**MCH Block Grant– 5 Year Action Plan**

**Women**

In addition to the Women priorities, the Action Group will address the cross-cutting priorities (ACEs and Equity) and incorporate non-traditional partners (per Public Health 3.0).

| MCH Priority | Objectives & Strategies<br>Objectives- statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (NPMs/SPMs) | National or State Outcome Measures (NOMs/SOMs) |
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| Decrease risk factors contributing to maternal morbidity | 1. By 2025, increase percent of women with a preventative medical visit by 5%.<br>Strategies: A) Provide well-woman visits within Title X clinics following ACOG guidelines B) Community needs assessment on barriers to pre- and inter-conception care through MP subgrant C) Implement culturally relevant community, clinical, or community-based services to address unique pre- and inter-conception issues for women 18-44 through MP subgrant D) Implement education and awareness for pre-conception and reproductive health targeting high-risk women through MP subgrant. E) Find and review data on quality and comprehensiveness of preventative medical visits as well as feasibility and evidence-based practices for promoting standards (include mental health, health behaviors, dental, social determinants, referrals) F) Work with partners to develop plan to increase coordination, referral, access, and uptake of high-quality services for at-risk women 18-44 G) Distribute guidelines on managing oral health care during pregnancy to perinatal and dental care providers H) Integrate oral health education, assessment and referrals for dental care into community-based health care systems that serve women of reproductive age (e.g., FQHCs, WIC, Home Visiting)<br><br>2. By 2025, reduce the rate of severe maternal morbidity by 12%.<br>A) Increase use of AIM safety bundles in healthcare systems for at-risk pregnant women. B) Increase women's health screenings during pediatric well visits C) Develop a statewide strategic maternal health plan through the Ohio Coalition to Address Maternal Health (OH-CAMH) D) Increase the percent of pregnant and postpartum women who receive urgent maternal warning signs education in WIC, Home Visiting, and Healthy Start programs E) Continue Gestational Diabetes QI projects to improve postpartum visit and testing rates F) Train emergency department providers to recognize, triage, and treat obstetric emergencies G) Train maternal health care providers on how to conduct effective telehealth encounters<br><br>3. By 2025, develop expanded maternal health surveillance to allow for adequate monitoring and tracking to inform programmatic interventions.<br>A) Expand data collections for COVID-19 for maternal population (SOARS, OPAS, ODRS linking to birth certificate) B) Enhance surveillance for maternal morbidity through PAMR program C) Develop maternal substance use surveillance system and provide epidemiologic support for implementation of associated activities (CSTE fellowship) D) Develop protocols for systemic data into action | % of birthing hospitals that have implemented the AIM hypertension bundle | 1- Percent of women (18-44) with a preventative medical visit in past year | 2- Rate of severe maternal morbidity per 10,000 delivery hospitalizations<br><br>SOM- disparity- Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations |
| Increase mental health support for women of reproductive age | 1. By 2022, develop plan to increase coordination, referral, and uptake of mental health services for women 18-44.<br>A) Develop plan in coordination with other state agencies to increase coordination, referral, and uptake of mental health services for women of reproductive age B) Continue to build trauma informed care into interventions in community-based settings for mental health C) Continue screenings for mental health/ substance abuse and provide referrals through Title X program | | SPM- Percent of women (18-44) with unmet mental health care or counseling services need in past year (OMAS) | 24- Percent of women who experience postpartum depressive symptoms |

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| | 2. Increase access, referral, and coordination of mental health services for pregnant and postpartum women 18-44.<br>A) Implement culturally relevant peer support behavioral health services for high risk pregnant and postpartum women through MP subgrant B) Implement programs and strategies to decrease alcohol use during pregnancy C) Continue Practice and Policy Academy participation to inform implementations of plans of safe care D) Increase women's postpartum depression/anxiety screening during pediatric well visits | | | following recent live birth<br><br>SOM- Percent of women (18-44) with 14 or more mentally distressed days in past month (OMAS) |
| Decrease risk factors associated with preterm births | 1. By 2025, reduce the proportion of women of reproductive age smoking by 15%.<br>A) Develop plan to re-engage partnerships and identify strategies for addressing smoking use among women of reproductive age (including 5 A's strategies and provider training through RHWP, WIC, OCHIDS, TUCP) B) Improve cross-referrals among programs addressing tobacco use (e.g., Quit Line refer to Baby and Me Tobacco Free); C) Identify and leverage cross promotional/marketing opportunities (media, partner collaborations) D) Continue to provide supports for pregnant women to quit smoking through Moms Quit for Two program.<br><br>2. By 2025, increase enrollment of high-risk populations in evidence-based home visiting programs by 10% each year.<br>A) Implement home visiting services for at risk pregnant and post-partum women. | Percent increase in enrollment of high-risk populations in evidence-based home visiting programs. | SPM- Percent of women (18-44) smoking in reproductive age (BRFSS) | 5- Percent of preterm births (<37wks) |

