

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: OH

APPLICATION YEAR: 2005

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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.

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 assurances and certifications for Ohio can be made available by contacting

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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; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

This section describes the process by which Ohio makes this application public for comment during development and after transmittal. (.5 page limit)

The Ohio Department of Health made the Maternal and Child Health application available for public input through a variety of methods. Last year's application (2004 Plan and 2002 Report) was mailed to our MCHBG Advisory Council prior to a telephone conference in May, 2004. The document will be placed on the ODH webpage and notification of such sent to CFHS subgrantees, OIMRI subgrantees, and RPEC subgrantees, as well as other MCH partners.)

The current application will be available on the ODH website at
<http://www.odh.state.oh.us/Resources/repts1.htm>

We received two e-mails from MCHBG Advisory Council members: 1) The Ohio Eye Care Coalition and 2) The Chief of the ODH Division of Prevention.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

This section puts into context the Title V program within Ohio's health care delivery environment, including understanding Ohio's current priorities and initiatives, process for determining priorities and factors impacting health services delivery. Discussion of the challenges of poverty, racial and ethnic disparities, geography, urbanization and private sector on the delivery of Title V services is included.

/2004/Overview

A weakening economy has added stresses on resources and activities supporting Ohio maternal and child health. During the biennium just ending (June, 2003), state unemployment and the proportion of uninsured increased in line with national trends. Repeated shortfalls in revenue, with state tax collections repeatedly falling below initial and revised projections, led the Legislature to impose three rounds of cuts to the initial two--year budget, with a cumulative reduction of about 22% for state--funded public health; this came concurrent with a reduction in Ohio's Title V block grant allocation following the 2000 Census. Some staff resources, both within the state agency and at numerous local sites, became less available to public health as a result. Local recipients appeared committed to minimizing the effects of cuts on direct services, with staffing and other activities taking a larger hit.

Following re--election the Governor signaled continued support for the Ohio Family and Children First (OFCF) initiative, despite ongoing economic concerns. Created in a previous administration, it is described as a multifaceted government--led approach to reforming Ohio's education, family services and social services delivery systems on state and local levels, focusing initially on health, child development, and education. The division chief and early intervention bureau chief serve on the statewide administering council; in addition there are local councils within each of Ohio's 88 counties consisting of major community stakeholders.

Consistent with this approach, eligibility for direct health care services to children and pregnant women (Medicaid) has not been reduced, despite the state's budget shortfalls. An active effort to post "benchmarks" for this initiative, similar in some ways to the block grant indicators, has been put on hold for the past six months, with resources shifted towards budget crises in large part.

Leadership within the Ohio Department of Health (ODH) produced a somewhat revised set of priorities for 2003. Title V and other programs in the department are guided by the following core values: leadership, excellence, accountability, partnership and citizenship. The Director's Performance Goals 2003 are as follows:

- * Encourage healthy choices
- * Prevent chronic, environmental, genetic, and infectious diseases
- * Eliminate health disparities
- * Assure public health preparedness and security
- * Assure quality and safety of health care services
- * Improve business performance

Within each goal there are specific objectives, outcomes, and responsible parties. For disparities the objectives are

- Assess the adequacy of agency efforts to address disparate needs (e.g., infant mortality, cancer rates, etc.) of populations (defined by factors such as race, ethnicity, income, geographic location, culture) by analyzing how state and federal funds are being allocated (by population) to address identified needs
- Increase children's access to primary care, dental care, and mental health care, as well as access to prenatal care, by developing a process for identifying underserved areas across the entire state.
- Enhance access to dental care by requesting authority to establish a state loan repayment program for dentists agreeing to practice in underserved areas
- Increase delivery of comprehensive pediatric services (e.g., medical home systems for children with special health care needs), enhance the social--emotional development of young children, improve early child care and education, and strengthen systems providing parent education and family support by increasing the collaboration and coordination of agency programs addressing these issues.

/2005/For 2004 the Director's Performance Goals remained the same as for 2003. However the objectives for disparities are:

- * Reduce racial, ethnic and cultural inequities by accomplishing adopted short-term goals;***
- * Increase the number of health care providers, including mental health providers, in underserved areas by continuing to recruit and place providers in those areas;***
- * Collaborate with the charitable giving community and the Ohio Dental Association to integrate dental care case management services for low-income Ohioans;***
- * Increase the collaboration and coordination of ODH programs for families with children 6 years and younger.//2005//***

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. We plan to use birth certificate and PRAMS (Pregnancy Risk Assessment Monitoring System) data, as well as less formal sources, to monitor trends and impacts of legislation.

The MCH Advisory Panel and the public reviewed agency priorities along with draft material associated with this application and provided comments. For the advisory group we highlighted four of our new initiatives or ongoing successes in some detail.

- * oral health--including the state's recently developed safety net guide www.dentalclinicmanual.com for community access coalitions (published in collaboration with the Indian Health Service, the Association of State and Territorial Dental Directors, and the National MCH Oral Health Resource Center), innovative population--based visual surveys of school and preschool children, proposed state legislation (dental loan repayment) and continued public--private partnerships to increase access;
- * universal newborn hearing screening--including new legislation rules effective 2/03, data linked to electronic birth certificate 8/03, training to enhance and insure appropriate follow--up and treatment Fall/03, full implementation by 7/04;
- * enhanced Medicaid funding through administrative match--the opportunities and costs in obtaining additional federal funds for existing "activities that are necessary for the proper and efficient administration of the Medicaid state plan;" and
- * medical home--including payments through the state CSHCN program for physician case management, development of a Medical Home Learning Collaborative (sponsored by NICHQ, the National Initiative for Children's Healthcare Quality), initial and follow--up meetings of medical home family focus groups (in collaboration with FAACT, the Foundation for Accountability).

Data gathering, analysis, and reporting capacities of the ODH have increased significantly during the past few years. Examples include

- * dramatic improvement in reporting to the National Center for Health Statistics,
- * development and implementation of PRAMS,
- * enhancement of birth records to include shortly both metabolic and hearing screening results reporting electronically, and development of a web--based information warehouse,
- * a series of Data Use Academies (in collaboration with the University of Nebraska Medical Center's Section on Child Health Policy) on improving perinatal outcomes that involves multiple multidisciplinary teams from around the state, and
- * use of Census data to target initiatives in childhood lead poisoning prevention and infant mortality reduction,

The state Title V program seeks to improve its capacity to use data for decision--making (for example, taking advantage of a new state capacity to link addresses with GIS--compatible identifiers), particularly in better focusing its limited capacity for direct service delivery. Related to that goal, we seek to increase utilization of best practices, not only for direct health care services, but also for enabling, population--based, and infrastructure building services. These guiding principles will help direct our planning activities for the next Title V needs assessment in two years.

Budget Cuts to CSHCN

The Bureau for Children with Medical Handicaps (BCMh) the CSHCN Program in Ohio has had a major decrease in funding from the Ohio General Revenue Funds. Over the past 4 years there has been a 50% drop in this funding source. This has required the BCMh to decrease its direct services and also make changes in the Financial Eligibility Formula for the Treatment Program. These changes will affect 25% of the children now on the treatment program. The BCMh program has maintained its service coordination, diagnostic, and other support programs and expanded efforts to enroll eligible children in Medicaid and to seek payments from other health insurance entities. The budget is being closely monitored and further changes in the program may be required to stay within budget.//2004//

/2005/ The Ohio CSHCN Program (BCMh) has had a decrease in state funding from 12.5 million dollars to less than 6 million dollars over the last 4 years. This has required the program to plan a 25% decrease in the the number of children covered by the program. The biggest change has been a change in the financial eligibility formula. This is affecting families in the middle income bracket (\$35,000 to \$55,000). Some of these families have Medical Insurance and some do not. An example is a family with a child with a complex medical condition and 2 other children in the family. They make \$50,000/year. Previously they were financially eligible for the BCMh Treatment Program. They have medical Insurance, but BCMh paid for medications and other treatments not covered by their insurance plan. They now have a \$3,000 cost share which they must meet out of pocket before they are eligible for the BCMh Treatment Program. Other families have cost shares of \$15 to \$25 thousand .This has caused distress among BCMh staff and public health nurses who work with these families on a one to one basis.//2005//

Process to Establish Title V Priorities:

During 1999 and 2000, in anticipation of the FY2001 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 judgement 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 2001-2005. Ohio utilizes the Community Health Improvement Cycle model that can be found in the attachments.

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 ODH'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 payors are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services.

In Ohio, 81% of the population lives in metropolitan areas. Pockets of inner city poor and the 19% 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. Last year, 18,801 pregnant women were served through Title V-funded prenatal clinics (approximately 12% of live births) and nearly 60,000 children

were seen in Title V-funded child health clinics. 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.

/2002/ For fiscal year 2000, 16,513 pregnant women were served through Title V-funded prenatal clinics; 57,135 children were seen Title-V funded child health clinics; and 15,577 clients were seen in Title V funded Family Planning clinics.//2002//

/2003/ For fiscal year 2001, 17,873 pregnant women were served under Title V; 155,721 infants < 1 year of age were served by Title V; 62,015 children 1 to 22 years of age were served by Title V; and 30,463 Children with Special Health Care Needs were served under Title V.//2003//

/2004/ Overview of the Child and Family Health Services Program

CFHS is a community based program that uses federal, state, and local monies from the ODH to offer clinical child and adolescent health, prenatal and family planning services to low income families and children in Ohio. BCFHS funds 79 local subgrantees with a combination of Title V and State GRF dollars.

Not only is CFHS a network of clinical service providers, it is 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. CFHS consortiums are also linked to the county Family and Children First Councils, Medicaid, and the Help Me Grow program.

CFHS providers are local health departments, hospitals, community health centers, community action agencies and other non-profit agencies that either employ or contract with physicians, nurses, nutritionists, social workers, and speech/language pathologists to provide personal health care to CFHS clients.

CFHS clinical service clients are women, infants, children and adolescents who need family planning, prenatal or child health services. While many CFHS clients are Medicaid recipients, a large number are uninsured and underinsured families who have difficulty accessing preventive and primary health care services because of financial and other barriers. CFHS perinatal clients are more likely to be younger, less educated, unmarried, and be African-American than the general population. In addition pregnant women who get their care in CFHS clinics are more likely to smoke than non-CFHS clients increasing the risk of a baby being born low birth weight.

CFHS supports services essential to maintaining and promoting the health of families and children. Such services include prenatal (e.g., before and after the birth), family planning (e.g., pap smear, contraceptive care, breast exam, counseling, education) and child health (e.g., physical exams, multiple preventive health screenings, uncomplicated acute care, immunizations). Promoting the integration of health care with other child and family systems including, for example, Head Start, Ohio Family and Children First, Help Me Grow and school health programs is also an important component of CFHS projects.

CFHS projects help enable families to identify and utilize resources through such services as outreach, care coordination, case management; health education and referral, transportation, translation, home visiting and nutrition counseling.

Even though more families with children are eligible for Medicaid/Healthy Start, CFHS clinics have been experiencing an increase number of families with children who are uninsured/underinsured. In

many rural counties however, the CFHS clinics may be the only provider in the community who will accept Medicaid eligible clients and those with no ability to pay for services.

In monitoring the utilization of CFHS services there are some trends in the proportion of uninsured clients. The proportion of uninsured prenatal clients, for example, has climbed from 10% in FY96 to 23% in FY2000. In this same time period there has been a slight increase in the proportion of prenatal clients served who are over the income eligibility threshold for Medicaid. In the CFHS clinics providing child health services, the proportion of Medicaid clients has increased slightly from 62% in FY96 to 67% in FY2000. In those clinics providing family planning services the proportion of uninsured clients has increased from 75% in FY96 to 82% in FY2000. Some of these trends may be explained by recent changes in the revision of the CFHS data collection system.

With the Medicaid expansion to 200% of the federal poverty level, and CFHS clinic staff taking an active role in assisting families in enrolling clients via the Combined Programs Application (CPA) up to 90 percent of the children currently served in the CFHS could be covered. In FY00, CFHS child health clinics served over 17,200 uninsured and underinsured children at or below 150% of poverty level. Based on these projections, CFHS clinics are in a strategic position to conduct outreach for these children who remain uninsured and underinsured.

CFHS clinics also serve children who are between 151--200% of the poverty level; it is expected a higher proportion of these children will be potentially Medicaid eligible as many more families are unable to maintain their current health coverage. In FY00, 27% of the children whose family income was between 151-200% of the poverty level were Medicaid eligible.

CFHS Projects are necessary even though Medicaid is increasing eligibility for low-income children. 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.

CFHS funds are also used to finance prenatal and family planning clinical services for working poor and Medicaid eligible clients who will not be affected by the increased eligibility for children. Because of the CFHS funds, the multidisciplinary clinic staffs are able to address the complex health and social needs of the high risk CFHS families. In addition, the subsidies support population based public health services such as outreach, community based education, identification of maternal and child health needs, and evaluation of the impact of services. These core public health functions are critical to the maintenance of the public health infrastructure in the State of Ohio.

Over the past two (2) state fiscal years, the CFHS program has absorbed a 22% reduction in funding resources. The cumulative loss of \$1,639,272 equates to a loss of 18,214* clinic visits for women and children. Further reduction of funding to the CFHS Projects will limit the capacity of projects to provide clinical and wrap around services essential to maintaining and promoting the health of families and children. Such services include child and adolescent health care (e.g., physical exams, lead poisoning screening, uncomplicated acute care, immunizations); prenatal care (e.g., before and after birth); and family planning services (e.g., breast and cervical cancer screening, contraceptive care, counseling, education).//2004//

/2005/Local CFHS clinics used a combination of MCHBG and State dollars to provide direct care services in FFY 2003. 14,404 unduplicated family planning clients (30,193 encounters) were seen. 15,167 unduplicated perinatal clients (88,753 encounters) were seen. 74,305 unduplicated child health clients (176,072 encounters) were seen.

Data has been collected for enabling hours that were provided in FFY 2003; 3,400 hours were spent with Family Planning clients; Over 23,000 hours were spent with Perinatal clients; and over 15,000 hours were spent with Child Health clients.

In the past three fiscal years, the overall total subgrantee award notices to CFHS projects have

been decreased by 23% (from \$14,822,162 in 2001 to \$11,437,290 in 2004.

Poverty levels and the percent of CFHS clients on Medicaid have remained relatively constant for the last few fiscal years. 65% of Family Planning clients are at 100% or less of the FPL and nearly 29% of the Family Planning clients have a Medicaid card. 92% of the Perinatal clients were at 150% or less of the Federal Poverty Level and nearly 79% of the Perinatal clients have a Medicaid card. Medicaid eligibility for pregnant women is limited to 60 days post partum which creates a challenge to fund family planning services to women who are more than 60 days post partum. 97% of the Child Health clients are at 200% or below the FPL and 75% of child health clients have a Medicaid card.//2005//

Overview of Special Supplemental Nutrition Program for Women, Infants, and Children:

The Ohio Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides highly nutritious foods, nutrition and breastfeeding education and support, immunization screening, and health care referral through local agencies to eligible individuals. WIC helps income-eligible pregnant, postpartum, and breastfeeding women, infants, and children who are at special risk with respect to physical and mental health due to inadequate nutrition, health care, or both. WIC provides nutritional help during critical times of growth and development to prevent health problems and improve the health status of eligible individuals. WIC is 100 percent federally funded through the United States Department of Agriculture. Ohio WIC program current initiatives include:

- A. Electronic Benefits Transfer (EBT): Special USDA funds were granted to pilot test EBT in Montgomery County. EBT is an electronic system that allows participants to obtain WIC foods at grocers by using the Ohio Directions smart card instead of paper coupons.
- B. WIC System Version 5.x: The WIC certification system used in clinics is undergoing a software, Windows based upgrade. Local project staff is trained on the system then State staff install the system on-site in each clinic and provide technical assistance.
- C. Electronic Documents: Special USDA funds were obtained to begin a conversion from paper documents to electronic documents. Ohio WIC's Policy and Procedure and Vendor Manuals have been converted and issued on compact disk.
- D. Farmers' Market Nutrition Program (FMNP): Ohio WIC received funds to provide FMNP coupons to 21,701 WIC participants in 30 counties for purchasing \$18 in fresh fruits, vegetables, and herbs at farmers' markets.
- E. World Breastfeeding Week and Month Celebration: Ohio WIC has coordinated the Governor's designation of Breastfeeding Awareness Week throughout Ohio on August 1-7, and the release of related celebration materials to Child and Family Health Services, WIC, and Healthy Start (Early Intervention) projects.
- F. Healthy Heroes Videos: Special USDA funds were obtained to develop five animated videos for child participants to teach five key health and nutrition messages that include:(1)I eat healthy foods every day;(2)I stay active. I play and explore the world around me;(3) I brush my teeth at least two times a day;(4)I buckle up in my car seat; and(5)I get my shots and health check-ups. The videos have been completed and were issued to local WIC projects in April 2003 for use in nutrition education classes for children.

Overview of the State Systems Development Initiative (SSDI):

The goal of Ohio's SSDI grant 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 MCHBG Health Systems Capacity Indicator #9(A),and will be addressed through seven project objectives:

- 1) To improve access to data linkages between Ohio birth records and Medicaid files;
- 2) To create data linkages between Ohio birth records and WIC eligibility files;
- 3) To obtain access to hospital discharge data;
- 4) To increase analyses of data from the Pregnancy Risk Assessment Monitoring System (PRAMS);
- 5) To increase analyses of data from the Youth Risk Behavior Survey (YRBS);
- 6) To 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; and
- 7) to provide quality data for MCH Block Grant performance measures and five-year needs assessment.

/2005/ The single most significant project accomplishment for SSDI during the last two years

has been progress toward obtaining access to hospital discharge data and toward improving access to data linkages between Ohio birth records and Medicaid eligibility or paid claim files. An ODH Public Health Data Committee has been meeting with OHA since July 2001 to discuss data sharing issues between the two agencies. As part of these activities, OHA may make relevant OHA data available to ODH. This MOU is currently being finalized by both parties. Additionally, a data sharing agreement with the Medicaid program was signed on May 15, 2003 and will be renewed annually. Medicaid and ODH staff now work collaboratively to identify priority projects. In Ohio, Medicaid already obtains birth certificate data from ODH and links these records with Medicaid claims data. The SSDI project is in discussion with Medicaid to 1) either have Medicaid do further analyses of these data for ODH purposes or 2) to provide the linked dataset to ODH for further analyses. The development of both the OHA and Medicaid data agreements were done at the ODH departmental level, but the SSDI project has been a catalyst that has helped to move the projects along.

The most significant products resulting from this project are 1) medical home focus group reports and presentations; 2)PRAMS focus group reports; 3) interagency data sharing agreements with Medicaid and the Ohio Hospital Association; 4) methodologies for linking and de-duplicating data sets; 5)PRAMS data analyses that were presented as reports at a national conference; and 6)PRAMS data reports and newsletters.//2005//

Overview of Children with Special Health Care Needs Program:

The Title 5 CSHCN Program is facing the challenge of decreased funding and increasing need. 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 medial record system which will aid greatly in the matching of CSHCN with services.

Overview of the Birth Outcomes Workgroup:

The BCFHS convened an internal Strategy Workgroup to address the cluster of Performance and Outcome Measures related to birth outcomes. Out of that grew the Birth Outcomes Workgroup. The group started with members from the Bureaus in the Division. It has now grown to include interested members of the MCH Block Grant Advisory Council, and others.

The group has heard presentations from and discussed outcomes of pregnant women whose care is paid for by Medicaid; a literature review on prematurity; a literature review on the effectiveness of care coordination/case management; an introduction to CDC/City MatCH's Perinatal Periods of Risk (PPOR) analysis of birth certificate data; a quality of perinatal care study conducted for Medicaid Managed Care; PRAMS data; and a study of pregnancy outcomes for women who receive their care in Title V funded clinics and the phase 1 analysis of Ohio's birth certificate data using the PPOR approach. The Birth Outcomes group will continue to work on building our capacity to use data to inform our program and policy decisions.

Overview of HB 248 Lead Bill:

The bill became effective on April 1, 2003. While the ODH was disappointed that the bill did not go as far as it could have to protect children from environmental lead hazards, it certainly took some important steps in that direction. The state statute now requires that each child at risk of lead poisoning undergo a blood lead test in accordance with guidelines established by the CDC. After a child is identified with lead poisoning, the source of the lead must be identified and abated. The statute requires that if the property owner does not comply with the order to abate, the property may be declared unfit for human habitation. This provides more enforcement opportunities for the local and state health departments.

The bill also creates a new category of worker entitled a "lead-safe renovator." The lead-safe renovator must attend a one-day training to learn how to employ lead safe work practices and clean

up any lead hazards to pass a clearance examination at the conclusion of the job. Because the ODH has concerns that the training is insufficient to prepare workers to do this thoroughly, a mechanism to monitor exposures that result from renovation and remodeling work in low income properties will be established. This and improving the lead testing rates for children at risk have been officially designated as Strategic Priorities for the ODH.

//2005/ The ODH has proceeded with the development of Public Health Council rules for the implementation of the bill. New program forms are in development and a schedule of training is set and a related public health lead investigator curriculum is in development. An interdisciplinary Lead Poisoning Advisory Council has been formed and they have met three times and are scheduled to meet monthly through June 2004. //2005//

Overview of Prenatal Smoking Cessation Program:

The BCFHS is amplifying its efforts to reduce prenatal smoking in Ohio. The Prenatal Smoking Cessation Program (PSCP) is designed to provide all pregnant smokers, and new mothers with the help they want and the support they need to quit smoking and stay tobacco-free. One of the PSCP goals is to ensure that all pregnant women will be screened for tobacco use, and will receive "The 5 As" evidence-based intervention.

The PSCP has taken the initiative to bring together statewide organizations. Through collaborative efforts we will increase the number of healthcare practitioners providing "The 5 As" intervention and increase the number of pregnant smokers receiving the intervention. The PSCP will establish ODH as a Master Training Center for "The 5 As" intervention based on current scientific evidence. It will calibrate and certify trainers; provide technical assistance to implement the intervention in healthcare systems; and evaluate "The 5 As" implementation. BCFHS will be convening all agencies that have expressed an interest in providing training on the "The 5 As" intervention. They include the Tobacco Use Prevention and Control Foundation, Ohio's tobacco settlement foundation; the March of Dimes; American Cancer Society; American Lung Association; and Medicaid Managed Care Plans.

While the PSCP has provided "The 5 As" training to over 350 healthcare providers across the state, they have not been in a concentrated enough geographic area or health system to measure progress in smoking cessation. In addition the training was offered with limited success in reaching physician providers. Therefore, vital records data, WIC data, and Title V prenatal clinic data were used to target four counties with the highest rates of prenatal smoking (30-43 %) in Ohio: Marion, Summit, Stark and Columbiana. Trainings will be concentrated in these four counties initially until all willing prenatal service providers have been trained. To reach more physicians with the trainings the PSCP has contracted with a physician to present "The 5 As" at hospital grand rounds in these counties.

The PSCP will further pursue activities to educate pregnant women who are smoking to ask their health care provider for help in quitting smoking; and evaluate the effectiveness of the prenatal smoking cessation by establishing a data collection infrastructure to analyze process, impact, and outcome data.

//2005/ BCFHS submitted a grant application to the Ohio Tobacco Use Prevention and Control Foundation for an 18-month Pregnant Women and Smoking Pilot Project to learn about effective strategies to reduce tobacco use among pregnant women in Ohio. BCFHS will partner with the Smoke Free Families National Dissemination Office, the Ohio Chapter of the American College of Obstetricians and Gynecologists, Help Me Grow, and WIC to build systems that encourage providers to screen all pregnant women for tobacco use and treat those who smoke with proven cessation treatment; evaluate messages used in media, clinical, and other settings to help pregnant smokers quit; and assess client participation in and satisfaction with tobacco treatment services.//2005//

Overview of Medicaid Administrative Claiming:

In exploring options for sustainability, ODH and its local partners began exploring several years ago

participating in Medicaid administrative claiming as federal regulations permit states to be reimbursed for the cost of activities that are necessary for the efficient administration of the State Medicaid Plan. The activities that are reimbursable meet the mission and vision of Ohio's MCH Block grant goals and objectives. The activities are synonymous with functions that ensure availability and access of medical services and medical providers, that assess the quality of care and that monitor the adequacy of care. Examples include outreach, quality assurance function, program planning and development, provider relations and interagency coordination.

Formal negotiations began with the Department of Job and Family Services (ODJFS) to establish Medicaid administrative claiming (MAC) for public health activities that support the efficient administration of the Medicaid program. Since November 2002 and each quarter thereafter, ODH and its local partners have participated in a MAC time survey. Over 350 individuals are participating in the quarterly time surveys. Currently 3 local health departments and 2 community based organizations and 6 ODH bureaus are participating in pilot time surveys. Preliminary invoices reflect Medicaid Administrative Claims will be a significant revenue stream and will be a major contributor for long-term sustainability.

Overview of Help Me Grow:

Help Me Grow is an innovative statewide program for mothers-to-be and their children. The program was started in 1995 by the Ohio Family and Children First Initiative in consultation with the state's healthcare, public health, social service and business communities. It has now expanded to include an array of services for Ohio families. These services include information about pregnancy, a home visit by a registered nurse, home visits to families with young children who are extremely vulnerable because of environment, family, or health circumstances and services and supports for children who have developmental disabilities.

