to provide TA/training/tools to local CFR boards re: ways to present/share information to various audiences, including the use of CFR data for funding applications. Include in agenda for annual CFR training.

2. Continue working with CFHS Program Consultants to strengthen collaborations between local CFR boards/CFHS projects, per the CFHS RFP. Review/monitor local CFHS work plans/activities related to the required strategy for CFR.
3. Share best practices for collaborations among CFR boards, especially for pedestrian safety in metro areas.
4. Prepare fact sheets which focus on data for vehicular deaths to 1-14 year olds and the risk factors unique to this age group.

D. Collaborate with injury programs within ODH and other state agencies such as the ODPS, to develop strategies to decrease MV injuries and deaths among children, including the proper use of safety devices and increasing pedestrian safety.

This infrastructure-level strategy will be accomplished through the following activities:

1. Use CFR Advisory Committee/strategy workgroup/Injury Community Planning Group recommendations to engage state partners and leverage influence to coordinate efforts to identify/implement needed changes to policy/practice/legislation to reduce child MV deaths.
2. Encourage Bureau of Health Promotion and Risk Reduction to create a sub-group of the ICPG to focus on vehicular deaths.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				28	34
Annual Indicator			33.3	31.5	31.5
Numerator			49469	46700	46700
Denominator			148555	148255	148255
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	34.5	35	35.5	36	36

Notes - 2007

Breastfeeding data from the CDC National Immunization survey are two years behind the MCH BG reporting year. so data from the 2005 reporting year are used to estimate 2007 data.

Notes - 2006

Data Source:

Numerator: CDC National Immunization Survey percentages for birth year 2005. were multiplied by the total number of Ohio resident Tbirths for 2005. the actual indicator is 33.3 +/-5.9

Denominator: 2005 OH resident births, Vital Statistics data.

These 2005 data were used as an estimate for both 2006 and 2007. CDC's data for birth year 2006 will not be available until August 2009.

Ohio is reporting information for NPM 11 using data from CDC's National Immunization Survey (NIS). For this reporting deadline, we are only reporting for children born in 2004\5. An

explanation follows:

Ohio has decided to use the NIS as the data source to track progress on NPM 11. Ohio has access to Ross Mother's survey data, but this data will not be used for reporting purposes.

As of 2007, the CDC has begun releasing breastfeeding information from the NIS by birth year rather than by survey year. Subsequently, there is about a 3-year lag from birth year to year of reporting. In summer of 2007, CDC released data for children born in 2004.

NOTE: 2005 data are the same as those reported for 2006 (the data reported in the table have been updated.).

Notes - 2005

Data Source: Ross Mothers's Survey, 2004 Breastfeeding Trends Report. (at 6 months). Denominator is 2004 OH resident births, provisional Vital Statistics data. These 2004 data were used as an estimate for 2005.

a. Last Year's Accomplishments

The target for FFY 2007 was that 34 percent of mothers would be breastfeeding their infants at age 6 months. Data for FFY 2007 are estimates based on birth year 2005, the latest data available from CDC, NIS.

A. Become a member of the statewide Ohio breastfeeding committee.

Accomplishments are ongoing. Two statewide coalitions are forming and efforts to combine them have failed. One invited the ODH director to appoint a representative to their steering committee. The MCH block grant director was chosen.

B. Explore the feasibility of hiring a state breastfeeding (BF) coordinator for activities with non-WIC eligible populations

Accomplishments are ongoing. Resources were not secured for a hired position. ODH will apply in FY08 for a CDC Public Health Prevention Service Fellow to address improvement of BF rates in Ohio.

C. Explore opportunities to reach hospitals and hospital-based health care providers through the DFCHS funded Regional Perinatal Centers (RPC)

Accomplishments are incomplete & priorities have changed. ODH's RPC coordinator position was vacant. One region did focus on improving BF.

D. Partner with Ounce of Prevention (an Ohio program that provides training and materials for physicians to prevent childhood obesity) to enhance BF protection, promotion, and support through that program

Accomplishments are ongoing. Materials were not revised in FY07-08 so there was no opportunity to fulfill this strategy. Updates are planned in the coming year and efforts will be made to improve the BF content.

E. Recruit outside partners into the BF workgroup

Accomplishments are complete. Members have joined for FY08 from 1) the Ohio BF Coalition steering committee and 2) the Ohio Community Health Workers Association. The ODH Ohio Infant Mortality Reduction Initiative (OIMRI) coordinator was recruited to assist with FY07-08 collaboration. A member from ODH's Healthy Ohio was recruited but declined to join.

F. Put products that were finished through past DFCHS BF committee work on the ODH website

Accomplishments are ongoing. The term "breastfeeding" in the ODH website A-Z list was secured. Two previously adopted policy statements are undergoing approval for posting.

G. Use results of DFCHS survey to identify a program in which to enhance BF protection, promotion and support. Begin working with that area to strengthen protection, promotion and support of BF, including training of staff and health care providers within that program
Accomplishments completed. Survey data were entered & analyzed. OIMRI was chosen because of its 1) focus on African American mothers, who have lower BF rates than white mothers in OH, 2) staff interest in enhancing BF efforts, and 3) intensive & ongoing relationship with mothers, which provides opportunities to impact mothers' decisions to initiate and to support mothers to continue BF. Information sharing has begun, the OIMRI coordinator joined the workgroup, and 2007-8 strategies include OIMRI collaboration.

H. Analyze and report data on mother's perceptions of maternity care practices related to BF in Ohio

Priorities have changed. This strategy wasn't begun and maternity leave which made the epidemiologist unavailable.

I. Learn about the ODH Division of Quality Assurance's role in licensing maternity units. Assess if there is an opportunity to strengthen positive maternity care practices

Accomplishments are ongoing. Ohio's legislation to license maternity units must be rewritten in FY08. Draft legislation calls for rules to be written by a committee appointed by the governor. Input from the workgroup ensured that the draft legislation includes an IBCLC required for committee membership. The workgroup continues to monitor the legislation.

J. Work with D. Martz in the Office of the Director to strengthen BF training among public health (PH) nurses in local health departments

Accomplishments are ongoing. WIC BF trainings were opened to PH nurses. PH nurses got announcements for trainings and information on obtaining BF literature for clients. Resources weren't identified for additional trainings.

K. Development of statewide plan for addressing childhood overweight.

Accomplishments are ongoing. By Sept. 07 a draft plan was produced by a committee including members of this workgroup. It included BF strategies related to social marketing, healthcare, communities and businesses, and ODH programs. The plan is being finalized & a budget prepared for the next 2 years. A grant for federal funding is being prepared

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Join the new statewide Ohio breastfeeding committee.				X
2. Explore hiring a state breastfeeding coordinator to work with non-WIC populations.				X
3. Explore opportunities to reach hospitals through the Regional Perinatal Centers.				X
4. Partner with Ounce of Prevention (See NPM 14) to enhance breastfeeding activities.				X
5. Put products developed by past ODH breastfeeding committee on ODH website.			X	
6. Use results of DFCHS survey to identify a DFCHS program in which to enhance breastfeeding activities.				X
7. Support hospital maternity care practices that positively impact, or that do not disrupt, breastfeeding.				X
8. Learn about the ODH Division of Quality Assurance's role in licensing maternity units re: positive maternity care practices.				X
9. Analyze and report data on mother's perceptions of maternity care practices related to breastfeeding in Ohio.				X

10. Participate in development of a State Plan for Addressing Childhood Obesity.				X
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b. Current Activities

A. Participate in state breastfeeding (BF) coalition.

Activities: Host CDC/USBC teleconferences; Attend coalition meetings and provide updates to both coalition and workgroup.

B. Strengthen BF activities within one DFCHS program.

Activities: Identify one program; Review data/literature relevant to BF and the program; With program choose/implement BF project.

C. Support BF components of childhood overweight state plan.

Activities: Identify BF-related areas in state plan that workgroup can support; Follow up with appropriate activities.

D. Strengthen BF training for local public health nurses.

Activities: Identify partners/funding for training; Plan/implement/evaluate training.

E. Analyze newly available 2006 birth certificate BF data.

Activities: Develop/distribute report.

F. Stay current on BF-specific topics. for future planning.

Activities: Review literature regarding how men can impact BF success.

G. Target BF improvement among Ohio African American's (AA).

Activities: Collaborate with ODH's OIMRI, which targets high risk AA mothers, to improve BF knowledge/skills of program staff; Seek AA health-professional organizations/advocacy groups to collaborate with to improve AA BF rates. Invite at least one of these groups to send a member to the workgroup; Assess if BF messages used in ODH programs are culturally appropriate for AA audiences.

c. Plan for the Coming Year

A. Be active participants in a state breastfeeding coalition.

1. Act as hosts for the state of Ohio for the bi-monthly CDC/USBC teleconferences.
2. Representative attends coalition meetings and updates coalition on work group activities
3. Representative gives monthly updates on coalition activities to workgroup.

B. Continue working to strengthen breastfeeding protection, promotion and support within the Ohio Infant Mortality Reduction Initiative (OIMRI) program. This program was chosen through 2007-8 strategy B.

1. Evaluate impact of breastfeeding training on OIMRI staff.
2. Continue to facilitate breastfeeding training for community health workers.
3. Explore cross program coordination in one county (e.g., coordination of OIMRI efforts with other programs such as WIC, CFHS and/or Help Me Grow)
4. Be available to review breastfeeding elements of proposed new OIMRI data system.
5. If a Public Health Prevention Specialist is secured, develop and implement breastfeeding programming for OIMRI.

C. Support the breastfeeding components of the ODH childhood obesity plan that is under development (strategy C in current activities section of the FFY 2009 application).

1. Identify objectives and activity steps from the plan that the workgroup can support.
2. Follow-up with appropriate activities.
3. If a Public Health Prevention Specialist is secured, implement a breastfeeding related activity step from the plan.

D. Review 2007 birth certificate breastfeeding data.

1. Compare to 2006.
2. Review rates among African-American mothers
3. Review rates among women residing in Appalachian counties

E. Become educated about breastfeeding in the Appalachian culture in order to make informed decisions when planning future strategies and activities.

1. Review the literature about breastfeeding and Appalachia.
2. Communicate with breastfeeding and other coalitions in Appalachian counties.
3. Explore primary data collection for new information.

F. Target breastfeeding improvement among African American's in Ohio. This group was found to have lower initiation rates in an analysis of Ohio PRAMS data.

1. Collaborate with ODH's OIMRI (see strategy B).
2. Actively seek African American health-professional organizations and/or advocacy groups to collaborate with in improving breastfeeding rates among African American's. Invite representatives from at least one of these organizations to be members of the workgroup.
3. Develop a relationship with the Office of Healthy Ohio Health Equity Coordinator.
4. Continue to assess if the breastfeeding messages used in ODH's programs are culturally appropriate for African American audiences.

NOTE: Ohio received public comments on breastfeeding. The comments and Ohio's responses are in the attachment.

An attachment is included in this section.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	30	30	50	92	99
Annual Indicator	39.3	91.1	98.8	90.2	90.2
Numerator	58976	138822	147117	136500	136500
Denominator	150014	152385	148903	151351	151351
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99	99	99

Notes - 2007

2007 data are not available; 2006 data are used as estimates.

Notes - 2006

Data Source: Numerator: Universal Newborn Hearing Screening data; the actual percent of newborns screened before hospital discharge during Calendar Year 2006. Ohio Vital Statistics birth data (2006 occurrent births).

NOTE: Methodology for calculating this measure was slightly different than in previous years.

Notes - 2005

Data Source: Numerator: Universal Newborn Hearing Screening data; the actual percent of newborns screened before hospital discharge from 7/01/05 - 6/30/2006. Ohio Vital Statistics birth data (2005 occurrent births).

a. Last Year's Accomplishments

The target for FY 2007 was 99.0 percent. The actual percent of newborns screened before hospital discharge in CY 2006 was 90.2 percent. Ohio has not met its target.

A. Monitor/provide TA to birthing hospitals, children's hospitals, free-standing birthing centers/health departments to assure infants receive hearing screenings and that referral rates are acceptable.

Ohio Department of Health (ODH) public health audiologists used a standard monitoring protocol and visited 74 hospitals during this period. They provided TA by phone/e-mail. Hospitals continued to submit universal newborn hearing screening (UNHS) results electronically via ODH's Integrated Perinatal Health Information System (IPHIS) and by mailing copies of the paper UNHS results report form to ODH. Regular extracts of UNHS results/ demographic information from IPHIS to import into the HI*Track hearing software program occurred throughout the year for well baby hearing screenings. Data on UNHS results for infants transferred to neonatal intensive care

units and/or children's hospitals were entered manually into HI*Track at ODH. Without access to birth data, it was not possible to assure hearing screenings were done on all newborns. The statewide referral rate has not yet been calculated for this time period due to a vacant researcher position. It will be done soon.

B. Connect auditory diagnostic evaluation information received by ODH with non-pass UNHS results to identify infants receiving hearing evaluations by 3 months of age; monitor tracking/follow-up.

ODH held a series of 6 regional trainings from 10/2006 for hospital personnel on UNHS. Content of each training included: basic information about early hearing detection/intervention, UNHS follow up, UNHS quality assurance process, communicating with parents, screening tips, statewide data/data management, and a parent/professional panel discussion. The meetings were well attended; feedback was positive.

C. Increase diagnostic audiology services for infants.

Audiologists conducting follow-up diagnostic evaluations on infants not passing their newborn hearing screenings send reports to ODH. Reports are sent to the Regional Infant Hearing Program (RIHP) tracking the infant; at ODH results are entered into HI*Track. RIHPs report quarterly on the status of infants being tracked. ODH works to match all diagnostic reports with birth /newborn hearing screening records. RIHPs currently report tracking data on more infants than are in HI*Track due to non-pass UNHS results.

D. Increase public/professional awareness of early hearing detection/intervention.

Audiologists, who participated in the Auditory Evaluation for Infants Referred from Newborn Hearing Screening: A Three Part Workshop held in Ohio in 2006, share information learned. ODH conducted a survey early in 2007 of all audiologists holding Ohio licenses and is completing a directory to post on the web. The directory lists audiologists/audiology service sites alphabetically and by county. The geo-map of audiologists serving the birth to three population will be updated. The survey asked respondents to indicate if they would be willing to serve as mentors. A request for proposals for incentive funding to enhance/increase diagnostic sites was posted in 2007; ODH issued 1 contract, to an entity in underserved SE Ohio.

Outreach to physicians continued through a unique collaborative effort involving ODH, the National Center for Hearing Assessment/Management, and the 11 Ohio chapters of Delta Zeta National Sorority. ODH conducted an initial training on UNHS for the sorority philanthropic chairs and provides names/addresses of physicians located near each campus who care for children following UNHS screenings. The sorority women contact physician offices for a time to hand deliver videos and printed materials about UNHS as well as a medical home chart of strategies related to hearing/language development throughout the early months of life. The Ohio Chapter Champion of the AAP is an active member of the UNHS Subcommittee, the advisory body for the Infant Hearing Program. The 2nd Annual Report to the Ohio Legislature was published in January 2007 and delivered to key government officials. The Infant Hearing Program and Genetics Program staffs met several times to discuss ways to collaborate. An ODH public health audiologist contacted each Ohio Au.D. program and medical school about education students receive on early hearing detection/intervention

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and provide TA to birthing and Children's hospitals, free-standing birthing centers and health departments (LHDs) to assure infants receive hearing screenings and that referral rates				X

are acceptable.				
2. Connect auditory diagnostic evaluation information received by ODH with non-pass UNHS results to identify infants receiving hearing evaluations by 3 months of age				X
3. Provide TA to RIHPs to reduce loss to followup: include site visits.				X
4. Increase diagnostic audiology services for infants by facilitating NCHAM Workshop.				X
5. Administer survey about EHDI to all audiologists licensed in Ohio.				X
6. Prepare updated Audiology Directory.				X
7. Distribute UNHS video and Medical Home Strategies chart to physicians of infants who do not pass UNHS.				X
8. Prepare and disseminate Annual Report to Legislature and UNHS Newsletter.				X
9. Work with ODH Genetics Program to identify areas for collaborative efforts.				X
10. Approach faculties of Au.D. programs and medical schools in Ohio about opportunities to educate their students on EHDI.				X

b. Current Activities

A. Monitor and provide technical assistance to birthing hospitals, children's hospitals, free-standing birthing centers and health departments to assure that infants receive hearing screenings and that referral rates are acceptable.

B. Connect auditory diagnostic evaluation information received by ODH with non-pass UNHS results to identify infants receiving hearing evaluations by three months of age; monitor tracking and follow-up of UNHS results to reduce the rate of loss to follow-up.

C. Increase diagnostic audiology services for infants: by participants in the Auditory Evaluation for Infants Referred from Newborn Hearing Screening: A Three Part Workshop (Ohio in 2006) sharing information; by updating a directory of audiologists and audiology services; and by working collaboratively with audiology educators and providers to enhance/increase diagnostic sites and opportunities for mentored experience with infants.

D. Increase public and professional awareness of early hearing detection and intervention (EHDI) by distributing educational materials to physicians, preparing/disseminating reports for legislators and others, identifying potential areas for collaboration with the ODH Genetics Program and working with faculties of Au.D. programs and medical schools to incorporate EHDI into their curriculums.

c. Plan for the Coming Year

A. Monitor and provide technical assistance to birthing hospitals, children's hospitals, free-standing birthing centers and health departments to assure that infants receive hearing screenings and that referral rates are acceptable (4% or less statewide).

Key activities:

1. Assure continual hospital data input and regular report extractions (IPHIS and/or HI-Track);
2. Review each hospital's UNHS data at least monthly;
3. Provide targeted technical assistance to hospitals with identified issues -- i.e., lack of reporting, missed babies, high or exceptionally low referral rates;
4. Create quarterly UNHS reports for individual hospitals in relation to statewide data;

5. Make focused monitoring site visits to hospitals based on data or other issues to observe UNHS process and identify areas for improvement; and
6. Work with local health departments on their legal obligations regarding EHDI and on identifying hearing screening sites for infants born at home.

B. Connect auditory diagnostic evaluation information received by ODH with non-pass UNHS results to identify infants receiving hearing evaluations by three months of age; monitor tracking and follow-up of UNHS results to reduce the rate of loss to follow-up.

Key activities:

1. Enter data from diagnostic audiology reports received by ODH into HI-Track;
2. Send audiology report data to RIHPs;
3. Monitor tracking and follow-up process within ODH and RIHPs; and
4. Provide TA to RIHPs: include site visits following uniform protocol.

C. Increase diagnostic audiology services for infants: by updating a directory of audiologists and audiology services; and by working collaboratively with audiology educators and providers to enhance/increase diagnostic sites and opportunities for mentored experience with infants.

Key activities:

1. Update Audiology Directory from survey data;
2. Update geo-map of Ohio audiologists working with infants, and;
3. Approach faculties of Au.D. programs/medical schools in Ohio about opportunities to educate on EHDI.

D. Increase public and professional awareness of early hearing detection and intervention (EHDI) by distributing educational materials to physicians, preparing/disseminating reports for legislators and others, identifying potential areas for collaboration with the ODH Genetics Program.

Key activities:

1. Prepare and disseminate Annual Report to Legislature and UNHS Newsletter;
2. Work with ODH Genetics Program to identify areas for collaborative efforts.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	7	7	7	7	7.5
Annual Indicator	8.4	7.9	8.0	6.6	7.1
Numerator	237500	224000	220006	182000	198000
Denominator	2815289	2833500	2765224	2754000	2787000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	7	7	7	7	7

Notes - 2007

CY 2007 data.

The Current Population Survey Annual Social and Economic Supplement (CPS – ASES) contains data on health insurance by state and age group. Data from the U.S. Census Bureau website (www.census.gov/hhes/www/cpstc/cps_table_creator.html) were used to construct the following table:

Ohio – Children Ages Birth Through 17 Years

Two- Year Average (2006 and 2007)

Notes - 2006

CY 2006 data.

The Current Population Survey Annual Social and Economic Supplement (CPS – ASES) contains data on health insurance by state and age group. Data from the U.S. Census Bureau website (www.census.gov/hhes/www/cpstc/cps_table_creator.html) were used to construct the following table:

Ohio – Children Ages Birth Through 17 Years

Two- Year Average (2005 and 2006)

Note: Previous version of calculation included 18 year olds. The above linked website uses the wording "Age: 00 to 17 years" to mean "00 through 17 years." This has been verified with the CPS-ASES tabular data.

Notes - 2005

CY 2005 data.