**Infant**

In addition to the Adolescent priorities, the Action Group will address the cross-cutting priorities (ACEs and Equity) and incorporate non-traditional partners (per Public Health 3.0).

| MCH Priority | Objectives and Strategies<br>Objectives- statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence-Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (NPMs/SPMs) | National or State Outcome Measures (NOMs/SOMs) |
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| Support healthy pregnancies and improve birth and infant outcomes | 1. By 2025, increase the percent of infants who are ever breastfed by 20% and percent of infants who are breastfeed exclusively through 6 months by 60%.<br>Strategies: A) Continue implementation and expand promotion of 24/7 breastfeeding hotline and virtual lactation consultants. B) Continue breastfeeding initiatives in hospitals, worksites, and childcare facilities C) Improve breastfeeding continuity of care<br><br>2. By 2025, increase the percent of infants placed to sleep on their back by 7%, alone on separate approved sleep surface by 17%, and without soft objects or loose bedding by 25%.<br>Strategies: a) Continue implementation of the Cribs for Kids Program to provide safe sleep education and safety-approved cribs to families b) Support local collaborative efforts to plan and implement safe sleep strategies through the Cribs for Kids Program C) Continue implementation of the annual safe sleep campaign to provide consistent messaging on safe sleep practices to families D) Revise safe sleep educational materials to reflect infant safe sleep recommendation updates, once released by the American Academy of Pediatrics (anticipated in 2021).<br><br>3. By 2022, develop plan for enhancing coordination of pregnancy and post-partum supports and messaging.<br>Strategies: A) Enhance partnerships with state agencies, local organizations, and stakeholders to improve coordination of pregnancy and post-partum services. B) Enhance partnerships with state agencies to improve coordination of state funding for local MCH activities. C) Explore coordination of safe sleep, breastfeeding, and smoking cessation messaging.<br><br>4. By 2025, reduce Black infant mortality rate to 6.0 per 1,000 live births.<br>A) Increase access to clinical and social services through outreach and identification of Black pregnant women. B) Increase use of social support services among high-risk Black pregnant women to address social determinants of health. C) Support local community-driven policy and practice change addressing social determinants of health that impact poor birth outcomes. D) Improve access to basic needs resources for pregnant and postpartum women (e.g., Cribs for Kids). E) Data to examine variations in cause of infant death by race and ethnicity to inform data to action.<br><br>5. By 2022, assess need for and explore opportunities to improve infant outcomes through enhancing screenings and education provided during well-baby visit.<br>A) Assess need for and explore opportunities to educate/train providers on enhanced screenings and education during well-baby visit (Bright Futures, including lead, hearing, vision, oral health, immunizations, safe sleep.) B) Explore cross-program support opportunities through partnership with State Immunizations program. | Percent of birthing hospitals receiving recognition from Ohio First Steps for Healthy Babies<br><br>Number of families provided with a crib and safe sleep education through Cribs for Kids | 4a- Percent of infants ever breast fed; 4b- Percent of infants exclusively breastfed through 6 months<br><br>5- Percent of infants placed to sleep on their back, alone on separate approved sleep surface, without soft objects or loose bedding | 9.2- Neonatal mortality rate per 1,000 live births<br><br>9.1- Infant mortality rate per 1,000 live births<br><br>SOM- Black infant mortality rate per 1,000 live births |

**Child**

In addition to the Child priorities, the Action Group will address the cross-cutting priorities (ACEs and Equity) and incorporate non-traditional partners (per Public Health 3.0).

| MCH Priority | Objectives and Strategies<br>Objectives-Statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (NPMs/SPMs) | National or State Outcome Measures (NOMs/SOMs) |
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| Improve nutrition, physical activity, and overall wellness of children | 1. By 2022, coordinate across programs to develop a plan to increase rates of primary care providers conducting quality comprehensive well child visits that include developmental and other screenings. Plan to address:<br>a. Increasing provider education/training for comprehensive well visits (Bright Futures, screenings and referrals to include: developmental screenings, lead, hearing vision, oral health, immunizations, BMI, social determinants of health, and ACEs).<br>b. Partnership between programs that can mutually promote comprehensive well visit (e.g., state immunization)<br>c. Explore opportunities to support/implement evidence-based models for pediatric primary care (e.g., HealthySteps)<br>d. Increase the awareness of the need for developmental screenings and other screenings among parents and caregivers.<br>e. Educate primary care providers on billings for provision of services (expand QI initiative for vision screening billing and use results to inform efforts on other billing codes).<br>2. By 2025, increase the percent of children, ages 9-35 months, that receive developmental screens via home visiting programs by 10%.<br>a. Support MIECHV and other home visiting programs to provide developmental screening using Ages and States Developmental Screening tool.<br>b. Implement Medicaid/CHIP reimbursement claim code for developmental screening activities at provider level.<br>c. Educate parents about developmental screening tools. | Percent of children, ages 1 through 66 months, receiving home visiting services who have received a developmental screening | 6- Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year | 19- Percent of children (0-17) in excellent or very good health<br><br>20- Percent of children (2-4) and adolescents (10-17) are obese<br><br>25- Percent of children (0-17) who were not able to obtain needed health care in the last year<br><br>SOM- elevated blood lead level (SHIP Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) (confirmed only))<br><br>14- Percent of children (1-17) who have decayed teeth or cavities in the past year |