Between July 2001 and June 2002 there were 40,920 newborn home visits and nearly 43,000 infants and toddlers who needed help with development or have a disability were served.

Overview of the Ohio Perinatal Data Use Consortium (DUC) project:

Since the 1970s, the ODH has continually sought to improve perinatal care and outcomes through its regional perinatal program. A case study (external review) conducted in 1999-2000 concluded that the greatest opportunities to improve the quality of perinatal health care in Ohio are in the area of data use and system-focused quality improvement. Beginning in SFY 2003, the Regional Perinatal Program Request for Proposal issued by the ODH called for increased data activities to be led by the Medical Directors and Education Coordinators of the six Regional Perinatal Centers.

A DUC) was formed to engage professionals concerned with maternal and infant health in a learning process. Ohio's six perinatal regional centers providing excellent outreach education, as well as a large number of other facilities providing obstetric and newborn care, create an institutional base. Public health agencies operate community-based programs to improve the health of women of childbearing age, the use of prenatal care, and the home environment during the first year. Private physicians serve women and infants inside and outside of hospital, sometimes working with local health agencies. Professionals from each of these spheres are engaged in the DUC learning process.

The DUC was designed to engage professionals in a learning process focused on quality improvement and performance monitoring in perinatal care. Evidence from past national studies suggests that, to improve the results of a system, health professional leaders must have the capacity and tools to understand and to redesign that system. Learning experiences with a special blend of practical insight and critical thinking will attract health professional leaders, and leaders will be the ones who have the right questions with which to promote local learning. (Batalden et al)

In light of DUC goal to advance data use and improve the quality of perinatal practices across systems, the process has created a collaborative process to gather data and information that can be applied to program planning, evaluation, quality improvement, and performance monitoring efforts. Activities included: a) creation of six regional interdisciplinary teams, b) statewide consortium training

meetings twice per year, c) all-team technical assistance calls on a bi-monthly basis, and d) Internet contact for sharing materials. Structured training emphasized data use strategies along the continuum of perinatal needs and services, as well as maximized use of available Ohio data. Led by the ODH, with the support of external consultants, the DUC process also promoted greater understanding of the importance of linkages between Ohio's community-based prenatal/postpartum services and the in-hospital services around the time of birth.

The results of work to date are reflected in the evaluation of the second meeting of the Perinatal DUC (held 4/21-22/2003). Six Regional Teams plus the State DUC Team attended. The level of satisfaction was high and the teams expressed a desire to continue the consortium. All respondents found the content of the meeting to be relevant to the conference goal, and almost all reported that the program objectives were met. All (100%) of the respondents found the Team Breakout times to be somewhat or highly useful.

Overview of Ohio Pregnancy Risk Assessment Monitoring System (PRAMS):

ODH is looking to PRAMS as a rich and important source of data which can help us better identify and understand trends in women's behavior and experiences during pregnancy. These data will also aid in the assessment of the DFCHS programs and activities for reducing adverse pregnancy outcomes and the development and re-directing of resources. Because of the importance of the PRAMS data, we are considering its collection, analysis, and use a priority in our Division.

Ohio PRAMS data regarding prematurity and its contributing factors were presented at MCHBG Strategy workgroups. Data were also presented and discussed at the MCHBG Unintended Pregnancy workgroup. Meetings regarding the MCHBG performance measures will continue and are intended to focus future PRAMS analyses toward program development and improvement. These meetings serve to provide a forum for program directors, policy makers, and MCH stakeholders to supply PRAMS staff with insight and recommendations regarding analysis priorities.

ODH's first Ohio PRAMS data book, which contains 1999 data, is available at the ODH website at www.odh.state.oh.us. This data book includes frequency tables by education and age for the majority of PRAMS survey questions and is organized by the following topics: demographics, prenatal care, smoking, alcohol use, domestic violence, hospitalization, protective/risk factors, family planning, pregnancy outcomes, breastfeeding, well baby care, and baby safety. In addition to frequency tables, each section includes a description of the topic's public health importance and a summary of findings.

As part of an initiative to assess the needs of Ohio's adolescents, 1999 PRAMS data were used to provide information about unintended pregnancy among teens. The information was included in an Adolescent Health Needs Assessment which was presented to the Ohio Adolescent Advisory Council and ODH policy makers. Specific data regarding unintended teen pregnancy were analyzed.

In May of 2002, two abstracts were submitted to the national Maternal Health and Child Health Epidemiology Conference. Both were accepted, resulting in an oral presentation of risk factors for not using postpartum contraception and a poster presentation comparing Ohio women's responses on the PRAMS survey to data on the birth certificate.

It has been a particular concern that Ohio's response rates in the black and low birth weight strata are too low to generate population-based comparisons. As these are the populations at higher risk for poor birth outcomes and infant mortality, they are also groups towards which ODH has tried to target its programs. We are striving to improve our response rates through a variety of strategies.

In order to continue to improve the data analysis capacity, and to continue with the management of this population-based surveillance system, PRAMS was transferred entirely to the BHSIOS in July 2003.

/2005/ During summer 2003, Ohio PRAMS began the process of evaluating current (Phase 4) survey questions. In the second half of 2003 and early 2004, several PRAMS data analysis

projects were completed. A newsletter on Unintended Pregnancy was produced and will be available on the ODH web page. Additional projects included a summary of data frequencies from 1999--2001, a summary of PRAMS responses categorized by WIC and/or Medicaid participation, a special study on co-sleeping and sleep position variables for BCFHS and a summary of PRAMS smoking related responses from 2001 for the Division of Prevention Tobacco Program. During the last year, all PRAMS staff have participated in a CDC mandated series of instructional modules on Human Subjects Protection. //2005//

Overview of Child Fatality Review:

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent another. Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 in July 2000 mandating Child Fatality Review (CFR) boards in each of Ohio's counties (or regions) to review the deaths of all children younger than 18 years of age.

The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will:

1. Promote cooperation, collaboration and communication among all groups that serve families and children;
2. Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths;
3. Recommend and develop plans for implementing local service and program changes;
4. Provide the ODH with aggregate data, trends and patterns found in child deaths.

Seventy-five CFR boards submitted annual reports describing their CFR board activity and death reviews conducted in 2002 through the required data count tool. An additional six counties submitted partial reports through the electronic Web-based CFR database but did not send the required complete report.

While 1,407 child death reviews were conducted by CFR boards in 2002 only 1,256 were entered into the CFR database and were included in the analysis. The findings from those reviews are summarized in this report. However, there are many limitations to these findings. The limitation of the current CFR database system and the pre-packaged reports does not provide the means to determine the preventability of deaths. Due to lack of confidentiality protection at the state level, access to relevant data necessary for an in-depth evaluation of the contributing factors associated with child deaths in Ohio is not possible.

The following key findings were determined after analyzing the 1,256 child death reviews reported by CFR boards:

- * A total of 1,407 reviews were reported by 75 CFR boards; of these reviews, 1,256 were in the CFR database and used for analysis.
- * Sixty percent of all reviews were deaths to infants under the age of 1 year.
- * Sixty-three percent of all reviews were natural deaths; 76 percent of all natural deaths were infants.
- * Black children and males died at a disproportionately higher rate than white children and girls for several causes of death.
- * Motor vehicle deaths accounted for 12 percent of all reviews; 57 percent were 15 -- 17 years old and 92 percent were white. Of the deaths for which age of driver was reported, the driver was most often 16 -- 18 years old (65 percent).
- * Seven percent of all review conducted were reported as SIDS. Black children died from SIDS at a disproportionately higher rate than white children; 41 percent of all SIDS deaths were black. Nearly 60 percent of all SIDS deaths were male. Of all SIDS deaths, 49 percent were reported as sleeping alone; 26 percent were sleeping in cribs; and 16 percent were sleeping on their backs at the time of death. Of the infants who died of SIDS, 84% were sleeping in an other recommended positions (on

their backs); or their sleeping positions were unknown.

* Four percent of all reviews were reported as suffocation and strangulation deaths. Of these, 27 percent were due to "strangulation by objects" and 22 percent occurred as a result of "other person lying on/rolling on child."

* Firearm deaths accounted for 3 percent of all reviews. Eighty percent were 15--17 years and 11 percent were 10--14 years old. Males and blacks died at a disproportionately higher rate than whites and females; 89 percent were male and 51 percent were black.

Two percent of all reviews were due to drowning. Of the deaths for which place of drowning was reported, 39 percent occurred in lakes; 25 percent occurred in swimming pools and 21 percent occurred in bathtubs. Two percent of all reviews were due to abuse and neglect. Of these, 50 percent were black.

Overview of Childhood Injury Prevention

One area of concern identified by the BCHSSD/School and Adolescent Health section relates to morbidity and mortality of Ohio's children and youth as a result of unintentional injuries. Ohio has approximately 5000 school buildings and about 1.8 million children enrolled in schools k-12. The opportunity for accidents related to play ground activities is great. The expertise available to assist school personnel in assessing the need for playground/school environmental improvements varies with each community. The intent of the school injury project has been to assist schools in standardizing the injury report forms and to aggregate the data from these reports for all of the projects elementary schools. The schools are required to form school safety teams which review the aggregated data on a quarterly basis and develop an improvement plan which would address the nature of the accidents. The preliminary results of this project have been an increase in staff and volunteer trainings. The purchase of walkie talkies to communicate to staff while outside supervising playground activities. Student training on safety issues and replacement of playground equipment and surfacing . The remediation of these problems has initially shown a decrease in minor injuries in one of the school projects.//2004//

B. AGENCY CAPACITY

This section addresses the capacity of the State Title V agency to promote and protect the health of all mothers and children, including CSHCN. It describes the State's capacity for preventive and primary care services for pregnant women, mothers, infants and children, and for services for CSHCN. (10 pages limit)

Director J. Nick Baird, M.D., of the Ohio Department of Health (ODH) is one of twenty-six directors or appointees who serve at the pleasure of Governor Bob Taft. Governor Taft is currently in the second year of his second term as Governor of Ohio. Dr. Baird, an obstetrician-gynecologist who has been with the ODH for three years, has extensive experience working as an administrator within a large health care system.

The ODH remains organized by function with nearly all programs in the department housed within three divisions. Maternal and Child Health (MCH) funded programs and positions (including the state's Children with Special Health Care Needs Program) are under the supervision of the Ohio Title V Director, David P. Schor, MD, MPH, FAAP, Chief of the Division of Family and Community Health Services (DFCHS). The Division of Prevention, one of the other two divisions within the department, receives limited Title V MCH Block Grant funding for the Women's Health Program. All three divisions within the ODH are under the supervision of the Assistant Director of Health who has in the past worked with the administration of the MCH Block Grant, served as Chief of the Bureau of WIC and as an advocate with the Ohio Office of the Children's Defense Fund.

Dr. Schor directs the work of the following seven bureaus: Bureau of Child & 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).

The MCH Advisory Council assists the Division of Family and Community Health Services by advising on block grant funded programs and the population served by the Title V Program. 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. /2004/ The maternal and Child Health Advisory Council met on June 12, 2003. The group reviewed the major accomplishments of the ODH and discussed challenges and emerging issues. Information was presented on Medicaid Administration Match, Newborn Hearing Screening, CSHCN Medical Home, and Oral Health. Dr. Schor facilitated a discussion on the current challenges facing our Department: Budget Cuts, limited resources, and the challenge of making strategic decisions about services delivery. //2004//.

/2002/ Kathy Peppe, the DFCHS chief will be retiring August 31, 2001. A national search was conducted and the selection process is currently underway. It is hoped that a new Division Chief will be on board prior to the start of the 2002 fiscal year. There have been no major organizational changes in either ODH or in DFCHS since the last application was prepared and submitted. A few personnel changes have occurred. Karen Lane, the BCMH chief nurse, will retire in June 2001. Sam Chapman replaced Karen Lane and began work May 2001. The DFCHS hired Adriana Pust in October 2000 to manage and coordinate the MCH Block Grant process. The BHSIOS has also hired two new research and evaluation administrators, Candace Taylor and Ruth Shrock, who will be working on various maternal and child health data issues.//2002//

/2004/ Candace Taylor is no longer at the ODH. Ruth Shrock is now the Data Contact for all MCHBG issues, as well as being the SSDI coordinator.//2004//

/2003/Dr. David Schor began serving as chief of the DFCHS on January 7, 2002. Dr. Schor served as medical advisor and director of health promotion and education for the Nebraska Health and Human Services System. He served as the director of MCH for the Nebraska Department of Health from 1991-1997. 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 master of public health from the University of Michigan in 1994.//2003//

/2005/

BCFHS has contracted with Dr. Cynthia Shellhaas to provide medical consultation to program areas in the bureau serving pregnant women, children and families (e.g., family planning, prenatal, lead poisoning, pediatric specialty services, and infant mortality reduction). Dr. Shellhaas is a licensed OB/GYN provider specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of Obstetrics and Gynecology. In addition, Dr. Shellhaas recently received a Master's in Public Health degree from the Ohio State University's College of Medicine and Public Health.//2005//

Program Capacity

The following is a description of preventive and primary health care services for pregnant women, mothers, infants, and children, including children with special health care needs provided through Ohio's Title V agency.

Bureau of Child and Family Health Services (BCFHS):

The BCFHS funds, monitors and evaluates the Child and Family Health Services Program (CFHSP)

which provides family planning, prenatal and child health clinical services in 81 of Ohio's 88 counties. Local programs are visited regularly by Title V program staff and are provided technical assistance on issues ranging from project administration, delivery of clinical services, confidentiality, Medicaid enrollment, working with managed care organizations, community health needs assessment, program planning and evaluation. Last year, 281,508 visits were made by 93,743 clients to CFHS clinics.

/2002/During FFY 2000, 226,303 visits were made by 89,225 clients.

/2003/During FFY 2001, 15,580 Family Planning Clients, 15,709 Perinatal Clients, and 65,683 Child Clients were seen in Child and Family Health Services Clinics.

/2004/During FFY 2004, the Child and Family Health Services clinics served 16,210 Family Planning Clients (totalling 35,551 Family Planning Visits); 15,853 Perinatal Clients (totalling 96,080 Perinatal Visits); and 71,999 Child Health Clients (totalling 177,250 Child Health Visits)//2004//

/2005/14,404 unduplicated family planning clients (30,193 encounters) were seen in FFY 2003. 15,167 unduplicated perinatal clients (88,753 encounters) were seen in FFY 2003. 74,305 unduplicated child health clients (176,072 encounters) were seen in FFY 2003. //2005//

During FY2000, Regional Perinatal Education Centers (RPECs) transferred from the ODH Division of Quality, to the DFCHS. The RPECs, multi-disciplinary teams from tertiary care centers, are funded through Title V to provide technical assistance on clinical services to local prenatal providers, especially those funded by Title V. /2004/ The RPECs are currently involved in the Data Use Consortium efforts and engagin in the Perinatal Periods of Risk methodology. //2004//

/2005/The Regional Perinatal Centers Program is continuing to advance data skills (e.g., using Perinatal Periods of Risk approach); strengthen linkages between public health and clinical practice through the Data Use Consortium process and activities; and focus on improving outcomes of pregnancy together. A meeting of Perinatal System stakeholders was held to assist in selecting key indicators that might be used to monitor perinatal progress in the next RPC competitive grant cycle.//2005//

The Ohio Infant Mortality Reduction Initiative (OIMRI) utilizes Title V funds to provide one-on-one case management and support services to at-risk pregnant women living in targeted areas with the highest infant mortality rates in Ohio. The community outreach workers work with women to facilitate access to prenatal care, and to assist women in improving their parenting skills. Outreach workers continue their involvement with a family until the child is two years old.

Specialty Clinics for children are provided in 52 counties in Ohio. The seven types of clinics, Cardiac, Developmental Delay, Hearing, Neurology, Orthopedic, Plastic Surgery and Vision, improve access to pediatric specialists in medically underserved areas. Both diagnosis and treatment services are provided through these itinerant clinics. Public Health Nurses at the local clinics assist families in applying for Medicaid and BCMH and help families make follow-up appointments for other testing or surgery.

/2005/Specialty Clinics are provided in 53 of Ohio's 88 counties. More than 8,000 client visits are provided annually. Currently the program is conducting a comprehensive needs assessment process to evaluate the future operation of this program. //2005//

The CDC supported Childhood Lead Poisoning Prevention Program funds its Regional Lead Resource Centers by using Title V funds to provide technical assistance to local providers (clinics, physician offices, etc.) and families on the importance of screening and public awareness of this health issue. The program works closely with other divisions within the ODH where certified lead abatement work is conducted. This completes the continuum of medical case management, environmental home inspections, identification of lead sources, and then abatement of the lead

sources.

The Save Our Sight (SOS) Program, funded through voluntary donations by Ohioans at the time of vehicle registration, provides over five hundred thousand dollars annually in grant funds to promote early detection of eye problems, eye safety and vision conservation programs for children.

//2005/The Save Our Sight(SOS) Program provides \$1,050,000 in grants to fund programs that support preschool vision screening, distribution of protective eye wear and eye health and safety education. The program also provides a contract for \$109,000 to support the operation of the nation's only Amblyopia (Lazy Eye) Registry that includes patient support services and parent education.//2005//

Bureau for Children with Medical Handicaps:

Ohio's BCMH Program continues to provide funding and ongoing support services to children with special needs and their families through its diagnostic, treatment and care coordination programs. Families are assisted through either the direct payment of approved health care bills by BCMH for services rendered by approved providers, or through BCMH's payment of health insurance premiums. The diagnostic program enables any child with a suspected handicapping condition to receive consultation or diagnostic testing, regardless of family income. The treatment program provides a third party pay source for medical services for financially qualified children with eligible handicapping conditions. The care coordination program provides public health nursing services to families in an effort to assist them in understanding their child's condition, the special needs they may have, and in liaison with the family's medical providers. There is close coordination of BCMH services with Medicaid and other third party payors; BCMH is the payor of last resort.

The state Title V program for CSHCN provides rehabilitation for blind and disabled individuals under the age of 16 receiving Supplemental Security Income (SSI). Although, in Ohio, these children are not automatically enrolled for Title XIX (Medicaid) benefits, they are financially eligible to receive BCMH benefits. BCMH may provide rehabilitation services for eligible children and coordinates with other agencies to assure that children receive needed services. BCMH also sponsors educational programs for parents and professionals regarding obtaining and maintaining Title XIX benefits.

Promotion of family-centered, community-based, coordinated care for children with special needs occurs in several ways. The BCMH Service Coordination Program links tertiary care center team coordinators, families and local services coordinators (i.e., public health nurses) together to develop a comprehensive service plan to address the needs of the child and family. The BCMH Medical Advisory Council meets regularly with the BCMH Chief and Parent Consultant to obtain current BCMH information and review BCMH plans and concerns related to the care and service provided by the CSHCN Program. Additionally, BCMH provides opportunities for other agencies such as the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) to meet with the Parent Advisory Committee (PAC) to share information, concerns and future plans.

//2004/ The Title V program for CSHCN is strongly supporting the Medical Home for CSHCN and participating in the National Medical Home Learning Collaborative. The Medical Home for CSHCN is a major priority of the Bureau.//2004//

//2005/The CSHCN Program has participated in "The Medical Home Learning Collaborative" with 12 other states and has developed a "Promise to the State" in collaboration with the Ohio Chapter of the AAP and other state Departments. The CSHCN program is collaborating with the state HMG program in a Pilot to assist children with medical diagnoses in having a single service coordinator from entry into the program until the age of 6.//2005//

Bureau of Community Health Services and Systems Development:

School nursing consultation and adolescent health programs are Title V-funded programs housed in this bureau. Other programs, funded through non-Title V sources include abstinence-only education

programs; the Ryan White AIDS Care Program; Primary Care and Rural Health and related programs to impact health provider shortages. These programs provide many services to women and children in Ohio and are collaborative with the MCH Block Grant and other Division of Family & Community Health Services initiatives.

School Nursing Consultation:

The ODH school nurse consultant provides consultation, technical assistance and conducts continuing education opportunities for school nurses through annual and regional statewide conferences. The ODH school nurse consultant provides assistance to the OHio Dept of Education on accreditation requirements for school nurse curriculum and offers direction for state policies related to the school nursing care of children with special health care needs. In addition various technical assistance documents and guidelines have been created for school nurse issues to assist in developing standards for school screenings, delegation of medication issues, management of school health records and management of chronic illness of school students to name a few.

/2005/ODH continues to provide regional trainings to all school nurses throughout the state of Ohio. Information on HIPPA, Bioterrorism, SARS and current school based mental health programs are just a few of the topics that were presented to over 800 school nurses in Spring of 2003. Additional technical assistance and training will be delivered to school nurses through the development of 4 web based continuing education modules.

ODH "Guidelines on BMI for Age" were developed to help local health departments and schools collect this information accurately and with sensitivity to the children and the families involved. This product which contains examples of proper equipment, model policies for school districts and sample letters to parents have been used by other Divisions within the ODH who work with local health departments on the CDC Cardiovascular Health Grants. Staff have presented this program to many local communities and have disseminated the product to every health department and school nurse in Ohio. A third Ohio school nurse profile survey is currently underway with a report on Ohio school nursing services to be released July/August 04.

Collaboration with Ohio Department of Mental Health continues on school based mental health initiatives. The ODH represents the school nurse perspective and we have co-sponsored a state wide 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.

ODH has collaborated with the BID, Homeland Security Program and will be receiving funds to develop school based training for emergency preparedness in schools. The ODH School Nurse Consultant has been a part of the Ohio School Emergency Task Force for the last year, and has assisted in developing a template that schools can use to plan for emergency response. The template is available on the ODH web as well as presentations have been provided to school administrators through the Ohio Association of Elementary School Administrators.//2005//

Adolescent Health Programs

/2004/ A statewide adolescent health advisory committee comprised of adolescent physicians, university personnel, adolescent wellness coordinators and interested parents and teens help to direct the program efforts of the adolescent program. The adolescent health coordinator is responsible for developing technical assistance materials to help our local health depts and funded grantees who work with adolescents. Regional trainings in the area of adolescent development to assist local health care providers in working with adolescents is one of the major ongoing training programs in this area. The Adolescent Health Coordinator also coordinates the implementation of the Youth Risk Behavior Survey in Ohio. The statewide weighted data obtained through this survey reports health behaviors of high school youth in grades 9-12 which is shared with a multitude of health partners throughout the state and used in program planning and resource allocation in prevention programming.

In an effort to improve overall health of the school aged child the School and Adolescent Health section in collaboration with the Division of Prevention has developed the Healthy Ohioan's, Governor's Buckeye Best Healthy School Awards Program which recognizes schools whose programs and policies reflect a high priority on nutrition, physical activity and tobacco education programs. Programs focus on improving health outcomes for youth by improving school nutrition, adding more physical activity and tobacco education.//2004//

/2005/The Adolescent Health Unit presented the updated "Adolescent Development Curriculum" at the National Association of School Nurses in June 03 and has conducted two regional trainings on the Curriculum to over 100 interdisciplinary health professionals who provide health services to the adolescent population in Ohio.

In collaboration with the ODH BHSIOS the Adolescent health section has developed a report entitled "The Health of Ohio's Adolescents, 21 Critical Indicators". Ohio has collected state and national data to produce a profile for Ohio's Adolescents. This report represents a subset of a more comprehensive assessment of Ohio adolescents which will shared with health professionals, policy makers and government/community leaders as they plan programs for adolescents.

The Adolescent Health Section co-sponsored the Ohio Suicide Prevention Symposium in Oct 03. The symposium brought together leaders in mental health, medicine and other state/community agencies to better understand and develop programs to address suicide. The Adolescent Health Unit is a member of the Ohio Suicide Task Force.//2005//

/2002/ The Abstinence-Only Education Program was moved to the Office of Women's Policy. The BCHSSD and BCFHS continue to collaborate on state-wide strategies and program efforts.

Bureau of Early Intervention Services (BEIS)

The BEIS administers nine programs to promote early identification and intervention services for young children. Most of the programs are funded through sources other than the MCH Block Grant, such as state General Revenue Funds (GRF) and the U.S. Department of Education. BEIS administers the Part C Early Intervention Program, Ohio Early Start (services for at-risk children 0-3), the Welcome Home Newborn Visitation Program, and coordinates these programs with MCH Block Grant programs. The Regional Genetics Centers, and Regional Sickle Cell Centers provide consultation, education, and treatment services to families and are funded primarily through the sale of newborn screening kits in Ohio. A declining birth rate, and improved testing methods have decreased the amount of funding realized through the newborn screening kits. Both genetics and sickle cell programs, as well as the Metabolic Formula Program are partially funded by the MCH Block Grant.

The BEIS also administers the Health Systems Development in Child Care (HSDCC) grant for health consultation in child day care; the Infant Hearing Program and the Hemophilia Program. Legislation proposed in Ohio is being monitored by ODH staff which would require a universal newborn hearing screening. ODH staff have also provided consultation to the Legislature and other interested parties about universal newborn hearing screening programs. The Hemophilia Program provides education, family support, and insurance premium payments for patients with Hemophilia or other related bleeding disorders. The program also provides clotting factor products for patients with no other source of paying for these services.