The Current Population Survey Annual Social and Economic Supplement (CPS – ASES) contains data on health insurance by state and age group. Data from the U.S. Census Bureau website (www.census.gov/hhes/www/cpstc/cps_table_creator.html) were used to construct the following table:

Ohio – Children Ages Birth Through 17 Years

Year	2004	2005	Two-Year Average
Uninsured	222,344	217,668	220,006
Insured	2,584,016	2,506,419	2,545,218
Total			
Population	2,806,361	2,724,087	2,765,224

In order to be consistent with ODH’s past practices, the numerator for this year’s application calculation should be the two-year average, or 220,006 and the denominator should be 2,765,224. This results in an Annual Indicator of 8.0%.

a. Last Year's Accomplishments

The CY 2006 target was 7.0 percent. The actual percent of children without health insurance was 7.1 percent. Ohio has nearly met its target for 2007.

A. Monitor data on rate of uninsured children served through DFCHS funded agencies, FQHCs, Free Clinics, the Ohio Family Health Survey and the Current Population Survey.

3,793 children receiving BCMH treatment services had no health insurance and 27,813 children had Medicaid and/or private insurance; 17,666 visits for un/underinsured child health clients were conducted by local CFHS projects; 30,800 visits for uninsured children were provided by FQHCs, Hospitals and Free Clinics with Health Priorities Trust Fund and Uninsured Care Fund dollars; 20 dental safety net clinics reported serving 23,788 uninsured/underinsured and Medicaid eligible individuals.

7.1% of Ohio's children were uninsured per the Current Population Survey, 2007; 5.4% were uninsured per the Ohio Family Health Survey 2004.

B. Work with DFCHS funded projects to provide information, TA, and/or training to providers/consumers on how to understand and navigate the health care system.

The WIC program screened all of its over 280,000 applicants/participants to determine if the individual is on Medicaid Healthy Start (HS) or needs referral to HS.

The WIC program, after working with ODJFS, issued All Projects Letter 096, Managed Care and Medicaid Verification, to assist local WIC staff in determining Medicaid eligibility status within the Managed Care environment.

34 monitoring site visits to local CFHS funded agencies were made to provide TA/information on how to ensure clients understand/navigate the health care system.

Critical Access Hospitals in 34 rural communities worked with local EMS to improve delivery of health care to rural Ohio; work to expand rural health clinics continued.

118 FQHC sites in 34 urban/rural counties and 22 Free Clinic sites worked to enroll children/families into Medicaid HS and to help providers/consumers navigate the health care system. 3 J-1 Visa Waiver Pediatric physicians who serve uninsured children were placed.

67,525 copies of the Help Me Grow Wellness Guide, containing an ad on the HS program to county programs in Ohio were distributed.

BEIS uses the CPA for the Early Intervention System of Payment for families with no other method of paying for needed early intervention services. The application is also used to apply for HS and requires determination of eligibility for HS prior to use of EI federal funds for services.

Child Care Health Consultants with the Healthy Child Care Ohio program promoted HS at 486 consultations with child care providers. BCMH provided TA to pharmacy staff to help them bill BCMH so clients can access their prescription medications; help parents understand policies/procedures of their private insurance, Medicaid and Medicare Managed Care (MMC) Plans.

BCMH provided training/TA to providers/consumers to enhance smooth delivery of services to BCMH clients. BCMH Hospital Based Service Coordinators assist families in coordinating services of specialists to enhance continuity of care.

BCMH's "Parent to Parent Newsletter" provided information to consumer parents learning to navigate health care system/BCMH.

BCMH Parent Consultant and Young Adult Advisory Council meet regularly at quarterly sharing events to address transitioning issues.

500 public health pediatric providers who receive referrals through the OCCSN Program of children reported with birth defects were trained. Trainings provided information about the

genetics of birth defects and various syndromes/disorders.

In March 2007, BOHS staff convened a meeting with the state Medicaid program, representatives of all 8 (MMC) health plans and dental subgrantees for a Q&A session. Medicaid implemented a statewide expansion of mandatory managed care for Medicaid recipients. There was much confusion about implementation of the expansion, especially the process of credentialing providers for MMC programs. BOHS staff developed relationships with reps of the MMC programs and enlisted their assistance when local programs need help getting reimbursement for services or credentialing providers.

C. Work with ODJFS to review/renegotiate ODH/Medicaid Interagency Agreement containing provisions re: Medicaid enrollment/outreach activities.

The interagency agreement for enrollment/outreach activities re: the Medicaid program and DFCHS programs was signed by ODH Director and by ODJFS Director.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect and monitor the number of uninsured/underinsured children served by DFCHS funded clinics; BCMH including Medicaid Spend-down; FQHCs; Free Clinics and charitable vision care.				X
2. Provide health insurance information to providers and consumers via such vehicles as the Help-Me-Grow Wellness Guide; regional school nurse conferences; project directors' meetings; program mailings; and direct mailings(infrastructure- and population		X	X	X
3. Promote Healthy Start to child care providers via Child Care Health Consultants with the Healthy Child Care Ohio program and assist in making referrals, as needed.		X	X	
4. Refer OPTIONS consumers appropriately to existing systems of dental care.		X		
5. Work with ODJFS to review and renegotiate ODH/Medicaid Interagency Agreement containing provisions re: Medicaid enrollment, outreach and training activities as needed.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Work with DFCHS funded projects to provide information, technical assistance, and/or training as appropriate to providers and consumers on how to understand and navigate the health care system.

B. Work with ODJFS to review and renegotiate ODH/Medicaid Interagency Agreement containing provisions re: Medicaid enrollment, outreach and training activities as needed.

C. Monitor the impact of Mandatory Managed Care into all counties on DFCHS funded projects.

D. Facilitate process to complete results-based accountability model developed by Mark

Friedman to produce performance measures and future interventions

E. Promote Healthy Start through schools: The DFCHS, BCHSSD School and Adolescent Health Program will include Healthy Start information in their new school nurse orientation and annual regional school health conference; ODH is also collaborating with the Ohio Department of Job and Family Services to increase HealthChek in Ohio and school nurses will play a critical role in informing parents about Healthy Start.

c. Plan for the Coming Year

A. Monitor data regarding the rate of uninsured children.

This infrastructure level strategy will be implemented by: (1) reporting health insurance data from the National Current Population Survey and Ohio's Family Health Survey; (2) examining where the maternal and child populations with the highest percentage of uninsured children exist in Ohio by developing and implementing a data plan to analyze such variables as income, race, ethnicity, geographic regions, etc.; and (3) ensuring that all DFCHS programs report the appropriate information on MCHBG Form 7-8.

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.

This population-based and infrastructure level strategy will be accomplished by providing health insurance information/materials to public and private sector providers, including child care health consultants, public health nurses, DFCHS funded agencies, local health departments, rural hospitals, and to the general public, families of CSHCN, parent advocacy groups. These communication tools include the Help Me Grow Wellness Guide, direct mailings, program meetings, trainings, and/or conferences.

C. Implement the ODH/Medicaid Interagency Agreement (IA) containing provisions regarding Medicaid enrollment, outreach and training activities.

This infrastructure level strategy will be implemented by DFCHS collaborating with ODJFS to review and renegotiate roles and responsibilities related to Medicaid enrollment, outreach and training activities; and monitoring all deliverables to ensure their completion.

D. Promote enrollment in Healthy Start (Medicaid) through schools and school-based programs.

This enabling level strategy will be implemented via DFCHS programs focus on school-based programs (i.e., School and Adolescent Health Program and Dental Sealant Program) by : (1) providing information and updates regarding Healthy Start via new school nurse orientation trainings and the annual regional school health conference for the purpose of assisting school nurses in conducting outreach for Healthy Start; (2) conducting enrollment and outreach through the BOHS dental sealant program; and (3) collaborating with Medicaid on strategies to improve children receiving Healthchek services in Ohio.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
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Annual Performance Objective				26.9	26.6
Annual Indicator			27.6	27.2	27.6
Numerator			31569	31010	32132
Denominator			114380	114008	116418
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	26.6	26.1	26.1	25.6	25.6

Notes - 2007

Numerator: Number of children in Ohio WIC program in 2007, aged 2-5 years, who had BMI at or above the 85th percentile

Denominator: Total number of children aged 2-5 years in Ohio WIC program in 2007 for whom weight and height data were available.

Data Source: CDC PedNSS data for Ohio WIC program

Notes - 2006

Numerator: Number of children in Ohio WIC program in 2006, aged 2-5 years, who had BMI at or above the 85th percentile

Denominator: Total number of children aged 2-5 years in Ohio WIC program in 2006 for whom weight and height data were available.

Data Source: CDC PedNSS data for Ohio WIC program

Notes - 2005

2005 data is an estimate based on 2004 PedNSS data.

a. Last Year's Accomplishments

The target for 2007 was 26.6 percent. The actual percent of children age 2-5 years in WIC whose BMI was greater or equal to the 85th percentile was 27.6. While this was only slightly higher than the 27.2 percent in 2006, Ohio did not meet its target. Note: 15.5 were at-risk for overweight and 12.2 percent were overweight (obese).

A. Conduct data surveillance and monitoring.

A Statewide inventory was conducted by surveying directors of WIC projects on obesity resources in their local area. This was conducted via the annual request for proposals (RFP) and will continue to be updated annually. The most recent PedNSS Data from 2006 for low income children in WIC, ages 2-5 years, who are overweight or at risk for overweight (BMI= 85th percentile), was reviewed. Based upon this information Ohio is currently at 27.2 percent compared to 30.8 percent (2005 data) for PedNSS nationally. Ohio's data shows an increase of 2.3 percent from 2005. Since only 15 percent of children would be expected to be above the 85th percentile for BMI, the fact that 27.2 percent are actually at this level is a finding that continues to be a major concern for Ohio's children.

B. Increase health care providers' awareness and involvement in prevention and treatment

The Ohio WIC program partnered with the Cardiovascular Health Program to host trainings on the program titled "An Ounce of Prevention." This program offers the MD nutrition education materials and age appropriate physical activity guidance that can be given out at regularly scheduled well child/immunization appointments to educate moms about proper feeding practices and activities. Attendee's ranged from local physicians, nurse practitioners, WIC staff, CVH staff and CFHS staff.

C. Continue current collaborations and facilitate the development of new internal and external partners.

In September 2006 a team of 8 ODH representatives began a year long program to develop a statewide plan for addressing childhood overweight through the Ohio Public Health Leadership Institute (OPHLI). During the upcoming year the team identified and surveyed internal and external partners who are addressing childhood obesity such as Healthy Child Care Ohio and Children's Hunger Alliance. In addition a draft plan for ODH was developed and reviewed by ODH leadership. Plan is attached.

D. Investigate evidence-based interventions for the WIC population age 2 to 5 years.

Last year, several members of the National Performance Measure #14 committee were trained on the use of an evaluation tool developed by the American Dietetic Association. Using this tool members planned to identify evidence based interventions for use with overweight children. Due to the time involvement of the OPHLI project this strategy was unable to be accomplished.

E. Participate in the development of a statewide plan for addressing childhood obesity.

See Strategy C.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inventory statewide resources/programs addressing the treatment of childhood obesity.				X
2. Review CDC PedNSS data on overweight in 2-5 year olds.				X
3. Continue expansion of Ounce of Prevention initiative to nurse practitioners, family practice offices, county WIC projects, and CFHS projects working on childhood obesity.				X
4. Identify and survey new partners re: level and type of activities on childhood obesity.				X
5. Work with Healthy Childcare Ohio and with Children's Hunger Alliance to promote nutrition and activity in childcare programs.				X
6. Use American Dietetic Association's evaluation tool to identify evidence-based interventions for childhood overweight.				X
7. With SPM 5 (3rd grade overweight) and NPM 11 (breastfeeding at 6 months); apply to the Ohio Public Health Leadership Initiative (OPHLI) to develop a state plan; identify a core group to participate in the training; create a plan for involving all sta				X
8.				
9.				
10.				

b. Current Activities

A. Conduct data surveillance/monitoring activities.

Activities: Update inventory of statewide resources/programs addressing treatment of child obesity (Obesity Inventory Tool) through WIC clinics, CFHS projects, and Rural Health programs; Develop database for inventory tool; Investigate differences between peer counties that have differing obesity rates based on 2005 PedNSS data; Investigate using WIC Participant Survey to collect child obesity-related information.

B. Increase health care providers' awareness/ involvement in prevention/treatment initiatives

Activities: Train appropriate Ohio physicians on Ounce of Prevention Program (OPP); Based on 2005 PedNSS data, expand OPP to focus on counties with highest rates of child obesity; Expand OPP education initiative nationwide to physicians/other health care professionals.

C. Continue current collaborations/facilitate development of new potential internal/external partners.

Activity: Collaborate with external partners to address child obesity based on results from OPHLI obesity committee.

D. Investigate evidence-based interventions for WIC population age 2-5 years.

Activity: Use CDC resources to identify evidence-based intervention programs that have been effective in WIC clinic settings.

E. Participate in development of ODH Child Obesity plan.

Activities: 1) Disseminate draft ODH Child Obesity Plan to internal/external partners; Form a plan to begin implementation of activities in Plan that address child overweight.

c. Plan for the Coming Year

A. Conduct data surveillance and monitoring activities.

1. Review and update the inventory of statewide resources/programs addressing the treatment of childhood obesity (Obesity Inventory Tool) as necessary through WIC clinics, CFHS projects, and Rural Health programs.

2. Work with the ODH Public Affairs Office in researching options for a web based distribution of the inventory data base titled, "ODH Childhood Obesity Community Resource Directory."

3. Conduct an analysis of Ohio 3rd grade BMI data and PEDNSS data to explore differences in trends of childhood obesity by county and by racial and Hispanic ethnicities.

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

1. Encourage and provide assistance, as applicable, for registered dietitians and dietetic technicians to attend the ADA sponsored training, "Certificate in Childhood and Adolescent Weight Management."

C. Explore new opportunities for collaboration.

1. Collaborate with the newly appointed ODH office of Healthy Ohio obesity coordinator to support efforts.

2. Work with the 3rd grade BMI Sentinel School Sample to assist with collection of data.

D. Investigate evidence based interventions for the WIC population age 2 to 5 years.

1. Work with WIC clinics to select potential evidence based programs to implement.

E. Evaluate WIC efforts to impact overweight

1. Conduct the WIC participant survey that will gather data on participant perception of weight, WIC obesity intervention and healthy eating behavior.

2. Implement and collect data on the use of the "WIC Activity Box" Pilot aimed to provide education to participants who at-risk for overweight or are obese.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				18.5	19
Annual Indicator			20.9	15.3	15.3
Numerator			31111	23058	23058
Denominator			148855	150510	150510
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	14	14	14	14	14

Notes - 2007

2007 data are not available. Data from 2006 were used to estimate 2007.

Notes - 2006

Data Source: 2006 Vital Statistics birth records - resident births and 2006 Census data.

Note: this is the first year smoking in third trimester has been available from the birth certificate. Previous data source was PRAMS

Notes - 2005

2005 data is an estimate using 2003 PRAMS data.

a. Last Year's Accomplishments

The target for 2007 was 19 percent and for 2006 was 18.5 percent. The actual percent of women who smoked in the last three months of pregnancy in 2006 was 15.3. Note that the data source changed between 2005 and 2006, from PRAMS to the revised standard birth certificate. Ohio did meet its target for 2006. Data for 2007 are not available.

Summary: Ohio did complete the activities for this performance measure as originally written.

A. Implement the 5 A's evidence-based systems approach for treating tobacco use and dependence

Accomplishments are complete. The ODH Perinatal Smoking Cessation Program (PSCP) contracted Smoke-Free Families National Dissemination Office (SFF-NDO) to pilot a systems approach for implementing the 5 A's into Ohio's WIC and Help Me Grow (HMG) Programs. Activities included: 1) needs assessments of existing provider systems and services for prenatal and postpartum tobacco treatment in 4 pilot counties; 2) developing and implementing quality improvement strategies; 3) incorporating messages that help women quit smoking, stay quit, or ask their healthcare provider for assistance with quitting (based on FFY06 Ohio's WIC & HMG focus group results); and 4) providing the tools, training and technical assistance needed to treat pregnant and postpartum smokers.

In addition, The Ohio Partners for Smoke- Free Families Pilot abstract submission entitled, "Incorporating Tobacco Treatment into Ohio's WIC and Help Me Grow Programs," was selected for presentation at both the Ohio Public Health Epidemiology Conference, August, 2007, and the 2007 National Conference on Tobacco OR Health, in Minneapolis Minnesota.

B. Monitor and analyze the prevalence of smoking among women of reproductive age, including pregnant women and the provision of the 5 A's approach.

Accomplishments are complete. Activities included: 1) monitoring baseline indices: LBW, prenatal smoking, three-month and six-month chart audits; and 2) implementing WIC and HMG data collection procedures for the provision of all components of the 5 A's in the four pilot counties (i.e., key informant interviews, baseline and provider follow-up surveys, chart audits and quitline referrals).

C. Collaborate with public-private partners to identify and implement strategies that impact the proportion of pregnant women who smoke.

Accomplishments are ongoing. PSCP received a MCH TA award to bring Cathy Melvin, PhD and Founder of the National Partnership for Smoke-Free Families to Ohio and facilitate the development of a statewide action plan to address tobacco prevention and cessation among women of reproductive age, including pregnant women. Through the process a Perinatal Workgroup was formed and agreed the first action was to create a separate goal in Ohio's Strategic Plan addressing tobacco use and cessation specific to pregnant women.

Partners include: ODH Division of Family and Community Health Services, ODH Division of Prevention, MCH BG Birth Outcomes Workgroup; MCH Division-Birth Outcomes Improvement Initiative; National Partnership to Help Pregnant Smokers Quit: State Action Learning Lab; Ohio Partners to Prevent Birth Defects; and Ohio Tobacco Control Resource Group

D. Refer to SPM 02: Strategy C

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct needs assessments of existing provider systems and services for prenatal and postpartum tobacco treatment in 4 pilot counties.				X
2. Based on results of the assessment develop quality improvement strategies and provide the tools, training and technical assistance needed to treat pregnant and postpartum				X

smokers, incorporating the client's perspective.				
3. Monitor baseline indices: LBW, including racial disparity; prenatal smoking; poverty and available safety net resources used to identify the four high need pilot counties.				X
4. Develop and implement data collection procedures for the provision of all components of the 5 A's in the four pilot counties.				X
5. Collaborate with the following partners: Birth Outcomes Workgroup; Birth Outcomes Improvement Initiative; ODH, DFCHS; National Partnership to Help Pregnant Smokers Quit: State Action Learning Lab; Ohio Partners to Prevent Birth Defects; and Ohio Toba				X
6. Refer to SPM 02: Strategy C.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Complete Ohio Partners for Smoke-Free Families pilot and report results and recommendations of the 5 A's evidence-based systems approach for treating tobacco use and dependence in/with ODH funded systems of care (i.e., WIC, Help Me Grow).

This infrastructure-level strategy is being accomplished through the following activities:

1. Implement quality improvement strategies and provide the tools, training and technical assistance needed to treat pregnant and postpartum smokers;
2. Implement process data collection procedures;
3. Test the provider/system-level quality improvement strategies and measure compliance; and
4. Conduct a process evaluation of the pilot activities.

B. Expand Ohio Partners for Smoke-Free Families based on pilot results then monitor and evaluate expansion.

C. Create a goal related to pregnant women in the "Ohio Comprehensive Tobacco Use Prevention" Strategic Plan to ensure a coordinated effort statewide to address tobacco use and cessation specific to this population.

D. Refer to activities for State Performance Measure 02: Strategy B and C (Ohio Birth Outcomes Improvement Initiative).

c. Plan for the Coming Year

A. Expand Ohio Partners for Smoke-Free Families 5 A's evidence-based systems-level approach for treating tobacco use and dependence in/with ODH funded systems of care (i.e., WIC, Ohio Infant Mortality Reduction Initiative, Family Planning).

This infrastructure-level strategy will be accomplished through the following activities:

- 1) Implement provider/system-level quality improvement strategies and provide the tools, training and technical assistance needed to treat pregnant and postpartum smokers;
- 2) Implement process data collection procedures;
- 3) Test the provider/system-level quality improvement strategies and measure compliance; and
- 4) Conduct a process evaluation.

B. Build an Ohio Partnership to address tobacco use and cessation among women of reproductive age, including pregnant women.

This infrastructure-level strategy will be accomplished through the following activities: 1) Identify and recruit public and private partners; 2) Bring together resources and implement proven clinical and community-based strategies; and 3) Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

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

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5	5	5	5	8.5
Annual Indicator	5.2	8.8	9.1	8.7	8.7
Numerator	42	72	74	71	71
Denominator	810850	813913	816936	813186	813186
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	8.5	8.5	8.5	8.5	8.5

Notes - 2007

2007 data are not available. 2006 data are used to estimate 2007 data.