**Adolescent**

In addition to the Adolescent priorities, the Action Group will address the cross-cutting priorities (ACEs and Equity) and incorporate non-traditional partners (per Public Health 3.0).

| MCH Priority | Objectives and Strategies<br>Objectives- statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (NPMs/SPMs) | National or State Outcome Measures (NOMs/SOMs) |
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| Increase developmental approaches and improve systems to reduce adolescent and young adult suicide rate | 1. By 2025, reduce risk and increase protective factors for adolescents (coordinated with objective 2 and priority 2 objective 3).<br>a. Implement evidence-based adolescent resiliency projects through MP grant<br>b. Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation and Bullying Initiative<br>c. Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease HIB<br>d. Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP.<br>2. By 2022, develop a plan for MCH to support implementation of Ohio Suicide Prevention Plan among targeted youth population<br>a. Increase MCH representation on State Suicide Plan implementation team<br>b. Identify gaps in state programming that would fit within MCH work<br>c. Explore programs that MCH can support<br>d. Coordinate work within MCH to align with state plan and external partner programs | | SPM- nonfatal intentional self-harm ED visits and hospitalizations ages 15-19 per 100,000 (VIPS) | 16.3- Adolescent suicide rate ages 15-19 per 100,000 |
| Increase protective factors and improve systems to reduce risk factors associated with the prevalence of adolescent substance use | 1. By 2025, increase percent of adolescent with a preventive medical visit in past year by 3%.<br>a. Continue collaborative efforts to convert sports physicals to comprehensive well-visits<br>b. Partner with payors to incentivize the well-visit<br>c. Partner with Medicaid and Education to support School Based Health Care initiatives<br>2. By 2022, develop plan for promoting comprehensive adolescent well-visit that includes:<br>a. Provider education/training for comprehensive well-visit emphasizing the connection between physical health and mental health, substance use including tobacco, trauma, and appropriate screenings and referrals to services (Bright Futures)<br>b. Partnership between programs that can mutually promote comprehensive well-visit (e.g., state immunization) | Percent of adolescents (12-17) in county served by Medicaid with adolescent well visit | 10- Percent of adolescents (12-17) with a preventive medical visit in the past year | SOM- Percent of high school students who have used alcohol within the past 30 days (YRBS)<br><br>SOM-Percent of high school students who have used marijuana within the past 30 days (YRBS)<br><br>SOM-Percent of high school students who have used cigarettes, smokeless tobacco (i.e. |

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| | c. Reviewing state/systems-level policies to assure equitable access to and uptake of high-quality well-visit.<br>3. By 2025, increase coordination and capacity of state and local partnership to support adolescent mental health and reduce adolescent substance use, including tobacco use<br>a. Identify existing collaboratives and build MCH representation and support<br>b. Collaborate with partners to conduct an environmental scan of current community prevention work, including risk and protective factors, at state and local levels, including youth led prevention programs<br>c. Explore with partners development of system for tracking and supporting mental health provider partnerships in schools<br>d. Analyze existing data to identify priority populations and disparities.<br>e. Continue trauma informed care efforts with public health partners (SADVPP)<br>f. Explore cross-program opportunities with TUPCP for youth tobacco use prevention and cessation (e.g., cross-program referrals; cross-program promotional/marketing opportunities) | | | chewing tobacco, snuff or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days (OYTS) |

**Children with Special Health Care Needs**

In addition to the CSHCN priorities, the Action Group will address the cross-cutting priorities (ACEs and Equity) and incorporate non-traditional partners (per Public Health 3.0).