/2002/ The Help Me Grow program, a communication and public awareness initiative for wellness programs at ODH, will now include the integration of several birth to three children's programs into one consolidated initiative. Help Me Grow will continue to provide important information on prenatal and infant care and development, positive parenting, safety, and abuse prevention. Current birth to 3 programs that will be included are Welcome Home, Ohio Early Start, and Early Intervention.

/2004/ There will be an increase in activity around coordinating early childhood programs within the Department as well as with other state agency programs. The state legislature passed a bill to require that every newborn receive a physiologic hearing screening prior to hospital discharge. Hospitals have until 6/2004 to implement. The Help Me Grow program has been transferred out of the BCHSSD and into the BEIS. //2004//

Bureau of Health Services Information and Operational Support (BHSIOS)

The BHSIOS provides support services to all program areas within the DFCHS. The Research and Evaluation section provides data analysis, program planning and evaluation assistance through the utilization of epidemiologists and researchers. Other sections within the BHSIOS provide grants processing support and purchasing/fiscal support to Division programs as well as the technological support of computer-based data collection systems. The State Systems Development Initiative (SSDI) and Pregnancy Risk Assessment Monitoring System (PRAMS) are administered in BHSIOS.

/2005/ The MCH BG application, annual report and needs assessment are all now coordinated in BHSIOS.//2005//

/2004/ State Systems Development Initiative (SSDI)

The goal of Ohio's SSDI grant in FFY 01-03 was to assist in building infrastructure that results in comprehensive, community-based systems of care for all children and their families. This goal was accomplished through a focus on the Title V MCH (MCH) Block Grant Core Health Status Indicator #8, and was addressed, over the two-year grant period, through seven project objectives: 1) Linked Ohio birth records and infant death certificates; 2) Obtained access to hospital discharge data; 3) Accessed linkages between Ohio birth records and Medicaid files; 4) Analyzed data from the Pregnancy Risk Assessment Monitoring System (PRAMS); 5) Analyzed data from the Youth Risk Behavior Survey (YRBS); 6) Monitored opportunities to access and/or link additional priority datasets that are unable to be addressed in the current project period; and 7) Linked Ohio birth records and WIC files.

The single most significant project accomplishment during this last budget period has been progress toward development of a standardized methodology for linking datasets, as well as the collaborative relationships with VS and the Office of Management Information Systems to develop the process of creating linked infant birth/death files. ODH created these starting with 2000 data files, via computer linking and hand matching and has obtained from the National Center for Health Statistics copies of Ohio's linked birth/death files for 1995-1998, which will be used to carry out a state Perinatal Periods of Risk analysis. Other data linking activities include progress toward linking birth records and WIC files. A subgroup of the OPHDRPAC, which includes the SSDI Project Director, has been meeting with OHA since July 2001 to discuss data sharing issues between the two agencies; OHA is interested in sharing data with ODH to the degree such efforts mutually support both agencies and also reduce redundancies in data collection from hospitals. An OPHDRPAC subgroup has also been meeting with Medicaid to discuss data sharing. The SSDI project has contributed biostatistical expertise for the analysis of Ohio's PRAMS data and SSDI staff are part of the planning committee for Ohio's YRBS survey.//2004//

//2005//Ohio's FFY 03-06 SSDI grant is focused on the Title V MCH Block Grant Health Systems Capacity Indicator #9(A) which is addressed through seven 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 the Pregnancy Risk Assessment Monitoring System (PRAMS); 5) increase analyses of data from the Youth Risk Behavior Survey (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; and 7) provide quality data for MCH Block Grant performance measures and five-year needs assessment.

The most significant accomplishment from recent SSDI activities has been the development of an automated process for creating linked infant birth/death files. Currently, epidemiologists at the both the state and local levels are using the linked files for a collaborative Perinatal

Periods of Risk project.

ODH does not link infant birth records with Medicaid files, but the Medicaid program, located in the ODJFS, does link these records for the purposes of preparing legislatively mandated reports. An ODH data committee co-chaired by the SSDI Project Director has developed an interagency agreement for data sharing with Medicaid. ODH has just linked birth records with WIC eligibility files so the program can obtain information about whether local WIC projects are targeting the highest risk mothers and whether appropriate penetration rates for WIC enrollment are being achieved. ODH has also developed a data sharing agreement with the Ohio Hospital Association (OHA). SSDI project staff will be involved in analysis of MCH-related data that are obtained. Ohio has participated in the CDC PRAMS since 1999. SSDI funds pay for a contracted biostatistician to assist with in-depth analyses of both the PRAMS and YRBS data. SSDI staff work collaboratively with MCH Block Grant strategy workgroup leaders in DFCHS to provide data needed to report on performance measures and activities. As in past years, SSDI staff will be responsible for collecting, analyzing, presenting and interpreting much of the data needed for the five year MCH Block Grant needs assessment.//2005//

Bureau of Nutrition Services (BNS)

The BNS administers primarily the State's WIC Supplemental Food and Nutrition Program for Women, Infants and Children. Since the target population for the WIC Program, and other Title V funded programs is the same, there is extensive collaboration on initiatives such as breastfeeding promotion, maximizing immunization opportunities, and assisting families in applying for Medicaid/CHIP. /2004/ Corey Hamilton is now the new BNS bureau chief, replacing Larry Prohs. The ODH BNS administers the Ohio WIC program through 76 local agencies with approximately 235 clinics throughout Ohio's 88 counties. Ohio is among the ten largest WIC programs in the United States and one of the largest in the Midwest. Ohio WIC served a monthly average of 253,923 participants during the federal fiscal year from 10/1/2001 through 9/30/2002. For the federal fiscal year 10/1/2002 through 9/30/2003, Ohio WIC has the capacity to serve an average of 260,000 participants per month. //2004//

/2005/BNS currently administers the Ohio WIC program through 75 local agencies with approximately 235 clinics in Ohio's 88 counties. Ohio WIC served a monthly average of 255,804 participants during the federal fiscal year from 10/1/2002 through 9/30/2003. For the federal fiscal year 9/12003 through 9/30/2004, Ohio WIC has the capacity to serve an average of 263,000 participants per month. //2005//

Bureau of Oral Health Services (BOHS)

The BOHS supports local agencies with grant funding to provide dental care services (primary care and dental sealants) to high risk children and women of childbearing age. The Bureau also develops program and training materials and provides technical assistance and monitoring to other DFCHS programs such as BCFHS clinics, BNS, Head Start, local schools and other public health related programs. Communities are assisted in conducting oral health needs assessments and 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.

/2002/ The Director of Health convened a Task Force on Access to Dental Care to develop recommendations for state level policy changes that will improve access to dental care for vulnerable Ohioans. Ohio was selected to participate in the National Governor's Association Policy Academy. This will provide an opportunity to craft the Director's Task Force recommendations into a practical work plan.

/2004/ BOHS worked in collaboration other federal and state partners on several projects of national significance The BOHS worked with the Association of State and Territorial Dental Directors (ASTDD)

and the Indian Health Services to develop an online Safety Net Dental Clinic Manual. Funded primarily by Ohio's Title V dollars, this on-line practical reference, hosted by the National MCH Oral Health Resource Center, will help agencies and organizations that are starting new dental clinics as well as those looking for ways to improve their existing clinics.

In addition, ODH, the ASTDD and the University of Texas, San Antonio, each were funded by HRSA for projects relative to improving oral health through Head Start. ODH worked on a multi-pronged assessment of Head Start families, staff and dental providers to better understand the factors affecting oral health for Head Start children in Ohio. The assessment included an open mouth survey of Head Start children, a mail survey of a sample of Ohio dentists and telephone interviews of Head Start parents and staff. Following the assessment, conducted in partnership with the University of Cincinnati, a broad-based group of stakeholders will meet to develop a plan to increase access to oral health services for Head Start children.

The Bureau Chief actively participated on the ASTDD advisory committee to develop an on-line database of dental public health best practices. In addition to those submitted by other states, this project highlights several programs operated by the BOHS including the state school-based dental sealant program, Dental OPTIONS, the statewide volunteer dental access program and the annual statewide oral health survey of sentinel schools.

The Bureau Chief also worked with Oral Health America to improve the Oral Health Report Card project. A small workgroup helped identify meaningful measures of the effectiveness of states to meet the oral health needs of their populations.//2004//

C. ORGANIZATIONAL STRUCTURE

The State organizational structure (Governor, State health agency, MCH and CSHCN programs in the State government) and its relationship to the administration of the Title V Block Grant is discussed in this section. Organizational charts have been included by uploading them as an attachment and providing a URL from where they can be accessed online. (4 pages limit)

/2004/ Organizational charts for the Department and for each Division can be found at the following URL <http://www.odh.state.oh.us/About/Org.Charts/orgmain1.htm>//2004//

D. OTHER MCH CAPACITY

This section discusses the MCH staff at work on the Title V programs including those who provide planning, evaluation, and data analysis. Brief biographies of senior level management employees and the role of parents of CSHCN on staff are included.

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

/2004/The BCMH employs a Parent Advocate who works closely with the BCMH Parent Advisory Council and involved in all Bureau decision making. Parents are involved on Bureau committees. Kathy Bachmann is a parent who works in the BCMH as a family advocate and established the BCMH Family Advisory Committee. She works as a liaison between families and BCMH. She provides information about BCMH to families, and brings families' issues to BCMH Program leadership. In addition, the BEIS provides funding through Part C of IDEA to establish family support activities within the Birth to Three Program.//2004//

/2002/ In order to improve capacity, a new position was created in October 2000 in the DFCHS. The MCH Block Grant Coordinator will be responsible for coordinating the various aspects of the MCHBG

application, as well as provide training on MCH issues such as program planning and evaluation. In the Spring of 2001, Ohio participated in a Capacity Assessment for State Title V (CAST-V). In collaboration with John Hopkins University and MCHB, over 60 ODH employees participated in a strategic planning process to determine the strengths, weaknesses, opportunities and needs of ODH as the State Title V agency. Several Key Issues and recommendations were identified:

?Data/Information Functions recommendation: Build capacity to collect, analyze, interpret and disseminate comprehensive, accurate, and useful data / info to meet the needs of multiple stakeholders.

?Structural Resources recommendation: Develop and improve relationships with other state agencies, media, within the agency.

?Competencies/Skills recommendation: Demonstrate understanding and ability to utilize data and data systems for program and policy development and evaluation.

?Organizational Relationships recommendation: Develop capacity and ability to translate data and other scientific and programmatic information for diverse professional and lay audiences and decision makers.//2002//

/2003/ The DFCHS is periodically reviewing the CAST-V document and recommendations. The MCHBG Coordinator has been identified as a CAST-V facilitator, and has provide technical assistance to other states.

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 ODH as division chief in January, 2002. He formerly served as MCH director, medical advisor, 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).

Virginia A. Haller

Medical Advisor, 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: 1.5 years Medical Advisor, DFCHS; 11 years Clinical Associate Professor of Pediatrics, OSU; 3.0 years Medical Director DFCHS; 1.5 years Medical Director, Ohio Department of Health; 2.5 years Medical Director, United HealthCare 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.

Duties: Formulates medical policy as advisor 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.

Bureau of Child and Family Health Services

Karen Hughes

Bureau Chief

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

Experience: 11 years BCFHS Chief; 1 year, Acting Chief, Bureau of Maternal and Child Health; 1 year Assistant Chief, Bureau of Dental Health; 1 year Acting Chief, Bureau of Dental Health; 4 years Program Administrator, Bureau of Dental Health; 3 years Public Health Dental Consultant; 3 years District Dental Consultant.

Duties: Directs the Bureau of Child and Family Health Services programs including Family Planning; Perinatal Health; Child Health; Childhood Lead Poisoning Prevention; Pediatric Specialty Clinics; Ohio Infant Mortality Reduction Initiative; SIDS; CFR; and Save Our Sight to assure that low income children and families receive comprehensive public health and clinical services.

//2005/ Bureau of Child and Family Health Services

Karen Hughes, Bureau Chief

Experience: 14 years BCFHS Chief

Duties: Directs the Bureau of Child and Family Health Services programs, including new programs: Women's Health Services; Prenatal Smoking Cessation; Pediatric Specialty Clinics (Cardiac, Developmental, Hearing, Neurology, Orthopedic, Plastic, Vision); Child Fatality Review; and SIDS. Co-directs Community Access and Medicaid Administrative Match Programs.//2005//

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: 22 years general practice of pediatric medicine with emphasis on CSHCN; 17 years full-time and continuing clinical practice part-time for past 5 years; 5 years Chief and Medical Director of BCMH; Associate Professor of Pediatrics, Wright State University School of Medicine; Faculty member Title V CSHCN Institute.

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 Blair

Bureau Chief

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

Experience: 4.5 years BCHSSD Chief; 4.5 years Certified Community Health Nursing Specialist, 10 years certified in pediatrics and 1.5 years certified as nurse case manager; 26 years of progressive experience including: program development, strategic planning, health care delivery, patient assessment, case management, research and evaluation, patient advocacy and standards development and training.

Duties: Directs the assessment, planning, implementation and evaluation of statewide programs including Primary Care and Rural Health, Black Lung, AIDS Client Resources, School and Adolescent Health Services, Abstinence Only Education, Help Me Grow and the activities of the Strategic Planning Section.

//2005/ 30 years of progressive experience

Duties: Directs the assessment, planning, implementation, policy development and evaluation of statewide programs including the offices of Primary Care and Rural Health (including health care provider placements), Ryan White Care Title II services, and the activities of the Strategic Planning Section including initiatives to improve health care access for underserved populations.//2005//

Bureau of Early Intervention Services

Debbie Wright

Bureau Chief

B.S. Nursing; M.S. Nursing Administration

Experience (related to MCH): 14 years nursing experience with obstetrics, neonatal and pediatric population; 2 years public health nursing; 4 years bureau chief; 4 months acting bureau chief; 4 1/2 years administrator Newborn Screening, Hemophilia, Sickle Cell and Genetics programs; 2 years genetics and newborn screening nurse consultant.

Duties: Directs the planning, development, implementation and evaluation of the following bureau programs: Help Me Grow (to include a helpline and general information on child development, health and safety and other statewide services; newborn homevisiting; and services and supports to infants and toddlers birth to three at risk or with developmental disabilities and their families); infant hearing screening (to include universal newborn hearing screening); Healthy Child Care Ohio (providing a health care consultant network for child care providers); metabolic formula; genetics; sickle cell.

//2005/ The metabolic formula program, genetics and sickle cell have been transferred to BCMH. Directs the State Early Childhood Comprehensive Systems (SECCS) Project.//2005//

Bureau of Health Services Information and Operational Support

Lynn Giljahn

Bureau Chief

B.S. Medical Technology; M.P.H. Infectious Disease Epidemiology

Experience: Data Coordinator, Division of Maternal and Child Health; Bureau Chief, Division of Family and Community Health Services

Duties: Directs BHSIOS which provides support to all other DFCHS bureaus in research and evaluation, information systems and operational support. Oversees the State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS).

//2005/ Lynn Giljahn left DFCHS in April, 2004.//2005//

Bureau of Nutrition Services

Larry Prohs

Bureau Chief

M.B.A.

Experience: 10 years BNS Chief; 5 years Assistant Chief, Illinois Department of Public Health, Health Promotion & Screening (WIC), 7 years National Association of WIC Directors (NAWD) Board of Directors, 4 years NAWD Treasurer.

Duties: Directs and supervises the Bureau of Nutrition Services serving approximately 250,000 eligible WIC participants in Ohio; the Farmer's Market Nutrition Program; and an Electronic Benefits Transfer system used by participants in both programs.

//2004/ The Bureau of Nutrition Services hired a new chief when Larry Prohs left the agency in the Winter of 2003. Corey Hamilton is the new chief.

Bureau of Nutrition Services

Corey Y. Hamilton, MS, RD, LD

Bureau Chief

Bachelor of Science degree in Nutrition from Miami University of Ohio and a Master of Science degree in Allied Health from The Ohio State University.

Experience: A Registered and Licensed Dietitian in the state of Ohio, Ms. Hamilton has 16 years of diverse service and experience in the Ohio WIC program at both the state and local levels. She was a certifying health professional at the Muskingum County WIC program from September 1987 to November 1992, and then was promoted to Muskingum County WIC Coordinator and directed the local WIC program until March 1997. In March 1997, Ms. Hamilton became the Administrator of Program Operations in BNS and served in that administrative position for six years. Ms. Hamilton has served as a member of the USDA WIC Nutrition Services Standards workgroup, as the Southeast Ohio Region WIC Representative, and on several collaborative groups including Early Intervention, Family and Children First Council, Early Start, and Head Start. *//2004//*

Bureau of Oral Health Services

Mark Siegal

Bureau Chief

D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health

Experience: 16 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

This section describes the organizational relationships among the State human services agencies and the relationship of the State and local public health agencies and federally qualified health centers and other organizations like associations and universities.

The DFCHS, through its seven bureaus, is responsible for the administration and implementation of many maternal and child health programs funded from sources other than Title V. The BCFHS houses the Title X Family Planning Program and the Centers for Disease Control and Prevention's Childhood Lead Poisoning Prevention Program. The BCHSSD administers the Primary Care and Rural Health Program which provides funding for primary care services, especially in medically underserved rural areas, and attempts to place health practitioners in rural areas; the Black Lung Disease Program; and the AIDS Client Resources Program which provides funding for health care and support systems to the community from the Ryan White Care Act. In addition, the BCHSSD also administers Ohio's Help Me Grow Program which promotes outreach to women to seek early prenatal care and preventive health care for their young children. BEIS administers the Early Intervention Program for infants and toddlers, the Ohio Early Start Program, the Welcome Home Program for home visits to first time and teen moms, and the state's Genetic, Sickle Cell and Hemophilia programs. The BNS is responsible for implementing Ohio's WIC Program and the Farmers Market Nutrition Program. All of these programs target much of the same population group(s) for services and are coordinated through their administration in the DFCHS. Since bureaus within DFCHS are responsible for administering these MCH-related programs, close coordination with MCH Block Grant programs occurs. DFCHS has approximately 47 different funding sources supporting its many public health service programs.

//2005/ BCFHS houses Title X Family Planning, Women's Health Services (General Revenue Funds)//2005//

The Ohio Family and Children First (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 Family and Children First Cabinet Council. Members of the Cabinet Council include the State Superintendent of Public Schools, and the Directors of the Departments of Alcohol and Drug Addiction Services; Budget and Management; Health; Job and Family Services (formerly Human Services); Mental Health; Mental Retardation and Developmental Disabilities; Aging; and Youth Services. The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities.

The Cabinet Council recognizes that to succeed the initiative must be "home grown", and as such, all 88 Ohio counties have created a Family and Children First 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. The state, however, has identified two core strategies under which interdepartmental efforts are organized. These are: 1) Community-based partnerships; and 2) Literacy and 4th grade reading guarantee.

/2002/ The Ohio Family and Children First Cabinet Council engaged many local partners in FY2000 to identify shared commitments 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.

/2004/Ohio Family and Children First Outcome Indicators for Measuring Child Well-Being

Expectant parents and newborns thrive

- * Annual percentage of children who live past their first birthday
- * Annual percentage of full-term births without serious complications

Newborns and toddlers thrive

- * Annual percentage of children receiving complete immunization series by age two
- * (Will be adding an indicator addressing child development status)

Children are ready for school

- * Annual percentage of children arriving at school with age appropriate literacy skills
- * Annual percentage of children with access to health care, including hearing and vision services

Children and youth succeed in school

- * Annual percentage of students who report parental involvement with their education
- * Annual percentage of students passing the 4th grade reading proficiency test*
- * Annual percentage of students who have a 95% attendance rate or better
- * Annual percentage of students who graduate from high school
- * Annual percentage of children not exposed to violence at home, school or in their neighborhoods as either a witness or a victim

Youth choose healthy behaviors

- * Annual percentage of youth who refrain from use or abuse of alcohol, tobacco or drugs
- * Annual birth rate to teenagers
- * Annual percentage of youth involved in school and community activities
- * Annual percentage of youth involved in regular physical activity

Youth successfully transition into adulthood

- * Annual percentage of high school graduates who continue their education
- * Annual percentage of employed young adults
- * Annual percentage of youth who did not graduate from high school earning the GED through age 20

Kids Card -- During FFY 2002, the HMG helpline received 33,434 calls

BEIS administers the Help Me Grow program which includes services and supports to infants and toddlers identified with developmental disabilities under Part C of IDEA. The bureau also coordinates the activities of the Healthy Child Care America Initiative by providing a network of health care consultants for child care providers.//2004//

Since February 1995, DFCHS has operated the Help Me Grow (HMG) help line, a statewide toll-free 800 number, which provides health and 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: Aging; Alcohol and Drug Addiction Services; Education; Health; Jobs and Family Services; Mental Health; and Mental Retardation and Developmental Disabilities, as well as local sites for clinical services. The HMG Program has created a free wellness guide offering expectant and new mothers step-by-step health information to encourage regular prenatal care and primary care for their children. The long term goal of the HMG helpline is to replace many of the state's current 800 numbers, allowing for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families and children. During FY99, the HMG help line received 42,838 calls of which 25,865 were transferred or referred to BCMH. The HMG help line is available to callers 24 hours a day, seven days a week. Between the hours of 8:00 am to 8:00 pm Monday through Friday and noon to 5:00 pm on Saturday and Sunday, calls are answered by a live operator. During other hours, callers leave their messages on an automated voice mail system to order their wellness guide or other packets of information. Weekly and monthly reports on calls received and referrals made are reviewed by state staff. Periodic evaluations of the help line are conducted to determine client satisfaction and outcome.

/2002/ During FFY2000, the HMG help line received 38,104 calls. The HMG staff also facilitated and were on hand to take calls after the nationally televised airing of a Prenatal Care Documentary on the Lifetime Channel.//2002//

/2003/ During FFY 2001, the HMG help line received 41,601 calls.//2003//

/2004/ The Help Me Grown Hotline is now located in the Bureau of Early Intervention Services. It is no longer in the Bureau of Community Health Services and Systems Development.//2004//

/2005/ The Help Me Grow Helpline received 46,474 calls requesting information on programs and services.//2005//

Ohio Kids Card (OKC) provides families with children under six years of age with a card that may be used throughout Ohio for discounts on products and services. The goal of the (OKC) is to help ease the financial burden of raising children while providing positive child health and educational opportunities. The program is scheduled to be launched August 2000.

/2002/ The Ohio KIDS Card was launched in the Spring of 2001.//2002//

/2004/ The Ohio KIDS Card is now housed in the Bureau of Early Intervention Services. It is no longer in the Bureau of Community Health Services and Systems Development //2004//

/2005/Healthy Ohioans, Family and Children First initiatives and the school and adolescent population:

The SAH Section has been involved in the last 3 years with the Governor's Healthy Ohioans Initiative to improve school health programs in the area of physical activity, tobacco and nutrition education/programs. Over 1000 schools and 50% of Ohio's school districts have participated in the Healthy Ohioans -- Buckeye Best Health School Awards Program. The awards program has been a great success in raising awareness in schools about the importance of health programs and policies. Local health departments and local cancer agencies are notified of the schools in their area who have requested TA and contacts are made by these health professionals to interested school staff.

The SAH Section is also involved in the Ohio Action for Healthy Kids Initiative, to improve 3 goals: 2 of which are aimed at improving nutrition in schools and the third is increasing physical activity in after school programs. The above activities are also supportive of Ohio's Family and Children First commitment, "Youth Choose Healthy Behaviors" which includes the performance measure, "Annual % of youth involved in regular physical activity". The SAH Section has been helping ODE and ODH to improve nutrition messages for school aged children, families and teachers. The program ideas are listed on the ODH web and can be downloaded for use. //2005//

The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards and committees, and shares some committees with organizations. The Ohio Chapter of the American Academy of Pediatrics 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 and educational issues of CSHCN in addition to medical issues.

The Immunization Unit in the Division of Prevention serves as the lead for statewide immunization services and develops the State Immunization Action Plan. In partnership with DFCHS-funded projects, DFCHS consultants coordinate and support statewide immunization compliance in CFHS and WIC clinics. 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 the Ohio Chapter of the American Academy of Pediatrics (AAP) in regard to the immunization education program for physicians and nurses.

Technical assistance and training are provided by DFCHS nutrition, oral health, nursing, and hearing and vision consultants to state Head Start Programs in collaboration with the Ohio Head Start Association and the Ohio Department of Education (ODE). At the request of the Ohio Head Start Association and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration between the two programs in the areas of nutrition screening/assessment, education, referral, and recruitment has been signed.

The DFCHS Chief represented ODH on a statewide task force to review the child welfare system in Ohio and to make recommendations to the Director of the Ohio Department of Human Services (effective July 1, 2000, ODHS will become the Ohio Department of Job and Family Services--ODJFS), for the improvement of the system. The review encompassed adoption programs, child abuse and neglect, child care and children's protective services.