Notes - 2006

Data Source:

Numerator: Ohio Vital Statistics 2006 final death files

Denominator: U.S. Census.NCHS Bridged Race, Vintage 2006 Ohio population estimates for 2006

Notes - 2005

Data Source:

Numerator: Ohio Vital Statistics 2005 final death files

Denominator: U.S. Census.NCHS Bridged Race, Vintage 2005 Ohio population estimates for 2005

a. Last Year's Accomplishments

The target for Calendar Year 2006 was 5 deaths per 100,000 and for 2007 was 8.5 deaths per 100,000. Based on final death data for 2006, the actual rate was 8.7 per 100,000. Ohio has not

met its target for 2006. Data for 2007 are not available.

A. Use data, including Child Fatality Review, Youth Risk Behavior Survey and Vital Statistics, to describe problems of youth suicide in Ohio, and then share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

The 2005 YRBS data was cross-tabulated to look at suicidal behaviors in youth compared to both risky behaviors and assets. A presentation was created and shared at the Ohio Valley Society of Adolescent Medicine Conference.

ODMH uses YRBS data in the ODMH Federal Block Grant as well as in response to media inquiries.

The rate of deaths and the contributing factors of suicide deaths for children 0-18 years have been monitored and analyzed via child fatality review (CFR) data.

B. Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

Information on the relationship between bullying and teen suicide, using YRBS data, was shared at the Inter-American Summit on Conflict Resolution Education.

Information and prevention resources on teen suicide and bullying were shared at the New School Nurse Conference.

The CFR Annual Report and data were shared at CFR trainings; a report-release announcements; numerous division meetings and overlapping work groups; the Combined Public Health Conference; the Ohio Public Health Epidemiology Conference; and CFR Advisory Committee, which includes representation from the Ohio Department of Mental Health. The report was posted on the ODH Website and published copies were distributed throughout ODH and to mandated elected officials, local CFR boards, Family and Children First Councils, and the State Library system.

C. Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide strategies.

D. The Ohio Suicide Prevention Foundation uses the YRBS data in their informational and training presentations. They have also included information from the YRBS in an Ohio Fact Sheet that will be distributed to legislators, possible corporate sponsors, and published on their website. CFR boards are encouraged to seek collaboration from other community agencies to develop activities and initiatives in response to CFR findings. Youth suicide prevention is a priority in many counties due to input from CFR. Local boards have partnered with schools and service organizations to implement or enhance programs to address risk factors and improve interventions regarding suicide. CFR boards have collaborated with suicide prevention task forces on comprehensive prevention plans. CFR boards use a variety of methods (newspaper and Web site articles, public meetings, posters and brochures to raise community awareness of risk factors and signs of depression.

The Injury Prevention Program at ODH is developing a statewide Injury Community Planning Group to improve collaboration and networking among state and local agencies working to prevent intentional and unintentional injuries. In addition to the Adolescent Health Program and the Child Fatality Review Program at ODH, the Departments of Mental Health and Drug and Alcohol and Drug Addiction Services are members of this group. This group will be reviewing data regarding the leading causes of injury and injury-related death in Ohio and selecting priority focus areas.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to distribute, and make available on-line, reports that include youth suicide data.			X	X
2. Develop a report on teen suicide and mental health issues targeted to those who interact directly with children and youth.			X	X
3. Collaborate with our partners through the work of the Ohio Suicide Prevention Foundation Advisory Committee, the Child Fatality Review Board and county grantees.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Use data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and then share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

This infrastructure-level strategy is being accomplished by continuing to distribute, and make available on-line, reports that include youth suicide data.

B. Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

This infrastructure-level strategy is being accomplished by the development of a report on teen suicide and mental health issues targeted to those who interact directly with children and youth.

C. Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide strategies.

This infrastructure-level strategy is being accomplished by continuing to collaborate with our partners through the work of the Ohio Suicide Prevention Foundation Advisory Committee, the Child Fatality Review Board, and county suicide prevention coalitions.

c. Plan for the Coming Year

A. Use data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and then share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

This infrastructure-level strategy will be accomplished by continuing to distribute, and make available on-line, reports that include youth suicide data.

B. Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

This infrastructure-level strategy will be accomplished by the development of a report on teen suicide and mental health issues targeted to those who interact directly with children and youth.

C. Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide strategies.

This infrastructure-level strategy will be accomplished by continuing to collaborate with our partners through the work of the Ohio Suicide Prevention Foundation Advisory Committee, the Child Fatality Review Board, and county suicide prevention coalitions.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	72	72	74	74	74
Annual Indicator	70.3	68.5	68.5	67.4	67.4
Numerator	1549	1585	1633	1642	1642
Denominator	2202	2313	2385	2437	2437
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	74	74	74	74	74

Notes - 2007

2007 data are not available. 2006 data are used as an estimate for 2007.

Notes - 2006

Data Source: Ohio Vital Statistics 2006 Final Birth File, resident births.

Notes - 2005

Data Source: Ohio Vital Statistics 2005 Final Birth File, resident births.

a. Last Year's Accomplishments

The target for calendar year 2006 was 74 percent. Based on final vital statistics data for 2006, the actual percent of VLBW infants delivered at facilities for high-risk deliveries and neonates was

67.4. Ohio did not meet its target. Data for 2007 are not available.

A. Design an analysis of Birth Outcomes by Hospital Level and Regional Perinatal Designation. This infrastructure-level strategy was to be accomplished by 1) convening a team including but not limited to representatives from DFCHS State Project Team, Medicaid, and Regional Perinatal Centers to further design the analysis of birth outcomes: a) outcomes by birth weight, survival, and proximity to Level III facilities by county of residence, length and method of transports, risk factors and mortality; b) VLBW infants born in Level I hospitals by Perinatal Region including root cause(s); and c) VLBW infants regardless of delivery site

An epidemiology team developed an analysis proposal that was reviewed by a larger workgroup. However, difficulties with access to timely data delayed the project. Due to later staffing and priority changes, this project was discontinued. However, profiles of each regional perinatal center are being developed that include the percent of VLBW infants delivered at each level facility.

B. Disseminate the results of Birth Outcomes by Hospital Level and/or Regional Perinatal Designation analysis to inform the design and delivery of services to improve access to risk-appropriate facilities.

This infrastructure-level strategy was to be accomplished through the following activities: 1) educate communities and health care providers on the importance of appropriate risk assessment with subsequent consultation or referral to risk-appropriate facilities for maternal patients who are at high risk for preterm delivery; and 2) work with state and local partners to alleviate barriers (i.e., transportation, healthcare systems, cultural competency, financial and/or lifestyle) to improve access to risk-appropriate facilities for maternal patients who are at high risk for preterm delivery.

This strategy was not completed due to the challenges described in (A) above. However, the profiles of each regional perinatal center will include the % of VLBW infants delivered at each level facility will be disseminated by the Regional Perinatal Data Use Consortium teams.

C. Fund, provide technical assistance, and monitor the success of Regional Perinatal Centers (RPCs) in meeting grant requirements.

This strategy was met by completing a competitive grant process for six (6) RPCs, providing ongoing technical assistance and monitoring performance measures. Site visits were made to each of the six RPCs to monitor grant requirements and provide technical assistance. In addition, RPCs were provided specific training and technical assistance on analyzing data and facilitating interventions based on data. Specifically, RPCs were provided technical assistance on how to use the Vermont Oxford Network data, understanding Medicaid and Medicaid Data, moving ahead with Perinatal Periods of Risk (PPOR), opportunities with HEDIS Data and National Efforts Using Medicaid Data for Perinatal Quality Improvement.

D. Implement and evaluate a Division-wide Birth Outcomes Improvement Initiative (BOII). Refer to State Performance Measure #2 (C)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convene a team including DFCHS State Project Team, Medicaid, Regional Perinatal Centers and others to design the analysis: a) birth weight, survival, and proximity to Level III facilities by county of residence, length and method of transports, risk				X

2. Educate communities and health care providers on the importance of appropriate risk assessment with subsequent consultation or referral to risk-appropriate facilities for maternal patients who are at high risk for preterm delivery.			X	X
3. Work with state and local partners to alleviate barriers to improve access to risk-appropriate facilities for maternal patients who are at high risk for preterm delivery.			X	X
4. Assure that RPC staff monitor national, state and local performance measures.				X
5. Assist RPCs in analyzing and facilitating interventions based upon the analysis of national, state and local performance measures.				X
6. Refer to State Performance Measure 02: Strategy C.				X
7.				
8.				
9.				
10.				

b. Current Activities

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.

B. Monitor and evaluate the components of the competitive Request for Proposals (RFP) for the Regional Perinatal Center funding.

This infrastructure-level strategy is being accomplished through the following activities:

1. Assure monitoring of national, state and local performance measures by ODH and RPC staff; and
2. Assist RPCs in analyzing and facilitating interventions based upon the analysis of national, state and local performance measures.

C. Refer to State Performance Measure 02: Strategy B and C (Ohio Birth Outcomes Improvement Initiative).

c. Plan for the Coming Year

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: 1) updating regional perinatal profiles that include information about the percent of VLBW babies born in each level designation; 2) disseminating regional profile reports to Birth Outcomes workgroup members and regional perinatal center teams; 3) planning a project that would: a) identify 2 regions with the highest percentage of VLBW babies born in level I facilities: and, b) 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.

B. Fund, monitor and evaluate the Regional Perinatal Center program.

This infrastructure-level strategy will be accomplished by: 1) implementing an interagency agreement with ODJFS for work with the Ohio Perinatal Quality Collaborative, and 2) working with RPCs and local urban health departments to plan and implement RPC Urban Project.

C. Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

See State Performance Measure 2 (B).

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88	88	88.5	88.5	88.5
Annual Indicator	87.7	87.8	87.2	72.7	72.7
Numerator	127346	124442	122663	80972	80972
Denominator	145209	141730	140748	111416	111416
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80.5	80.5	80.5	80.5	80.5

Notes - 2007

2007 data not available; 2006 data are used as estimates.

Notes - 2006

.Data Source: 2006 final Ohio Vital Statistics data - Resident Births, information on prenatal care not missing. However, with change to revised NCHS 2003 birth certificate standards, 26 percent of entry into prenatal care data is missing. Substantive changes in both question wording and the sources for this information have resulted in data that are not comparable between revisions.

Notes - 2005

Data Source: 2005 final Ohio Vital Statistics data - Resident Births, information on prenatal care not missing.

a. Last Year's Accomplishments

The target for CY06 was 88.5 percent. Based on final birth data for 2006, the actual percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 72.7. Ohio did not meet its target. 2007 data are not available. NOTE: In the switch to the NCHS 2003 birth certificate standard, 26% of the entry into care data are missing. The revised standard also requires collection of data using a different methodology, accounting for some of the discrepancy between years.

A. Assure that all DFCHS funded programs interacting with women of childbearing age focus on populations at greatest risk for early entry into prenatal care.

DFCHS funded programs incorporated language in their Requests for Proposals to help local grantees focus on populations at greatest risk. The Perinatal Periods of Risk was updated for Ohio and the results were shared with DFCHS funded programs to assist them in identifying populations at greatest risk for poor birth outcomes. Child and Family Health Services (CFHS) projects that were in the process of evaluating their need to provide direct care services, were in the process of transitioning out of direct care services, or that were conducting a community health assessment were offered the opportunity to participate in an intensive technical assistance opportunity designed to identify populations at greatest risk and to identify appropriate interventions. As part of the Family Planning Needs Assessment process, data have been compiled for indicators related to family planning, birth outcomes, sexually transmitted diseases and other health related issues. These data are being used to demonstrate disparities and assist in the prioritization of need process. The priorities that result from this process will be used to target services to populations at greatest risk.

B. Provide technical assistance to DCFHS funded programs to strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care.

ODH family planning programs provided referrals and other pregnancy related services to over 35,000 unduplicated clients. Data forms for 2008 were revised to record all post partum patients served by DCFHS funded family planning programs. Data forms from prenatal care services regarding patients referred from perinatal care to family planning services was revised to retrieve data from prenatal programs in 2008.

C. Assess the cultural competency and acceptability of family planning and prenatal care services in DCFHS funded programs.

Information submitted as part of RFP requirements concerning cultural competency for family planning and prenatal care services was reviewed by program consultants. Cultural competency training, specifically on providing health care services to immigrants, was provided to Child and Family Health Services grantees.

D. Implement and evaluate a Division-wide Birth Outcomes Improvement Initiative (BOII). Refer to State Performance Measure #2 (C)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All DFCHS funded programs are evaluating their current interaction with populations at greatest risk.				X
2. All DFCHS funded programs are incorporating procedures to help local grantees focus on populations at greatest risk.				X
3. DCFHS funded prenatal care and family planning services are to monitor programs for referrals between family planning and prenatal care services.				X
4. Analyze findings from RFP requirements concerning cultural competency.				X
5. Provide TA to DCFHS funded programs on strategies to improve cultural competency.				X
6. Refer to activities for State Performance Measure 02: Strategy C.				X
7.				
8.				
9.				

10.				
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b. Current Activities

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.

B. Provide technical assistance to BCFHS funded programs to strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care based on data (see A), literature review and evidence-based practices.

This infrastructure-level strategy is being accomplished by asking all BCFHS funded prenatal care and family planning services to monitor programs for increased referrals between family planning and prenatal care services.

C. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in BCFHS funded programs.

This infrastructure-level strategy is being accomplished by providing training and/or TA to BCFHS funded programs on strategies to improve cultural competency.

D. Refer to State Performance Measure 02: Strategy B and C (Ohio Birth Outcomes Improvement Initiative).

c. Plan for the Coming Year

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.

This infrastructure-level strategy will be accomplished by: 1) analyzing positive pregnancy test and referral to prenatal care data from the Family Planning Data System, specifically looking at racial disparities; 2) developing and implementing a plan to analyze FP referral data including chart audits, Family Planning data, other qualitative data; 3) developing report based on analysis that identifies trends and opportunities for technical assistance and/or quality improvement recommendations; 4) partnering with Ohio ACOG to develop/modify and implement pre/interconception service protocols for public health and private providers; and 5) using focus group results of women of childbearing age and providers of WCA women of childbearing age re: pre/interconception care (P/IC) to inform design/delivery of health education messages interventions;

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

This infrastructure-level strategy will be accomplished by: 1) gathering data about first trimester entry into prenatal care in BCFHS funded programs by age, marital status, income, education, parity, payer, race and ethnicity; 2) analyzing first trimester entry into prenatal care in BCFHS funded programs by age, marital status, income, education, parity, payer, race and ethnicity; 3) literature review and review of evidence-based practices on getting women into prenatal care in the first trimester; 4) providing technical assistance to BCFHS funded programs to strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care based on data (see 1).

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.

This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup to 1) identify appropriate training on cultural competency; 2) to train DCFHS managers and consultants on cultural competency; 2) to identify common language for cultural competency and linguistic competency in ODH RFPs; and 4) to apply for MCHBG TA assistance in #2 above.

D. Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

See State Performance Measure 2 (B).

D. State Performance Measures

State Performance Measure 1: *Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	3
Annual Indicator				1	2
Numerator				1	2
Denominator	4	4	4	4	4
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	3	4	4	4	4

Notes - 2007

Progress for this process measure is measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was to reach three of these benchmarks: 1) identify baseline rates of unintended pregnancy rates in Ohio; 2) identify populations and areas at risk for poor birth outcomes; and 3) identify and apply appropriate evidenced-based practice standards and interventions for the target population. Ohio has met benchmarks 2 and 3 and has made progress toward #1 through analysis of PRAMS data.

Notes - 2006

This is a capacity building performance measure that is measured by the extent to which four benchmarks can be reached. Ohio has reached one and is making progress on the second.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

Progress for this process measure is measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was to reach three of these benchmarks: 1) identify baseline rates of unintended pregnancy rates in Ohio; 2) identify populations and areas at risk for poor birth outcomes; and 3) identify and apply appropriate evidenced-based practice standards and interventions for the target population. Ohio has met benchmarks 2 and 3 and has made progress toward #1 through analysis of PRAMS data.

A. Identify baseline rates of unintended pregnancy in Ohio.

State level data on unintended pregnancy that is available through the Pregnancy Risk Assessment Monitoring System (PRAMS) for the years 2000-2003 demonstrated that 86% of live births among teens 15 to 17 years of age were unintended, and that 80% of live births for 18-19 year olds were unintended . Identification of model methods appropriate for determining rates of unintended pregnancy in Ohio at the state and county levels remains ongoing.

B. Assess population groups and geographic areas at risk for poor birth outcomes.

Updated analysis for risks of unintended pregnancy and poor birth outcomes was completed using PRAMS and Vital Statistics data. Qualitative analysis of focus group data was completed and summarized, with implications of these findings currently under review.

C. Identify and apply appropriate, evidence-based practice standards and interventions for the target population.

Applying ODH data, efforts to reach at risk populations has focused on building capacity for cultural competency. The ODH family planning project implemented a tool for assessment of cultural competence within delegate agencies (See <http://www.odh.ohio.gov/odhPrograms/cfhs/famx/familyx1.aspx>). The completed assessments have progressed toward implementation of strategic plans to improve culturally competent policies and health services.

Literature review of evidence-based practice and interventions to decrease rates of unintended pregnancy is ongoing. The planning process is applying evidence-based criteria to identify model programs of outreach and preventive education within Ohio. Best practice criteria have been distributed for clinical protocols and program guidelines through technical assistance visits with 53 delegate agencies. Resources have been identified toward improved program evaluation, including assessment of consumer satisfaction and outcome measures.

D. Implement a Family Planning Medicaid Waiver

ODH is collaborating with Ohio Department of Job and Family Services toward submission of a Family Planning Medicaid Waiver to the Centers for Medicaid & Medicare Services (CMS). This waiver would provide family planning services to cover men and women ages 18 to 44 whose incomes were at or below 250% poverty and would increase eligibility for family planning services that would include natural family planning along with HIV testing. The goal of these services would be to increase the preconception/interconception care for men and women in order to improve general health and birth outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify baseline rates of unintended pregnancy in Ohio				X
2. Assess population groups and geographic areas at risk for poor birth outcomes.				X
3. Identify and apply appropriate, evidence-based practice standards and interventions for the target population.				X
4. Implement a Family Planning Medicaid Waiver by expanding an existing workgroup to other collaborative partners (e.g. hospitals, HMG, Medicaid Managed Care Providers).				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Examine disparities in pregnancy rates in regards to age, relationship status, income, education, and race and ethnicity

This infrastructure-level strategy is being accomplished through the following activities: 1) Review literature regarding population groups at risk for poor birth; 2) Review current Ohio data on populations at risk for unintended and unwanted pregnancy; and 3) Summarize and report results from focus groups regarding unintended pregnancy, reproductive health and birth outcomes.

B. Work with Ohio's Medicaid program to expand eligibility for family planning services to uninsured men and women aged 18-55 with incomes at or below 200% of the FPL.

C. Refer to State Performance Measure 02: Strategy B and C (Ohio Birth Outcomes Improvement Initiative).

D. Assess progress in providing culturally competent care

The ODH family planning project developed a Cultural Competency tool for agencies to assess their progress in developing culturally competent care. This assessment is a required part of the grant application for family planning, perinatal, well-child, OIMRI and several other programs at ODH. The tool can be viewed at <http://www.odh.ohio.gov/odhPrograms/cfhs/famx/familyx1.aspx>. This process began in 2005 and requires each agency to report on their progress with their application. The use of this tool will continue to be required.

c. Plan for the Coming Year

This infrastructure-level strategy will be accomplished through the following activities:

A. Examine disparities in pregnancy rates in regards to age, relationship status, income, education, and race and ethnicity

1. Use current Ohio data to establish rates of unintended and unwanted pregnancies among diverse population groups.
2. Identify the level of risk for poor birth outcomes by categories of pregnancy intention.
3. Conduct regional focus groups regarding pregnancy intention, reproductive health and birth outcomes.
3. Complete a qualitative summary of focus group data on intention of pregnancy
4. Review data results with community stakeholders for prioritizing evidence-based interventions among diverse population groups.

B. Work with Ohio's Medicaid program to expand eligibility for family planning services to uninsured men and women aged 18-55 with incomes at or below 200% of the Federal Poverty Level (FPL).

1. Sustain collaboration with Ohio Medicaid Program (Ohio Department of Job and Family Services) to determine eligibility criteria for family planning services for low income (<250% FPL) women and men aged 18 to 44 years of age.
2. Continue to provide information to relevant stakeholders about the impact of the family

planning waiver on federal and state resources.

C. Refer to State Performance Measure 02: Strategy B and C (Ohio Birth Outcomes Improvement Initiative).

D. Assess progress in providing culturally competent care.

1. Ongoing self-assessment of the Culturally and Linguistically Appropriate Services (CLAS) objectives and strategies by delegate agencies of ODH family planning programs (See Office of Minority Health, DHHS [2001]. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Retrieved February 15, 2008, from <http://www.omhrc.gov/assets/pdf/checked/executive.pdf>).

2. Summarize the priority CLAS objectives among delegate agencies for family planning programs.

3. Provide training and technical assistance for staff members of delegate agencies based on the prioritized CLAS educational needs and objectives.