| MCH Priority | Objectives and Strategies<br>Objectives- statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (NPMs/SPMs) | National or State Outcome Measures (NOM/SOM) |
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| Increase prevalence of children with special health care needs receiving integrated physical, behavioral, developmental, and mental health services | 1. By 2025, Increase percent of Ohio's adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care by 10%.<br>A. Work with adult and pediatric medical providers to assure knowledge and awareness of transition<br>B. Work with partners to increase the number of adult providers that serve CSHCN population and participate in transition planning<br>C. Work with partners to assure family and teen knowledge and support regarding transition<br>D. Release RFP for children's and adult hospital system in the same geographic area to conduct pilot transition project that includes a coordinator in each system and standard model for charting and implementing a life course plan<br>E. Identify social determinant barriers in medical transition and require transition planning model to address<br>2. By 6/30/2023, develop a plan for increasing the percent of Ohio's adolescents with special health care needs, ages 12 through 17, who received services to support transitions to adulthood outside health care.<br>A. Explore non-health care transition resources and methods of sharing, including in health care transition planning and education (including identifying and educating those who will be responsible for sharing resources with individuals and families)<br>B. Explore mechanisms for automatic referrals for children at certain age to those other programs that would help transition to other supports/ systems<br>3. By 2025, Increase percent of Ohio's children with special health care needs, ages 0-17, who receive care in a well-functioning system by 10%.<br>A. Work with partners to coordinate services within clinical and non-clinical service delivery systems (e.g., explore interagency agreements, automatic referral mechanisms, coordinated outreach and education)<br>B. Leverage partnerships with children's hospitals who provide Hospital-Based Service Coordination (HBSC) for CSHCN enrolled in the CMH program to embed service coordination plans in electronic medical records for access/use by all clinicians and caregivers.<br>C. Seek ways to expand HBSC for CSHCN not enrolled in CMH.<br>D. Promote Parent-to Parent mentoring model to assist parents with navigating complex medical systems<br>E. Work with partners to develop action team to examine previous preparedness workbook and develop new plan for increasing resources to develop emergency preparedness plans among CSHCN. | Percent of CSHCN ages 17 and older enrolled in CMH with a transition plan in place | 12- Percent of adolescents (12-17) who received services necessary to make transitions to adult health care | 17.2- Percent of CSHCN (0-17) who receive care in well-functioning system |

## Cross-cutting

Cross-cutting priorities are incorporated into each population and this Action Group. The CC Action Group will also incorporate non-traditional partners(per Public Health 3.0).

| MCH Priority | Objectives and Strategies<br>Objectives- statement of intention with which results can be measured and compared (SMART)<br>Strategies- General approaches taken to achieve objectives (activities are specific actions to implement the strategies and are updated annually as part of the AP narrative) | Evidence Based or Informed Strategy Measures (ESMs) | National or State Performance Measures (SPMs) | National or State Outcome Measures (NOMs/SOMs) |
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| Prevent and mitigate the effects of adverse childhood experiences | 1. By 2022, enhance data collection to inform ACEs prevention and intervention.<br>A) Apply for funding from CDC to add ACEs questions to the Youth Risk Behavior Survey (YRBS) B) Coordinate YRBS and OHYes data collection efforts<br><br>2. By 2025, reduce the number of children 0-17 who experience two or more ACEs by 10%. Cross-strategies with other priorities:<br>A) Explore opportunities to support/implement evidence-based models for pediatric primary care to identify and address ACEs exposure with brief screening and assessments and referral to intervention services and supports (Child) B) Implement evidence-based adolescent resiliency projects through MP grant (Adolescent) C) Continue MCH participation in existing prevention workgroups and coalitions, such as Ohio Anti-Harassment, Intimidation and Bullying Initiative (Adolescent) D) Provide resources, technical assistance and professional development to health professionals working in the school and early childhood level to support resiliency and decrease HIB (Adolescent) E) Support programming in local communities for professionals and community members on preventing violence and identifying and responding to victims of violence through SADVPP (Women & Adolescent). | | SPM- Percent of children, ages 0-17, who have experienced two or more adverse experiences (NSCH/ODJFS) | |
| Improve healthy equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes | 1. By 2022, develop plan to build system to advance health equity in MCH staff and programs.<br>A) Select and implement health equity-increasing strategies in all state priority areas<br>B) Build bureau equity workgroup<br>C) Develop plan for improving internal MCH organization equity and staff capacity through bureau workgroup<br>D) Develop plan to institutionalize health equity in policy, program, grant, and contract administration through bureau workgroup<br>E) Build diversity in CMH Parent Advisory Committee | | SPM- Percent of performance measures that include at least one strategy focused on social determinants of health, at-risk populations, or health disparities. | SOM- (Women) Non-Hispanic Black rate of severe maternal morbidity per 10,000 delivery hospitalizations<br>SOM- (Infant) Black infant mortality rate per 1,000 live births<br>SOM- (Child) Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) |