DFCHS staff prepared a proposal for CHIP Outreach and Enrollment which was submitted by ODH to ODHS in December 1999. While ODHS has not approved the proposal to date, DFCHS staff meet regularly with Medicaid policy staff to work out issues of common interest. For example, Ohio's Combined Program Application form (used by Medicaid, CHIP, WIC, CFHS, and BCMH) is currently being revised and will be used by early intervention and Ohio Early Start Programs as well.

/2004/ The ODH and the Ohio Department of Job and Family Services signed an inter-agency agreement for data sharing between the two agencies. A memorandum of understanding for data sharing between the ODH and the Ohio Hospital Association is in process. //2004//

DFCHS staff serve on the ODHS Day Care Advisory Council, a legislatively mandated body that advises ODHS on child care policy and implementation of child care law. The BCMH Chief also represents the ODH, DFCHS on the Ohio Developmental Disabilities Planning Council. DFCHS staff serve on the Interagency Nutrition Committee of Ohio, made up of all USDA-funded agencies. Members coordinate USDA nutrition activities that currently include support of the USDA Team Nutrition Initiative for the Schools. The DFCHS Chief and BCFHS Chief also 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. The DFCHS Medical Director sits on the Medicaid Medical Advisory Committee for the ODHS, and serves on the Executive Committee for that group.

BCHSSD staff serve on the ODE Literacy Task Force, coordinate with the Ohio State University School of Public Health in the development of a Bio-nutrition Center and in developing a locus for maternal and child health in the School of Public Health's curriculum.

/2004/ The Office of Primary Care and the Office of Rural Health within the Bureau of Community Health Services and Systems Development maintains many collaborative relationships with outside agencies and systems.

BCHSSD & Ohio Rural Development Partnership:

The Ohio Rural Development Partnership (ORDP) is an advocate for effective collaboration in rural development through public-private and inter-governmental cooperation to enhance the quality of life for rural Ohioans. The Partnership itself is housed at the Ohio Department of Agriculture. The structure of the ORDP is such that it is governed by a Steering Committee, with three standing issues committees that meet regularly: Agriculture, Rural and Economic Development, and Health. Heather Reed is a member of the Steering Committee by virtue of her role as Chair of the Health Committee, now called the Ohio Rural Health Coalition.

BCHSSD & Rural Health:

The ORDP has developed a 501c3 organization, the Ohio Rural Partners (ORP) that is able to apply for and receive federal, foundation and other funding. The Ohio Rural Health Coalition has successfully garnered support from the National Rural Health Association (NRHA) for further development of Coalition activities, and the Ohio Rural Partners receives and administers this funding. In addition, the State Office of Rural Health (SORH) partners with the ORDP each year to conduct an annual statewide rural health conference. Registration fees and sponsorship money are sent to the ORP, and the Ohio Rural Health Coalition and SORH staff takes the lead in planning the event

BCHSSD & the Ohio Hospital Association:

The Ohio Hospital Association (OHA) is the membership and advocacy organization for most of Ohio's small and large hospitals. In recent years the OHA has developed a strong interest in its small and rural hospitals, and has created a standing Small and Rural Hospital Committee. In addition, the OHA has partnered with the State Office of Rural Health (SORH) in the development and implementation of the State Rural Hospital Flexibility Grant Program, beginning with the development of a State Rural Health Plan (SRHP) approved in September 2000 that enabled Ohio to begin designating Critical Access Hospitals (CAHs). Early on the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the Ohio Primary Care Association, the Ohio State Health Network, Division of EMS, Ohio Rural Development Partnership, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly, and since its inception this meeting has been hosted by the OHA.

BCHSSD & the Ohio Primary Care Association:

Primary Care and Rural Health is taking the lead for two Presidential Initiatives in Ohio -- the development and expansion of Federally Qualified Health Centers (FQHC), and the growth of the National Health Service Corps. A coordinated effort is underway with the Ohio Primary Care Association to develop Federally Qualified health Centers in medically underserved areas. Primary Care and Rural Health is the largest recruiter of health professionals in Ohio, and the National Health Service Corps. is on the programs used to recruit health professionals to care for the underserved. The physicians placed last year provided over four million medical visits to Ohio residents.

BNS and Other State Agency Coordination:

BNS continues coordination with the Ohio Department of Job and Family Services Healthy Start Medicaid program, updating WIC income guidelines in conjunction with the Medicaid guidelines, and referring applicants via the Combined Programs Application. With the Division of Prevention Immunization program, BNS piloted a new tracking system in 10 sites with Immunization outreach workers. The new tracking system is part of the Windows upgrade to the WIC certification system and will be used in all WIC clinics. BNS has also partnered with the Bureau of Child and Family Health Services in a lead screening pilot project at 18 WIC clinic sites. BNS worked with the Ohio Environmental Protection Agency to release the 2003 Sport Fish Consumption Advisory for use in WIC clinics.

BCMh and Other State Agency Coordination:

Representatives from other state departments such as Education, ODJFS, ODMRDD, ODMH, and the DD Council serve on BCMH committees. Representatives from BCMH serve on the State DD Council, the state Autism Advisory Group, the State Folic Acid Advisory Committee, and the State Brain Injury Advisory Committee. There is an active joint BCMH/ ODJFS BMHC workgroup which

meets every 6 weeks to discuss common concerns and issues.

Coordination through Dr. Virginia Haller:

Dr. Haller is the liaison from the ODH to the state Trauma Committee. The state Trauma Committee is a legislated committee of the state EMS Board, which is staffed by the Ohio Department of Public Safety. Dr. Haller has represented the needs of those served by the DFCHS and ODH. A major focus during the past year has been provisional designation of trauma centers. Dr. Haller chaired an interagency workgroup, which produced a white paper on various options available to the state on provisional designation. Related to the development of the trauma system in Ohio, Dr. Haller was assigned by Asst. Director Anne Harnish to oversee the work of two legislated Commissions: the Injury Prevention Commission and the Post Critical Trauma Care Commission. Reports from both Commissions are due to the Governor and the Ohio General Assembly in November 2003.

Dr. Haller was appointed by the Governor as one of the ten member state team to address disaster mental health. Following training in NYC in November 2001, the team developed a plan for incorporating mental health preparedness into state disaster preparedness. This resulted in the Ohio Department of Mental Health being given an official seat on the Ohio Homeland Security Task Force. Currently, the group is working on education of first responders and credentialing methods for volunteers in the time of disaster. Related to her work on the Trauma Committee and the Disaster Mental Health Team, Dr. Haller sits on the newly formed Hospital Preparedness for Children Group.

Oral Health Partnerships:

BOHS partners with the Ohio Dental Association (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 and case management program matches clients with dentists who provide discounted or donated care in their offices. The Bureau Chief is a member of the ODA's SubCouncil on Access to Dental Care and Dental Specialty Councils. The SubCouncil on Access successfully put forth resolutions supporting recommendations of the Director's Task Force on Access to Dental Care. BOHS staff work closely with the Anthem Foundation, the Osteopathic Heritage Foundations and the Sisters of Charity, three private foundations which are funding initiatives to increase access to dental care. BOHS staff are involved with over 13 community groups which have identified dental needs as a priority. These groups typically include local agencies such as: health departments, job and family services, WIC, EI, dental societies, community action agencies, and schools. BOHS also is collaborating with the Association of State and Territorial Dental Directors (ASTDD), the Indian Health Services (IHS) and local dental clinics to develop a web-based safety net dental clinic manual to provide technical assistance on starting and operating a non-profit clinic.//2004//

/2005/ Offices of Primary Care and Rural Health activities to serve the MCH population: The ODH strategic priorities for 2004 include a goal to Eliminate Health Disparities and increase health care providers in federally designated underserved areas. An additional 149 physicians are needed to serve the 1.6 million Ohioans residing in 79 designated areas. As part of continuing efforts to eliminate health disparities and improve access to health care for the MCH population, the Office of Primary Care placed 4 pediatricians, 3 OBGYNs, 1 Pediatric Nurse Practitioner, and 1 Certified Nurse Midwife in FY2003 through their 6 provider placement programs. From 7/1/2002 through 6/30/2003, 592,078 women and 775,918 children (unduplicated) were provided care from placed physicians.

F. HEALTH SYSTEMS CAPACITY INDICATORS

This section will discuss "health systems capacity" (formerly health status indicators 1, 2, 3, 6, 7, 8; performance measure 1; and developmental health status indicator 4.(5 pages limit)

Ohio has reported on all the below indicators in the Forms Section of this application. All data have

been reported. Data on the HSCI #9c is not available on a population level. We are using program data as a proxy.

#01 HEALTH SYSTEMS CAPACITY INDICATOR

The rate of children hospitalized for asthma (10,000 children less than five years of age) - Formerly Core Health Status Indicator #01 BCMH works closely with the ODH state Asthma program in assessing and collecting data on children with asthma in Ohio.

//2005/The Division of Family and Community Health Services continues to work with the ODH State Asthma Program in assessing and collecting data on children with asthma in Ohio. ODH is working with the Ohio Hospital Association and the Ohio Association of Children's Hospitals to obtain hospital discharge data on children with asthma. BCMH is working with the ODH State Asthma Program on an Asthma Pilot which hopefully will increase medication compliance and decrease emergency room visits and hospitalizations.//2005//

#02 HEALTH SYSTEMS CAPACITY INDICATOR

The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen. - Formerly Core Health Status Indicator #02A

//2005/The Division of Family and Community Health Services provides technical assistance in DFCHS funded projects to assist consumers in enrolling in 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.//2005//

#03 HEALTH SYSTEMS CAPACITY INDICATOR

The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. - Formerly Core Health Status Indicator #02B

//2005/Refer to #02 as SCHIP is part of the Medicaid Program. //2005//

#04 HEALTH SYSTEMS CAPACITY INDICATOR

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. - Formerly Core Health Status Indicator #03

//2005/The Kotelchuck Index combines two independent dimensions of prenatal care. It characterizes the timing of prenatal care initiation and the frequency of visits received after the initiation of prenatal care compared to ACOG recommendations. While the Kotelchuck Index is a valuable index in measuring the adequacy and timing of prenatal care, it does not measure the quality of prenatal care. The Division of Family and Community Health Services (DFCHS) recognizes the importance of the adequacy of prenatal care and has several program strategies to improve the measure. The DFCHS is funding and providing technical assistance to projects that employ community health workers to improve access to care through culturally competent care coordination. The BCFHS is also committed to ensuring that culturally competent is provided in its CFHS funded perinatal clinics. All CFHS subgrantees are monitored in their capacity to provide culturally competent care. An analysis that was done this past fiscal year revealed that many subgrantees do not provide ongoing cultural competency training for their providers and do not have access to training resources. As a result of this analysis, the DFCHS will work this next fiscal year to provide technical assistance

and training.//2005//

#05 HEALTH SYSTEMS CAPACITY INDICATOR

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. - Formerly Core Health Status Indicator #06

/2005/ODH typically receives information from the Medicaid Program in the Ohio Department of Job and Family Services. The information is used to identify and target higher risk populations for outreach and services. The Medicaid Program may not be able provide the data to ODH in time for the MCH Block Grant submission this year due to delays in processing the death files.//2005//

#06 HEALTH SYSTEMS CAPACITY INDICATOR

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women. - Formerly Core Health Status Indicator #07

/2005/ 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 for infants (0 to 1), children, and pregnant women annually. //2005//

#07 HEALTH SYSTEMS CAPACITY INDICATOR

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. - Formerly Developmental Health Status Indicator #04

/2005/ODH and ODJFS are working 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.//2005//

#08 HEALTH SYSTEMS CAPACITY INDICATOR

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program." - Formerly Block Grant Performance Measure #1 BCMH works with the Regional SSI office to determine numbers for this indicator.

/2005/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. //2005//

#09(A) HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data. - Formerly Core Health Status Indicator #08

/2005/The ability of Ohio to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and 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 Maternal and Child Health (MCH) Block Grant Health Systems Capacity Indicator #9(A), and will be addressed, over the three-year grant period, through seven project objectives:

1) To improve access to data linkages between Ohio birth records and Medicaid files; 2) To create data linkages between Ohio birth records and WIC eligibility files; 3) To obtain access to hospital discharge data; 4) To increase analyses of data from the Pregnancy Risk Assessment Monitoring System (PRAMS); 5) To increase analyses of data from the Youth Risk Behavior Survey (YRBS); 6) To 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; and 7) to provide quality data for MCH Block Grant performance measures and five-year needs assessment. //2005//

#09(B) HEALTH SYSTEMS CAPACITY INDICATOR #09(B)

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. - Formerly Developmental Health Status Indicator #05

/2005/

Ohio has been conducting the Youth Risk Behavior Survey (YRBS) since 1993; the most recent survey (2003) was 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. //2005//

#09(C) HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to determine the percent of children who are obese or overweight. - NEW

/2005/ ODH has the ability to collect data on overweight status of certain subpopulations of children who are obese or overweight, and has established a State Negotiated Performance measure on childhood overweight among the low income population of 0-5-year olds (WIC). Self-reported data on weight status of youth in high school are available from YRBS. Program staff are exploring ways to collect population based data on overweight among school-aged children. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

This section will provide an overview and background of Ohio's priorities, performance measure and program activities. (2 pages limit)

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

//2005/ See latest document.//2005//

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

- 1 -- (State 1): The unintended pregnancy rate per thousand in women of childbearing age.
- 2 -- (State 5): The percentage of low income children who are overweight.
- 3 -- (State 7): Percent of third grade children with obvious need for dental care.
- 4 -- (State 9): The percentage of children with elevated blood lead levels as defined by the Centers for Disease Control and Prevention.
- 5 -- (State 11): The low birth weight rate (LBW) per 100 live births.
- 6 -- (State 12): Implementation of a statewide Child Fatality Review (CFR) System. *//2005/To be retired end FFY 2004. //2005//*
- 7 -- (State 13): The ratio of black perinatal mortality rate to the white perinatal mortality rate.
- 8 -- (State 14): The reported cases of physical assault by current or former intimate partners (domestic violence).
- 9 -- (State 15): Percentage of children in Kindergarten and 1st grade failing a vision screening.
- 10 -- (State 16): Development of the role of the new Genetics in public health programs. *//2005/Reworded to: Assess the capacity to integrate genomics* into public health programs.//2005//*

B. STATE PRIORITIES

This section looks at the relationship among the priority needs, the National Performance Measures and the State Performance Measures, and the capacity and resource capability within Ohio. (5 pages limit)

Summary of Needs Assessment

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

Direct Health Care Services

1. Access for low-income women to high-risk perinatal and family planning safety net services
2. Access for low-income children and adolescents to dental care (including dental sealants)
3. Adolescent and family planning safety net services
4. Providers accepting Medicaid
5. Direct funding of payment for health care services for those portions not covered by other funding sources.
6. Special equipment for CSHCN
7. Home health care for CSHCN

8. Mental health services for CSHCN
9. Respite care for CSHCN
10. Specialized daycare for CSHCN
11. Nutrition services for CSHCN
12. Medical homes for CSHCN

Enabling Services

1. Assistance in the enrollment process for available health insurance plans
2. Targeted outreach efforts to bring high-risk women into early prenatal care
3. Culturally appropriate family planning materials
4. Prenatal smoking cessation programs
5. Programs that employ community health workers to improve access to care through culturally competent care coordination
6. Assistance in the enrollment process for available health insurance plans
7. Effective community-based outreach and enrollment strategies to ensure that children receive needed health care services through Medicaid/SCHIP
8. Information for families of CSHCN
9. Assistance with navigating benefits systems for families of CSHCN
10. Distance to specialty care

Population-Based Services

1. Public awareness about reproductive health and family planning services
2. Awareness among low-income women about the importance of early and continual prenatal care
3. Understanding among pregnant women of the harmful effects on the fetus from smoking during pregnancy
4. Public awareness about the following:
 - * Overweight children and healthy eating and exercise
 - * Community-based fluoride promotion
 - * Health effects of childhood lead poisoning
 - * Importance of early professional vision 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
5. Educational materials on immunizations that are low literacy and culturally sensitive

Infrastructure Building Services

1. Information and training for providers on the following:
 - * Breastfeeding
 - * Factors contributing to low and very low birth weight
 - * Culturally competent practices
 - * Identifying populations at risk for poor birth outcomes
 - * Domestic violence
 - * Pediatric obesity
 - * Oral health status, oral health resources, and access to dental care
 - * Blood lead screening policy
 - * Vision assessment
 - * Screening and referral
 - * Immunization schedule
 - * Adolescent risk assessment inventories
 - * Adolescent skill building and decision making models

- * Promotion of motor vehicle safety
 - * Healthy Start/SCHIP information
 - * Risk factors for adolescent suicide
 - * Suicide prevention initiatives
2. Quality data and information for policy development and program planning on the following:
 - * Smoking among pregnant women
 - * Access to early prenatal care, including high-risk
 - * Adequacy of prenatal care
 - * Effective outreach strategies
 - * Education needs of prenatal providers
 - * Low and very low birth weight factors and trends
 - * Rates of breastfeeding
 3. A plan for a statewide system for infant, child, and adolescent death review
 4. Information for legislators, policymakers, and MCH stakeholders on risk factors contributing to low birth weight and the effect of prenatal care on birth outcomes
 5. Understanding among prenatal service providers of the barriers to care that pregnant women face.
 6. Capacity among local public health agencies to conduct a community health assessment and planning process
 7. A plan for a statewide system for infant, child, and adolescent death review
 8. Quality data and information for policy development and program planning on the following:
 - * Childhood lead poisoning prevention
 - * Effective immunization outreach strategies
 - * Contributing factors for teen pregnancy and low birth weight
 - * Motor vehicle crashes
 - * Rate of uninsured children served through safety net health care programs
 - * Medicaid provider recruitment, training, and reimbursement
 - * Uninsured rates for children
 - * Medicaid eligible children receiving services
 - * Barriers to Medicaid enrollment
 9. Coordination/collaboration with ODHS regarding blood lead screening for Medicaid eligible children
 10. Collaboration among public and private agencies to coordinate immunization planning efforts
 11. Information for legislators, policy makers, and MCH stakeholders regarding contributing factors related to teen birth rates
 12. Coordination among complex government programs.
 13. Access to providers
 14. Continuity of care with the established provider for CSHCN
 15. Establishment of a network of providers in both urban and rural areas who are needed to diagnose and treat asthma and PDD
 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 (a) maternal and infant, (b) child and adolescent, and (c) CSHCN populations (B.1)
- II. Unified for the entire MCH population (B.2)

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

Maternal and Infant Health Issues Ranking

1. Very Low Birth Weight
2. Low Birth Weight
3. Perinatal Mortality
4. Births to Teens

5. Infant Mortality
6. Neonatal Mortality
7. Postneonatal Mortality
8. Neural Tube Defects
9. Maternal Mortality
10. Perinatal Transmission of HIV
11. Cesarean Sections

Child and Adolescent Health Issues Ranking

1. Oral Health Problems & Access to Dental Care
2. Overweight
3. Lead Poisoning
4. Tobacco Use
5. Alcohol Use
6. Teen Sexual Intercourse
7. Suicide Attempts
8. Vaccine-Preventable Diseases
9. STIs Ages 15 Through 19
10. Mortality Overall Ages 5 Through 14
11. Mortality Due to MV Crashes Ages 1 Through 14
12. Child Abuse and Neglect
13. Suicide Ages 15 Through 19
14. Mortality Overall Ages 1 Through 4
15. Anemia
16. Mortality Due to MV Crashes Ages 15 Through 24
17. Non-Fatal Injuries due to MV Crashes Ages 15 Through 24
18. Mortality Overall Ages 15 Through 19
19. Vision Problems & Access to Vision Care
20. Non-Fatal Injuries Due to MV crashes Ages 0 Through 15
21. HIV Ages 15 Through 19

Children with Special Health Care Needs

Health Issues Ranking

1. Gaps in Services
2. Coordination of Individual Services
3. Lack of Population-Based Data
4. Medical Home
5. Genetic Services
6. Information to Families
7. Health & Safety in Child Care
8. Infant Hearing
9. Systems Barriers
10. Family Participation in Title V
11. Uninsured Served by Title V
12. SSI Served by Title V

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

- * The overall mortality rate of children and adolescents should be reduced.
- * The incidence of low birth weight in infants should be reduced.
- * The infant mortality rate should be reduced.
- * The percentage of children and adolescents who are overweight should be reduced.
- * The percentage of teens in grades 9 through 12 who have had sexual intercourse should be reduced.

- * Policies and strategies should be implemented to facilitate coordination of services for CSHCN.
- * The gaps in services for CSHCN should be eliminated.
- * The percentage of children and adolescents who require oral health care and do not receive it should be reduced.
- * The percentage of teens who use tobacco should be reduced.
- * Population-based data for CSHCN should be established and maintained.

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 2001 MCH Block Grant 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 that were identified through that process and will formulate our research agenda for FFY 2001.

CPM 3, Medical Home

Conduct programmatic research and literature reviews to identify various methodologies used in the identification and quantification of children with special health care needs. Research the validity of these methodologies, particularly the definition of CSHCN that was utilized to identify and quantify these children. Collaborate with research and evaluation partners to determine the number of CSHCN in the state.

CPM 8, Motor Vehicle Death Rates (children ages 1 through 14)

Research available data sources, compare/contrast data components, and communicate results in order to identify at-risk populations, gaps in data, and opportunities for future programs.

CPM 11, CSHCN with a Source of Insurance for Primary and Specialty Care

Monitor data on enrollment rates of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

CPM 15, Very Low Birth Weight Live Births

Analyze association of Artificial Reproductive Technology, multiple births, and VLBW trends.

CPM 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.

CPM 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.

SNPM, Unintended Pregnancy

Identify characteristics of Ohio women experiencing unintended pregnancy and contributing factors (e.g., use of birth control) and communicate results to legislator/policy makers, and Family Planning Stakeholders.

SNPM, Children with Elevated Blood Lead Levels as Defined by CDC

Develop a new science based high-risk blood lead screening policy.

SNPM, Racial Disparity in Perinatal Mortality Rates

Identify subpopulations in the Black population at risk for poor birth outcomes.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 100 percent. The actual percent of newborns who are screened and confirmed with conditions mandated by the state and who receive appropriate follow up is 100 percent. Ohio met its target.

A. Monitor status of newborn screening cases (open and closed) from ODH Lab.

* ODH Genetics Section staff met with ODH Lab staff 6 times during FFY03 to reconcile open and closed cases with Genetics and Sickle Cell projects.

* ODH Lab staff reported on case closing activity at 3 Genetic Center Directors meetings and 3 Sickle Cell Center Directors meetings.

B. Actively participate in the Newborn Screening Advisory Committee meetings.

* ODH Genetics Section staff attended and participated in 3 Newborn Screening Advisory Council meetings.

* Genetics Section staff made recommendations for council membership to fill a vacancy for FFY05.

C. Fund, monitor, and evaluate activities of Regional Comprehensive Genetic Centers (RCGC) and Sickle Cell Projects through site visits, programmatic reports and data collection.

* Newborn screening rules were revised and approved to improve process for follow-up services and reporting back to ODH Lab.

* Programmatic reports were submitted timely and reviewed by Genetics and Sickle Cell Program Coordinators.

* Annual data summary reports were developed and distributed for Genetics and Sickle Cell projects.

D. Provide metabolic formula to individuals with PKU and homocystinuria without third party health insurance coverage that covers metabolic formula.

* ODH provided metabolic formula to 287 Ohio residents with PKU and homocystinuria.

* 71 of the 287 (25%) had no insurance coverage.

* Approximately 106 of the 287 (37%) had insurance, but their insurance did not cover metabolic formula.

b. Current Activities

A. Attend and participate in Newborn Screening Advisory Council meetings.

B. Evaluate operations of current metabolic formula program and make recommendations for program revision to be less ODH labor intensive and more cost efficient.

C. Participate in the development and implementation of Ohio's Integrated Perinatal Public Health Information System (IPPHIS), a common data portal for newborn and birth information.

D. Collaborate with ODH Vital Stats staff to train birthing hospitals to collect the newborn screening kit number via the Electronic Birth Certificate screening information.

c. Plan for the Coming Year

A. Convene work group of staff from Division of Family, Regional Comprehensive Genetics Centers, Regional Sickle Cell Services Projects and ODH Lab to draft definition of newborn screening follow-up for Ohio, including indicator(s) for measuring newborn screening follow-up for evaluation and reporting, and submit to the Newborn Screening Advisory Council for approval.

B. Review and evaluate Metabolic Formula Program operations and submit option(s) for program revision to ODH administration for determination of future program direction.

C. Collect baseline data on the reporting practices of primary care providers regarding newborn screening, i.e., their responsibility per Ohio Administrative Code to follow up on abnormal screening results of their patients.

D. Monitor progress of hospitals reporting of newborn screening kit number on electronic birth certificate (EBC).

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)

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 60 percent. The actual percent of CSHCN whose families partner in decision making at all levels and are satisfied with the services they receive was 59.3 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has not met its target.

A Parents partner closely with BCMH.

a. BCMH Parent Advisory Council expands and actively advises Bureau

* Membership now includes parent of Hispanic culture.