State Performance Measure 2: Percent of low birth weight black births among all live black births.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				13.4	13.3
Annual Indicator	13.5	13.8	13.6	14.2	14.2
Numerator	3041	3284	3278	3615	3615
Denominator	22550	23862	24116	25494	25494
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	13.2	13.1	13	13	13

Notes - 2007

2007 Vital Statistics birth data are not available; 2006 data are used as estimates.

Notes - 2006

Data Source: Ohio Vital Statistics final birth data- 2006; resident births where birth weight not missing.

Notes - 2005

Data Source: Ohio Vital Statistics birth data- 2005 final; resident births where birth weight not missing.

a. Last Year's Accomplishments

The target for calendar year 2007 was 13.3. Based on final data for 2006, the actual percent of low birth weight black births was 14.2. Data for 2007 are not available. Ohio did not meet its target.

A. Assure that all DFCHS funded programs interacting with women of childbearing age focus on populations at greatest risk.

Refer to National Performance Measure #18 (A)

B. Continue to refine RFPs and provide technical assistance to DFCHS funded program and

Medicaid providers to ensure the target population is served.

Child and Family Health Services grantees were provided training on best practices in the state on conducting outreach to black women at high-risk of delivering a low birth weight baby. ODH provides support to the Ohio Community Health Workers Association, which provides ongoing support and technical assistance to programs designed, in part, to reduce the percent of low birth weight black births among all live black births. The Florida State University Partners for a Healthy Baby training was provided to Ohio Infant Mortality Reduction Initiative community health workers and Child and Family Health Services program perinatal staff who work on the area to improve birth outcomes in an at-risk population through care coordination.

C. Implement and evaluate a Division-wide Birth Outcomes Improvement Initiative (BOII).

In an effort to design and deliver BOII health education messages, interventions and clinical service protocols, focus groups were conducted by the OSU College of Nursing to assess the knowledge and attitudes of women and providers toward preconception and interconception interventions. Three focus groups were held with non-physician health care providers and interviews were conducted with physicians in three regions of the state. Nine focus groups were conducted with African American women aged 19-24. Six focus groups were conducted with women aged 19-24 who reside in an Appalachian county. A total of 73 women were in these focus groups. Recommendations were provided and are being considered by ODH. Pre/Interconception Protocols are being developed pending results from focus groups. In an effort to design a preconception intervention, data on OIMRI programs have been analyzed, programs have been mapped and the larger topics have been placed a logic model for ongoing discussion. The Help Me Grow (HMG) Postpartum Depression Pilot finalized the pilot with seven counties. The EPDS (Edinburgh Postnatal Depression Scale) was administered on 569 eligible mothers. 14.6% screened positive for maternal depression and of those women, 65% were referred for mental health services. In an ongoing effort to implement the 5A's smoking cessation intervention in four identified high risk counties and to provide the highest standard of care in tobacco screening to pregnant women, a pilot was complete in the four pilot counties in WIC and HMG programs. Results are being used to inform a statewide dissemination effort. Ohio Partners for Birth Defects Prevention (OPBDP) provided five trainings to nearly 100 participants around the state targeting women's health providers on preventable birth defects. The trainings are based on the document Birth Defects: Strategies and Prevention Handbook, developed by OPBDP. Plans have been initiated for a Women's Wellness Symposium on pre and interconception care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure DFCHS funded programs interacting with women of childbearing age are focusing on populations at greatest risk.				X
2. Educate providers regarding how to conduct outreach to black women at high-risk of delivering a LBW baby.				X
3. Promote coordination and collaboration of ODH DFCHS bureaus in implementing and evaluating a Birth Outcomes Improvement Initiative.				X
4. Use focus group results of women of childbearing age and providers of women of childbearing age re: pre/interconception care to inform design/delivery of health education messages and interventions.				X
5. Partner with Ohio ACOG to develop/modify and implement prenatal/Interconceptional service protocols for public health and private providers.				X

6. Add pre- and interconception content to care coordination and home visiting programs.				X
7. Partner with Ohio Department of Mental Health to assess physical/mental health of postpartum women in HMG. Plan a 2008 Ohio Summit for pre- and interconception health to report on state/national best/ promising practices.				X
8. Support Ohio Partners for Birth Defects Prevention and Fetal Alcohol Spectrum Disorders Statewide Initiative to increase public awareness re: preventable birth defects.				X
9. Develop and implement an evaluation logic model for each BOII strategy.				X
10.				

b. Current Activities

A. Survey DFCHS programs interacting with women of childbearing age (WCBA) to determine if services are provided to populations of greatest risk per PPOR data.

B. Implement/evaluate a Division-wide Birth Outcomes Improvement Initiative (BOII). Assure that DFCHS bureaus collaborate on the BOII; Use focus group results of WCBA and providers regarding pre/interconception (P/I) care and their knowledge/attitudes to inform the design/delivery of interventions; Develop/modify/implement P/I service protocols for DFCHS programs/other public health/private providers; Add P/I content to care coordination/home visiting programs; Partner with Ohio Department of Mental Health to assess physical/mental health of women in HMG during postpartum period; Include state/national best/promising practices in 2008 Ohio Summit for P/I Health; Support Ohio Partners for Birth Defects Prevention and FASD Statewide Initiative to increase public's awareness re: preventable birth defects.

C. Facilitate process to complete results-based accountability model developed by Mark Friedman
Bring together Ohio's MCH programs, early intervention, WIC, genetics/birth defects programs, Ohio Medicaid/Medicaid Managed Care, March of Dimes, ACOG, and community partners/stakeholders to collaborate on action steps including CDC Recommendations to Improve Preconception Health.

D. Analyze data to identify TA needs of local ODH funded P/I care providers to improve access to services for African American women.

c. Plan for the Coming Year

A. Survey DFCHS programs interacting with women of childbearing age to determine if services are provided to population of greatest risk according to PPOR data. Utilize data to determine future policy and funding direction.

This infrastructure-level strategy will be accomplished by: 1) reviewing identified populations of greatest risk for women of childbearing age in CFHS community health assessment. Compare to VS data; 2) providing feedback to CFHS grantees from (1) above; 3) reviewing findings from OIMRI data needs assessment and begin work on revising data collection efforts; 4) funding and monitoring 13 OIMRI programs; 5) exploring ideas to work with OIMRI projects to increase AA response rates to PRAMS; and 6) adding pre/interconception content to DCFHS care coordination and home visiting programs.

B. Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

This infrastructure-level strategy will be accomplished by building on existing Friedman work to identify pre/ interconception intervention for OIMRI.

C. Continue to strengthen breastfeeding protection, promotion and support within the Ohio Infant Mortality Reduction Initiative (OIMRI) program. This infrastructure-level strategy will be accomplished by: 1) evaluating the impact of breastfeeding training on OIMRI staff; strengthening training on breastfeeding training for community health workers; and 3) exploring cross program coordination in one county (e.g., coordination of OIMRI efforts with other programs such as WIC, CFHS and/or Help Me Grow).

D. Collaborate with internal partners e.g., the Bureau of Oral Health Services, the Office of Ohio Health Equity, Help Me Grow, Bureau of Prevention, etc. to address eliminating the disparity of infant mortality.

This infrastructure-level strategy will be accomplished by building on existing collaborations and identifying new opportunities collaborate in eliminating the disparity of infant mortality.

State Performance Measure 3: *Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	3
Annual Indicator				1	1
Numerator				1	1
Denominator	4	4	4	4	4
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	3	4	4	4	4

Notes - 2007

Progress for this process measure will be measured by the extent to which 4 benchmarks can be reached. The target for FFY 07 was 1) assess social/emotional health needs of MCH populations; 2) develop mechanisms to promote early identification of social/emotional health needs of MCH populations; 3) develop prevention services for MCH populations at risk. Ohio has made some progress toward meeting these targets.

Notes - 2006

Progress for this process measure was measured by the extent to which four benchmarks could be reached. The target for CY 2006 was "assess the social/emotional health needs of MCH populations". Ohio has made some progress toward meeting this target.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

Progress for this process measure will be measured by the extent to which 4 benchmarks can be reached. The target for FFY 07 was 1) assess social/emotional health needs of MCH populations; 2) develop mechanisms to promote early identification of social/emotional health needs of MCH populations; 3) develop prevention services for MCH populations at risk. Ohio has made some progress toward meeting these targets.

A. Identify evidence-based practices (as related to tools, processes/skills) to screen for

social/emotional health of the following MCH populations, and refer as appropriate:

1. Infants/toddlers (birth to 3)
2. Preschool children (3 to 6)
3. School age children and adolescents (6 to 18)
4. Women of child bearing age
5. Pregnant/postpartum women

This strategy was to be accomplished through the following activities: 1) create an inventory of current practices related to social/emotional health screening/referral in DFCHS programs (Include protocols, standards/guidelines for screening/referral; screening tools currently used; training provided to develop skills; data sources/types of data collected on screening/referrals, etc.); 2) develop survey of DFCHS programs; 3) administer survey; 4) analyze survey/summarize results (The Inventory); 5) identify evidence based practices by population group; 6) identify need for services; 7) identify partners/collaborators (current/potential; invite to meetings; 8) identify gaps between "what is" (current practices and "what ought to be" (evidence-based practices); then prioritize a set of recommendations based on resources/reality.

A survey of state programs has not been conducted due to the development of other opportunities around social/emotional health for young children as well as new mothers. In Spring 2007, ODH was selected by the Vermont Child Health Improvement Partnership (VCHIP), in partnership with the National Association of State Health Policy (NASHP), to participate in "Improvement Partnerships: Building Collaboration to Improve Child Health Care". The Ohio Department of Job and Family Services/Office of Medicaid (ODJFS) was also chosen by NASHP to participate in ABCD project to improve developmental screening for young children eligible for Medicaid. The goal of this partnership is to improve use of structured developmental screening/assessment by primary care practitioners for young children ages birth through 6. A group of stakeholders are addressing issues around the implementation of the project. Workgroups have been formed and are discussing screening tools/schedules; efficient/effective workflow in the pediatric practice to accommodate the use of a standardized tool; reimbursement for use of the tool; referral processes when a child has been identified; public awareness/parent education. General developmental, social/emotional, and autism screening tools are being discussed.

ODH is also partnering with the ODJFS Bureau of Child Care and Development and the Ohio Department of Mental Health to train local providers on the use of the Ages/Stages Questionnaire (ASQ) and the ASQ: Social/Emotional. ODH will provide a Train-the-trainers event in December 2007 for 50 potential trainers who will then provide training to physician practices, child care (center-based and in-home) facilities, Help Me Grow (HMG) (birth to 3 program) service coordinators, and other early childhood educators. Over 150 training sessions are planned between January to June 2008 to teach professionals how to use the screening tools. This statewide program is promoting early identification, prevention, and services by teaching professionals at the child's medical home and child care provider how to use a standardized tool to identify children with potential needs as early as possible.

Additionally, the ability of Ohio to assess social/emotional health needs of pregnant/postpartum women has increased in the last year. In a pilot study that occurred in 2006-2007, all new mothers in the HMG program in 6 counties who received a newborn home visit were assessed using the Edinburgh Depression Scales. The pilot study has been expanded to additional counties in Ohio for 2007-2008.

In 2008, Ohio will expand use of standardized developmental screening tools across health provider practices, early intervention, and early childhood education which promotes early identification, prevention, and services for social/emotional health among MCH populations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Create an inventory of current practices related to social emotional health screening and referral in DFCHS Programs.				X
2. Develop, implement, analyze and summarize survey of DFCHS programs.				X
3. Identify evidence based practices by population group.				X
4. Identify need for services.				X
5. Identify Partners/ collaborators (current and potential; and invite to meetings.				X
6. Identify gaps between "what is" (current practices and "what ought to be" (evidence-based practices); then prioritize a set of recommendations based on resources and reality.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Conduct a follow-up survey to those programs which self-identify as serving MCH populations and assessing social/emotional health in MCH populations. More specifically, the survey will identify (a) protocols, standards and guidelines for screening and referral; (b) screening tools currently being used to assess social/emotional health; (c) training provided to develop skills; (d) data sources and types of data collected on screening and referrals; (e) needs for services by population group; and (f) partners/ collaborators.

B. Conduct analysis of the data collected from the above survey.

C. Based on the data collected and analyzed, identify the gaps between "what is" (current practices) and "what ought to be" (evidence-based practices) happening across the state in regard to social/emotional health.

c. Plan for the Coming Year

A. Conduct focus groups with the state's new 168 mental health consultants to find out the extent to which children birth to age 8 are being referred for further evaluation of their social emotional health needs. Additionally, this data will be compared to what we would expect the referral rates to be based on the programs using a screening tool. (Intervention)

B. Examine data being collected within Ohio's Help Me Grow program and NASHP pilot study for the past 12 months on the prevalence of (a) physicians and (b) Help Me Grow home visitors using social-emotional screening tools. (Identification)

C. Calculate the number of individuals who have been trained throughout the state on the Ages and Stages: Social Emotional screening tool who are (a) physicians, (b) clinicians other than MDs, (c) child care providers, (d) Help Me Grow staff, and (e) pre-school teachers. (Prevention):

State Performance Measure 4: Degree to which Division of Family and Community Health Services programs can incorporate and evaluate culturally appropriate activities and interventions

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	3
Annual Indicator				2	3
Numerator				2	3
Denominator	5	5	5	5	5
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	4	4	5	5	5

Notes - 2007

The FFY 07 target for this process measure was to complete 3 of 5 steps: 1) Programs describe the racial/ethnic/cultural makeup of MCH populations served and underserved; 2) Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities; and 3) Assess existing tools used for cultural competence. Ohio has completed all three steps, and has met the FFY 07 target.

Notes - 2006

The FFY 06 target for this process measure was to reach 2 of 5 benchmarks: “Programs describe the racial/ethnic/cultural makeup of MCH populations served and underserved; and “Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities”. Ohio partially completed the benchmarks, but has not met the 06 target.

Notes - 2005

New performance measure. No data available

a. Last Year's Accomplishments

The FFY 07 target for this process measure was to complete 3 of 5 steps: 1) Programs describe the racial/ethnic/cultural makeup of MCH populations served and underserved; 2) Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities; and 3) Assess existing tools used for cultural competence. Ohio has completed all three steps, and has met the FFY 07 target.

A. Develop DFCHS profile of populations served by programs

The DFCHS Cultural Competency workgroup developed a data collection spreadsheet to capture information needed for SPM 04, as well as data needed for MCH BG Form 7 (Individuals served in Title V programs by types of individuals and primary source of health coverage); and data needed for MCH BG Form 8 (deliveries and infants served by Title V and entitled to benefits under Title XIX, by race and Hispanic ethnicity). Information requested included: program descriptions; target population; eligibility requirements; method used to collect racial/ethnic data; numbers served by population type/race/Hispanic ethnicity/primary source of health coverage; percent of population served by race/Hispanic ethnicity; estimates of racial/Hispanic populations expected to be served, based on program target population.

Using information collected, a profile of populations served by DFCHS program was described. Problems identified for future work included: 1) not all programs collect data on race and ethnicity; 2) not all programs adhered to the ODH standard for collection of race and ethnicity; 3) reporting of such data was not standardized; and 4) a few programs did not appear to target the populations with greatest disparities

B. Compile a description of program requirements for cultural competency, including definitions of "culturally appropriate/competent" and a description of tools used for cultural competence.

A survey to gather information about program requirements and activities related to cultural competency, as required for MCH BG State Performance Measure 04, was administered in all

program bureaus in DFCHS. Thirty surveys covering 44 programs were completed by the six DFCHS program bureaus. This represented the majority of DFCHS programs. Nearly half (14) of survey respondents reported that their programs had some type of requirement or mandate to address cultural competency and/or to provide culturally appropriate services to their customers. Of the 14 programs with a stated requirement for cultural competency, five respondents provided a definition of cultural competency for their programs. Only two of the definitions were the same, while the others were similar. Forty percent of the 30 respondents assess the degree to which a specific program can incorporate culturally appropriate activities and interventions. Less than half stated that assessment/monitoring process was part of the RFP process. Other responses included annual program reports, site visits, audit tools, MCH Block Grant Annual report, etc. Three programs use the CLAS self assessment tool to monitor. The Universal Newborn Screening program uses a very comprehensive tool required by MCHB for that grant category. There are few common or consistent themes in DFCHS in regard to any of the dimensions of cultural competency covered by the survey: definitions, requirements that cultural competency be addressed, training and assessment/monitoring. On the other hand, it was apparent that DFCHS programs are aware of cultural competency as an important element in service delivery, but not seemingly aware of definitions or guidance on cultural competency that were embedded in regulation and guidance. Survey findings were forwarded to DFCHS chiefs and ODH Disparities Council for direction on next steps. Their suggestions for next steps were incorporated into the FFY 2008 plan.

C. Participate in National Center for Cultural Competence's (NCCC) Community of Learners meeting and year-long initiative: "Leadership to Advance and Sustain Cultural and Linguistic Competence in Systems Serving Children and Youth with Special Health Care Needs."

Ohio was chosen as one of 18 states to participate in the NCCC's Community of Learners (COL) year-long initiative. The strategy workgroup leader from the MCH BG State Performance Measure 04 is serving as Ohio's representative to the initiative and has attended one face-to-face meeting at Georgetown University and has participated in four conference calls with the COL.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop DFCHS profile of populations served by programs.				X
2. Compile a description of program requirements for cultural competency, including definitions of "culturally appropriate/competent"				X
3. Participate in National Center for Cultural Competence's Community of Learners meeting and year-long initiative: "Leadership to Advance and Sustain Cultural and Linguistic Competence.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- A. Develop/enhance division-wide profile of populations served by DFCHS programs
 - 1. Include eligibility requirements

2. Identify populations eligible for services
3. Identify racial/ethnic composition of workforce that serves DFCHS populations.
4. Identify how racial, ethnic, cultural data are collected

Activities: 1) Update DFCHS profile of populations served by program; 2) Identify gaps in population profile data collected from DFCHS programs; 3) Prioritize gaps to be addressed in FFY 2008; 4) Address prioritized gaps; 5) Work with ODH Public Health Data/Research Policy Advisory Committee to train ODH staff on ODH data standards to improve collection of data on race/ethnicity across programs.

B. Incorporate selected culturally appropriate activities/interventions into State DFCHS programs

Activities: 1) Participate in National Center for Cultural Competence's initiative for leadership; 2) With ODH Health Disparities Council, incorporate core requirements for cultural competency(CC) into ODH contract/RFP templates; 3) Develop standards/guidance for moving to CC for grantees/vendors who must comply with RFP/contract language; 4) Develop CC monitoring tools; 5) Develop training plan to address training needs of all public health audiences at state/local levels: policy makers, administrators, consultants, clinicians, etc.; 6) Develop training curriculum (Identify existing curricula; adapt as possible; or create new curricular material; 7)) Assist grantees to to develop plans for CC.

c. Plan for the Coming Year

A. Continue to develop and enhance a division-wide profile of populations served by DFCHS programs

1. Include eligibility requirements that specify populations to be served
2. Identify how racial and ethnic data are collected and reported

This infrastructure-level strategy will be accomplished through the following activities:

1. Update DFCHS profile of populations served by program (information also needed annually for MCH BG Forms 7 and 8).
2. Share profile information, especially in regard to collection and reporting of racial/ethnic data, with all DFCHS Bureaus.
3. Based on identified gaps in population profile data collected by DFCHS programs; e.g., racial/ethnic data; collaborate with the ODH Public Health Data/Research Policy Advisory Committee to train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.
4. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.
5. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to train DFCHS staff on standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.
6. Complete the development and field testing of guidance on collection of race/ethnicity data for local grantees, especially as related to compliance with CLAS standards.

B. Incorporate selected culturally appropriate activities and interventions into State DFCHS programs

This infrastructure-level strategy will be accomplished through the following activities:

1. Continue to participate in the National Center for Cultural Competence's new initiative for leadership in cultural and linguistic competence. The learning collaborative was extended to a second year.
2. Continue to support ODH efforts, through the ODH Health Disparities Council and the Office of Healthy Ohio, Health Equity program, to incorporate core requirements for cultural competency into ODH contract and RFP language. Activities include the development of a common definition

of cultural competence that can be used across ODH programs.

3. Based on technical assistance requested from the National Center for Cultural Competence, train ODH staff and local grantees on requirements/recommendations for cultural/linguistic competence, as outlined in Title VI of the Civil Rights act and as recommended in CLAS standards. Training would emphasize the the planning for and the process of becoming culturally/linguistically competent what tools to use to monitor progress..

4. Collaborate with ODH efforts to develop standards and performance measures for moving toward cultural and linguistic competence for ODH staff and for grantees/vendors who must comply with RFP/contract language.

State Performance Measure 5: Percent of 3rd graders who are overweight

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				36.5	36
Annual Indicator		35.6	35.6	35.6	34.3
Numerator		45342	45342	45342	43212
Denominator		127364	127364	127364	125956
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	35.5	35	34.5	34	34

Notes - 2007

Source: Data is from Oral Health / BMI Survey of 3rd graders conducted in the 2006 - 2007 school year from a sentinel sample of 25 schools. Numerator: The actual number of children who met the definition of risk for or at overweight =397(population estimate = 43,212). Denominator: The actual number of children who were surveyed = 1,198 (population estimate = . 125,956).

Notes - 2006

Source: Data is from Oral Health / BMI Survey of 3rd graders conducted in the 2004 - 2005 school year. Data originally reported for reporting year FFY 2005 were corrected. There was an error in the weighting of the data in the first round of data analysis. Data originally reported was 37.4%; correct figure is 35.6%.

Notes - 2005

Source: Data is from Oral Health / BMI Survey of 3rd graders conducted in the 2004 - 2005 school year. Data originally reported for reporting year FFY 2005 were corrected. There was an error in the weighting of the data in the first round of data analysis. Data originally reported was 37.4%; correct figure is 35.6%.

a. Last Year's Accomplishments

The target for FFY 2007 was 36 percent (overweight or at risk for overweight). The actual percent of third graders in the 2006/2007 school year who were overweight/obese (BMI greater than or equal to 95th percentile) was 16.6, and the actual percent of third graders who were at risk for overweight (BMI at 85th to 95 percentiles) was 17.7, for a total of 34.3 percent. There was no statistically significant change in overweight or obesity from 2004-2005 to 2006-2007. Ohio has met its goal for 2007. See report at

A. Conduct data surveillance and monitoring activities

In 2006-7 30 schools were selected and all participated in the third grade sentinel surveillance project. Of 2,208 students in the sampled schools, 1,447 returned consent forms; 1215 were screened, 16.6% of the students screened were at the overweight/obese level (BMI at 95% and greater) 17.7% were at risk for overweight (BMI at 85% to 95

Results of the sentinel revealed no statistical differences this year than from the major state wide surveillance project of 2004. Data was also collected on referral sources by county from MCH grant funded programs through the ODH Child and Family Health Services program.

A random sample of middle schools and school nurses was conducted this year to begin conducting a surveillance project for obtaining BMI on the 7th grade population. Data will be available at the state level by summer of 08.

B. Increase health care providers awareness and involvement in prevention and treatment initiatives

Over 15 trainings of the CATCH curriculum was done by ODH staff in partnership with the Ohio Department of Education's Child and School Nutrition program. More than 300 teachers received the curriculum free to take back to school districts throughout Ohio. The training includes nutrition and physical activity guidelines for students in grades k-8.

A statewide inventory of stakeholders was conducted for the ODH, Ohio Public Health Leadership Institute. Survey results are attached.

C. Continue current collaborations and facilitate the development of new potential internal and external partners.

Ohio Department of Education collaboration continues with the joint CATCH trainings.

Collaboration with Action for Healthy Kids includes: Participation on Ohio Action for Healthy Kids steering Committee; assistance in planning three regional zone meetings; and provision of data on childhood BMI for third grade and low income preschool children.

Buckeye Best continues to be a program that is part of the ODH Office of Healthy Ohio and the ODH initiative to reduce obesity. The Buckeye Best awards program has been endorsed by the ODE and the Ohio Association of Health Physical Education, recreation and Dance (OAHPERD). OAHPERD has contributed to revising the physical education portion of the application and plans to assist ODH in the scoring of the applications.

D. Investigate evidence based intervention for school aged population.

We Can! , another physical activity and nutrition program, was researched for use in Ohio schools. A train- the-trainer program is being planned for this year.

E. Participate in the development of a statewide plan for addressing childhood obesity

A draft plan has been developed and is scheduled to be shared in December with the ODH senior staff.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct surveillance/monitoring of overweight in third graders.				X
2. Conduct inventory of statewide resources/programs addressing treatment of childhood obesity.				X
3. Expand training on BMI guidelines for heights/weights to ODH funded grantees.				X
4. Promote physical activity/nutrition programs in schools through Action for Healthy Kids Steering Committee.			X	
5. Investigate evidence based interventions for schoolagers.				X
6. Participate in development of State Plan for Addressing Childhood Obesity.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Conduct surveillance/monitoring

Collect heights/weights of Sentinel School sample; Develop/distribute report on BMI for year 1 of sentinel schools; Use new database to input data from obesity inventory tool from WIC, CFHS and Rural Health; Analyze BMI data/PedNSS to ID differences in child obesity trends by county.

B. Increase health care providers' awareness/involvement in prevention/treatment initiatives

Assist OPHLI team to inventory of state resources/programs addressing treatment of child obesity; Expand training on BMI height/weight guidelines to all ODH grant recipients; Find educational information on BMI/nutrition/physical activity standards for medical providers to use with school age patients; Expand dissemination of Ounce of Prevention and CATCH to CFHS projects.

C. Continue current collaborations; identify new partners

Promote physical activity/nutrition programs in schools through Action for Healthy Kids; Coordinate CFHS grantees who focus on child obesity with CVH grantees in Division of Prevention; Work with ODE Child Nutrition Program to assess number of wellness plans through Buckeye Best Program; Use OPHLI program survey to identify new external partners who address child obesity.

D. Investigate evidence-based interventions for school aged population

With ODE, identify best practices re: nutrition/PE/PA; disseminate information to Ohio school districts; Train schools in CATCH.

E. Participate in development of a state plan to address child obesity.

c. Plan for the Coming Year

A. Conduct data surveillance and monitoring activities

This infrastructure-level strategy will be carried out through the following activities:

1. Continue to collect heights and weights of Sentinel School Sample (third grade)
2. Continue to develop and distribute report on BMI for year two of sentinel schools
3. Collect heights and weights of 7th graders for state level BMI data
4. Begin planning for 2009-2010 data collection of state and county level third grade BMI survey
5. Review and update the ODH Childhood Obesity Community Resource Data base developed for collecting data from the obesity inventory tool from WIC, CFHS and Rural Health
6. Conduct analysis of BMI data and PEDNSS to explore differences in trends of childhood obesity by county and by race and Hispanic ethnicity
7. Work with the ODH Public Affairs Office in researching options for a web based distribution of the ODH Childhood Obesity Community Resource Directory

B. Increase health care providers' awareness and involvement in prevention and treatment initiatives

This infrastructure-level strategy will be carried out through the following activities:

1. Expand training on the BMI guidelines for heights and weights to all ODH funded CFHS grantrecipients
2. Explore available educational information on the "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity" to share with medical providers for use on school age patients

C. Continue current collaborations and facilitate the development of new potential internal and external partners

This infrastructure-level strategy will be carried out through the following activities:

1. Continue to promote physical activity and nutrition programs in schools through the Action for Healthy Kids
2. Coordinate CFHS grantees who are focusing on childhood obesity with CVH grantees in the ODH Office of Healthy Ohio to encourage collaboration and share resources
3. Work with Ohio Department of Education child nutrition program to assess the number of wellness plans through the Buckeye Best Program
4. Continue to work with local WIC clinics and staff as BMI screeners in the BMI school surveillance projects for third and seventh grade.

D. Investigate evidence based interventions for the school aged population

This infrastructure-level strategy will be carried out through the following activities:

1. Work with the ODE to Identify best practices related to nutrition and PE/PA and disseminate information on best practice models to school districts throughout the state
2. Continue training in CATCH curriculum to school buildings throughout Ohio
3. Partner with OAHPERD with the Buckeye Best Program and training for PE teachers on CDC Physical Education Curriculum Analysis Tool (PECAT)

State Performance Measure 6: *Assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	1
Annual Indicator				1	1
Numerator				1	1

Denominator	3	3	3	3	3
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	2	2	3	3	3

Notes - 2007

This is a process measure that will be measured by the extent to which three benchmarks can be reached. The target for Calendar Year 2007 was that one benchmark: "Method is developed to measure access to care" would be reached. Ohio did meet its objective.

Notes - 2006

This is a process measure that will be measured by the extent to which three benchmarks can be reached. The target for Calendar Year 2006 was that one benchmark: "Method is developed to measure access to care" would be reached. Ohio is still in the planning process for this benchmark; therefore has not met its target for 2006.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

This is a process measure that will be measured by the extent to which three benchmarks can be reached. The target for Calendar Year 2007 was that one benchmark: "Method is developed to measure access to care" would be reached. Ohio did meet its objective.

A. Develop a methodology that can be used across the Division of Family and Community Health Services to measure gaps in access to primary care, mental health, and dental services and the contribution of safety net providers in meeting these needs.

This infrastructure-level strategy included the following activities: 1) conduct literature review to identify existing methodologies to measure gaps in access to primary care, mental health, and dental services and the contribution of safety net providers in meeting these needs; 2) develop consensus on the definitions of terms such as access, safety net providers, unmet need, primary care services, mental health services, dental services, medical home, medically handicapping conditions, and children with special health care needs; 3) access technical assistance from MCHB on approaches to development of the methodology; 4) develop/adapt a methodology to pilot (see strategy C.).

Activities 1(literature search) and 2 (definition of terms) have been completed (see attached). Activity 3 (accessing TA) was not necessary as the workgroup was not at a stage to best utilize TA. The ODH Bureau of Oral Health Services (BOHS) was successful in initiating the steps needed to begin the development of a planning model (activity 4) through a collaborative effort with Anthem Foundation of Ohio, Osteopathic Heritage Foundations, and Sisters of Charity of Canton.

B: Increase ODH capacity to measure the efficiency and productivity of safety net dental clinics.

This infrastructure-level strategy included the following activities: 1) develop capacity to analyze Medicaid data for safety net dental clinics; 2) assess federal Uniform Data System (UDS) data for Federally Qualified Health Centers (FQHCs); 3) develop and implement a plan to conduct in-depth analyses of BOHS subgrantee safety net dental clinics; 4) collaborate with Anthem on the development and evaluation of its safety net dental clinic technical assistance project, especially the front-end assessment portion; and 5) assess the need for an ODH survey of all safety net dental clinics in Ohio.

Activities 1, 2 and 3 have been completed or are currently underway. A collaboration was formed among BOHS, Anthem and Osteopathic Heritage Foundations, and Sisters of Charity to contract

with a consulting firm to conduct an in-depth assessment of financial and operational activities of six Ohio safety net dental clinics. Once the assessment is complete, the firm will provide technical assistance to improve efficiencies and sustainability. BOHS is serving on the advisory committee of this project with an interest in replicating this model with ODH-funded safety net dental clinics. Once the assessment is complete, the firm will provide technical assistance to improve efficiencies and sustainability. BOHS is serving on the advisory committee of this project with an interest in possibly replicating this model with ODH-funded safety net dental clinics. Site visits to the selected clinics are under way.

Activities 4 and 5 have been completed or are currently underway. BOHS, in collaboration with Anthem Foundation and Georgetown University, will develop a "one-stop shop" web-based information center for Ohio dental safety net clinics. An advisory committee consisting of representation from Ohio and national experts has met to discuss the make-up of this site. A distance learning component will be housed on this site and pertinent subjects of interest will be developed for clinical and non-clinical staff. Distance learning will allow clinical staff to obtain needed credit hours for licensure without a major disruption in service to patients. This project will be linked to the web-based "how-to start a dental clinic" manual.

C. Assess capacity to measure gaps in access to primary care and the contribution of safety net providers in meeting these needs.

This infrastructure-level strategy proposed the application of the model identified in strategy A to be used in a pilot for primary care services. The model under development by BOHS may be applied to primary care when it is complete. Whether the model can be applied is unknown at this time.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct literature review to identify existing methodologies to measure gaps in access to primary care, mental health, and dental services and the contribution of safety net providers in meeting these needs.				X
2. Develop consensus on definitions of terms such as access, safety net providers, unmet need, primary care/mental health/dental services, medical home, medically handicapping conditions, and CSHCN.				X
3. Develop capacity to analyze Medicaid data for safety net dental clinics.				X
4. Collaborate with Anthem Foundation of Ohio on development/evaluation of its safety net dental clinic TA project				X
5. Apply methodology identified in Activity #1 to pilot on primary care services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Apply Health Professional Shortage Area (HPSA) methodology for use across the Division of Family and Community Health Services to recruit/retain primary care health care providers who serve the medically underserved in HPSAs.

Report number of: 1) current HPSAs due for renewal; 2) current HPSAs that meet federal criteria for renewal; 3) new HPSAs requested by outside entities; 4) potential new HPSAs identified by internal staff. Identify other programs in DFCHS that can apply HPSA methodology to identify unmet needs in primary care

B. Measure gaps in access* to primary care/contribution of safety net providers

*Access is defined for purpose of this measure as the correct ratio of primary care providers to eliminate the HPSA designation based on federal guidelines.

Report number of primary care vacancies in HPSAs that have been vacant for at least 6 months (through review of OPPS, NHSC and J-1 site apps); Report number of primary care providers placed in HPSAs through PCO recruitment/retention programs; Develop/implement system to monitor retention rate of primary care providers placed for 2 years past their final obligation date

C. Assess access to care in HPSA's

Assess feasibility of collecting utilization data using existing surveys/ new surveys; 2) Conduct analysis of Ohio Hospital Association data for ambulatory sensitive conditions such as pediatric asthma and type 2 diabetes.

D. Assess availability/accessibility of mental health data.

c. Plan for the Coming Year

A. Apply the Health Professional Shortage Area (HPSA) methodology to recruit and retain primary care, mental health, and dental health providers who serve the medically underserved in these federally designated HPSAs.

This infrastructure-level strategy will be accomplished through the following activities:

1. Report the number of requests received for designation of primary care HPSAs;
2. Report the primary care HPSAs that are designated and the priorities assigned to them;
3. Report the number of requests received for designation of mental health HPSAs;
4. Report the mental health HPSAs that are designated and the priorities assigned to them;
5. Report the number of requests received for designation of dental health HPSAs; and
6. Report the dental health HPSAs that are designated and the priorities assigned to them.

B. Measure gaps in access to primary care, mental health, and oral health services and the contribution of safety net providers in addressing these gaps.

Access is defined for purposes of this measure as the ratio of primary care, mental health, and oral health providers needed to eliminate the HPSA designation based on federal guidelines.

This infrastructure-level strategy will be accomplished through the following activities:

1. Report the number of HPSAs that have not been matched with an adequate number of primary care physicians, mental health providers, or dental health providers;
2. Report the number of primary care providers placed in HPSAs through Primary Care and Rural Health Program/Primary Care Unit recruitment/retention programs and the Dental Loan Repayment Program; and
3. Develop and implement a system to monitor the retention rate of primary care providers placed for at least 2 years past their final obligation date.

C. Assess access to primary care, mental health, and oral health services in HPSAs.

This infrastructure-level strategy will be accomplished by measuring the following:

1. Uncontrolled diabetes hospital admission rate;
2. Hypertension hospital admission rate;
3. Pediatric asthma hospital admission rate;
4. Oral health - % without visit in last year.

State Performance Measure 7: Percentage of 3rd grade children with untreated caries

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	22	21	20	29	20
Annual Indicator	34.6	29.9	25.4	23.9	23.7
Numerator	437	344	3565	225	30159
Denominator	1262	1152	14029	941	127147
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	19	18	18

Notes - 2007

Data Source: From the 2006/2007 Sentinel School Survey consisting of 25 schools from which a population based estimate can be determined..

Numerator: Actual number of children with untreated caries in the sample = 270 (population estimate = 30159). Denominator: Actual number of children screened = 1147 (population estimate = 127146).

Notes - 2006

Data Source: From the 2005/2006 Sentinel School Survey consisting of 25 schools from which a population based estimate can be determined.

Notes - 2005

Data Source: 2004/2005 Statewide Oral Health Survey of schoolchildren.

a. Last Year's Accomplishments

The target for FFY 2007 was 20 percent. The actual percent of third graders with untreated caries was 23.7. Ohio has not met its target.

A. Prevent dental caries through community-based fluoride promotion

Funds and technical assistance were provided to the Northern Area Water Authority to implement fluoridation, 9200 additional Ohioans benefit from water fluoridation. Six water systems were provided assistance purchasing new or replacement equipment for water fluoridation.

44,387 students in 183 high-risk elementary schools (non-fluoridated water and low-income) participated in the school-based fluoride mouth rinse program.

B. Increase capacity of dental care safety net programs to serve vulnerable populations.

22,584 patients received care through the Safety Net Dental Care grants (Title V funds). In addition, the Access to Dental Care and Safety Net Dental Care II programs (state GRF) enabled expansion of dental clinic facilities through space renovation and equipment purchases. Data for safety net clinics receiving grants from ODH are being analyzed to establish benchmarks for

evaluating subgrant performance.

Technical assistance was provided to local dental clinics and communities starting clinics to serve the low-income, including assistance developing mentoring relationships with established clinics.

Five dentists were funded through The Ohio Dentist Loan Repayment Program in 2007 (three new and two renewals). ODLRP dentists reported serving 22,194 unduplicated patients in 2007.

Two renewal and one new application for federal Dental HPSAs were submitted to the Division of Shortage Designation.

C. Help communities assess their oral health needs and resources and develop strategies to meet them.

The Ohio Oral Health Surveillance System was posted on the ODH Web site. This is a county-level, internet-based system that describes oral health status, demographics and access to dental care factors.

BOHS produced two reports relating to oral health and access to dental care:

- Make Your Smile Count! A Survey of the Oral Health of Ohio Schoolchildren, 2004-05, reports on the statewide survey of oral health of third grade students conducted during the 2004-05 school year. The report includes county-level data on several measures of oral health
- Oral Health and Access to Dental Care for Ohioans, 2007, a report which summarizes previous reports on access to dental care in Ohio, was published and made available on the ODH Web site. An executive summary was also produced.

BOHS continued to coordinate with the Maternal and Child Oral Health Resource Center on content for the Ohio Safety Net Information Center Web site.

A draft manuscript on the validation of the sentinel school survey methodology was written and will be submitted for publication in October, 2007.

Help Me Smile (HMS) materials, oral health risk assessment protocols and training modules for families of children 0-5 years, were distributed via regional trainings: Help Me Grow (60 sites), WIC (22 sites), CFHS (22), Early Learning Initiative (54 programs) and BCMH (43 sites). Two age groups (6-10 and 11-21) were added to the materials and will be part of the regional trainings in 2008. A training DVD on how to use the HMS materials was developed and will be available in 2008.

BOHS staff identified sites (private practices, FQHC's, institutions/hospitals and local health departments) where high numbers of Medicaid-eligible children aged 0-3 years are served by primary care providers. These sites were contacted and encouraged to schedule Smile for Ohio Fluoride Varnish trainings. 48 sites were trained by BOHS staff during this fiscal year. BOHS staff worked with the Ohio chapter of the American Academy of Pediatrics to encourage training at local meetings. BOHS staff has worked closely with ODJFS and its Office of Managed Care to reduce problems with payments of claims for physicians.

D. Promote policy-maker awareness of the importance of access to dental care as a public policy issue.

BOHS participated on the planning committee for the second Ohio Oral Health Summit that will be held in early FFY 2008 and will seek to develop an action agenda for improving access to dental care.

BOHS produced two reports (as hard copy and PDF files residing on the Department's Website) relating to oral health and access to dental care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve public access to high quality information on fluorides/water fluoridation by maintaining on the BOHS website, current data, information/links to other resources.			X	
2. Maximize impact of Ohio's fluoridation statute through fluoridation promotion/education.			X	
3. Provide limited reimbursement for fluoridation start-up/maintenance costs.				X
4. Fund subgrants for start-up/expansion/maintenance support to Safety net dental clinics.				X
5. Increase knowledge base of SNDC through consultation, TA, con't. ed., and mentoring relationships with other clinics.				X
6. Update the on-line SNDC Manual (www.dentalclinicmanual.com); assist SNDC in placing dentists using Practice Sights software.				X
7. Administer Ohio Dentist Loan Repayment Program.				X
8. Make data/other info. available to help communities describe local OH status and access to dental care to assess community OH needs.			X	X
9. Support community oral health partnerships/coalitions/initiatives.				X
10. Enable non-dental health professionals (home visitors and physicians' offices) to improve OH of populations served.				X

b. Current Activities

A. Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.

This population-level strategy is being accomplished through the following activities:

1. Improve public access to high quality information on fluorides and water fluoridation by maintaining on the BOHS website, current data, information and links to other resources;
2. Maximize the impact of Ohio's fluoridation statute through fluoridation promotion and education efforts;
3. Provide limited reimbursement for start-up and maintenance costs of water fluoridation.

B. Strengthen and support the dental care safety net.

This infrastructure-level strategy is being accomplished through the following activities:

1. Fund subgrants for start-up/expansion and maintenance support to safety net dental clinics;
2. Collaborate with private foundation partners to implement and evaluate the technical assistance program of the Oral Health Capacity Building project and continue to provide technical assistance to agencies interested in operating efficient safety net dental clinics;

c. Plan for the Coming Year

A. Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.