* Two Parent to Parent newsletters published, generated and edited by PAC

* Individual members of PAC contacted by BCMH parents because their names were published in Newsletters

* Parents on PAC testified at Budget Hearings to try to save BCMH cuts and then expressed their priorities regarding what to cut

b. BCMH included parents as part of Medical Home Learning Collaborative Pilot Practices

* Parents receive stipends to attend practice meeting and national learning collaborative meetings

* Parents of Learning Collaborative Practices speak at Medical Home trainings

c. BCMH and Bureau of Managed Health Care of Ohio Medicaid Present 4 workshops on Medical Home using parents on the team of presenters in every session

d. BCMH conducted 9 focus groups inviting CSHCN families from 6 different places in State to report satisfaction with medical services, satisfaction with health system, and reaction to the concept of medical home

* BCMH published a report of what families said in focus groups

* BCMH returned to those same locations within the year to further listen and assist B, Parents partner closely with DFCHS

a. BEIS, by policy, included family members as co-chairs of every Help Me Grow Committee

and as co-presenters of most HMG required trainings

- b. BEIS continued ongoing support of Family information Network which informs and supports family participation at the local level
- c. BFCHS received many positive comments in support of Specialty Clinics during BCMH focus group sessions

b. Current Activities

A. Develop and implement a plan to increase cultural diversity, family involvement, and financial support for parent activities and family member participation on more DFCHS advisory committees and task forces.

B. Develop and begin to implement a system of transition to adult health care as youth with special needs age out of the pediatric system.

c. Plan for the Coming Year

A. Increase financial and informational support for parents to participate in meetings of PAC, BCMH committees, DFCHS committees

B. Develop more methods of getting information to parents, over and above the Newsletters

C. Develop method to evaluate BCMH/BEIS joint venture in which PHNs are HMG service coordinators, relying heavily on family satisfaction

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)

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 55 percent. The actual percent of CSHCN who received coordinated, ongoing, comprehensive care within a medical home is 55.9 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. Parent focus groups facilitated by FAACT were held in 7 areas/regions around the state. The data were compiled by ODH/BCM/ODJFS. The report was shared with focus group participants and is now being prepared for distribution to state.

B. State medical home workgroup has combined with the Joint Ohio AAP/BCM Children with Disabilities Committee. This group has developed a "promise to the state." This will be implemented in FFY 2004.

C. BCMH has distributed education materials to physicians and parents of CSHCN on the medical home and related issues.

D. Joint regional meeting planned and facilitated by ODH BCMH and ODJFS BMHC in 4 regions of state to inform public health nurses, HMG service coordinators, and others of the medical home concept and local services.

E. Worked with the National AAP on medical home issues in Ohio.

F. BCMH facilitated and participated in the National NICQ Medical Home Training Collaborative. BCMH actively supported a large family practice group and a large pediatric

group in the training collaborative.

G. Began the analysis of national CSHCN survey/national and state data to be incorporated into state planning.

H. Worked with HMG/CFHS to promote the medical home within the Division of Family.

b. Current Activities

A. Survey and analyze data to determine quality of medical home for CSHCN in Ohio conjunction with FACCT.

B. Participate in the State Medical Home workgroup comprised of state administrators, statisticians, epidemiologists and parents to coordinate projects, share data and implement recommendations and strategies.

C. Ensure physicians and their patients receive education on the AAP Medical Home guidelines distributed via BCMH mailings to providers, parents newsletters and EI newsletters.

D. Develop Medical Home Pilots within Medical Home Learning Collaborative.

E. Contract with OSU to perform in-depth analysis of SLAITS survey for baseline measurement of the Medical Home. Contract with OSU.

F. Develop educational brochures for families. Work with PAC for appropriate "talking points" to empower parents to discuss medical home needs with current providers.

G. Develop speaker educational package and speakers bureau so that other programs who serve the CSHCN population such children seen in specialty clinic, BCFHS, Medicaid, BEIS, etc. teams can inform their providers and clients.

H. Use Cooley survey tool to develop satisfaction measures relative to medical home with the Medical Home Learning Collaborative pilot families and compare to non-pilot CSHCN families.

c. Plan for the Coming Year

A. Investigate feasibility of expanding Medical Home Pilots within Medical Home Learning Collaborative model to 3 new practices.

B. Perform in-depth analysis of CSHCN (SLAITS) survey for baseline measurement of the Medical Home. Contract with a university for biostatistics contract.

C. Distribution of speakers' educational package on Medical with input from the AAP joint committee on Children with Disabilities so that other programs who serve the CSHCN population seen in specialty clinic, BCFHS, Medicaid, BEIS, etc. teams can inform their providers and clients.

D. Use Cooley survey tool to develop satisfaction measures relative to medical home with the Medical Home Learning Collaborative pilot families and compare to non-pilot CSHCN families.

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)*

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 60 percent. The actual percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need is 60.8 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. Monitored data related to enrollment rates of uninsured BCMH treatment program recipients enrolled in Healthy Start (SCHIP) program and conducted analyzation related to reasons for non enrollment. BCMH coordinates benefits of children enrolled on the program. The BCMH Third Party work unit assists with Medicaid issues, and an account examiner worked with insurance companies and families of CSHCN to coordinate benefits. A data management analyst coordinated the BCMH insurance premium payment program and performed other cost analysis duties. BCMH staff referred all potentially eligible families and individuals to county department of Job and Family Services for Medicaid/Healthy Start eligibility determination. BCMH staff monitored data on Medicaid/Healthy Start drop off rates and analyzed reasons for drop-off. BCMH provides services for a significant number of Amish children who are uninsured and will not accept Medicaid assistance.

B. Paid health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services. BCMH paid private insurance premiums of \$89,403 for 26 children which saved the program \$379,629 in treatment service expenditures.

C. BCMH staff provided enrollment assistance for potentially eligible Healthy Start (SCHIP) children. BCMH coordinated the benefits for children enrolled on the BCMH program through direct intervention by the BCMH Nurse Case Managers and Resource Payment Specialists. Additional assistance was provided to children at the local level by public health nurses through public awareness contracts with 102 local health departments.

D. Collaborated with DFCHS bureau representatives to provide outreach to uninsured children. BCMH provided training to hospital based service coordination, child find specialists, local public health nurses, Early Intervention Specialists and school based nurses related to BCMH benefits and enrollment process. BCMH nursing administrator participates in the states dental OPTION program and Brain Injury Advisory Council as a member of these advisory committees.

b. Current Activities

A. Monitor data on enrollment of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

B. Pay health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services.

C. Provide enrollment assistance for potentially eligible Healthy Start (SCHIP) children.

D. Ensure collaboration between BCMH, BCFHS, and BEIS for outreach to uninsured children identified through BCFHS Specialty Clinics, the BCMH Diagnostic clinics, and BEIS Programs.

c. Plan for the Coming Year

- A. Monitor data on enrollment of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.
- B. Pay health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services.
- C. Provide enrollment assistance for potentially eligible Healthy Start (SCHIP) children through collaboration with local public health nurses and Team Service Coordinators located at the Children Hospitals.
- D. Ensure collaboration between BCMH, BCFHS, and BEIS for outreach to uninsured children identified through BCFHS Specialty Clinics, the BCMH Diagnostic clinics, and BEIS Programs.

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)*

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 80 percent. The actual percent of youth who received the services necessary to make transition to all aspects of adult life was 80.2 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. BCMH conducted 9 family focus group throughout the state. These focus groups were designed to assess the parents of CSHCN awareness and understanding of medical home concept. The results of the focus group identified issues related to access to community based services. BCMH has analyzed the focus group results and shared this information with various stakeholders (i.e., families, local health departments, hospitals, medical providers, other ODH bureaus and ODJFS). The survey results are being used to respond to concerns of parents related to community based services and to assist with capacity building. The survey summary is available on the ODH website, www.odh.state.oh.us.

b. Current Activities

A. BCMH through its Public Awareness contracts with 102 local public health departments nurses provided information to families related to the availability of local services and resources utilizing direct contact, print media, radio and television announcements.

c. Plan for the Coming Year

A. Provide assistance through Public Awareness contracts with local health departments to inform families of community-based services.

B. Conduct educational activities with local public health nurses, hospital based service coordination related to public awareness activities for informing families of community based services.

C. Follow upon specific recommendations from parent focus groups to assist policy makers in funding for specific community-based services.

Performance Measure 06: *The percentage of youth with special health care needs who received*

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 10 percent. The actual percent of youth who received the services necessary to make transition to all aspects of adult life was 5.8 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio did not meet its target.

A. Conducted interviews with various stakeholders related to transition activities and opportunities for youth.

b. Current Activities

A. Collaborated with CSHCN stakeholders to assess transition activities for adolescent from pediatric to adult oriented healthcare. BCMH held meetings with hospital based team service coordinator to discuss transition activities and ways to strengthen successful transition outcomes.

B. Support transition activities of BCMH hospital-based team service coordinators through funding, educational activities and monitor inclusion of transition plan an annual service coordination plan.

c. Plan for the Coming Year

A. In state fiscal year 05 the ODH sickle cell program, is requiring each of its grantees to address a transition performance indicator that estimates the number of adolescents that have a written transition plan in place which addresses needed services, provider of services and how services will be financed.

B. Conduct 3 adolescent focus groups related to transition.

C. Collaborate with Cincinnati Children's Hospital to develop an adult transition service coordination component for adolescent clients with cerebral palsy and myelomeningocele served by the hospital based clinics.

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.

a. Last Year's Accomplishments

The target for Calendar Year 2002 for the 4:3:1:3 series was 75 percent. The actual percent of 19 to 35 months olds who received the full schedule of appropriate immunizations for age was 75. Ohio has met its target.

A. Monitor immunization data from DFCHS-funded clinics.

* 39 CFHS clinics received comprehensive monitoring visits in 2003. Match data was used when evaluating immunization data, during the desk audit, prior to the comprehensive monitoring visits. Collaboration occurred with the Division of Prevention's Immunization Program to analyze and report data.

B. Promote immunization compliance for children under age 2 with DFCHS funded clinics.

* 48% of the 79 counties with CFHS funded clinics have chosen an immunization focused performance measure as a strategy. Activities and services, to promote immunization compliance, include: Literature distributed at various health fairs and immunization and well

child clinics; Networking with local pediatricians and their professional staff to assure all children receive childhood immunizations per recommended guidelines; Health promotion campaign in partnership with the county Help Me Grow, WIC, Head Start and early education and day care centers to provide immunization education; Partnership with the Department of Job and Family Services and Children's Day Care Centers to develop educational immunization program for home based day care providers; Meetings with providers and their professional staff to communicate latest information on childhood immunizations per Maximizing Office Based Immunization (MOBI) presentations.

C. Provide and monitor the use of culturally competent educational materials on the importance of immunizations to various population groups within DFCHS-funded clinics.

* Child and Family Health Services, WIC and Early Intervention all have Cultural Competency requirements in their Request For Proposals. All grant applications must complete a cultural competency checklist or describe how their program is culturally sensitive to their clients. All subsequent monitoring visits include review and evaluation of culturally sensitive brochures, advertisements and activities.

D. Collaborate and coordinate immunization planning and programming efforts with State, National, and local health professionals.

* Immunization Action Project targeted eleven WIC clinics. The Department of Prevention sends a consultant to the WIC clinics to screen and counsel clients regarding immunization completion.

WIC clinics' immunization data is uploaded to State WIC. State WIC program consultants review the information and then contact the county clinics with the immunization screening rates.

b. Current Activities

A. Monitor immunization data from DCFHS funded programs including CFHS, Primary Care clinics and WIC.

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

C. Promote immunization compliance within DCFHS funded programs.

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

c. Plan for the Coming Year

Monitor immunization data from DCFHS funded programs including CFHS, BCMH, Primary Care clinics and WIC.

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

Promote compliance, within DCFHS funded programs, of the immunization schedule according to the MCHBG series.

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 21.5 births per 1,000. Ohio's actual rate was 19.9. Ohio met its target.

A. Identify and communicate best practices to DCFHS funded projects regarding clinics that serve adolescents (e.g. CFHS and other community-based clinics).

B. Identify and communicate results regarding model risk assessment inventories that identify at risk adolescents to DFCHS funded agencies.

C. Identify successful skill building models (e.g. mentoring, peer training) and communicate best practices to DCFHS funded projects.

* ODH sponsored the 3rd Annual Community Care Coordinators Conference July 31st & August 1, 2003. The 206 attendees included community care coordinators, outreach professionals, lay home visitors, nurses, social workers, case managers, and supervisors.

D. Partner with community and parent groups (e.g. abstinence only education programs) to encourage age-appropriate adolescent health programs that encourage responsible health decision-making.

* The ODH Abstinence Only Education Program co-sponsored Ohio's first Statewide Abstinence Conference -- "Giving Hope?Getting Results."

* Abstinence Only Education Program subgrantees held meetings throughout Ohio to share and disseminate abstinence until marriage messages and programming.

E. Educate legislators, policy makers, community leaders, local programs, and agencies regarding contributing factors (e.g. lack of access, confidentiality) relating to birthrate to teens ages 15-17.

F. Collaborate with DFCHS funded agencies and other public health agencies to encourage teen sexual activity postponement.

* Ashland CFHS program activities: LEAPER Program (Learn that Early Abstinence Promotes Esteem and Respect) was presented and completed with Catholic Charities for Ashland City schools and current program being developed in collaboration with Ashland Parenting Plus to include all city schools.

* Fulton CFHS program activities: The GCHS participates in teen pregnancy prevention activities by providing asset building activities in the after school program and through projects such as Baby Think It Over.

G. Fund, monitor, evaluate and provide technical assistance to family planning sites to ensure quality service.

* Monitoring and home visits were completed to five OIMRI Community Care Coordination Programs

H. Identify hard to reach teen populations and contributing factors for teen pregnancy, and communicate results with DCFHS funded projects.

I. Collaborate with Ohio's Abstinence-Only Education programs to share resources and materials and to promote training opportunities for state and local agency staff.

* The ODH Abstinence Only Education Program co-sponsored National Certification Training Seminar -- "Teaching the Whole Person about Love, Sex and Marriage."

b. Current Activities

- A. Conduct resource mapping process to identify counties with increased pregnancy rates and match to community resources for those counties.
- B. Identify through survey to Local Health Departments, CFHS clinics, Family and Children First Council and FQHC's, types of prevention programs targeted to adolescents and communicate results to partners.
- C. Convene an internal ODH work group to share adolescent programming resources in their respective service areas.
- D. Educate policy makers, community leaders, local programs and agencies regarding contributing factors relating to birthrate to teens 15-17 and available resources.
- E. Collaborate with DFCHS funded agencies and other public health agencies to encourage teen sexual activity postponement.
- F. Fund, monitor, evaluate and provide technical assistance to family planning sites to ensure quality service.

c. Plan for the Coming Year

- A. Conduct resource mapping process to identify counties with increased pregnancy rates.
- B. Identify types of prevention programs targeted to adolescents.
- C. Convene an internal ODH work group to share adolescent programming resources in their respective service areas.
- D. Collaborate with DFCHS funded agencies, The Office of Abstinence Education, and other public health agencies to share resources and materials and to promote training opportunities to encourage teen sexual activity postponement.
- E. Fund, evaluate and provide technical assistance to family planning projects that provide services to adolescents to improve preconception, inter-conception periods and identify risk reduction activities that can reduce births to 15-17 girls.
- F. Identify characteristics of teens with poor outcomes in the counties with increased pregnancy rates.
- G. Compile Data Fact Sheets on state-level birthrates and state/county level STD's and share with partners.

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 38 percent. The actual percent of third grade children who received sealants was 39.9. Ohio has met its target.

- A. Expanded currently funded school-based and school-linked dental sealant programs to reach additional high-risk children in Ohio. Technical assistance was provided for the expansion of three existing sealant programs (Columbiana, Jackson/Vinton, and Athens) and to

three communities interested in starting new dental sealant programs (Elyria, Scioto and Allen). In addition, Tobacco Settlement monies were used to help start a large school-based sealant program in the Cleveland City Schools using dental students from Case Western Reserve University to place the dental sealants. A Sealant Sharing Day was held in August 2002 for the benefit of new school-based dental sealant programs funded by ODH. Two of the long-standing programs assisted with the program. Technical assistance about appropriately billing Medicaid was provided to the dental sealant programs.

Information on companies to contract with to bill Medicaid or to help identify Medicaid numbers for students was provided to the dental sealant programs.

B. Continued to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs. Eighteen school-based dental sealant programs were funded and served 30,622 students in 43 counties. Monitoring was accomplished via quarterly program and expenditure reports.

On-site monitor visits were conducted with three new dental sealant programs (Elyria, Scioto Co., Lima) and one long-established program (Toledo). All programs received technical assistance via phone calls and e-mail.

b. Current Activities

A. Expand currently funded school-based and school-linked dental sealant programs to reach additional high-risk children in Ohio.

1. Provide technical assistance to agencies that express interest in expanding existing dental sealant programs.
2. Facilitate/coordinate sharing and learning opportunities for sealant subgrantees to exchange successful programmatic and clinical practices to continually improve the quality and efficiency of services (sealant sharing day).
3. Provide technical assistance to sealant programs that have difficulty obtaining maximum reimbursement for dental sealants provided to children who are eligible for Medicaid.

B. Continue to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.

1. Fund 17-19 school-based dental sealant programs.
2. Monitor all sealant programs via quarterly program and expenditure reports to assure that programs are operating within acceptable standards. Receive quarterly program reports electronically.
3. Conduct on-site monitor visits with programs selected on the basis of program needs/concerns.
4. Provide consultation and technical assistance to all funded programs as needed to improve programs operations and fiscal stability.

c. Plan for the Coming Year

A. Expand currently funded school-based and school-linked dental sealant programs to reach additional high-risk children in Ohio.

B. Continue to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 2.5 deaths per 1000,000 children. Ohio's actual rate was 3.4. Ohio did not meet its target.

A. Monitor the rate of deaths and analyze the contributing factors of motor vehicle crash fatalities for children.

* The rate of deaths and the contributing factors of motor vehicle crash fatalities for children have been monitored and analyzed via child death review data. Child fatality review identifies the contributing factors related to motor vehicle crashes deaths of children under 18 years of age. In 2002, 154 reviews were conducted for children who died in motor vehicle crashes. Recklessness was cited in 22 percent of the deaths. Lack of restraints and speeding were cited in 19 percent of the deaths. In 61% of the deaths, the driver was younger than 18 years of age.

B. Examine Child Fatality Review data and share results with DFCHS-funded subgrantees that work with teens.

* CFR data has been shared throughout the division during meetings and overlapping work groups. The Annual Report has been distributed throughout ODH and is available on the ODH website.

C. Collaborate with injury programs within ODH and other state agencies to assess, develop, and implement strategies to decrease motor vehicle injuries and deaths among children.

* A Motor Vehicle Death subgroup has been formed with members from ODH, Public Safety, law enforcement and coroners groups, to share information and develop prevention strategies. A representative from Department of Public Safety presented a session on "Rural Issues, Injuries, and Motor Vehicles" at the Child Fatality Review Second Annual Training.

D. Promote statewide education to increase awareness and proper use of safety devices to prevent deaths to children caused by motor vehicle crashes.

* Statewide education was promoted to increase awareness and proper use of safety devices to prevent deaths to children caused by motor vehicle crashes. Education on the proper use of safety devices provided through the newborn home visiting program in Help Me Grow, through the Child and Family Health Services clinics in MCH and through various programs in DOP's injury Prevention Program. A training video for parents of teenagers learning to drive has been distributed through the driver training courses throughout the state by the Adolescent Health Program.

b. Current Activities

A. Monitor the rate of deaths and analyze the contributing factors of motor vehicle crash fatalities for children.

B. Examine state Child Fatality Review (CFR) data and share the results with ODH programs, other state agencies and local child health partners.

C. Encourage local CFR boards to share motor vehicle data with local agencies who provide services for children.

D. Collaborate with injury programs within ODH and other state agencies to develop strategies to decrease motor vehicle injuries and deaths among children.

E. Provide resources and information to professionals on child vehicular safety including the proper use of safety devices.

c. Plan for the Coming Year

A. Monitor the rate of deaths and analyze the contributing factors of motor vehicle crash fatalities for children.

B. Examine state Child Fatality Review (CFR) data and share the results with ODH programs, other state agencies and local child health partners.

C. Encourage local CFR boards to share motor vehicle data with local agencies who provide services for children.

D. Collaborate with injury programs within ODH and other state agencies to develop strategies to decrease motor vehicle injuries and deaths among children, including the proper use of safety devices.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 65 percent. The actual percent of Ohio mothers who breastfed their infants at hospital discharge was 63.7. Ohio has not met its target.

A. The Ohio Department of Health (ODH) has 3 Lactation Consultants on staff. Two within the WIC program and one within the BCFHS.

B. There is a breastfeeding best practice policy that all of our programs providing health care to pregnant and lactating women use that is standard.

C. ODH provides a training opportunity annually for all practitioners interested in learning the basics of supporting breastfeeding.

D. ODH monitors breastfeeding rates using the ROSS mother's survey, WIC (PEDNSS) and CFHS MATCH data information.

E. The Medicaid health card provides coverage for breastfeeding supplies.

F. ODH has suggested best practice and monitors, through Maternity Licensure survey that all delivering facilities and nurseries have a lactation consultant on staff.

G. WIC, BEIS and BCFHS encourage community resource lactation consultant use and availability.

H. ODH Breastfeeding committee has worked on an initiative (currently not complete) to provide workplace policy/information to support and promote breastfeeding returning mothers.

b. Current Activities

A. Collect and monitor Ohio breastfeeding rates.

B. Provide education and technical assistance regarding breastfeeding to DFCHS funded projects.

C. Work with local and national maternal and child health stakeholders to promote Breastfeeding.

c. Plan for the Coming Year

A. Participate in the ODH Breastfeeding Committee. (BCFHS, BNS, BEIS, BCMH, BSHIOS, BOHS)

B. Assess what is currently being done to promote Breastfeeding in Ohio through the ODH Breastfeeding Committee. (BCFHS, BNS, BEIS, BCMH)

C. Observe World Breastfeeding Week through a display in the ODH lobby. (BNS)

D. Provide information to CFHS projects regarding "Back to Basics" training and encourage attendance. (BCFHS)

E. Fund 6 RPEC projects to promote breastfeeding throughout their perinatal regions. (BCFHS)

F. Support and encourage hospitals to achieve baby friendly certification.

G. Support and encourage mother friendly workplace policies.

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 8 percent. The actual percent of newborns who have been screened for hearing before hospital discharge was 92% for the month of July 2004. Ohio has met its target.

A. Software problems delayed the implementation of the Early Track Information System which will collect and track data on newborn hearing screening.

B. Implement HB 150, which mandates universal newborn hearing screening (UNHS) for all newborns by June 2004.

* Collect, analyze, and disseminate information about UNHS. All of Ohio's 124 birthing hospitals, 9 children's hospitals and 1 birthing center have begun implementing UNHS programs prior to July 1, 2004. During the period January to July 2004, 53,184 screening results were reported to ODH, with a referral rate of 4.7%

* Provide training and technical assistance to hospitals with nurseries that are establishing UNHS programs. UNHS training sessions held at six regional sites in 2003 for 260 representatives from 112 hospitals. Technical assistance provided throughout the year and a video of the UNHS training was available. Mailings sent re: law (HB 150), regulations and guidelines for hearing screening protocols.

C. Increase public awareness about the need for newborn hearing screening and appropriate follow-up.

* Produce or purchase literature about deafness and reduced hearing acuity and communication methodologies. New "Sounds of Life" video distributed to hospitals explains UNHS and illustrates actual screenings on newborns. "Parent Information about UNHS" is a multi-colored easy to read, tri-fold brochure that hospitals give to parents before discharge.

Presentations: Ohio Speech-Language-Hearing Association, Ohio University's speech and

audiology students, Ohio County Boards of Health, the Ohio Hospital Association, the Ohio School for the Deaf's Family Learning Weekend, a Toledo area professional meeting, an RN Coordinators Conference for Specialty Clinics and a regional meeting held at Cincinnati Children's Hospital. Displays: national Early Hearing Diagnosis and Intervention conference, Ohio Academy of Audiology conference.

The UNHS Subcommittee provided input on the video and brochure for parents, considered how to meet Part C's hearing testing requirements, and discussed other issues.

D. Monitor the Regional Infant Hearing grant program that includes tracking and follow-up of infants referred on for diagnostic testing and provision of habilitative services for infants and toddlers who are deaf or hard of hearing.

The Audiology Consultants gave technical assistance to the nine Regional Infant Hearing Programs, reviewed reports submitted and held quarterly meetings of grant project directors. Eight Ohio audiologists were awarded grants to participate in an intensive training in Auditory Evaluation for Infants by the National Center for Hearing Assessment and Management (NCHAM). They will conduct regional workshops for Ohio audiologists in 2004.

b. Current Activities

A. Implement and monitor the Early Track (ET) Information System which will collect and track data on universal newborn hearing screening through the Electronic Birth Certificate data submitted by birthing hospitals.

B. Provide technical assistance and consultation to hospitals which are establishing Universal Newborn Hearing Screening Programs.