This population-level strategy will be accomplished through the following activities:

- 1) improve public access to high quality information on fluorides and water fluoridation by maintaining on the BOHS website, current data, information and links to other resources;
- 2) maximize the impact of Ohio's fluoridation statute through fluoridation promotion and education efforts;
- 3) provide limited reimbursement for start-up and maintenance costs of water fluoridation.

B. Strengthen and support the dental care safety net.

This infrastructure-level strategy will be accomplished through the following activities: 1) fund subgrants for support to safety net dental clinics; 2) continue to collaborate with private foundation partners to implement and evaluate the technical assistance program of the Oral Health Capacity Building project and continue to provide technical assistance to agencies interested in operating efficient safety net dental clinics; 3) continue to collaborate with the National Maternal and Child Oral Health Resource Center on development of a Web-based Ohio Dental Safety Net Clinic Information Center and distance learning curriculum; 4) administer the Ohio Dentist Loan Repayment Program; and 5) prepare and submit renewal and new applications for federal Dental Health Professional Shortage Area (HPSA) designations in Ohio.

C. Assist communities in taking action to improve oral health.

This infrastructure-level strategy will be accomplished through the following activities: 1) make data and other information available to help communities describe local oral health status and access to dental care in order to assess community oral health needs; 2) encourage and support community oral health partnerships/coalitions and initiatives; and 3) enable non-dental health professionals (home visitors and physicians' offices) to improve the oral health of the populations they serve.

State Performance Measure 8: *Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	3
Annual Indicator				1	3
Numerator				1	3
Denominator	4	4	4	4	4
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	4	4	4	4	4

Notes - 2007

This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was that three benchmarks would be reached: 1) implement a birth defects data collection and referral to services pilot project; 2) build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration; and 3) implement a state plan of action for birth defects prevention activities. Ohio has met its goal for 2007.

Notes - 2006

This is a process measure that is measured by the extent to which four benchmarks can be reached. The target for Calendar Year 2006 was that one benchmark: "Implement a birth defects data collection and referral to services pilot project" would be reached. Ohio has met its goal for 2006 by reaching this benchmark.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was that three benchmarks would be reached: 1) implement a birth defects data collection and referral to services pilot project; 2) build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration; and 3) implement a state plan of action for birth defects prevention activities. Ohio has met its goal for 2007.

Strategies to meet Benchmark #1: Implement a birth defects data collection and referral to services project.

1. Conduct evaluation on data collection and referral to services implementation that began in FFY06 in 4 counties of the state.

Accomplishments: Partially completed. An evaluation was conducted on the data collection system. The results were presented to the OCCSN Advisory Council, and used in the planning for statewide reporting. The referral to services pilot and subsequent evaluation will take place in FFY08.

2. Expand the implementation of birth defects data collection and referral to services system to additional areas of the state.

Accomplishments: Partially completed. All hospitals in the state began reporting birth defects cases. The referral to services component will be pilot tested, evaluated and implemented statewide by the end of FFY08.

Strategies to meet Benchmark #2: Build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration.

3. Develop web-based application as an alternative to the electronic data extract for low volume birth defects reporters; include manual data entry screens and pre-packaged reports for ODH program staff.

Accomplishments: Completed

4. Explore including information from other ODH program data systems in the birth defects system, i.e., newborn metabolic screening and newborn hearing screening.

Accomplishments: Completed. Upon review, it was determined not to include metabolic and hearing screening information in the birth defects system at this time.

Strategies to meet Benchmark #3: Implement a state plan of action for birth defects prevention activities.

5. Disseminate the grid of known risk factors for birth defects to members of the Ohio Partners for

Birth Defects Prevention and other interested programs.

Accomplishments: Completed. Five regional trainings were conducted targeting women's health providers on preventable birth defects utilizing the "Birth Defects: Causes and Prevention Strategies" handbook. Approximately 500 attended the trainings.

6. Collect information on prevention activities conducted on the 4 priority areas (multivitamins, smoking, alcohol, and preconception health).

Accomplishments: Partially completed. Information was collected on prevention activities that took place around the state during January (Birth Defects Prevention Month). Data was not collected on the topics addressed during these activities. Multivitamins, smoking, alcohol and preconception health were highlighted during the 5 regional trainings on preventable birth defects.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct evaluation on data collection and referral to services implementation that began in FFY06 in 4 counties of the state.				X
2. Expand the implementation of birth defects data collection and referral to services system to additional areas of the state.				X
3. Develop web-based application as an alternative to the electronic data extract for low volume birth defects reporters; include manual data entry screens and pre-packaged reports for ODH program staff.				X
4. Explore including information from other ODH program data systems in the birth defects system, i.e., newborn metabolic screening and newborn hearing screening.				X
5. Disseminate the grid of known risk factors for birth defects to members of the Ohio Partners for Birth Defects Prevention and other interested programs.				X
6. Collect information on prevention activities conducted on the 4 priority areas (multivitamins, smoking, alcohol, and preconception health).				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Implement a birth defects data collection and referral to services project.

Activities:

1. Collect monthly birth defects reports from all hospitals in the state;
2. Refer children reported to OCCSN who are not already known to BCMH and Help Me Grow; and
3. Sponsor regional trainings for local EI and public health nurses on birth defects to improve services to families.

B. Build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration.

Activities:

1. Utilize expertise from genetics centers, and BCMH cardiac, myelodysplasia and craniofacial subcommittees to confirm OCCSN diagnoses to improve data quality;
2. Work with BEIS to develop outcome report from Early Track on referrals made from OCCSN; and
3. Utilize VS data (electronic birth and death records) to enhance OCCSN system.

C. Implement a state plan of action for birth defects prevention activities.

Activities:

1. Sponsor trainings to local family planning, obstetric and public health providers on the Guidelines for Birth Defects Prevention Handbook; and
2. Develop coordinated activity for the Ohio Partners for Birth Defects Prevention to promote for birth defects prevention month 2008 (i.e., bookmark w/information, calendar, etc.)

c. Plan for the Coming Year

A. Implement a birth defects data collection and referral to services project.

This infrastructure-level strategy will be carried out through the following activities:

1. Continue collecting data from hospitals monthly.
2. Implement OCCSN referral to Help Me Grow protocol statewide (88 counties).
3. Provide training on working with children with birth defects as an ongoing component of the Help Me Grow Leadership Institute.

B. Build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration.

This infrastructure-level strategy will be carried out through the following activities:

1. Improve the quality of the data reported through monthly monitoring of missing data; building routines to alleviate problems; improve matching records with Vital Statistics; and reducing duplicate records.
2. Conduct open, monthly technical assistance calls with data reporters to discuss common problems with reporting, troubleshoot issues, and obtain feedback.

C. Implement a state plan of action for birth defects prevention activities.

This infrastructure-level strategy will be carried out through the following activities:

1. Promote Birth Defects Prevention Awareness Month, January 2009.
2. Explore data sources to determine if there are special populations in Ohio at risk for birth defects for targeted birth defects prevention education.
3. Implement prevention project as determined by Ohio Partners for Birth Defects Prevention.

State Performance Measure 9: *Increase the proportion of children who receive age-and risk-appropriate screenings for lead, vision, and hearing.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	2
Annual Indicator					25.0
Numerator					1
Denominator	9	9	9	9	4
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	2	3	3	4	4

Notes - 2006

This is a process measure; progress for this process measure is based on a scoring system that quantifies the degree to which expected proportions of children in defined age-and risk categories were screened for three health disorders: lead, vision, and hearing. During the reporting year, the committee working on this measure decided that the issues to be addressed with this measure were primarily capacity-building. Thus a new set of measures in the form of benchmarks (See Detail Sheet) were identified and progress toward them will be reported in the Annual Report for FFY 2007.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY 2007 was that one benchmark: "Referral to services pilot project" would be reached. Ohio has met its goal for 2007 by reaching this benchmark.

A. Identify data collection methods to measure screening rates.

The workgroup has reached agreement on the definition of screening for lead, vision, and hearing and has defined the population on which the group will focus. Screenings meet the standard definitions of visual acuity, stereopsis, and other guidelines established for school-aged children and by AAP for vision; a pure tone hearing screen and optional OAEs/tymps when available for hearing; and a blood lead test for lead. The hearing and vision groups will focus on improving screening rates for the preschool population (specifically ages 3 through 5); the lead group will focus on screening 1 and 2 year olds. The workgroup established agreement upon those definitions as benchmarks for FFY07, and both are completed. The group continues to discuss ongoing data collection methods for assessing impact on preschool screening rates as a result of workgroup activities; Ohio has made changes to its vision and hearing screening survey and school nurse survey in an effort to establish a baseline for screening rates.

B. Develop outreach/educational strategies to influence primary care providers on screening practices for lead/vision/hearing.

The workgroup focused on this activity in FFY07 and will continue to focus on this activity in FFY08. First and foremost, the workgroup has drafted a provider survey to determine the successes with and barriers to providing vision/hearing/lead screenings; in FFY08, the workgroup will focus on distributing and analyzing the survey. Results will provide the basis for future activities. In addition, the state continues to educate primary care providers on the importance of lead testing through PLANET; this curriculum was evaluated and revised in FFY07. The evaluation points to additional revisions necessary in FFY08, including more concentrated efforts toward evaluating the success of PLANET and its impact on screening rates. The state also continues to work with partners to assure medical students are trained on the importance of vision and screening during residency.

C. Formulate specific plans of action/activities within each screening area.

For vision screenings, Ohio has successfully trained Healthy Child Care Ohio consultants to train local child care providers on conducting vision screenings for children in their care; they also provide vision screening equipment to child care providers. For hearing screenings, the same

Healthy Child Care Ohio consultants have received pure tone audiometers to conduct hearing screenings in child care settings. For lead testing, the workgroup continues to collaborate with the Ohio Lead Advisory Council, specifically its targeted testing workgroup, to improve lead testing rates. In FFY07, the state initiated blood lead testing in WIC clinics, which has dramatically improved Ohio's ability to reach at-risk children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Seek consensus on definition of screening for each area, age group to measure; what constitutes a "screening" for purposes of this measure; and availability of baseline data.				X
2. Develop method of sampling providers (survey, focus groups) to evaluate influences on screening practice.				X
3. Develop outreach strategy to educate private insurers re: best practices/regulations; consider survey of private insurers to evaluate coverage options.				X
4. Formulate specific plans of action/activities within each screening area.				X
5. Identify an area of focus for the coming year (improve 2 year old lead screening rates).				X
6. Develop a plan to train local staff for provision of vision/hearing screenings; research existing regulations); develop strategic plan to increase lead screening rates of 2 year olds.				X
7. Develop plan to provide "train the trainer" opportunities within local health departments for vision/hearing screenings.				X
8. Research child care laws regarding hearing screenings.				X
9.				
10.				

b. Current Activities

A. Identify ways to measure impact of activities on preschool screening rates for lead/vision/hearing.

The workgroup identified benchmarks to accomplish over the next 3 years, but will continue to search for ways to measure impact on screening rates, particularly for vision/hearing.

B. Collect/analyze data to identify barriers to screening of preschoolers for lead/vision/hearing in primary care settings.

The workgroup will analyze data from a survey (or other methodology) to summarize barriers that prohibit screenings in primary care settings. The analysis will form a basis for future outreach activities with primary care providers.

Goal is to complete analysis of survey by end of FFY08. Survey is intended to focus on 3 key points: Are pediatricians/family practitioners screening children under age 6? Are they screening correctly? What are barriers to correctly screening this target population?

When these questions are answered, we will be able to provide appropriate outreach and/or TA

to providers, which will be the plan of action for FFY09.

C. Identify one specific activity for each screening area.

The workgroup has formed 3 subcommittees focused on lead/hearing/vision screenings; each subcommittee identified focus areas for the coming year (revise PLANET training for lead screening; expand Healthy Child Care Ohio collaboration for vision/hearing screenings; conduct literature review of screening practices).

c. Plan for the Coming Year

A. Identify available data sources and/or explore data collection methods to measure specific impact of activities on preschool screening rates for vision and hearing.

The group will explore development of data collection/reporting methodology for vision and hearing screening rates of preschoolers. Ohio's Childhood Lead Poisoning Prevention Program has a statewide surveillance system and statutory requirements for laboratories to report screening results. However, there is no effective data collection tool to measure how many preschoolers are receiving vision and hearing screenings. The group will continue to seek out a methodology that accommodates tracking of the number of preschool children screened. This strategy will complement the existing measure of comparing kindergarten screening fail rates over time.

B. Utilize results and analysis of the FFY08 provider survey in developing strategies to improve capacity to screen children in the well-child health care setting.

The workgroup successfully distributed a survey to primary care providers throughout the state and will analyze data to identify and prioritize barriers to screening; develop strategies to overcome identified barriers; and begin implementation of strategies in primary care settings. It is impossible to assume the barriers that will emerge from the survey analysis; however, the workgroup has the potential to provide solutions to training needs and, at a policy level, cost limitations. This follow-up will help to advance the population-based service of improving screening rates of children before they enter school.

C. Identify one specific activity for each screening area (lead, hearing, and vision).

The workgroup has formed three subcommittees focused on lead, hearing, and vision screenings; each subcommittee has identified an area of focus for the coming year. The lead subcommittee will work on maintaining blood lead testing in WIC clinics; this funding source is unavailable after 6/30/08. While strategies are in place to reimburse Medicaid-eligible children, other sources of funds must be identified to test children who are not Medicaid-eligible. The vision and hearing subcommittees will continue to work through the Healthy Child Care Ohio program to train and provide screening equipment to child care providers (vision) and train Healthy Child Care Ohio nurses to conduct screenings while on-site (hearing). The workgroup will initiate a literature review of best practices in screening preschool children for vision, hearing, and lead.

State Performance Measure 10: Integrate ODH Maternal and Child Health Information Systems

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	2
Annual Indicator				1	1
Numerator				1	1
Denominator	6	6	6	6	6
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	3	4	5	6	6

Notes - 2007

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for FFY 2007 was to assess data information needs. While some progress was made, Ohio did not meet this target in FFY 2007.

Notes - 2006

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for FFY 2006 was to assess data information needs. While some progress was made, Ohio did not meet this target in FFY 2006.

Notes - 2005

New performance measure. No data available.

a. Last Year's Accomplishments

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for FFY 2007 was to meet two of the six benchmarks: 1) assess data information needs; and 2) identify barriers to data integration and propose recommendations to overcome them. While some progress was made, Ohio did not meet this target in FFY 2007. All activities related to assessing data integration needs have been accomplished with the exception of prioritization of the division's data linkage opportunities. We plan to address this last activity in the near future. The completed activities included identifying the division's data linkage needs and assessing the potential use of data linkage software. Target dates for meeting the remaining benchmarks have been changed, as the workgroup for this measure modified the work plan.

A. Assess the data integration needs of bureaus and identify opportunities for data integration.

Activities:

1. identify staff from each DFCHS bureau to attend strategy group meetings;
2. identify and discuss DFCHS data integration projects/activities;
3. identify the resources needed to complete the assessment of data integration needs;
4. conduct the assessment; 5) write up the findings from the assessment and identify DFCHS data integration opportunities.
6. prioritize DFCHS data integration opportunities.

Status: All activities related to this strategy have been accomplished with the exception of prioritization of the division's data linkage opportunities. We plan to address this last activity 9/07. The completed activities included identifying the division's data linkage needs, and assessing the potential use of data linkage software.

B. Assess the ongoing data integration activities of ODH and identify opportunities for data integration

Activities:

1. identify ODH staff from other divisions to attend strategy meetings; and
2. identify and discuss other divisions' data integration projects/activities.

Status: These activities are in progress.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess the data integration needs of DFCHS bureaus and identify opportunities for data integration.				X
2. Prioritize DFCHS data integration opportunities.				X
3. Assess the ongoing data integration activities of ODH at the department level and identify opportunities for data integration.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Develop an Implementation Plan

This infrastructure-level strategy is being accomplished through the following activities: develop goals and core functions; identify data bases; develop performance measures and data standards; determine the quality of collected data and make recommendations to improve quality; identify confidentiality/privacy issues; identify data access and sharing issued; identify data users.

c. Plan for the Coming Year

A. Develop a long term implementation plan for data integration

This infrastructure-level strategy will be carried out through the following activities:

1. Develop goals
2. Identify data bases
3. Develop performance measures and data standards
4. Determine the quality of collected data and make recommendations to improve quality
5. Identify confidentiality/privacy issues
6. Identify data access and sharing issues
7. Identify data users

B. Secure funding

E. Health Status Indicators

LBW & VLBW

The Division of Family and Community Health Services (DFCHS) has analyzed birth outcome information by level of hospital, birth weight and county types to determine the appropriateness of the delivery facility. Staff identified data issues and worked to put into place a system to regularly monitor birth outcomes by level of facility.

HSI 01A: The percent of live births weighing less than 2,500 grams

Based on provisional Vital Statistics data for 2004, the percent of Ohio live births weighing less than 2,500 grams was 8.5, which is higher than the 8.3 in 2003 and 2002 and the 8.0 in 2001.

//2008/Based on final Vital Statistics data for 2005, the percent of Ohio live births weighing less than 2,500 grams was 8.7, which is higher than the 8.5 in 2004 and the 8.3 in 2003 and in 2002. 2006 data are not available//2008//.

//2009/ Based on final Vital Statistics data for 2006, the percent of Ohio live births weighing less than 2,500 grams was 8.8, which is higher than the 8.7 in 2005; the 8.5 in 2004 and the 8.3 in 2003. 2007 data are not available. Ohio's trend for LBW is going in the wrong direction. //2009//.

Based on the DFCHS recent analyses of disparities, contributing factors, and opportunities for improvement in birth outcomes, a Division-wide Birth Outcomes Improvement Initiative (BOII) has been developed. This Initiative is about refining the message of pre/interconception care in DFCHS maternal and child health serving programs. The initiative will focus on a few really important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to improve birth outcomes. This initiative brings together Ohio's Maternal and Child Health programs, Early Intervention, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies listed below.

1. Conduct focus groups of women of childbearing age and providers for women of childbearing age;
2. Partner with Ohio Section of the American College of Obstetricians and Gynecologists (ACOG) to develop or modify and implement Preconception/Interconception service protocols;
3. Pilot MOM focused interconception visits;
4. Focus all programs on populations at greatest risk;
5. Partner with Ohio Department of Mental Health to conduct a Maternal Depression Screening Pilot Project;
6. Implement 5 A's Prenatal Smoking Cessation Program;
7. Advance use of the Perinatal Data Use Consortium (PDUC);
8. Support Ohio Partners for Birth Defects Prevention;
9. Support the Fetal Alcohol Spectrum Disorders (FASD) Statewide Initiative;
10. Convene an Ohio Summit for Pre/Interconception Health.

Ohio has established a new State Performance Measure on black low birth weight. Strategies and activities include:

1. Assure that all DFCHS funded programs interacting with women of childbearing age focus on populations at greatest risk.

This infrastructure-level strategy will be accomplished through the following activities: 1) evaluate programs interacting with women of childbearing age to identify their current interaction with populations at greatest risk; and 2) incorporate procedures to help local grantees further define and refine their focus on populations at greatest risk.

2. Continue to refine RFPs and provide technical assistance to DFCHS funded program and Medicaid providers to ensure the target population is served.

This infrastructure-level strategy will be accomplished by providing education to providers to conduct outreach to black women at high-risk of delivering a low birth weight baby.

C. Implement and evaluate a Division-wide Birth Outcomes Improvement Initiative (BOII).

This infrastructure-level strategy will be accomplished through the activities described above.

/2008/ See Section IV D: State Performance Measures, for discussion of Past Year's Performance, Current Activities and Plans for the Coming Year for Ohio's State Performance Measure 02. //2008//

/2009/ See State Performance Measures, for discussion of Past Year's Performance, Current Activities and Plans for the Coming Year for Ohio's State Performance Measure 02. //2009//

HSI 01B: The percent of live singleton births weighing less than 2,500 grams

Based on provisional Vital Statistics data for 2004, the percent of Ohio live singleton births weighing less than 2,500 grams was 6.6, which is higher than the 6.3 in 2001, and the 6.5 in 2002.

/2008/ Based on final Vital Statistics data for 2005, the percent of Ohio live singleton births weighing less than 2,500 grams was 6.8, which is higher than the 6.6 in 2004; and the 6.5 in 2003 and in 2002. 2006 data are not available. Ohio's trend in singleton low birth weight is going in the wrong direction.//2008//

/2009/ Based on final Vital Statistics data for 2006, the percent of Ohio live singleton births weighing less than 2,500 grams was 6.9, which is higher than the 6.8 in 2005; the 6.6 in 2004 and the 6.5 in 2003. 2007 data are not available. Ohio's trend in singleton low birth weight is going in the wrong direction.//2009//

For current activities, see HSI 01A

HSI 02A: The percent of live births weighing less than 1,500 grams

This HSI was also formerly reported as National Performance Measure 15.

Based on provisional Vital Statistics data for 2004, the percent of Ohio live births weighing less than 1,500 grams was 1.6, which is higher than the 1.5 in 2001 and the same as the 1.6 in 2002.

/2008/ Based on final Vital Statistics data for 2005, the percent of Ohio live births weighing less than 1,500 grams was 1.6, which is the same as 2004, but higher than the 1.5 in 2003, and the same as the 1.6 in 2002. 2006 data are not available.//2008//

/2009/ Based on final Vital Statistics data for 2006, the percent of Ohio live births weighing less than 1,500 grams was 1.6, which is the same as 2005 and 2004, but higher than the 1.5 in 2003. 2007 data are not available.//2009//

The Division of Family and Community Health Services (DFCHS) has analyzed birth outcome information by level of hospital, birth weight and county types to determine the appropriateness of the delivery facility. Identified data issues and worked to put into place a system to regularly monitor birth outcomes by level of facility.

DFCHS has implemented phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target

DFCHS resources. Specifically:

* Provided a two-day Data Use Consortium (DUC) meeting for Regional Perinatal Center DUC teams focused on quality improvement in perinatal care including Using NICU Collaborative Quality Improvement Tools for Broader Purposes; overview of the California Perinatal Quality Care Collaborative (CPQCC): Strategies for Data Use; and Discussion of opportunities for using collaborative quality improvement tools in Ohio.

* Initiated a statewide report of Vermont Oxford Network data. //2008//Provided DUC meeting for RPC DUC teams focused on Preconception Care: Data into Action; additional meeting focused on the use of statewide and local VON data//2008//

The DFCHS, Bureau of Child and Family Health Services, Provided funding and technical assistance to six (6) Regional Perinatal Center programs. Each program presented their work at the Data Use Consortium meeting. Monitored required performance measures reported by each region on perinatal indicator.

DFCHS developed best practice fact sheets for the Birth Outcomes Work group and were shared with DFCHS staff and funded programs.

Based on the DFCHS recent analyses of the disparities, contributing factors, and opportunities for improvement in birth outcomes, a Division-wide Birth Outcomes Improvement Initiative (BOII) has been developed. This Initiative is about refining the message of pre/interconception care in DFCHS maternal and child health serving programs. The initiative will focus on a few really important evidenced-based strategies that include existing programs as well as new approaches identified in the review of best practices to improve birth outcomes. This initiative brings together Ohio's Maternal and Child Health programs, Early Intervention, WIC, Genetics and Birth Defects programs, along with community partners to collaborate on the strategies. New approaches include conducting focus groups of women of childbearing age to assess their attitudes toward preconception and interconception interventions; partnering with Ohio Section of the American College of Obstetricians and Gynecologists to develop or modify and implement Preconception/Interconception service protocols; partnering with the Ohio Department of Mental Health to assess the physical and mental health of women during the postpartum period; and adding a Help Me Grow (HMG) visit focused on high-risk Moms in four pilot counties. The BOII will continue to support the 5 A's Prenatal Smoking Cessation Program and the Ohio Partners for Birth Defects Prevention; and advance the use of the Perinatal Data Use Consortium. /2008/ Delete paragraph from Based on the DFCHS.....to strategies//2008// (duplicative of paragraph 4 on first page)//2008//

/2009/ See State Performance Measures, for discussion of Past Year's Performance, Current Activities and Plans for the Coming Year for Ohio's State Performance Measure 02. //2009//.

HSI 02B: The percent of live singleton births weighing less than 1,500 grams

Based on provisional Vital Statistics data for 2004, the percent of Ohio live singleton births weighing less than 1,500 grams was 1.2, which is the same as the 1.2 in 2001 and in 2002.

/2008/ Based on final Vital Statistics data for 2005, the percent of Ohio live singleton births weighing less than 1,500 grams was 1.2, which is the same as 2004 and all prior years through 2001. 2006 data are not available.//2008//

/2009/ Based on final Vital Statistics data for 2006, the percent of Ohio live singleton births weighing less than 1,500 grams was 1.3, which is higher than the 1.2 in 2005 and all prior years through 2001. 2007 data are not available.//2009//

For current activities, see HSI 02A.

FATAL INJURIES

HSI 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger

Based on provisional Vital Statistics data for 2004, Ohio's death rate per 100,000 due to unintentional injuries among children aged 14 years and younger has increased from 8.1 in 2001 and 7.5 in 2002 to 8.2 in 2004.

/2008/ Based on final Vital Statistics data for 2005, Ohio's death rate due to unintentional injuries among children aged 14 years and younger was 9.1 per 100,000 (206 total deaths), which is an increase from the 8.7 in 2004. 2006 data are not available.//2008//

/2009/ Based on final Vital Statistics data for 2006, Ohio's death rate due to unintentional injuries among children aged 14 years and younger was 8.5 per 100,000 (193 total deaths), which is a decrease from the 9.1 in 2005; the 8.7 in 2004; and the 9.3 in 2003. 2007 data are not available.//2009//

Child fatality review (CFR) boards in each of Ohio's 88 counties review the deaths from all causes for all children younger than 18. Boards share their findings with local stakeholders and seek collaboration to develop activities and initiatives for the prevention of injuries and deaths. Boards have partnered with schools and service organizations to provide bike safety events, free bike helmets, seat belt use incentives, intensive fire safety education, smoke alarm distributions, and swimming and water safety education. ODH provides technical assistance, training and tools to local CFR boards regarding ways to present and share information with stakeholders including using CFR data for funding applications.

/2008/ Staff from the ODH Title V program are participating in the newly re-convened ODH Internal Injury Prevention Coordinating Committee (IPCC). The committee is facilitated through the Violence and Injury Prevention Program in the ODH Division of Prevention, Bureau of Health Promotion and Risk Reduction. The internal IPCC was developed at ODH with the mission to strengthen and mobilize efforts to reduce the morbidity and mortality associated with injury and violence; provide a forum for the planning and coordination of injury prevention activities; and to maximize ODH injury prevention resources. Meetings will provide an opportunity for updating participants about injury-related activities occurring throughout ODH. In addition, the Injury Prevention program is in the process of developing an external statewide Injury Planning Group comprised of key stakeholders in Ohio. The IPCC will serve in an advisory role to the formation of this external group.//2008//

/2009/ Staff from the ODH Title V program are participating in a newly developed statewide Injury Planning Group, named the Ohio Injury Prevention Partnership comprised of key stakeholders with interests in injury prevention throughout Ohio. The mission of the group is to prevent injuries in Ohio using data and collaborative partnerships. This group has undergone a strategic planning process and identified five priority injury areas including falls, poisonings, motor vehicle pedestrian-related injury, suicide and firearm-related violence.//2009//

/2009/CFR activities continued as previously noted. Internal Injury Prevention Coordinating Committee activities continue as previously noted. Staff from the ODH Title V program are also participating in the Ohio Injury Prevention Partnership, an external statewide group of stakeholders convened by the Injury Prevention program.//2009//

HSI 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes

Based on provisional Vital Statistics data for 2004, Ohio's death rate per 100,000 for unintentional

injuries among children aged 14 years and younger due to motor vehicle crashes was 2.5, which is lower than 2003 (3.1); higher than 2002 (2.3); and lower than 2001.

/2008/ Based on final Vital Statistics data for 2005, Ohio's death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 2.6 per 100,000, which is lower than 2004 (2.9) and 2003 (3.1); and higher than 2002 (2.3) and 2001 (2.8). 2006 data are not available. //2008//

/2009/ Based on final Vital Statistics data for 2006, Ohio's death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 2.6 per 100,000 (55 deaths), which is the same as 2005 and lower than 2004 (2.9) and 2003 (3.1). 2007 data are not available. NOTE: the data for 2006 do not include infants. //2009//

ODH engages state partners to coordinate efforts to identify and implement needed changes to policy, practice or legislation to reduce child deaths. Each year CFR boards have noted that vehicular crashes account for large numbers of child deaths, particularly in the adolescent age group. ODH convened a state-level work group to look more closely at the issue. The work group includes members from various programs with ODH, as well as other state and local agencies involved in motor vehicle crash prevention, such as the Department of Public Safety (DPS) and the Department of Education. The work group collected information from several sources on crash, injury and fatality data, current prevention programs and best practice guidelines, and made a recommendation to support strengthening the Ohio graduated driver license laws. /2008//ODH participated in an Ohio team in the State and Territorial Injury Prevention Directors Association (STIPDA) special roundtable meeting focused on strategies for collaboration on preventing adolescent-related motor vehicle crashes and their resulting deaths and injuries.//2008//

ODH Injury Prevention program works closely with the DPS and the Governor's Highway Safety Office to address child passenger safety issues. Car seat fines and a DPS grant funds the purchase of educational materials and safety seats that are distributed through a network of programs throughout the state.

/2009/ Booster seat legislation was introduced in the Ohio House of Representatives this year. It was approved by the House on April 30th. The Bill will now go to the Senate for their review. The legislation would fill needed gaps in Ohio's child restraint law including requiring the use of booster seats until a child can be safely restrained by the car's adult seat belt restraint system.//2009//

/2009/ CFR activities and state-level partnerships continue as previously noted. //2009//

HSI 03C: The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes

Based on provisional Vital Statistics data for 2004, Ohio's death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes was 21.3, which is lower than 2001 (22.1) and 2002 (24.3).

/2008/ Based on final Vital Statistics data for 2005, Ohio's death rate for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes was 19.0 per 100,000, which is lower than the 23.6 in 2004, and the 20.6 in 2003. 2006 data are not available. //2008//

/2009/ Based on final Vital Statistics data for 2006, Ohio's death rate for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes was 18.7 per 100,000, which is slightly lower than the 19.0 in 2005 and lower than the 23.6 in 2004, and the 20.6 in 2003. 2007 data are not available. //2009//

For current activities, see HSI 03B.

//2009/ CFR activities and state-level partnerships continue as previously noted. //2009//

NON-FATAL INJURIES

HSI 04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger

Based on data from the Ohio Hospital Association, Ohio's rate per 100,000 of all non-fatal injuries among children aged 14 years and younger was 140.0 in 2004, higher than the 126.8 in 2003, and the 125.6 in 2002, but much lower than 2001 (161.4).

//2008/ Based on data from the Ohio Hospital Association, Ohio's rate per 100,000 of all non-fatal injuries among children aged 14 years and younger and that required a hospital visit, was 177.8 in 2005, much higher than in the four previous years (140.0 in 2004; 126.8 in 2003; 125.6 in 2002; and 161.4 in 2001). This increase may reflect an increase in the number of hospitals submitting E-Codes rather than a true increase in injury rates. 2006 data are not available.

Note: Hospitals are not licensed or otherwise regulated by the state of Ohio. ODH relies on a relationship with the Ohio Hospital Association to obtain the hospital discharge data that they collect from their 170 member hospitals. Upon analysis of the data and comparison of injury hospitalization rates by year to death rates and to other states' rates, a major issue has been identified with regard to the quality of the OHA data for injury analysis, namely the proportion of hospitalized injury cases without an E-code. The proportion of incomplete coding varies greatly throughout Ohio's 88 counties from a high of 93% of the injury cases with no E-code to a low of 8%. Overall, approximately one-quarter of the injury cases are missing an E-code

The variance in reporting affects the validity of Ohio's injury morbidity rates and tends towards underestimating the burden of injury in Ohio. The lack of e-coding will continue to be a barrier for statewide injury surveillance. Other sources of data, such as the Ohio Trauma Registry and EMS Incident Reporting System data, will be explored for use in statewide injury reporting as well.*//2008//*

//2009/ Based on data from the Ohio Hospital Association, Ohio's rate per 100,000 of all non-fatal injuries among children aged 14 years and younger and that required a hospital visit, was 178.4 in 2006, which is higher than in the three previous years: 177.8 in 2005; 140.0 in 2004; and 126.8 in 2003. This increase may reflect an increase in the number of hospitals submitting E-Codes rather than a true increase in injury rates (See notes for FFY 2008). This increase may also reflect the fact that in 2006, infants were not included in the data. 2007 data are not available. //2009//

ODH Save Our Sight program focuses on the prevention of eye injuries by purchasing and distributing protective eyewear to youth, educating parents and youth about eye safety, and assisting local communities to develop policies and procedures regarding eye safety.

Activities and initiatives that result from CFR impact the incidence of injuries as well as fatalities. Child fatality review (CFR) boards in each of Ohio's 88 counties review the deaths from all causes for all children younger than 18. Boards share their findings with local stakeholders and seek collaboration to develop activities and initiatives for the prevention of injuries and deaths. Boards have partnered with schools and service organizations to provide bike safety events, free bike helmets, seat belt use incentives, intensive fire safety education, smoke alarm distributions, and swimming and water safety education. ODH provides technical assistance, training and tools to local CFR boards regarding ways to present and share information with stakeholders including using CFR data for funding applications.

/2009/ CFR activities and state-level partnerships continue as previously noted. //2009//

HSI 04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger

Based on data from the Ohio Hospital Association, Ohio's rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 19.6 in 2004, which was lower than the 20.8 in 2003, extending the trend toward a lower non-fatal injury rate in this age group: down from 28.1 in 2001 and 22.0 on 2002.

/2008/ Based on data from the Ohio Hospital Association, Ohio's rate of all non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 24.8 per 100,000 in 2005, which was higher than the 19.6 in 2004 and the 20.8 in 2003. This increase may reflect an increase in the number of hospitals submitting E-Codes rather than a true increase in injury rates (see discussion in HIS 04A). 2006 data are not available. /2008//

/2009/ Based on data from the Ohio Hospital Association, Ohio's rate of all non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 28.1 per 100,000 in 2006, which was higher than the 24.8 in 2005; the 19.6 in 2004 and the 20.8 in 2003. This increase may reflect an increase in the number of hospitals submitting E-Codes rather than a true increase in injury rates (see discussion in HSI 04A). This increase may also reflect the fact that in 2006, infants were not included in the data. 2007 data are not available. //2009//

/2008/ODH engages state partners to coordinate efforts to identify and implement needed changes to policy, practice or legislation to reduce child deaths. Each year CFR boards have noted that vehicular crashes account for large numbers of child deaths, particularly in the adolescent age group. ODH convened a state-level work group to look more closely at the issue. The work group includes members from various programs with ODH, as well as other state and local agencies involved in motor vehicle crash prevention, such as the Department of Public Safety (DPS) and the Department of Education. The work group collected information from several sources on crash, injury and fatality data, current prevention programs and best practice guidelines, and made a recommendation to support strengthening the Ohio graduated driver license laws.//2008//

/2008/ODH participated in an Ohio team in the State and Territorial Injury Prevention Directors Association (STIPDA) special roundtable meeting focused on strategies for collaboration on preventing adolescent-related motor vehicle crashes and their resulting deaths and injuries.//2008//

ODH Injury Prevention program works closely with the DPS and the Governor's Highway Safety Office to address child passenger safety issues. Child restraint fines and a DPS grant funds the purchase of educational materials and safety seats that are distributed through a network of programs throughout the state.

/2008/ See HSI 03A for discussion of Ohio Title V program participation in the newly re-convened ODH Internal Injury Prevention Coordinating Committee IIPCC).//2008//

/2009/ CFR activities and state-level partnerships continue as previously noted. //2009//

HSI 04C: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

Based on data from the Ohio Hospital Association, Ohio's rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 127.1 in 2004, down from the 142.3 in 2003, the 140.1 in 2002 and the 161.6 in 2001.

/2008/ Based on data from the Ohio Hospital Association, Ohio's rate of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 120.6 per 100,000 in 2005, down from 127.1 in 2004, 140.1 in 2002 and 161.6 in 2001. It is not clear how the possible increase in hospitals' submission of E-Codes affects these rates (see discussion in HIS 04A.). 2006 data are not available.//2008//

/2008/ Based on data from the Ohio Hospital Association, Ohio's rate of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 120.6 per 100,000 in 2005, down from 127.1 in 2004, 140.1 in 2002 and 161.6 in 2001. It is not clear how the possible increase in hospitals' submission of E-Codes affects these rates (see discussion in HIS 04A.). 2006 data are not available.//2008//

/2009/ Based on data from the Ohio Hospital Association, Ohio's rate of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 115.6 per 100,000 in 2006, down from 120.6 in 2005; 127.1 in 2004; and 142.3 in 2003. It is not clear how the possible increase in hospitals' submission of E-Codes affects these rates (see discussion in HIS 04A.). 2007 data are not available.//2009//

For current activities, see HSI 04B.

/2008/ See HSI 03A for discussion of Ohio Title V program participation in the newly re-convened ODH Internal Injury Prevention Coordinating Committee IIPCC).//2008//

/2009/ CFR activities and state-level partnerships continue as previously noted. //2009//

CHLAMYDIA

HSI 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

Based on data from the ODH Division of Prevention, State STD Surveillance, the rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia was 29.9 in 2001, and has increased through the years to 31.8 in 2004.

/2008/ Based on data from the Ohio Department of Health Data Warehouse (data submitted by ODH Division of Prevention, State STD Surveillance Program) , the rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia was 29.9 in 2001, and has increased through the years to 35.7 in 2005. 2006 data are not available. //2008//

/2009/ The Ohio Department of Health Division of Prevention submitted a correction for 2005 data. The correct rate for 2005 is 34.9 cases of chlamydia per 1,000 women aged 15 through 19 years.

Based on data from the Ohio Department of Health Division of Prevention, State STD Surveillance Program, the rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia was 32.6 in 2006, a decrease from 2005. 2007 data are not available. //2009//

The Assessment & Planning Section of the DFCHS Bureau of Child and Family Health Services (BCFHS) has the responsibility of interpreting disease data as reported by subgrantees that participate in the bureau's Family Planning program. Adolescents and young adults are at greatest risk for acquiring an STD. Women and children suffer a disproportionate amount of the STD burden. Many sexually transmitted infections, such as chlamydia facilitate transmission of

the human immunodeficiency virus and are risk factors for the development of cervical cancer.

Testing for sexually transmitted diseases continues to be an important component of the family planning services provided through the CFHS. In 2005, ODH Title X sites provided 31,365 tests for women and 1,814 tests for men. A recent increase in chlamydia infection rates in adolescents has been noted. The Ohio chlamydia disease overall rate has increased from 286.5/100,000 in 2000 to 342.6/100,000 in 2004.

Program strategies to address the HSI: Family Planning has revised family planning clinical protocols and will provide them via disks and on the ODH web site. This effort provides a minimum protocol and policy for subgrantees to use to determine screening, testing and treatment for family planning patients.

Fifty percent of ODH family planning agencies are members of the CDC Infertility Prevention Project. This project provides training, and testing materials for its members to use for patient chlamydia testing. The project had also provided medication to the agencies but has expended all available funding and the cost of medication is now on the agencies.

The overall chlamydia disease rate has increased 17% since 2000. There have been revisions in the data reporting for ODH family planning agencies that will enable program to track changes over time. The available data has assisted in reinforcing the need for patient screening and for partner notification training and management.

/2008/ ODH supported family planning agencies performed 40,474 chlamydia tests (38,395 female; 2,078 male). ODH supported family planning agencies performed 37,575 gonorrhea tests (35,582 female; 1,995 male). This is 8% less than the chlamydia testing numbers.

Family planning clinics test patients according to several criteria, among them are whether patient is at risk for a particular disease, and the county or city positivity rate. Family planning clinics with a chlamydia positivity rate of at least 2% are included in the CDC Infertility Prevention Program. This program provides testing kits and lab services through CDC and medications through GRF funds. Because of funding limitations, any agency with a chlamydia rate of less than 2% was dropped from the program (one site) and any agency with a gonorrhea rate of less than 1% was dropped from the program (12 sites). All sites are reviewed by the CDC project coordinator every six months; only after a 12-month positivity under the cutoffs is testing terminated.//2008//

/2009/ODH supported family planning agencies performed 35,366 Chlamydia tests (1,768 male; 33,598 female). ODH supported family planning agencies performed 32,758 gonorrhea tests (1,637 male; 31,120 female). Fewer gonorrhea tests are performed (9%) than Chlamydia tests as Chlamydia tests are performed as a screening procedure but gonorrhea testing is done only if clinically indicated or is necessary for the prescription of a particular birth control method.

Family planning clinics test patients according to several criteria, among them are whether patient is at risk for a particular disease, the county or city positivity rate and the use of a particular contraceptive method. Family planning clinics with a chlamydia positivity rate of at least 2% are included in the CDC Infertility Prevention Program. This program provides testing kits and lab services through CDC and medications through GRF funds and requires Chlamydia testing of each new and annual exam patient under the age of 25. Because of funding limitations, any agency with a chlamydia rate of less than 2% was dropped from the program and any agency with a gonorrhea rate of less than 1% was dropped from the program. All sites are reviewed by the CDC project coordinator every six months; only after a 12-month positivity under the cutoffs is testing terminated. Family planning providers submit monthly data to a central data system that enhances program monitoring.//2009//

HSI 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia

Based on data from the ODH Division of Prevention, State STD Surveillance, the rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia was 7.8 in 2001, rose to 9.1 in 2003 and then decreased to 6.8 in 2005.