C. Increase primary care physician awareness of UNHS and the importance of screening and appropriate follow-up.

D. Continuing convening the Infant Hearing Sub Committee of the BCMH Medical Advisory Committee in order to obtain input and feedback on newborn hearing screening issues.

E. Fund, monitor and evaluate Regional Infant Hearing Programs to conduct follow up and tracking of newborn hearing screening referrals, and provide habilitative services to children identified with a hearing loss up to the age of three years.

F. Incorporate a genetics component as a standard of care for children identified with hearing impairments.

G. Develop video for parents to view to show importance of UNHS.

c. Plan for the Coming Year

A. Monitor and analyze the data on universal newborn hearing screening submitted by birthing hospitals.

B. Provide technical assistance and consultation to hospitals conducting Universal Newborn Hearing Screening programs.

C. Increase outreach to primary care and specialty physicians regarding Universal Newborn Hearing Screening, the follow-up and habilitative services provided through the nine Regional Infant Hearing Programs (RIHP), and the need for communication and coordination between families/physicians/audiologists and RIHPs.

D. Fund, monitor and evaluate through data and site visits the Regional Infant Hearing Programs that follow-up on newborn hearing screening referrals and provide habilitative services to children (up to three years) identified with a hearing loss.

E. Evaluate the effectiveness of the follow-up process by the Regional Infant Hearing Programs.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 9.8 percent. The actual percent of children without health insurance was 7.8. Ohio has met its target.

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.

* In FFY02, CFHS child health clinics served 19,994 uninsured children in 26,455 health care visits.

* FQHCS provided 11,730 health care visits for children.

* Clinics funded by the Health Priority Trust Funds provided 10,914 health care visits for children.

* Seven BOHS funded Safety Net Dental Care programs reported 6,435 dental visits for mothers and children who were uninsured and paid for services using the sliding fee schedule offered by the programs.

* BCMH paid Medicaid Spenddown for 15 children on the Treatment Program.

B. Monitor data regarding the rate of uninsured children through the Current Population Survey.

* An Analysis by the Children's Defense Fund of the recently released (September 2003) Current Population Survey by the U.S. Census for 2002 reveals that 8.9 percent (270,000 est.) children are uninsured in Ohio. In 2001, 8.0 percent of the children were reported uninsured in Ohio's MCH annual report.

C. Work with DFCHS funded projects to provide technical assistance on how to educate and inform consumers to understand and navigate the health care system.

* Child and Family Health Services program funds 79 local agencies and 10 Ohio Infant Mortality Reduction Initiative projects to provide care coordination services to clients and their families.

* Help Me Grow distributed nearly 200,000 publications called Help Me Grow: A Wellness Guide for Mother's-To-Be and Their Babies and Health Diary

* BOHS was awarded a HRSA State Oral Health Collaborative Systems (SOHCS) grant, which includes developing oral health screening, educational and referral information for use by HMG coordinators.

* BCMH Parent to Parent Newsletter regularly focuses on providing updates on Health Start/Health Families.

* BCMH initiated a Pilot Project with several Children's Hospital Pharmacists to collaborate with Managing Physician Pediatric Pulmonologists to monitor prescription drug use for asthmatic children to improve treatment outcomes.

* BCMH's Third Party Staff followed-up with problems reported by families in getting prescriptions filled by pharmacies.

* BCMH/BMHC (Bureau of Managed Health Care) Regional Trainings sponsored workshops on community resources for CSHCN families in spring 2003.

* Every pregnant, postpartum and breastfeeding woman, infant, and child (under the age of five) is screened at every initial and subsequent WIC certification to determine if an application

needs to be taken and sent to Medicaid/CHIP. There are over one-half million screenings per year in the 230 WIC clinics throughout all 88 of Ohio's counties.

* Ohio WIC program increased its income eligibility guidelines in conjunction with the increase in Ohio Medicaid/Healthy Start income guidelines.

b. Current Activities

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.

B. Monitor data regarding the rate of uninsured children through the current population survey.

C. Work with DFCHS funded projects to provide technical assistance on how to educate and inform consumers to understand and navigate the health care system.

c. Plan for the Coming Year

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.

B. Monitor data regarding the rate of uninsured children through the current population survey.

C. Work with DFCHS funded projects to provide technical assistance on how to educate and inform consumers to understand and navigate the health care system.

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 82 percent. The actual percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program was 89.9. Ohio met its target.

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

* For FFY99, according to the latest CMS (HCFA)-416 report, HEALTHCHEK (Ohio's EPSDT program) percent of initial periodic screening services was 49% (391,516 receiving at least one screening of 841,821 expected number to be screened) of the children enrolled in Medicaid/Healthy Start.

* In FFY02, CFHS provided health care services to 52,055 children who were potentially Medicaid/Healthy Start eligible. Analysis of the MATCHr data shows that 72.3% of the children who received CFHS services had services paid by Medicaid/Healthy Start.

* For FFY99, according to latest CMS (HCFA)-416 report, 215,773 total Medicaid eligible children received dental preventive services.

* Seven BOHS funded Safety Net Dental Care grant programs reported billing Medicaid and Medicaid MCOs for 15,623 visits/encounters in FFY2003.

B. Provide assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.

* Child Care Health Consultants provided child care centers with Healthy Start applications and educational materials to parents and staff.

* OPTIONS referred over 3241 patients to existing systems of dental care, such as Medicaid providers, dental safety nets, and sources of emergency care.

- * The Third Annual Community Care Coordination Conference, Building Unity in the Community: Caring, Sharing and Empowering was held on July 31 & August 1, 2003.
- * School and Adolescent Health Services provided information to 130 school nurses at the New School Nurse Orientation regarding the Healthy Start/Healthy Families.

C. Collaborate with interdepartmental, state, local agencies and initiatives to provide technical assistance, publicize and disseminate Healthy Start information to providers, consumers, and employers.

* Agreement with the Department of Job and Family Services (ODJFS) was reached to establish Medicaid Administrative Claiming (MAC) for public health activities that support the efficient administration of the Medicaid program. A work plan has been developed by ODJFS including timelines which take the project to completion.

* DCFHS provided a leadership role in establishing the Community Care Coordination Collaborative (C4) which is a statewide coalition focused towards improving access to health care services and enrolling children and families in Healthy Start.

* DCFHS collaborative efforts included participation in the state/local coalition of the Ohio Children's Defense Fund's Covering Kids and Families Initiative funded by the Robert Wood Johnson Foundation, and local Joint Medicaid/Healthy Start Advisory Councils in the mandatory managed care counties.

b. Current Activities

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

B. Provide assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.

C. Collaborate with interdepartmental, state, local agencies and initiatives to provide technical assistance, publicize and disseminate Healthy Start/Healthy Families information to providers, consumers, and employers.

c. Plan for the Coming Year

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

B. Provide assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.

C. Collaborate with interdepartmental, state, local agencies and initiatives to provide technical assistance, publicize and disseminate Healthy Start information to providers, consumers, and employers.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 1.4 percent. The actual percent of very low birth weight infants among all live births was 1.6 percent. Ohio did not meet its target.

A. Collaborate with the Ohio Section of ACOG and other perinatal health stakeholders to identify and implement a stress scale tool in DFCHS funded clinics.

B. Collaborate with the Ohio Section of ACOG to identify and implement strategies that impact VLBW.

C. Implement a perinatal risk assessment.

* The Department of Jobs and Family Services prenatal risk assessment is being used as the screening tool in all CFHS programs. In addition, ODH employees have been trained on Domestic Violence and psycho-social screening activities and a tool is being developed for the opportunity to appropriately refer to services.

D. Involve the Regional Perinatal Centers in evaluating Ohio's perinatal health care planning activities.

* The six regional perinatal centers have convened a Perinatal Data Use Consortium comprised of perinatal providers and stakeholders. The purpose of the consortium is to use existing data sources to evaluate the health care activities for the region. These meetings have resulted in better psycho-social screening and referral in the Cleveland area; Educational programs in the Toledo and Akron area; the development of Help Me Grow collaboration in the Dayton area; education and implementation of best-practice protocol toward improved data collection in the Columbus area; neonatologists in Cincinnati are using PPOR data to develop community based.

* Perinatal Data Use Consortium teams are using the Perinatal Periods of Risk approach to mobilize and prioritize prevention efforts. The Perinatal Periods of Risk Approach has six major steps for addressing fetal-infant mortality: engage community partners early to gain consensus and support; map fetal-infant mortality by birth weight and age; focus on reducing the overall fetal-infant mortality rate; examine potential opportunity gaps between population groups target further investigations and prevention efforts ; and mobilize for sustainable systems change.

b. Current Activities

A. Partner with the March of Dimes on the national campaign regarding Prematurity.

B. Implement Phase II of the PP or R methodology to enhance information from birth outcome data in order to target DFCHS resources and inform stakeholders.

C. Collaborate with the Ohio section of ACOG to identify and implement strategies that impact very low birth weight.

D. Partner with OPCA, TUPAC, March of Dimes, to develop and implement a standardized training program for prenatal smoking cessation.

E. Conduct an assessment of the effectiveness of CFHS programs to impact birth outcomes.

c. Plan for the Coming Year

A. Partner with the March of Dimes on the national campaign regarding prematurity.

B. Implement the 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 Division of Family and Community Health Services (DFCHS) resources.

C. Collaborate with the Ohio section of the American College of Obstetricians and Gynecologists (ACOG) to identify and implement strategies that impact birth outcomes.

D. Partner with the Tobacco Use Prevention Control Foundation (TUPCF), March of Dimes, and other stakeholders to develop and implement strategies for perinatal smoking cessation.

E. Conduct an assessment of the effectiveness of Child and Family Health Services (CFHS) programs to impact birth outcomes.

F. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

G. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 6.5 deaths per 100,000. The actual rate was 5.7. Ohio met its target.

A. Examine Child Fatality Review data and share results with DFCHS funded grants that work with teens.

* The 2003 Child Fatality Review Report that contains information on child death reviews conducted in calendar year 2002 was published and distributed to various stakeholders including the governor and the legislative leadership. The report was also available in PDF format on the ODH website and was accessible through the Ohio Public Library System. The report included local board recommendations to reduce the risks associated with suicide and recommendations to prevent future suicides.

B. Monitor and share information on county teen suicides to DFCHS projects.

* Conducted training to new Public Health Nurses on teen suicides in Ohio. There were nurses present from local health districts throughout Ohio.

C. Provide training and distribute educational materials to those CFHS sub-grantees that have identified adolescent suicide as a community priority.

* The video "Lights in the Darkness" was distributed to all CFHS subgrantees that provide Child Health service.

* Eight CFHS projects (10%) determined that adolescent suicide was a priority in their community after conducting a needs assessment. The projects implemented various enabling, population based and infrastructure activities to address the issue.

D. Collaborate with the Ohio Suicide Prevention Coalition

* The ODH is a member of the state Suicide Prevention Team (SPT). The SPT is working on various plans to improve identification and referral of depressed youth and adults.

* The ODH co-sponsored a state wide suicide prevention symposium with the Ohio Department of Mental Health. Over 250 participants comprised of medical professionals, families, community based agencies, and mental health providers attended the event with positive feedback.

E. Collect and distribute adolescent depression educational materials and screening/assessment tools to DFCHS funded projects.

* Lights in the Darkness video and curriculum on depression awareness was sent out to 144 local health departments and 80 CFHS clinics.

F. Collaborate with the Ohio Department of Mental Health in distributing the teen depression video and curriculum to all interested high schools in Ohio.

* ODH is partnering with ODMH to support the local mental health coalitions which provide training and services to area schools.

* ODH is partnering with ODE and ODMH to continue in supporting the screening for depression of youth in Ohio's schools. Currently the Columbia Teen Screen is being used as a pilot in school districts within two Ohio counties. Results from the counties indicated a large percentage of high school students that needed referral and approximately 100 high school students that needed immediate hospitalization for depression.

b. Current Activities

A. Conduct resource mapping process to identify counties with increased teen suicide rates and match to community resources for those counties.

B. Examine Child Fatality Review data and share results with DCFHS funded grants that work with teens.

C. Educate Pediatricians, Local Health Departments, CFHS clinics and FQHC's in the identification of mental health issues and proper referral for treatment.

D. Collaborate with the Ohio Department of Mental Health and the 10 regional mental health coalitions to identify and support depression awareness and intervention activities to target groups (i.e., school nurses, school staff, community coalition groups).

E. Collaborate with the Suicide Prevention Committee and share state wide strategies.

c. Plan for the Coming Year

A. Conduct resource mapping process to identify counties with increased teen suicide rates.

B. Examine data, including Child Fatality Review, Youth Risk Behavior Survey, and Vital Statistics, and share results with DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

C. Conduct activities aimed to educate Pediatricians, Local Health Departments, CFHS clinics and FQHC's in the identification of mental health issues and proper referral for treatment.

D. Collaborate with the Ohio Department of Mental Health and the 10 regional mental health coalitions to identify and support depression awareness and intervention activities to target groups (i.e. school nurses, school staff, community coalition groups, school based mental health).

E. Collaborate with the Suicide Prevention Team and share state wide strategies.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 71 percent. The actual percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates was 70.5. Ohio has not met its target.

A. Provide technical assistance to the Regional Perinatal Centers to assure that they provide education to perinatal care providers regarding high risk mothers receiving appropriate prenatal

care.

* There have been two, two-day conferences for the regional perinatal centers regarding data use and the perinatal periods of risk approach to data dissemination. Each of the six regional perinatal projects has received at least one technical assistance in FY2003.

B. Fund and monitor regional outreach and education programs to monitor outcome of VLBW babies are delivered by level of hospital and assure that high-risk mothers are appropriately transferred for delivery.

* ODH provides funding for six regional perinatal centers to implement such activities as collecting transport information; assisting the local hospitals of their region to understand the SB50 reporting requirements; and the ACOG recommendation of appropriate birth facility relative to the risk of the mother and fetus.

C. Assure that BCFHS funded perinatal clinics assess the risk of their client and refer them to high-risk facilities when appropriate.

* All 61 CFHS perinatal projects have been trained to use the Medicaid perinatal risk assessment tool. All projects are compliant with assessing risk and referring the client appropriately.

b. Current Activities

A. Conduct research to determine why all VLBW babies are not born at high risk facilities and share results with Regional Perinatal Centers and other stakeholders.

B. Analyze CFHS Birth Outcomes information to determine the demographics of VLBW babies to monitor the appropriateness of the delivery facility.

C. Implement Phase II of the Perinatal Periods of Risk methodology to enhance information from birth outcome data in order to target DFCHS resources and inform stakeholders.

c. Plan for the Coming Year

A. Analyze birth outcomes information to determine the demographics of very low birth weight babies to monitor the appropriateness of the delivery facility.

B. Implement the 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 Division of Family and Community Health Services (DFCHS) resources.

C. Fund, provide technical assistance, and monitor the success of the Regional Perinatal Centers (RPCs) in meeting the competitive federal fiscal year 2005 grant requirements.

D. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

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

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 87 percent. The actual percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 86.6. Ohio has not met its target.

A. Develop & analyze an integrated assessment of entry into prenatal care using population based & programmatic data.

- * Analyzed perinatal periods of risk data to target technical assistance & program funding.
- * Utilized the Performance Measurement Monitoring System to summarize how CFHS project are addressing entry into prenatal care in their program plans.
- * Used CFHS data to strengthen referrals for prenatal care by providing technical assistance to sites.
- * Provided MATCH data regarding prenatal care to OIMRI projects for targeting outreach.
- * Communicated data analysis of entry into prenatal care to the Birth Outcomes work group including RPC project directors, representatives of Medicaid, ACOG & OHA.

B. Provide technical assistance to DFCHS-funded agencies to strengthen referral & follow-up systems between perinatal & family planning services.

- * Used CFHS data to strengthen referrals for prenatal care & family planning care by providing technical assistance.

C. Provide information to legislators & policy makers regarding the importance of supporting safety-net providers of perinatal services, community --based outreach & care coordination.

- * Provided information to legislators & policy makers concerning the impact of safety-net providers during the budget process.

D. Promote collaboration & coordination between OIMRI, RPC, & CFHS projects at the local level to ensure high risk women are appropriately transferred to high risk facilities.

- * Included required description of collaboration of services between OIMRI, RPC & CFHS projects in all grant proposals.
- * Included review of collaboration efforts in monitoring visits to OIMRI, RPC & CFHS projects.
- * Included RPC, OIMRI & CFHS Project Directors to Birth Outcomes workgroup meetings.

E. Fund, monitor & provide technical assistance to CFHS, Ohio Infant Mortality Reduction Initiative, (OIMRI) & Regional Perinatal Education Centers (RPEC) projects.

- * Funded & provided technical assistance to 6 RPC, 79 CFHS, & 12 OIMRI projects.
- * Provided comprehensive monitoring visits to 39 CFHS & 5 OIMRI projects.
- * Sponsored the 3rd Annual Community Care Coordinators Conference. The 206 attendees included community care coordinators, outreach professionals, lay home visitors, nurses, social workers, case managers, & supervisors.
- * Convened committee to revise OIMRI Policy & Procedures.
- * Expanded the OIMRI program to include 2 additional projects.
- * Provided a presentation at OIMRI project director's meeting to improve access to prenatal care for targeted populations.
- * Collaborated with the Community Health Access Project to develop a 2 day Community Care Coordinators Workshop to foster the development of Core Competencies for supervisors. Forty-two supervisors registered for the training.

b. Current Activities

A. Develop and implement a periods of risk approach for analyzing birth outcomes data to target technical assistance and funding for DFCHS funded programs.

B. Raise awareness among women served in DFCHS funded projects on the importance of early prenatal care.

C. Educate legislators and policy makers to understand the importance of safety net providers of perinatal services, community-based outreach and care coordination.

D. Fund, monitor and provide technical assistance to CFHS, Ohio Infant Mortality Reduction

Initiative (OIMRI), and Regional Perinatal Education Centers (RPEC) projects.

c. Plan for the Coming Year

A. Implement the 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 Division of Family and Community Health Services (DFCHS) resources.

B. Implement the National Association of City and County Health Officials (NACCHO) Strategic Decisions for Service Delivery at the local Child and Family Health Services project level to determine the most effective use of resources that can impact birth outcomes.

C. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

D. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Monitored status of newborn screening cases (open and closed) from ODH lab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Developed and implemented case disposition forms to be used by any providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborated with maternal and child health stakeholders to discuss ways to increase screenings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitored activities of RCGC and Regional Sickle Cell Service programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborated with ODH Laboratory to discuss parental refusals of screenings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Expanded the membership and cultural diversity of the Parent Advisory Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increased the family member participation in maternal and child health planning efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Surveyed and analyzed data to determine quality of medical home for CSHCN in Ohio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participated in the Medical Home workgroup.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Ensured physicians were following medical home guidelines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promoted the concept and function of a good medical home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Monitored data on enrollment rates of uninsured BCMH treatment recipients on Healthy Start (SCHIP).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitored data on Healthy Start/Medicaid drop and analyze reasons for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

drop-off.				
3. Paid health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provided enrollment assistance for potentially eligible Healthy Start (SCHIP) children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Collaborate with DFCHS bureau representatives to provide outreach to uninsured children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Monitored data on Healthy Start/ Medicaid drop-off and intervene in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assessed data quality and availability issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. BCMH conducted 9 family focus groups to assess the parents of CSHCN awareness and understanding of medical home. concept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Conducted interviews with various stakeholders related to transition activities and opportunities for youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Monitored immunization data quality from DFCHS funded clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promoted immunization compliance for children under age 2 with DFCHS funded clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Ensured that DFCHS funded immunization education provided to various population groups is culturally appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Collaborated and coordinated immunization planning and programming with local, state and national health officials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Promoted abstinence education by distributing information to DFCHS funded clinics that provide services to teens.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Identified and communicated best practices of reducing the rate of teens births to DCFHS funded projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promoted programs that encouraged responsible adolescent health decision-making.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Identified and communicated best practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Funded and provided technical assistance to DFCHS funded projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Funded local CFHS subgrantees to provide Family Planning direct care services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Expanded currently funded school-based and school-linked dental sealant programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continued to fund, monitor and provide consultation and technical assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Monitored the rate of deaths and analyze the contributing factors of motor vehicle crash fatalities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborated with the Division of Prevention (DOP) Injury Prevention Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promoted statewide education to increase awareness and proper use of safety devices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Collected and monitored Ohio breastfeeding rates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provided education and technical assistance regarding breastfeeding to DFCHS funded projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Worked with maternal and child health stakeholders to promote Breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Implemented Early Track Information for hearing impairment before hospital discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implemented universal newborn hearing screening, per state mandate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Partnered with stakeholders to implment the current risk-based program and began the implementation of NBHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provided training and technical assistance to hospitals with tertiary care nurseries which are establishing NBHS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increased public awareness about the need for newborn hearing screening and appropriate follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Expanded the habilitative services programs that included follow-up into regional infant hearing programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Monitored data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitored data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provided TA to DFCHS funded projects on how to educate and inform consumers to navigate the health care system.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Monitored the percentage of Healthy Start eligible children who receive services paid by the Medicaid program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provided assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborated with interdepartmental, state, local agencies and initiatives to provide technical assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Implemented a periods of risk approach to target technical assistance and funding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborated with the Ohio Section of ACOG to identify and implement strategies that impact VLBW.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Involved the Regional Perinatal Centers in evaluating Ohio's perinatal health care plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborated with the Ohio Section of ACOG and others to identify and implement a stress scale tool.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Monitored and shared information on county teen suicides.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborated with stakeholders to monitor, fund, and assess suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

prevention initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Informed providers/clinicians on the warning signs, risk factors, and interventions for suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provided training and educational materials to CFHS grantees who prioritized teen suicide as an activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Provide TA to the Regional Perinatal Centers regarding education to perinatal care providers on high risk mothers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Funded and monitored regional perinatal outreach and education programs to monitor outcomes of VLBW.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitored the use of the Prenatal Care Risk Assessment tool in CFHS Prenatal Clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Developed and implemented a periods of risk approach for analyzing birth outcomes data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Raised awareness with women in DFCHS funded projects on the importance of early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Educated legislators and policy makers to the importance of safety-net perinatal services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Funded, monitored and provided technical assistance to CFHS, OMRI, & RPEC projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Funded local CFHS subgrantees to provide Perinatal direct care services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *State Measure #1: The unintended pregnancy rate per thousand in woman of childbearing age.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 400 per thousand women of childbearing age. The actual unintended pregnancy rate was 406.9. Ohio did not meet its target.

A. Analyze and disseminate PRAMS data regarding unintended pregnancy issues.

* An unintended pregnancy newsletter was developed. The newsletter will be distributed in 2004.

B. Fund, monitor, evaluate and provide technical assistance to local family planning agencies.

* BCFHS funded 49 family planning agencies to provide family planning services. In addition to Title X and CFHS, a new program, Women's Health Services, was created to provide family planning services with funds redirected from the Title X family planning program.

* Family planning consultants monitored all funded family planning programs, providing comprehensive site reviews and technical assistance to every agency. Each agency was evaluated for key indicators such as sexual coercion education for all adolescents; conforming to mandated reporting laws regarding sexual abuse; client education to encourage increased condom use and quality assurance issues for clinical standards.

C. Provide information to DFCHS health care providers regarding protective activities for their clients.

* ODH distributed 2.1 million dollars in state and federal funds to support an abstinence-only program in middle and senior high schools in Ohio.

* Family planning providers provided education to all adolescents to learn methods to avoid sexual coercion.

* Family planning and perinatal providers provided education, methods and treatment for clients and their partners to prevent sexually transmitted diseases.

* DFCHS coordinated the Youth Risk Behavioral Survey (YRBS) to complete these surveys in forty-two schools in Ohio.

* Family Planning funding provided reproductive health care to 132,000 unduplicated clients in 2002. 17% of clients seen in ODH funded family planning agencies were under 18 years of age.

D. Identify and promote programs and interventions that encourage male involvement in the DFCHS subgrantee programs.

* The public school nurse program provided health information and primary health care assistance to male and female students in Ohio middle and senior high schools.

* Family Planning programs collaborated with the CDC Infertility Project to provide treatment and counseling to partners of STD positive clients.

b. Current Activities

A. Fund, monitor, evaluate and provide technical assistance to local family planning agencies

to affect outcome measures.

B. Target family planning program services to those women at highest risk to have poor birth outcomes.

C. Ensure that postpartum clients are connected to family planning services.

c. Plan for the Coming Year

A. Fund, monitor, evaluate and provide technical assistance to local family planning agencies to affect outcome measures.

B. Target family planning program services to those women at highest risk to have poor birth outcomes.

C. Ensure that postpartum clients are connected to family planning services.

State Performance Measure 2: *State Measure #5: The percentage of low income children who are overweight.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 8.9 percent. The actual percent of Ohio's low income children under age five years who were overweight was 11.8. Ohio did not meet its target.

A. Monitor the growth of children through WIC (via PedNSS) and MATCH data.

* PedNSS data 2002 was distributed to projects and was posted on the ODH website.

* MATCH program data was reviewed for Adams/ Brown, Athens, Butler, Coshocton, Fairfield, Hamilton, Hardin, Henry, Madison, Montgomery, Pickaway, Pike, Portage and Shelby counties.