/2008/ Based on data from the Ohio Department of Health Data Warehouse (data submitted by ODH Division of Prevention, State STD Surveillance Program), the rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia was 7.8 in 2001; rose to 9.1 in 2003; decreased to 8.2 in 2004; and was back up to 8.9 in 2005. 2006 data are not available.

/2009/ Based on data from the Ohio Department of Health Division of Prevention, State STD Surveillance Program, the rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia was 11.2 per 1,000 women aged 20 through 44 years, up from all of the previous three years (8.9 in 2005); 8.2 in 2004) and 9.1 in 2003). 2007 data are not available.//2009//

/2008/ See HSI 05A for discussion of activities.//2008//

F. Other Program Activities

Title V Help Line

Since February/1995, DFCHS has operated the Help Me Grow (HMG) helpline, a statewide toll-free 800 number, which provides health/social service referrals and information to callers and is also the toll-free number for Title V programs. Information on programs from the following state agencies is currently available: ODE; ODH; ODJFS; ODMH; and ODMR/DD, as well as local sites for clinical services. The goal of the helpline is to allow for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families/children. In SFY04, the HMG helpline received 43,277 calls; 15,036 were transferred or referred to BCMH. The HMG helpline is available to callers 24 hours a day, 7 days a week. Weekly/monthly reports on calls received and referrals made are reviewed by state staff. Periodic evaluations of the helpline are conducted to determine client satisfaction and outcome. /2007/ In SFY05 the HMG help line received 33,088 calls; 10,693 were transferred to BCMH.//2007///2008/Correction to SFY05: HMG Helpline received 54,763 calls; 11,439 were transferred to BCMH (original figures did not include IVR transfers in the total calls). In SFY06 HMG Helpline received 54,951 calls; 11,763 were transferred to BCMH.//2008// ***/2009/The total number of calls includes 10,857 BCMH transfers, so there was a reduction of approximately 9,000 calls from the previous year. The reason is assumed to be due to a decrease in advertising for the helpline. Some state and local programs have stopped putting the MCH Helpline number on their materials because they have created their own Hotlines/Helplines. BCMH, which puts the MCH Helpline number on all materials, did not see a drop in calls. //2009//***

HMG helpline is collaborating with the Incident Command System to handle incident related calls. The helpline is prepared to take these calls 24 hours a day, 7 days a week and has developed a plan to quickly prepare and respond to calls.

The State Trauma Committee (STC)

The DFCHS provides a liaison from the ODH to the STC. The STC is a legislated committee of the state EMS Board, staffed by the Ohio Department of Public Safety. The liaison represents needs of those served by the DFCHS and ODH. The statewide Trauma System authorized through state legislation in 2000 has completed the basic tasks for organizing the system and is now in a maturation phase. The DFCHS liaison has facilitated discussions between Trauma

System stakeholders and programs within ODH, including Bioterrorism Program, Injury Prevention Program, BCMH, School Health Program and provisionally designated trauma centers.

Ohio Compassionate Care Task Force (OCCTF)

As Chair of the OCCTF, the DFCHS Medical Adviser has become involved with the Ohio Partners for Cancer Control and the Ohio Pain Initiative, organizations which will participate in implementing Task Force recommendations. The recommendations address individuals with chronic pain and those in need of palliative care connected with terminal illness. The OCCTF is legislatively mandated, and is to make recommendations to the Governor and the Ohio General Assembly on ways to improve the practice of pain management for those with chronic pain and those who are terminally ill. 2007/ The OCCTF has completed its work. Per the recommendations of the Task Force, the Director has appointed the ongoing Palliative Pain and Palliative Care Advisory Committee. Dr. Haller chairs this committee.//2007///2008/The ODH Medical Adviser is now the ODH Medical Director//2008//

Dental OPTIONS

BOHS collaborated with the Ohio Dental Association to administer OPTIONS, the statewide dental program for Ohioans with no dental insurance or resources to pay for care. Four agencies were funded to administer OPTIONS regionally. 5,403 people were helped; \$1,153,068 in dental care was discounted/donated; 778 dentists and 91 dental labs are enrolled in OPTIONS. /2007/ In FFY 2005 4 agencies were funded to administer OPTIONS regionally. 5,688 people were helped; \$1,204,819 in dental care was discounted/donated; 852 dentists and 98 dental labs are enrolled in OPTIONS. //2007///2008/ In FFY 2006 4 agencies were funded to administer OPTIONS regionally, 6,956 people were helped; \$1,382,624 in dental care was discounted/donated;910 dentists and 98 dental labs are enrolled in OPTIONS//2008//

School Injury Report Form (SIRF)

An ODH standardized SIRF has been created and piloted in 2 rural school districts over the last 2 years. This second year of the pilot included computerizing the reports and electronically reporting on a quarterly basis to the ODH. The SIRF has been widely accepted due to its objective nature and ease in completing. Based on the pilot the guidelines for use were expanded to include minor injuries that are recorded more often than emergency visits or loss of school days due to injuries. Each of the 2 pilot school districts formed a school safety committee to review the injury data on a quarterly basis and will continue that process as a forum for recommendations on school safety issues. Additionally schools in the rural part of Ohio need assistance in computerization of records which do not exist currently, complicating the electronic injury record keeping. The school injury report form was shared with all school nurses in Ohio. The injury report form has become a standard ODH form which is accessible on the web and is being used and marketed to schools./2007/The SIRF was piloted and is used in many Ohio schools.The form is not required, but is available through our distribution center and is provided at no cost to schools requesting the form.//2007// /2008/The SIRF was recently edited and reformatted for posting to the ODH, School Nursing Program website. In addition, the form and guidelines for use have been added to the recently revised Emergency Guidelines for Schools, 3rd Edition.//2008//

/2007/Data Analysis and Reporting

Child Fatality Review Report for 2005 (Based on 2003 deaths): 1,498 reviews of 2003 child deaths were reported by 87 local CFR boards. Of these, 1,483 were used for analysis. /2008/CFR Report for 2006 (based on 2004 deaths): 1,623 reviews of 2004 child deaths were reported by 88 local CFR boards. All Ohio CFR reports are posted at <http://www.odh.ohio.gov/odhPrograms/cfhs/cfr/cfrrept.aspx> //2008//

Oral Health Survey (OHS): In 2004-05, the Bureau of Oral Health Services (BOHS) conducted its 4th statewide OHS, which will provide county-level data, making oral health status and access data available to local planners. An OHS was also conducted with a sentinel group of Head Start

(HS) programs to assess the oral health status of HS children.

To monitor progress toward meeting the Title V oral health performance measures, BOHS continued annual surveys of 25 sentinel schools that were found to be highly representative of the 336 Ohio elementary schools selected for the 1998-99 county-specific survey. The sentinel schools approach will be evaluated after the 2004-05 data have been analyzed. //2007//

/2008/ Oral Health Survey: During 2005-06, the BOHS began to analyze data collected from its 4th statewide OHS of schoolchildren. The results of the survey will become part of a Web-based, county-level oral health surveillance system to be implemented in 2007 to provide local planners with oral health status and access to care information. An OHS was also conducted with a sentinel group of 15 HS programs.

BOHS conducted the annual "sentinel" school survey. The survey provides annual statewide estimates of various oral health measures such as the percentage of children with untreated cavities and the percentage with one or more dental sealants.//2008//

G. Technical Assistance

Technical Assistance Requests (not listed in order of preference or importance):

1. The Division of Family and Community Health Services is requesting technical assistance to support a visit to Ohio to provide assistance on data integration in relation to activities needed to develop new State Performance Measure 10 (MCH data Integration). The planned strategies for the first year call for assessing the cost and benefits of an integrated information system and prioritizing the data integration needs. Assistance is requested from Alan Hinman, Public Health Informatics Institute and a representative from another state.

2. Ohio is requesting technical assistance on state funding sources for Title V CSHCN Programs and assistance in researching how other state Title V CSHCN programs are organized and funded. Ohio has a BCMH (CSHCN Title V) Legislative Taskforce that is exploring ways to fund CSHCN programs.

/2007/ Ohio is requesting technical assistance on various processes that could be used to make the MCH Block Grant application available for public comment, in particular, how to reach and engage consumers. Would like information on what works best with consumers (Beyond the report, "Facilitating Comment on the Title V MCH Clock Grant: A Report on States' FY 2005 Practices").//2007//

/2008/ Technical assistance requests include the following:

1. Ohio is requesting technical assistance on the provision of services to local CFHS subgrantees in response to a recent Community Health Assessment technical assistance survey. Based on responses to the CFHS RFP, from monitoring visits and from the recent CFHS Community Health Assessment Survey, local CFHS grantees and their partners lack basic knowledge and skills in community health assessment.

2. Ohio is requesting technical assistance to provide on-site cost analysis training to health agencies that provide family planning direct care services. The training would also include training for ODH consultants. Family Planning providers need to be able to accurately assess the costs of providing the program and to be able to determine charges based on these costs.

3. Ohio is requesting technical assistance to achieve a better understanding of other states' activities and best practices for vision, hearing and lead screenings for preschool children. Ohio

would like to know what states are doing to improve screening rates in any and all of lead, vision and hearing, with specific emphasis on the preschool population. Ohio wants to replicate best practices from other states.

4. Ohio is requesting technical assistance in the development of an appropriate and effective data collection system for the Ohio Infant Mortality Reduction Initiative (OIMRI) component of CFHS. The current data collection system for OIMRI no longer meets the needs of the state program or local programs. Ohio needs assistance in identifying appropriate data collection elements and the development of a system.

5. Ohio is requesting technical assistance in the development of a guidance document for getting started with cultural competence - both at the state and local levels. The purpose is to strengthening our capacity to reduce disparities through the delivery of services that are culturally competent. We want guidance on core competencies that would be integrated into RFP and contract requirements and guidance on how to assess current status and how to measure progress. Ohio is already working with the National Center for Cultural Competence and will request the technical assistance through them.

6. Ohio is requesting technical assistance in improving the quality of the CSHCN section of the next five-year needs assessment. Consultation is especially needed on how best to describe the CSHCN population and Ohio's capacity to meet their needs. //2008//

/2009/ Ohio technical assistance requests include the following:

1. Ohio is requesting technical assistance on the development of child health standards that are consistent with the Bright Futures guidelines, and as follow up to Ohio's NASHP screening initiative. Consultation is requested to improve content and quality of child health standards for Ohio's Title V program.

2. Ohio is requesting consultation on approaches for prevention of prematurity. TA is requested to further the work of Ohio's Title V program in improving birth outcomes.

3. ODH will request funds for technical assistance in communicating state MCH data and research findings. This assistance will build general capacity across MCH performance measures, however, activities in the first year will focus on information derived from Ohio vital statistics birth data.

Funds are requested to bring a consultant onsite to train up to 24 staff (approximately 1/2 epidemiology and 1/2 program staff) on written and oral communication skills. During the training, staff will work in teams to produce both a written document and an oral presentation for identified target audiences.

ODH requires this TA to enhance our ability to communicate MCH needs, priorities and strategies to stakeholders and decision-makers. The Department will be completing a one-year "pilot" to enhance use of birth data, and communication of information is a vital part of ensuring that data will be used to inform program and policy actions.

The preferred consultant is Elliott Churchill, MS, MA. Ms. Churchill is former CDC writer, editor and communications specialist and Owner of A World of Words (2436 Northrup Drive Tucker, GA 30084 USA), an international training organization, focused on teaching writing and presentation skills to public health professionals.

4. ODH will request funds for technical assistance to build capacity for NPM#11.

Funds are requested to bring consultants to Columbus, OH to train state and local staff on breastfeeding promotion and support for African-American women. Targeted local staff

will include 1) Help Me Grow home-visitors, 2) OIMRI home-visitors, and 3) WIC staff. Staff will learn about the issues audience and be trained to use the evidenced-based "Best Start 3-Step Counseling" technique.

ODH requires this TA to enhance our ability to improve breastfeeding duration and to reduce breastfeeding disparities. Ohio has the 7th lowest bf rates in the country, and has a wide disparity between black and white breastfeeding rates.

The preferred consultants will be 1) a speaker from the African American Breastfeeding Alliance (Joppa, MD • 1-877-771-7461), and 2) Cathy Carothers BLA, IBCLC, RLC (EVERY MOTHER, INC., P.O. Box 615 Greenville, MS 38702-0615).//2009//

V. Budget Narrative

A. Expenditures

A. Expenditures

Form 3 -- FFY07

Ohio will to use the un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year until the arrival of the new notice of award.

The FFY07 Federal-State Title V Block Grant Partnership expenditures were \$46,127,976. This is \$5,445,561 below the FFY06 expenditures of \$51,573,537

Overall FFY07 expenditures (including other federal funds) related to MCH activities were \$316,613,561. This is \$7,934,596 above the FFY06 expenditures of \$308,678,744.

Form 4 -- FFY07

FFY07 expenditures for pregnant women of \$5,647,207 infants of \$2,464,671, and children (1-22) of \$15,816,966 are all below the FFY06 expenditure levels for each respective category. The FFY 07 expenditures for children with special healthcare needs of \$21,685,341 is below the FFY06 amount of \$25,445,830 by \$3,760,489.

The FFY07 administration expenditures were \$513,791. This is \$264,783 above the expenditures amounts for FFY06 which were \$249,008. The increase administration cost is due to the replacement of positions lost in the previous federal fiscal years. At 2.3% of the total MCH-BG expenditures, the administration costs are well within the 10 percent restriction requirement.

Form 5 -- FFY07

FFY07 expenditures for Direct Health Care Service of \$21,268,794, Enabling Services of \$9,889,014 Population Based Services of \$5,366,289, and Infrastructure Building Services of \$9,603,879 are 46.1 percent, 21.4 percent, 11.6 percent, and 20.8 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively.

For the first time Ohio's federal-state partnership direct service expenditures have fallen below 50% of total partnership expenditures. This is confirmation of Ohio's long efforts to conform to requirements of the MCH pyramid. According to the pyramid, most of the MCH-BG funds should be spent in the following areas: Infrastructure; Population-Based; and Enabling Services. Prior to the establishment of the pyramid, Ohio dedicated a significant portion of its MCH-BG resources to provision of direct services versus the other layers of the pyramid. For the past approximately ten years, Ohio has struggled to reverse this expenditure pattern. The reduction of direct service expenditure below 50% is seen by the administrators of Ohio's MCH program as a major landmark in the process of aligning the state's expenditures with the pyramid.

B. Budget

B. BUDGET

3.3 Annual Budget and Budget Justification

Summary Budget FY2009

Component A: Services for Pregnant Women, Mothers and Infants up to age one year

Component B: Preventive and Primary Care Services for Children and Adolescents

Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs and their families.

Component A: \$3,954,233

Component B: \$9,877,283

Component C: \$7,329,784

Subtotal: \$21,116,300

Administrative Costs: \$641,040

GRANT TOTAL: \$21,802,339.

* Administrative costs are applied proportionally to Components A, B and C.

Budget Justification

Services for Pregnant Women, Mothers and Infants to Age One

In its FFY2009 request, Ohio has budgeted \$90,347,707 for services for Pregnant Women, Mothers and Infants to Age One; 22.22 percent of the total funds (\$406,526,238) targeted for Title V related activities. For this component, MCH Block Grant funds total \$3,954,233 which is 18.14 percent of the FFY 09 MCH Block Grant request of \$21,802,339. Other State and Federal funds for this component total \$86,393,474 or 22.46 percent of the budgeted \$384,723,899 in other Title V related funds.

Preventive and Primary Care Services for Children and Adolescents

In its FFY2009 request, Ohio has budgeted \$275,165,678 for Preventive and Primary Care Services for Children and Adolescents or 67.69 percent of the total funds (\$406,526,238) designated for Title V and related activities. For this component, MCH Block Grant funds total \$9,877,283 which is 45.3 percent of the FFY 09 MCH Block Grant request of \$21,802,339. Other State and Federal funds for this component total \$265,288,395 which is 68.96 percent of the \$384,723,899 of other Title V related funds.

Children with Special Health Care Needs

In its FFY2009 request, Ohio has budgeted \$40,235,005 for activities for Children with Special Health Care Needs or 9.90 percent of the percent of the total funds (\$406,526,238) budgeted for Title V and related activities. For this component, MCH Block Grant funds total \$7,329,784 which is 33.62 percent of the FFY 09 MCH Block Grant request of \$21,802,339. Other State funds for CSHCN total \$32,905,221 which is 8.55 percent of the \$384,723,899 of other Title V related funds.

Administrative Costs

\$641,040 in MCH BG funds.

Maintenance of State Effort

In 1989, Ohio's MCH Block Grant award was \$19,369,474 and the state provided \$23,812,983 in support of the MCH activities. The fiscal year 2009 federal MCH award is expected to be \$21,802,339 and the state will provide \$35,757,499. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2009 are shown below.

Description	1989	2008	
Sickle Cell Control		\$421,347	\$1,035,344
Genetic Services		\$1,144,281	\$882,449
Child & Family Health Services		\$5,652,423	\$5,034,219
Adolescent Pregnancy	\$400,000		\$0
Medically Handicapped Children	\$4,682,744	\$10,791,784	
Cystic Fibrosis	\$325,394		\$0
Medically Handicapped Audit Funds		\$1,312,168	\$3,693,016
Medically Handicapped County Funds		\$9,874,626	\$14,320,687
Totals	\$23,812,983	\$35,757,499	

To determine the total amount of state match and funding of MCH programs, the Division of Family and Community Health Services totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations. The above Maintenance of Effort chart lists the 2009 state appropriations as outlined in the Ohio Department of Health (Division of Family and Community Health Services) spending plan. The cystic fibrosis appropriation line item is no longer shown as match/maintenance of effort because they are dedicated to the provision of services to adults. Services for children with cystic fibrosis are supported by other state CSHCN funds. \$1,700,000 of the state Child and Family Health Services appropriation is not included as match for the Title V award because it is designated as part of a state initiative called Women's Health (previously dedicated to family planning services). An additional \$2,150,000 of the CFHS appropriation is set-aside for Federally Qualified Health Centers and is not included on Form 424, Line 15c as match to Title V funds. These funds are included in Line 15e because the population to be served is broader than the population served by MCH funds.

Ohio's maintenance of effort has increased by \$1,359,074 from \$31,794,862 in 2008 to \$35,757,499 in 2009. The major reasons for this increase are additional funding for the CSHCN program.

Ohio continues to experience a drop in expected revenue receipts. This continues to have an impact on the amount of General Revenue funds available to support MCH and other state initiatives.

In CY 07, The Ohio Department of Health received the first reimbursement under the Medical Administrative Claiming program. Funds earned under this program will be used by the department and local health departments to support Title V activities.

Rate Agreement STATE AND LOCAL DEPARTMENT/AGENCIES

EIN NO: 1-316402047-A1

DEPARTMENT/AGENCY: Ohio Department of Health Date: February 13, 2003
246 North High Street
P.O. Box 118 FILING REF: The preceding
Columbus, Ohio 43266-0118 Agreement was dated 9/24/01

The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

Type	From	To	Rate	Locations	Applicable to
Fixed	7/1/07	6/30/09	30.5%	On Site	Unrestricted (1)
Fixed	7/1/05	6/30/07	30.0%	On Site	Unrestricted (1)
Fixed	7/1/05	6/30/06	12.7%	On Site	Restricted (2)
Fixed	7/1/06	6/30/07	21.9%	On Site	Restricted (1)
Provisional 7/1/07 until amended, use same rates and conditions as those cited for fiscal year ending June 30, 2007.					

Restricted rate is for U.S. Department of Education Programs which requires the use of a restricted rate as defined by 34 CFR Parts 75.563 & 76.563.

- 1) Base -- Direct salaries and wages including all fringe benefits.
- 2) Base -- Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations, sub-awards and flow-through funds).

Administrative Costs

The administrative costs of Ohio's 2009 MCH Block Grant request are based on budget and expenditures related to the Operational Support Section of the division chief's office. The Operational Support Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs.

FFY2009 Carry Over Funds

The amount of carryover funds is based on the total amount of funds available in FFY 2008 less projected expenditures through September 30, 2008. In FFY2008 a total of \$27,710,837 in MCH Block Grant funds were available to the State of Ohio. According to the Department's accounting reports, which reflect activity through June 2008, the projected FFY2007 MCH expenditures will total \$23,057,845. When total available funds are reduced by total projected expenditures the unencumbered balance will be \$4,652,992.

The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 1.5 months worth of its 1st quarter expenditures.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.