B. Provide technical assistance to Division of Family & Community Health Services funded projects with more than 5% of children who are overweight.

* Reviewed MATCH program data and other data to determine need for technical assistance.

* Distributed new nutrition educational materials with mailings and at regional project directors' meetings.

* Provided educational tools (i.e. nutrition cards) to local projects for use with overweight children and their care givers. The following educational materials were distributed to WIC projects: "Being active as a family", "Being active during and after pregnancy", "I eat healthy foods everyday".

* Analyzed and distributed results of the surveys that were completed by local projects.

Buckeye Best surveys were sent to schools and as the result packets of information on nutrition, physical education and smoking cessation were sent out.

C. Coordinate nutrition activities and trainings to provide a Department wide coordination of obesity initiative

* Worked with schools and other local agencies to address the issue of childhood obesity. BMI packets were developed and presentations were held at 6 conferences attended by school nurses and representatives from several local health departments. Information on accurate anthropometrics measurements and BMI values was shared.

* A survey was done for food service personnel in schools in conjunction with the Ohio Department of Education and as a result technical assistance was provided to schools.

* Staff participated in state level discussions about changing the school nutrition environment.

* Staff attended the "Ohio Action for Healthy Kids" conference. Staff learned about local action

plans addressing childhood obesity, school nutrition and fitness plans for children.

* Staff participated in review of childhood obesity proposals for the Osteopathic Heritage Foundation.

* Provided training to local health professionals with regards to motivational interviewing which has been proven as an effective technique in behavior modification. Motivational interviewing was implemented in the WIC clinics. Follow-up information has been provided to all projects.

* WIC provided quarterly Advanced Health Professional Trainings for personnel who have been WIC professionals > 5 years. During these trainings additional technical assistance and materials were provided to address the issue of childhood obesity.

b. Current Activities

A. Monitor the growth of Children through WIC (via PedNSS) and MATCH data.

B. Provide technical assistance to DFCHS funded projects with a high percentage of children with inappropriate weight.

C. Coordinate nutrition activities to provide a Department wide coordination of the obesity initiative.

c. Plan for the Coming Year

A. Monitor the growth of children through WIC (via PedNSS) and MATCHr data.

* Review PedNSS data on a regular basis to determine need for technical assistance

* Review MATCHr data before regularly scheduled CFHS site visits and periodically to determine need for technical assistance in counties with a high percentage of kids with inappropriate weights.

B. Provide technical assistance to Division of Family & Community Health Services funded projects with high percentage of children with inappropriate weight.

* Review MATCH and other available data to determine need for technical assistance.

* Distribute appropriate educational materials at regularly scheduled project directors' meetings and or mailings.

* Provide educational tools (i.e. nutrition cards) to local projects for use with overweight children and their care givers

C. Coordinate nutrition activities and trainings to provide a Department wide coordination of the obesity initiative.

* Work with schools and other agencies in the community to address the issue of childhood obesity.

* Provide training to BCFHS health professionals with regards to motivational interviewing which has been proven to as an effective technique in behavior modification.

* Revise CFHS Child and Adolescent Program Standards to include new BMI guidelines and additional resources as applicable.

State Performance Measure 3: State Measure #7: Percentage of 3rd grade children with obvious need for dental care.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 23 percent. The actual percent of 3rd grade children with obvious need for dental care was 34.6. Ohio did not meet its target.

A. State level planning to improve access to dental care.

1. July 2003, the Senate created a state dentist loan repayment program, ODH began writing the rules to administer the program.

B. Fund dental safety net programs and help build the infrastructure of these programs.

1. Funded seven agencies to provide dental care to 12,970 high-risk children and women.
2. Utilized the new web-based manual, developed by ODH, IHS and ASTDD to provide TA to seven agencies starting or expanding dental safety net programs.
3. Two counties were designated dental HPSAs, one new and five renewal applications were submitted.

C. Collaborate with the Ohio Dental Association to administer OPTIONS, the statewide dental program for Ohioans with no dental insurance or resources to pay for care.

Reported under Other Program Activities

D. Maintain data on oral health status, resources and access, provide data and technical assistance to communities.

1. Oral screenings conducted at 25 sentinel schools, trend data posted on website. Oral screenings were conducted at 50 Head Start (HS) centers and 50 public preschools. Data analyzed, a manuscript is being written for publication.
2. List of dental safety net programs was printed, distributed and is on the web page.
3. Meetings were held with Medicaid requesting provider and utilization data.
4. Dentists and HS sites were mapped to show relationship between their locations.

E. Facilitate local partnerships, help local coalitions assess the oral health needs of their clients and implement strategies to meet needs.

1. Dental Clinic Manual www.dentalclinicmanual.com was completed and on-line June 2003.
2. BOHS staff provided TA to 18 communities on different oral health initiatives.
3. The OHIO Initiative, a 4 yr project to develop local oral health coalitions and state/local partnerships, was evaluated by a private consultant who is writing a manuscript for publication.
4. Surveys were conducted to assess HS staff and parents, dentists and safety net programs attitudes and practices related to accessing dental care for children 0-5. Findings will be used to develop an action plan for improving access to dental care for HS children.

F. Prevent dental caries through community-based fluoride promotion

1. Worked with EPA data specialist to develop an ODH database to report water fluoridation to CDC.
2. Updated fluoridation reports for 40 of Ohio's 88 counties.
3. Provided fluoridation assistance to committee in Lancaster as they developed info packets for city council.
4. Met with Medicaid to discuss reimbursing for fluoride varnish application by physicians for children under three.
5. 51,126 students in 219 elementary schools participated in the school fluoride mouthrinse program.
6. Provided \$47,000 to three communities for fluoridation equipment.

b. Current Activities

A. Continue momentum for state level planning to improve access to dental care.

B. Fund, monitor, and evaluate dental safety net programs and help build the infrastructure of safety net dental care programs in Ohio.

C. Collaborate with the Ohio Dental Association to coordinate and monitor OPTIONS, the statewide dental care access program for Ohioans with no form of dental insurance and limited resources to pay for care.

D. Maintain current statewide data on oral health status, oral health resources and access to dental care for statewide planning and continue to provide data and technical assistance to communities for local needs assessment.

E. Increase access to oral health care services by facilitating local partnerships and by helping to build the capacity of local agencies and health care providers to assess the oral health needs and resources of their clients and implement strategies to meet those needs.

F. Prevent dental caries through community-based fluoride promotion (i.e., community-based water fluoridation and school-based fluoride mouth rinse programs).

c. Plan for the Coming Year

A. Continue state level planning to improve access to dental care.

1. Work with the Ohio Dental Association and appropriate state agencies to implement recommendations of the Director's Task Force on Access to Dental Care.
2. Support and participate in Ohio Coalition for Oral Health (OCOH) activities.

B. Fund, monitor, and evaluate dental safety net programs and help build the infrastructure of safety net dental programs.

1. Fund, monitor and provide technical assistance to 13 local agencies to provide dental care to Ohioans with poor access to oral health services.
2. Identify and assist communities interested in establishing or renewing federally designated dental HPSAs.
3. Administer the dentist state loan repayment program.

C. Maintain current statewide data on oral health status, resources and access, provide data and technical assistance to communities.

1. Conduct oral health surveys to assess the oral health status, treatment needs of Ohio children in Head Start and third grade.
2. Survey key groups (dentists, social service agencies) working with Ohioans having difficulty obtaining dental care.
3. Update and distribute dental safety net listing.
4. Update oral health access-related data in county profiles for state and local use.

D. Facilitate local partnerships, help local coalitions assess the oral health needs of their clients and implement strategies to meet needs.

1. Provide consultation and technical assistance to communities interested in developing dental partnerships/coalitions.
2. Maintain county-specific narratives on oral health status and resources.
3. Initiate contacts to start new dental partnerships/coalitions in counties ranked as priority for community development activities.
4. Monitor the percentage of Ohio Head Start children who have received dental treatment, using Region V Program Information Report data.
5. Support and implement, where feasible, the strategies and actions of the Ohio Head Start Oral Health Action Plan developed through the Ohio Head Start Oral Health Forum.
6. Fund, monitor and provide technical assistance to local projects to pilot test the Head Start oral health systems models recommended in the Ohio Head Start Oral Health Action Plan.

E. Prevent dental caries through community-based fluoride promotion.

1. Identify and prioritize communities not optimally fluoridated utilizing an assessment tool that objectively scores communities on several weighted parameters.
2. Provide financial assistance to communities beginning to fluoridate and to communities needing to purchase new equipment.

3. Provide, monitor and assess the Fluoride Mouthrinse program in communities without optimal fluoridation or with high free and reduced cost meal program participation. Improve quality of data and access to information on fluorides and fluoridation by revising and updating information to the ODH website.

State Performance Measure 4: State Measure #9: The percentage of children with elevated blood lead levels as defined by the Centers for Disease Control and Prevention

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 6.0 percent The actual percentage of Ohio children with elevated blood lead levels was 5.3. Ohio met its target.

A. Increase awareness on the health effects of childhood lead poisoning.

- * Four Lead Regional Resource Centers were funded that provided education on proper nutrition, assisted in neighborhood initiatives to teach interim dust cleaning techniques, & coordinated screening efforts.

- * The Statewide Lead Education Committee met quarterly to develop strategies to increase knowledge about the dangers of lead poisoning & to increase compliance by physicians with screening standards & the follow-up of confirmed cases of lead poisoning.

- * Technical assistance regarding health promotional strategies was provided to local communities during Lead Awareness Week in July.

B. Increase compliance with screening standards & physician follow-up of confirmed cases.

- * Case management follow-up was done for cases of poisoning > 45 ug/dL which require chelation. Physicians were contacted within 5 business days of test results, to assure that children had been referred for chelation therapy.

- * 1,250 environmental investigations were conducted in homes of children with a blood lead level > 15 ug/dL.

- * The PLANET program (peer based lead education) was presented to over 200 health care providers.

- * A scientific approach to evaluate the Ohio lead testing guidelines to identify new risk factors & high risk areas was developed that superceded the 1998 set.

- * A Lead/WIC Pilot Screening Project was implemented. All 1 & 2 year olds who participated in a WIC Clinic visit were offered a blood lead test.

C. Increase the number of children enrolled in Medicaid that receive a blood lead test.

- * 2002 STELLAR & Medicaid Eligibility databases were matched. Over 65,000 (65%) of the children in STELLAR were matched in the Medicaid system. The one year old testing rate rose from 36% to 39%. The two year old testing rate rose from 22% to 32%.

- * A third round of letters was sent to all Medicaid providers, detailing their practice lead testing rates.

- * A birthday reminder card was sent to all to children enrolled in Medicaid, reminding their parents to schedule their 12 & 24 month well-child exams.

D. Increase primary prevention efforts through collaboration with stakeholders.

- * Local agencies were supplied cleaning kits and a listing of centers that participate in the HEPA Vacuum loaner program. They instructed families on interim cleaning controls methods.

- * In-services to Head Start staff were conducted.

E. Coordinate with stakeholders to plan & implement strategies for childhood lead poisoning prevention.

- * The Lead Ad-Hoc Advisory Committee met quarterly.

- * Staff collaborated with the Welcome Home Newborn Nurse Visiting Program to implement a

lead primary prevention initiative. This project will consist of nurses offering an environmental lead assessment. The process will target mothers in high risk areas.

b. Current Activities

A. Increase public awareness on the health effects of childhood lead poisoning by providing funds to four Lead Regional Resource Centers for statewide education and outreach.

B. Increase compliance with blood lead screening standards and follow-up of confirmed cases by physicians.

C. The number of children enrolled in Medicaid that receive a blood lead test will increase by 6 percent. Increase primary prevention efforts through collaboration with local agencies and intra and inter agency programs.

D. Coordinate with inter-agency and intra-agency partners to plan, and implement program strategies and activities in support of childhood lead poisoning prevention.

E. Decrease the disparity of lead poisoning in racial, ethnic, and cultural groups.

c. Plan for the Coming Year

A. Increase public awareness on the health effects of childhood lead poisoning by providing funds to four Lead Regional Resource Centers for statewide education and outreach.

B. Increase compliance with blood lead screening standards and follow-up of confirmed cases by physicians.

C. The number of children enrolled in Medicaid that receive a blood lead test will increase by 6 percent. Increase primary prevention efforts through collaboration with local agencies and intra and inter agency programs.

D. Coordinate with inter-agency partners to plan and implement program strategies and activities in support of childhood lead poisoning prevention.

E. Decrease the disparity of lead poisoning in racial, ethnic, and cultural groups.

State Performance Measure 5: *State Measure #11: The low birth weight rate (LBW) per 100 live births.*

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 7.7 per 100 live births. The actual low birth weight rate was 8.3 per 100 live births. Ohio did not meet its target.

A. Analyze Ohio PRAMS data to identify factors related to prematurity and LBW.

* PRAMS data were analyzed to identify factors related to prematurity among singleton births. Ten percent of the births were born prematurely, and 91% of these births were singletons. Compared to women with full-term pregnancies, previous premature and previous low birthweight births were more common among women who have gave birth prematurely to singleton live births in 1999. Ohio's response rate was not high enough to analyze by race.

B. Develop a DFCHS wide approach and recommendations for addressing prematurity and low birth weight.

* The Birth Outcomes Strategy workgroup met on a quarterly basis to discuss the issue & to share best practices for achieving good birth outcomes.

C. Identify and implement best practices that will impact prematurity and low birth weight.

* Convened a Community Care Coordination Program Advisory Committee of Program Managers for revision of the OIMRI Policy and Procedures. The revision included reviewing and including best practices that will impact prematurity and low birth weight.

* The 3rd Annual Community Care Coordinators Conference was held. The 206 attendees included community care coordinators, outreach professionals, lay home visitors, nurses, social workers, case managers, and supervisors.

D. Enhance perinatal smoking cessation activities in Ohio.

* BCFHS contracted with a physician to present the "5 A's" at hospital grand rounds.

* Vital Statistics, WIC, & Title V prenatal clinic data were used to identify counties with the highest rates of prenatal smoking. Hospitals located within those counties were utilized as 5 A's training sites.

* A statewide collaboration was developed with organizations that expressed an interest in providing training on the "5 As" Prenatal Smoking Cessation Intervention. Partners include the Tobacco Use Prevention and Control Foundation, Ohio's tobacco settlement foundation; the March of Dimes; American Cancer Society; American Lung Association; and Medicaid Managed Care Plans. This partnership will continue work to disseminate information and educate clinicians on the evidence-based "5 A's".

* BCFHS and the Centers for Disease Control and Prevention (CDC) developed baseline indices to identify high-risk counties where the "5 A's" should be implemented. Indices for identifying high-risk counties included: percentage of babies born low birth weight, number of low birth weight babies, percent of births to mothers who smoked, percent ratio of black-white disparity, and percentage below poverty level.

* OIMRI programs incorporated smoking cessation programs as a part of their care coordination process.

b. Current Activities

A. Partner with the March of Dimes on the national campaign regarding Prematurity.

B. Collaborate with the Ohio Section of ACOG to identify and implement strategies that impact low birth weight.

C. Partner with OPCA, TUPAC, March of Dimes, to develop and implement a standardized training program for prenatal smoking cessation.

D. Conduct an assessment of the effectiveness of CFHS programs to impact birth outcomes.

c. Plan for the Coming Year

A. Partner with the March of Dimes on the national campaign regarding prematurity.

B. Implement the 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 Division of Family and Community Health Services (DFCHS) resources.

C. Collaborate with the Ohio section of the American College of Obstetricians and Gynecologists (ACOG) to identify and implement strategies that impact birth outcomes.

D. Partner with the Tobacco Use Prevention Control Foundation (TUPCF), March of Dimes, and other stakeholders to develop and implement strategies for perinatal smoking cessation.

E. Conduct an assessment of the effectiveness of Child and Family Health Services (CFHS) programs to impact birth outcomes.

F. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

G. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

State Performance Measure 6: *State Measure #12: Implementation of a statewide Child Fatality Review (CFR) System.*

a. Last Year's Accomplishments

This is a process measure that includes the following steps:

1. Convene a state level CFR team to develop standardized protocol for local CFR teams;
2. Work with state level teams to develop training materials, manuals and training sessions for local CFR's;
3. State level team will review annual reports from community-based CFR teams and prepare statewide report;
4. Encourage all Ohio county to implement (sic).

The target for Calendar Year 2003 was to have all steps completed. Ohio has met its goal.

A. Use findings & recommendations of CFR to reduce childhood morbidity & mortality.

* The third annual CFR report was published & distributed to the Ohio Legislature, Local CFR Boards, Family & Children First Councils, CFR Advisory Committee & other interested parties. The report provided information on the contributing factors to child deaths and recommendations for actions that might prevent other deaths.

B. Increase the capacity of local Ohio CFR Boards to review all deaths of children under the age of eighteen.

* The Second Annual Training CFR Conference was held with over 200 participants from 70 counties. The agenda included information on annual reporting requirements and issues related to the review process. Local and national experts presented sessions on best practices. Participants received training handouts & CFR resources. The training provided participants an opportunity to network and share best practices. The discovery of variations & discrepancies in reporting has generated much discussion & policy changes which will lead to an improved CFR system with more meaningful data. In addition to the training opportunities at the conference, technical assistance was provided throughout the year to 7 local CFR boards regarding board process & data reporting.

C. Explore CFR legislative needs in Ohio.

* During the three years since the establishment of a statewide CFR program, several weakness have been identified that will need changes in the current CFR law & rules in order to strengthen the system. The security of the confidentiality of CFR data on the state level; inconsistencies in data reporting; & the current incompatibility of CFR reports with Vital Statistics Data are three of the areas targeted for improvement. The changes have been discussed with ODH legal counsel.

D. Promote partnerships at the local & state levels to enhance the exchange of information about child fatality reviews & their findings.

* The CFR Advisory Committee members reflect members of local CFR boards, state agencies & other organizations. CFR information & findings have been shared with Children's Trust Fund, SID Network of Ohio, & other stakeholders. CFR information has been shared with MCH Block Grant Strategy groups & Emergency Medical Services for Children groups. A Motor Vehicle Death subgroup has been formed with members from ODH, Public Safety, law enforcement & coroners groups, to share information & develop prevention strategies.

b. Current Activities

A. Ensure the quality of CFR data at the state and local levels.

B. Increase the capacity of local Ohio CFR boards to review all child deaths.

C. Encourage ODH, other state agencies and local CFR boards to use findings and recommendations to promote policy, legislative and program changes to reduce the incidence of childhood morbidity and mortality.

c. Plan for the Coming Year

A. Ensure the quality of CFR data at the state and local levels.

B. Increase the capacity of local Ohio CFR boards to review all child deaths.

C. Encourage ODH, other state agencies and local CFR boards to use findings and recommendations to promote policy, legislative and program changes to reduce the incidence of childhood morbidity and mortality.

State Performance Measure 7: State Measure #13: The ratio of black perinatal mortality rate to the white perinatal mortality rate.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 1.9:1. the actual ratio of black perinatal mortality rate to the white perinatal mortality rate was 2.4. Ohio did not meet its goal.

A. Developed and implemented a periods of risk approach for analyzing birth outcome data to target technical assistance and funding for DFCHS funded programs. Monitored MATCH data to identify subpopulations. Worked with BHSIOS to analyze Vital Statistics data to identify subpopulations and to target funding for additional OIMRI projects. Provided TA to BCFHS funded projects to assess their community resources. Collaborated with Community Health Centers and Federally Qualified Health Centers to assess community resources.

B. Ensured BCFHS funded clinics were implementing culturally competent practices in the community setting. Included a Culturally Competent Self-Assessment Checklist in the RFP for BCFHS funded projects. Provide training of cultural competence (per CFHS standards) during new PD orientation (4/02). Monitor 14 CFHS PN sites for culturally competent compliance per CFHS standards.

C. Collaborated with the Ohio Commission on Minority Health to adopt policies that define and mandate culturally competent practices. Collaborate with the Ohio Commission and participated in planning groups.

D. Expanded and enhanced programs that employed community health workers to improve access to care through culturally competent care coordination, and other social support. Staff

from BCFHS and BCHSSD serve on the Executive Council and actively participate on the Community Care Coordination Collaborative (C4) Group. Developed and implemented standardized care coordination training for community care coordinators in DFCHS funded programs such as the Ohio Infant Mortality Reduction Initiative (OIMRI) and Community Access Program (CAP). Developed and implemented standardized care processes used by DFCHS funded programs (OIMRI, CAP). Continued to explore data collection and evaluation systems designed to accurately assess the effectiveness of community care coordination programs.

E. Provided TA support to local communities addressing racial and ethnic disparities in perinatal and infant mortality.

b. Current Activities

A. Implement the Perinatal Periods of Risk analytic tool to enhance information from birth outcome data to targeting DFCHS resources.

B. Facilitate the implementation of culturally competent practices in DFCHS funded projects.

C. Collaborate with the Ohio Commission on Minority Health and other stakeholders to identify barriers to prenatal care and infant care for African-American women and infants.

D. Expand and enhance programs that employ community health workers to improve access to care through culturally competent care coordination, and other social support.

E. Identify and implement a stress scale tool in the target population.

c. Plan for the Coming Year

A. Implement the 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 Division of Family and Community Health Services (DFCHS) resources.

B. Communicate findings of the analysis conducted on the cultural competency of Child and Family Health Services (CFHS) projects.

C. Provide technical assistance and training regarding culturally competent practices to Division of Family and Community Health Services (DFCHS) funded projects.

D. Fund, monitor, and provide technical assistance to program that provide community care coordination services.

E. Fund, monitor, and provide technical assistance to the Ohio SIDS program, especially in regards to reducing the African American Sudden Infant Death (SID) rate in Ohio.

F. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

State Performance Measure 8: *State Measure #14: The reported cases of physical assault by current or former intimate partners (Domestic Violence)*

a. Last Year's Accomplishments

The target for Calendar Year 2002 is 3.5 percent. The actual percentage of reported cases of

physical assault by current or former intimate partners (domestic violence) was 1.8. Ohio did meet its goal.

A. Ensure DFCHS funded agencies are providing appropriate referrals and care coordination to women who are in domestic violence situations.

* ODH collaborated with the Ohio Domestic Violence Network (ODVN) to provide training in basic and advanced methods and protocol for health care providers.

B. Provide information on Battered Women's Syndrome to DFCHS staff.

* The Women's Health Program provided regional training in basic protocol for health care providers to screen and assess patients for evidence of Domestic Violence.

* On-line training is available for basic Domestic Violence protocol through the Association of Women's Health, Obstetric and Neonatal nurses, www.awhonn.org. Credit hours are available for nurses.

C. Provide DFCHS funded agencies with information and skill building opportunities to educate women about risk factors associated with sexual coercion, rape and substance abuse.

* DFCHS funded agencies were provided training and materials to identify, educate and assist clients about sexual coercion, sexual abuse and rape.

* On-site monitoring to agencies includes chart audits to ensure adherence to clinical standards that require each client to be screened for Social/Behavior Risk Factors that include alcohol abuse, drug use, Domestic Violence, Lack of Social Support and Tobacco Use.

b. Current Activities

A. Train all DFCHS ODH staff to identify Battered Women's Syndrome.

B. Assess the capacity of health care providers and other collaborative partners in DFCHS-funded agencies to assess domestic violence and to provide appropriate referrals for clients.

C. Train and evaluate providers of the 15-34 year old target group to educate their clients to identify domestic violence and date violence in their relationships.

D. Provide DV training for ODH project supervisors to increase the awareness of the providers and enable them to provide technical assistance to locals during monitoring visits.

E. Hold a needs assessment of DV 2006 that will include regional training from the Ohio Domestic Violence Network.

c. Plan for the Coming Year

A. Train all DFCHS programs to identify Battered Women's Syndrome.

B. Assess the capacity of health care providers in DFCHS-funded agencies to assess domestic violence and to provide appropriate referrals for women.

C. Educate providers in DFCHS-funded agencies and school nurses with the legal system's application of penalties and adjudication regarding domestic violence.

D. Provide training for providers of the 15-44 year old target group about identifying domestic violence and date violence.

and 1st grade failing a vision screen.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 6 percent. The actual percentage of Ohio children in kindergarten and first grade failing a vision screen was 7 percent in 2001. Ohio did not meet its goal, but the survey is done every other year.

A. Improve and increase training on vision assessment and referral for primary care providers.

- * Preschool vision screening pocket cards and posters were distributed to Ohio's family practice doctors and pediatricians.

- * Vision assessment information was presented at 4 regional conferences and the new school nurse conference.

- * A vision screening videotape emphasizing school aged children was produced and distributed

- * Nursing programs, especially those that offered graduate level training, were contacted and offered the opportunity for workshops and vision trainings. Two trainings were conducted.

B. Increase utilization of existing vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services.

- * Submitted bureau request form to Medicaid requesting vision examination data to determine utilization of vision care services by children on Medicaid.

- * Met with the Ohio Primary Providers Vision Screening Coalition to discuss barriers to vision care and ways of increasing utilization of vision resources. ODH will provide preschool vision screening training to medical providers and educational outreach.

C. Increase compliance with preschool vision screening standards of the Ohio Department of Health.

- * Participated in quarterly meetings of the Ohio Primary Providers of Vision Screening Coalition to discuss compliance of preschool vision screening rates.

- * Included preschool vision screening procedures and recommendations during the regional vision screening training and in-house vision screening trainings.

D. Participate in Bureau of Oral Health statewide preschool dental survey to determine the number of preschool children that have received a vision examination or vision screening.

- * Survey results are being analyzed. Preliminary data shows that two thirds of children in this survey had their eyes screened or examined prior to entering Kindergarten.

E. Increase public (parent) awareness of the importance and need for early professional eye care for children.

- * Worked with the Ohio American Academy of Pediatrics to develop a preschool vision screening poster to use in the office of pediatricians and eye doctors to promote the need for early professional eye care for children.

- * Produced public service video segment to stress the importance of early vision care however.

- * Collaborated with the Bureau of Early Intervention to reviewing the development of screening methods for the early intervention population birth to three year of age.

F. Collaborate with ODJFS and ODE to include a vision screening prompt on the annual medical evaluation form for child day care centers.

- * No progress to date.

b. Current Activities

A. Improve and increase training on vision assessment and referral for primary care providers.

- B. Increase utilization of existing vision resources with specific emphasis on reducing racial disparity in access and utilization of vision care services.
- C. Increase provider compliance with preschool vision screening standards of the Ohio Department of Health.
- D. Participate in Bureau of Oral Health statewide preschool dental survey to determine the number of preschool children that have a received a vision examination or vision screening.
- E. Increase public (parent) awareness of the importance and need for early professional eye care for children.
- F. Collaborate with ODJFS and ODE to explore the possibility of including vision screening on the medical evaluation forms.

c. Plan for the Coming Year

- A. Improve and increase training on vision assessment and referral for primary care providers.
- B. Increase utilization of existing vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services.
- C. Increase compliance with preschool vision screening standards of the Ohio Department of Health.
- D. Develop a statewide unified preschool vision screening data collection system.
- E. Increase public (parent) awareness of the importance and need for early professional eye care for children.
- F. Collaborate with ODHS and ODE to include a vision screening prompt on the annual medical evaluation form for child day care centers.

State Performance Measure 10: *State Measure #16: Assess the capacity to integrate genomics into public health programs.*

a. Last Year's Accomplishments

Formerly: Development of the role of the new Genetics in public health programs.

Revised to: Assess the capacity to integrate genomics* into public health programs.

This is a process measure that includes the following steps:

1. The director of health will convene a task force on genetics to review new genetics information;
2. The task force will develop a work plan of activities that will result in a document of recommendations to the director of health;
3. ODH will develop a state genetics plan for 2002/2007, incorporating recommendations from the task force. The target for Calendar Year 2003 was to complete Step 2. The target has been achieved.

A. Re-focus priorities and activities of ODH-funded RCGCs based on recommendations from the Genetics Task Force report that will be completed Summer 2002.

* Genetics Task Force report released in March 2003 and recommendations have been

addressed in planning for State Fiscal Year 2004-2005 RCGC grant program.

B. Collaborate with program staff in the Division of Prevention to implement broad prevention/educational recommendations of the Genetics Task Force statewide.

* Planning meetings have been held with staff of the Division of Prevention Cancer Programs to collaborate on joint projects in State Fiscal Year 2004-2005.

C. Develop genetics state plan to be used for next grant funding cycle.

* First draft of genetics state plan developed.

* Survey of genetics center staff to determine emerging issues completed.

D. Monitor activities of RCGC through site visits, programmatic reports and data collection.

* Programmatic reports were submitted timely and reviewed by Genetics Program Coordinator.

* Annual data summary report was developed and distributed for Genetics projects.

b. Current Activities

A. Re-focus priorities and adjust activities of ODH-funded RCGCs based on recommendations from the Director's Genetics Task Force.

B. Collaborate with program staff in the Division of Prevention to identify activities and implement broad prevention/educational recommendations of the Genetics Task Force statewide.

C. Revise genetics state plan to incorporate new genomics and integrate genetics and prevention activities.

D. Monitor activities of RCGC through site visits, programmatic reports and data collection.

E. Integrate genetics component into Ohio's Universal Newborn Hearing Screening Program.

c. Plan for the Coming Year

Formerly: Development of the role of the new Genetics in public health programs.

Revise to: Assess the capacity to integrate genomics* into public health programs.

Genomics is defined by the Association of State and Territorial Health Officials (ASTHO), as the study of the functions and interactions of all the genes in the genome*. This encompasses gene interactions with environmental factors, and all of the scientific discoveries and the health and social implications connected with this process.

Genome is defined as all the DNA contained in an organism or cell, which includes both the chromosomes within the nucleus and the DNA in the mitochondria.

Activities:

A. Identify public health programs for possible integration with genetics/genomics.

B. Monitor integration activities of the Regional Comprehensive Genetics Centers (RCGC) with public health programs including metabolic services, newborn screening, specialty medical teams (such as BCMH Myelodysplasia and Craniofacial teams, etc.), birth defects surveillance and local health departments.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) State Measure #1: The unintended pregnancy rate per thousand in woman of childbearing age.				
1. Analyzed and disseminated PRAMS data regarding unintended pregnancy issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Funded, monitored, evaluated and provided technical assistance to local family planning programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provided information to DFCHS health care providers regarding protective activities for clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identified and promoted programs and interventions that encourage male involvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provided technical assistance to perinatal and family planning agencies regarding referrals and access.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) State Measure #5: The percentage of low income children who are overweight.				
1. Monitored the growth of Children Through WIC (via PedNSS) and MATCH data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Povided technical assistance to Division of Family & Community Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Coordinate nutrition activities and trainings to provide a Department wide coordination of obesity initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provided educational tools to local projects for use with overweight children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) State Measure #7: Percentage of 3rd grade children with obvious need for dental care.				

1. Continued momentum for state level planning to improve access dental care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Funded, monitored, and evaluated dental safety net programs and help build the infrastructure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborated with the Ohio Dental Association to coordinate and monitor OPTIONS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Maintained current statewide data on oral health status, oral health resources and access.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increased access to oral health care services by creating local partnerships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Built the capacity of local agencies and health care providers to assess the oral health needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Prevented dental caries through community-based fluoride promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) State Measure #9: The percentage of children with elevated blood lead levels as defined by the Centers for Disease Control and Prevention				
1. Increased public awareness on the health effects of childhood lead poisoning.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Increased compliance with blood lead screening standards and follow-up of confirmed cases.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Strove to increase the number of Medicaid eligible children receiving a blood lead test by piloting screening in WIC.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Increased primary prevention efforts through collaboration with community-based organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Coordinated with inter-agency and intra-agency partners to plan and implement program strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Decreased the disparity of lead poisoning in racial, ethnic, and cultural groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Funded local CFHS subgrantees to provide Child Health direct care services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) State Measure #11: The low birth weight rate (LBW) per 100 live births.				
1. Analyzed PRAMS data to identify factors related to LBW for Ohio mothers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Developed and implemented a periods of risk approach for analyzing birth outcome data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Expanded perinatal smoking cessation programs in Ohio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identified and implemented best practices that will impact prematurity and low birth weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) State Measure #12: Implementation of a statewide Child Fatality Review (CFR) System.				
1. Established and sustained county or regional child fatality review programs in Ohio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promoted partnerships at the local and state levels to enhance the exchange of information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Used findings and recommendations from child mortality review programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Explored CFR legislative needs in Ohio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) State Measure #13: The ratio of black perinatal mortality rate to the white perinatal mortality rate.				
1. Developed and implemented a periods of risk approach for analyzing birth outcome data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensured BCFHS funded clinics are implementing culturally competent practices in the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborated with the Ohio Commission on Minority Health to adopt policies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Expanded and enhanced programs that employ community health workers to improve access to care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provided technical assistance support to local communities addresssing racila and ethnic disparities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) State Measure #14: The reported cases of physical assault by current or former intimate partners (Domestic Violence)				
1. Trained all DFCHS programs to identify Battered Women's Syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assessed the capacity of health care providers in DFCHS-funded agencies to assess DV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Educated providers in DFCHS-funded agencies and school nurses on the legalities of DV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provided training for providers of the 15-34 year old target group about identifying DV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) State Measure #15: Percentage of children in kindergarten and 1st grade failing a vision screen.				
1. Improved and increased training on vision assessment and referral for primary care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increased utilization of existing vision resources to reduce racial disparity in vision care service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Increased compliance with preschool vision screening standards of the Ohio Department of Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Developed a statewide unified preschool vision screening data collection system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increased public (parent) awareness of the importance and need for early professional eye care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Collaborated with ODJFS and ODE to include a vision screening prompt on the annual medical eval form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) State Measure #16: Assess the capacity to integrate genomics into public health programs.				
1. Collaborated with the Genetics Task Force to develop recommendations re: the public health role in genetics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

This section allows for discussion of program activities that are not covered by the priority needs and the National and State Performance Measures sections. (2 pages limit)

/2004/ Dr. Haller chairs the legislatively mandated Compassionate Care Task Force. This group 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.

The BOHS increased funding to support increased access to oral health services with \$1M in Health Priorities Trust Fund dollars (Tobacco settlement money), in addition three private foundations made significant money available to local agencies to improve access to dental care services.//2004//

/2005/ 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. 4,764 people were helped; \$912,757 in dental care was discounted/donated; 747 dentists and 92 dental labs are enrolled in OPTIONS;

HRSA funds were received to explore merging foundation-funded case management programs for Medicaid patients with the ODH case managed dental care program OPTIONS for the uninsured and

OPTIONS staff participated in time studies to draw down Medicaid Administrative Match funds.

Dental Safety Net Infrastructure

Nearly \$2 million from Tobacco settlement funds were obligated in the state 2003-04 biennium budget for BOHS to fund the start up of new and expansion of existing dental safety net programs in Ohio. The funds will pay for providing uncompensated dental care and care for minority and low-income populations.

ODH was not selected for RWJF funding. Without funding, a dentist support unit could not be created in the Medicaid program. Work toward other components of the grant--funding

demonstration projects for Medicaid case management, dentist recruitment and working with the high-risk children, birth-age three, will begin in FFY04 with funds from HRSA's State Oral Health Collaborative Systems (SOHCS) grant.

Ohio Coalition on Oral Health (OCOH)

OCOH focused their energy on preserving adult dental benefits in the state Medicaid program, when proposed state budget cuts included eliminating dental coverage for adults. Through the grass roots efforts of coalition members (letter writing, meeting with legislators and providing testimony at budget hearings) the adult dental benefits were preserved. OCOH created a listserv for communication among members and others interested in issues related to oral health including how to run an efficient, viable dental safety net program. Directors of several dental safety net programs are part of this listserv.

Coordinate and monitor OPTIONS and collaborate with selected foundations and the Ohio Dental Association to enhance communication model to serve Ohioans with Medicaid coverage, no form of dental insurance and/or limited resources to pay for care.

Plan for 2005

Fund, monitor and provide technical assistance to four or more agencies to provide dental care case management services.

Implement the pilot through training and technical assistance on policies created for an enhanced case management program as developed by the Case Management Steering Committee.

Monitor and oversee OPTIONS dentist recruitment, enrollment, participation and retention activities related to case management programs overseen by ODH. .

Collaborate with the ODH and the partnering foundations to evaluate the dental case management programs in Ohio.

Participate in Medicaid Administrative Claiming activities to determine the level of funding that may be available from Medicaid Administrative Match funds.//2005//

/2005/ The Bureau of Early Intervention Services collaborates with the Ohio DEpartment of Job and Family Services' Bureau of Child Care and the Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health and safety information to licensed child care providers.

Developed medication administration curriculum for child care providers and provided training statewide.//2005//

/2005/ The Office of Primary care will collaborate with the Ohio Prevent Blindness Coalition to discuss their concerns that of the 103 FQHC sites only 3 (central Columbus and 2 NEON sites) have vision clinics. The Coalition recently provided grant money to the central Ohio site to increase services from 950 to 2500 patients at <200% FPL by paying for an Optician and using public private partnerships to access needed eyewear. The Coalition also has CDC funding to provide training and equipment to PCPs for vision assessment. The following website includes state and county level data for adults with eye health problems:

<http://www.preventblindness.org/Ohio/Agingeye/VPOH.html>.//2005//

/2005/ An ODH standardized school injury report form has been created and piloted in 2 rural school districts over the last two years. This second year of the pilot included computerizing the reports and electronically reporting on a quarterly basis to the ODH. The standardized report form has been widely accepted due to its objective nature and ease in completing. However the guidelines for use must be expanded to include minor injuries that are recorded more often than emergency visits or loss of school days due to injuries. Each of the two 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

Overview of Women's Health Services Program/2005/

State General Revenue Funds (GRF) that had previously been assigned to the Title X family planning grantees in Ohio have been redirected to a newly established program, Women's Health Services (WHS). These funds, \$1,700,000/fiscal year have been awarded to twenty-two health departments, representing an addition of 10 new family planning programs in health departments. All but one program is currently a CFHS provider. The majority of the WHS programs are located in rural counties or small cities. The impact on family planning in Ohio will be monitored. //2005//

F. TECHNICAL ASSISTANCE

The purpose of this section is to discuss in more detail the technical assistance needs of Ohio as reported on Form 15. (5 pages limit)

Technical Assistance Requests (not listed in order of preference or importance):

1. Ohio is requesting Technical Assistance to support a site visit to Ohio from Ralph Shubert and Belinda Waller from the Illinois Title V program to provide detailed information about their Family Case Management Program which has helped them reduce their low birthweight rates among participants. The assistance is needed because Ohio is striving to reduce its low birthweight rate, particularly among the African American population.

2. BCMH requests technical assistance on the integration of relevant program data reported in the MCH Block Grant application and other federal grant programs with state birth defects surveillance system. Ohio is developing a birth defects information system and wants to ensure that children identified with birth defects are linked with appropriate services, especially traditional MCH services such as CSHCN.

3. Ohio requests TA in creating indices that consolidate a variety of MCH and population indicators in order to provide an overall description of MCH problems and subsequently target funds. There is difficulty in targeting funds when some MCH and population indicators indicate a problem and others do not. Ohio requests TA in assisting in the development of funding formulas through a process that would develop a standard set of indices that all funding formulas should be based on and then a more specific set of indices that would be program-specific. Virtually all of our programs do this independent of other program areas and do not use a standard set of indices. A more standardized approach would be beneficial to the state agency.

4. Ohio requests TA for expertise in two areas:

- 1) using data sets for quality improvement in perinatal centers
- 2) using the DUC and Perinatal Periods of Risk (PPOR) data to improve access to culturally competent care and reduce racial and ethnic disparities in perinatal outcomes. The Ohio Perinatal Data Use Consortium (DUC) links medicine and public health leaders for the purpose of improving perinatal outcomes through quality improvement and performance monitoring. The DUC holds two meetings per year for statewide training and convenes regular technical assistance conference calls. The TA is needed for the next meeting in Winter 2004.

Possible experts (two topics) include: Jeffrey B. Gould, MD, MPH to discuss the California Perinatal Quality Care Collaborative; Jeffrey Horbar, MD, to discuss the Vermont Oxford Network; Cheryl Major, RNC, BSN, Senior Associate in Pediatrics at Vanderbilt University to discuss cultural competence in perinatal care; Tawara D. Goode, MA, National Center on Cultural Competency to speak about the SIDS project.

Reason Why TA is Needed - At the Spring DUC meeting, teams described a need for more intensive technical assistance on: 1) quality improvement data sets, and 2) cultural competency (particularly to eliminate racial/ethnic disparities). Ongoing technical assistance for the DUC is being provided under a contract between ODH and Dartmouth College, and, using Title V grant funds awarded through the regional perinatal program, each team supports the cost of their travel expenses for each DUC meeting. However, additional funds are needed for travel and honoraria costs to bring in experts on these two additional topics. This technical assistance will reach key staff in regional perinatal centers, urban health departments, Healthy Start program, home visitors, and state infant mortality reduction team.

What State, Organization or Individual would you suggest provide the TA: George Little and Kay Johnson, Department of Pediatrics, Dartmouth College (We could return to Johnson Group Consulting, Inc. if that is easier to use.) Rationale is that Little and Johnson are the core TA consultants who would put together the program and experts for Winter 2004 meeting.

V. BUDGET NARRATIVE

A. EXPENDITURES

A. Expenditures

Form 3 -- FFY03

Ohio continues to spend more than its federal allocation. The result is its unobligated balance is decreasing. Typically, Ohio plans to use its unobligated balance to support MCH activities during the first quarter of the new federal fiscal year while it waits on the arrival of the new notice of award.

The FFY03 Federal-State Title V Block Grant Partnership expenditures were \$61,955,089. This is \$1,263,184 above the FFY02 expenditure amount of \$60,691,905.

Overall FFY03 expenditures (includes other federal funds) regarding MCH activities were \$294,858,294. This is \$13,607,798 above the FFY02 amount of \$281,250,496.

Form 4 -- FFY03

FFY03 expenditures for pregnant women of \$7,385,963, infants of \$3,235,176, and children (1-22) of \$20,631,866 are all above the FFY02 expenditure levels for each respective category. However, FFY03 expenditures for children with special healthcare needs of \$29,788,019 are \$1,480,699 below the FFY02 amount of \$31,268,718. This can be attributable to budget cuts that directly impacted funding for children with special healthcare needs.

Additionally, the expenditures for administration of \$914,065 was above FFY03 budgeted amounts of \$840,878 and above FFY02 expenditure amounts of \$904,681. However, Ohio is still well within the 10% administration requirement.

Form 5 -- FFY03

FFY03 expenditures for Direct Health Care Service of \$33,751,769, Enabling Services of \$11,787,116, Population Based Services of \$5,893,561, and Infrastructure Building Services of \$10,522,643 are 54.4%, 19.0%, 9.6%, and 17.0% of total Federal-State Title V Block Grant Partnership expenditures, respectively.

Ohio is aware that its pyramid structure is heavy in the area of direct services; however, Ohio is making a concerted effort to model the MCH service pyramid. For example, Ohio's Community and Family Health Services bureau is in the process of making significant changes in how it funds the Community and Family Health services sub-grant program (i.e., become more in line with the MCH pyramid). Ohio will continue to strive to make changes to its methods of service delivery and become more focused on population, enabling, and infrastructure services.

B. BUDGET

3.3 Annual Budget and Budget Justification

Summary Budget FY2005

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: \$ 5,570,589

Component B: 9,398,995

Component C: 7,681,030

Subtotal: 22,650,614

Administrative Costs: 659,963

GRANT TOTAL: \$ 23,310,577

* 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 FFY2005 request, Ohio has budgeted \$ 66,438,017 for services for Pregnant Women, Mothers and Infants to Age One; 22.2 percent of the \$ 299,260,578 total funds targeted for Title V related activities. For this component, MCH Block Grant funds total \$ 5,570,589 or 23.9% of the \$ 23,310,577 MCH Block Grant request. Other State and Federal funds for this component total \$ 60,867,428 or 22.1% of the budgeted \$ 275,950,001 in other Title V related funds.

Level of Pyramid

Direct Health Care Services:

The FFY2005 Component A direct health care services budget is associated with State Negotiated Performance Measure 1 in the Annual Plan. Other funds designated for this function include National Student Loan Repayment program and WIC.

Enabling Services:

FFY2005 Component A enabling services does not have any associated performance measures.

Population-Based Services:

The FFY2005 Component A population-based services budget is associated with Core Performance Measures 1, 11, 12 and State Negotiated Performance Measures 11, 13, and 14.

Infrastructure Building Services:

The FFY2005 Component A infrastructure building services budget is directly associated with Core Performance Measures 15, 17, 18 and State Negotiated Performance Measure 16.

Preventive and Primary Care Services for Children and Adolescents

In its FFY2005 request, Ohio has budgeted \$ 199,607,500 for Preventive and Primary Care Services for Children and Adolescents or 66.7 percent of the \$ 299,260,578 total of all funds designated for Title V and related activities. MCH Block Grant funds for this component total \$ 9,398,995 which is 40.3 percent of the \$ 23,310,577 MCH Block Grant request. Other State and Federal funds for this component total \$190,208,505 or 68.9 percent of the \$ 275,950,001 in other Title V related funds.

Level of the Pyramid

Direct Health Care Services:

The FFY2005 Component B direct health care services budget is associated with State Negotiated Performance Measure 7 in the Annual Plan. Other state and federal funds designated for this level include: State Child and Family Health Services funds.

Enabling Services:

The FFY2005 Component B enabling services budget is directly associated with State Negotiated Measure 5 in the Annual Plan.

Population-Based Services:

The FFY2005 Component B population-based services budget is associated with Core Performance Measures 7, 8, 9, 10 and State Negotiated Performance Measures 9 and 15.

Infrastructure Building Services:

The FFY2005 Component B infrastructure building services budget is associated with Core Performance Measures 13, 14 and 16.

Children with Special Health Care Needs

In its FFY2005 request, Ohio has budgeted \$ 32,677,414 for activities for Children with Special Health Care Needs or 10.9 percent of the \$ 299,260,578 of total funds budgeted for Title V and related activities. For this component, MCH Block Grant funds total \$ 7,681,030, which is 32.9 percent of the \$ 23,310,577 MCH Block Grant request. Other State funds for CSHCN total \$24,996,384 or 9.1 percent of the \$275,950,001 in other Title V related funds.

Level of the Pyramid

Direct Health Care Services:

FFY2005 Component C direct health care services budget is associated with Core Performance Measures 5 and 6 in the Annual Plan. The "other funds" designated for this level includes state subsidy; medically handicapped children audit funds; and the medically handicapped children county funds.

Enabling Services:

FFY2005 Component C enabling services budget is associated with Core Performance Measure 3 in the Annual Plan.

Population-Based Services:

FFY2005 Component C population-based services does not have any associated performance measures.

Infrastructure Building Services:

The FFY2005 Component C infrastructure building services budget is associated with Core Performance Measures 2 and 4 in the Annual Plan.

Administrative Costs

Function	MCH Funds	Other Funds	Total Budget
Administrative	\$ 659,963	0	\$ 659,963

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 2005 federal MCH award is expected to be \$ 23,310,577 and the state will provide \$ 23,984,359. 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 2005 are shown below.

Description 1989 2005

Sickle Cell Control	\$ 421,347	595,420
Genetic Services	1,144,281	480,850
Child & Family Health Services	5,652,423	150,000
Adolescent Pregnancy	400,000	0

Medically Handicapped Children 4,682,744 6,074,974
Cystic Fibrosis 325,394 0
Medically Handicapped Audit Funds 1,312,168 2,362,428
Medically Handicapped County Funds 9,874,626 14,320,687
Total \$ 23,812,983 23,984,359

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 2005 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 it is dedicated to the provision of services to adults with cystic fibrosis. Services for children with cystic fibrosis are supported by other state CSHCN funds. One million, seven hundred thousand (\$1,849,719) 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 new state initiative called Women's Health (previously dedicated to family planning services). An additional \$717,408 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 continues to experience a drop in expected revenue receipts. This has had an impact on the amount of General Revenue funds available to support MCH and other state initiatives. Additional, Ohio has made a cognitive decision to not include \$4,444,586 of State Child and Family Health Services appropriation with the expectation that it may be used to draw down additional federal funds through the Medicaid Administrative Match program. This will enhance Ohio's ability in the future to direct additional funds towards MCH program initiatives. Therefore, Ohio's maintenance of effort has decreased by 6,329,718 from 30,314,077 in 2004 to 23,984,359 in 2005. The State Child and Family Health Services appropriation will continued to be used to conduct MCH activities; however, Ohio will not use these funds to match the MCH Block grant.

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 7/1/01 6/30/02 31.5% On Site Unrestricted (1)
Fixed 7/1/02 6/30/05 32.0% On Site Unrestricted (1)
Final 7/1/01 6/30/02 16.4% On Site Restricted (2)
Provisional 7/1/02 6/30/05 16.4% On Site Restricted (2)
Provisional 7/1/05

Until amended, use same rates and conditions as those cited for fiscal year ending June 30, 2005. Restricted rate is for U.S. Department of Education Programs which require 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 2005 MCH Block Grant request are based on budget and expenditures related to the Operational Support Section of the Bureau of Health Services Information and Operational Support. The Operational Support Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs. In FFY2003, an administrative time study was conducted. The goal of the study was to measure the time spent by administrative staff supporting activities of the Division of Family and Community Health Services (where Title V funds are administered) for all major funding sources.

FFY2005 Carry Over Funds:

The amount of carryover funds is based on the total amount of funds available in 2004 less projected expenditures and encumbrances as recorded through February 2004. In FFY2004 a total of \$ 28,228,648 in MCH Block Grant funds were available to the State of Ohio. According to the Department's accounting reports, which reflect activity through February 2004, projected expenditures and encumbrances to be posted against FFY2004 MCH funds will total \$ 25,322,970. When total available funds are reduced by total project expenditures and encumbrances, the Division expects to have an unencumbered balance of \$2,905,678.

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. Therefore, Ohio will need to receive its FFY05 NOA no later than November 15, 2004 in order to provide continuity of services to our local partners who otherwise could be forced to interrupt services.

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.