



## HEALTHCARE SERVICES

The Ohio Department of Job and Family Services (ODJFS) Office of Families and Children (OFC) monitors compliance with state mandates designed to ensure youth in the child welfare system (foster children and those receiving in-home services) acquire timely health evaluations and needed follow-up treatment. To fulfill this responsibility, OFC has established a collaborative oversight and coordination plan with partners from the Ohio Department of Medicaid (ODM), the Ohio Department of Health (ODH), the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the Ohio Department of Developmental Disabilities (DODD), health care providers, and consumers to evaluate provision of health care services. In addition, these partners continue to work together to jointly address the ongoing health care needs of these children through program development and revisions to *Ohio Administrative Code* (OAC) rules.

## OVERSIGHT PLAN

### Child Welfare Policies

PCSA workers examine each child's physical, intellectual, and social development when conducting investigations of abuse or neglect. Findings are recorded and updated on the *Comprehensive Assessment and Planning Model-I.S. Family Assessment*. If concerns are identified and ongoing services are recommended, a case will be open. Details of any recommended medical services must be noted in the case plan, and the agency is required to provide health care resources to the family.

Public children services agencies (PCSAs) and private child placing agencies (PCPAs) must coordinate comprehensive health care for each child in custody who is placed in an out-of-home setting. To ensure coordination of care and increase family engagement in services, agencies are required to: arrange services from the child's existing and previous medical providers; and involve parents, guardians, and custodians in the planning and delivery of health care services. Placement agencies are also required to complete the JFS 01443, *Child's Educational and Health Information* form. The JFS 01443 is reviewed and updated any time there is a change in medical information, whenever there is a placement change, and at each semi-annual administrative review. The form must contain the following information:

- Name(s) and address(es) of the child's health care provider(s);
- Child's known medical problems, including any condition that is preventing the child from attending school on a full-time basis;
- Child's medications, including psychotropic medications;
- A record of the child's immunizations; and
- Any other pertinent information concerning the child's health (e.g., known allergies, including allergies to medications; childhood illnesses; and dates of the last physical, optical, and dental exams).

PCSAs are required to provide parents, guardians, custodians, pre-finalized adoptive parents (if applicable) and the substitute caregivers a copy of the JFS 01443 at the time the case plan is completed and whenever the form is updated. Additionally, agencies must provide personal medical histories to each youth at the time he/she emancipates from care.

Within five days of placement or a change in placement, the agency must secure a medical screening for the child to prevent possible transmission of communicable diseases and to identify symptoms of illness, injury, or maltreatment. Coordination of any needed care is to be completed within the child's first 60 days of placement. Specifically, agencies must:

- Secure an annual physical examination no later than 30 days from the anniversary date of the child's last comprehensive physical examination.
- Ensure that a child age three or under receives required pediatric care as prescribed by a licensed physician according to the *Bright Futures* periodicity schedule recommended by the American Academy of Pediatrics.
- Refer a child age three or under, who is the subject of a substantiated case of child abuse or neglect, to the county early intervention program for developmental screening.
- Assure a psychological examination is completed for a child adjudicated delinquent (unless a psychological examination was conducted within 12 months prior to the date the child was placed in substitute care).
- Secure appropriate immunizations.
- Ensure that treatment for any diagnosed medical or psychological need is initiated within 60 days of diagnosis, unless required sooner.

All healthcare information is to be documented in the child's case record within the state automated child welfare system (SACWIS). In SFY15, ODJFS made the following enhancements to SACWIS to improve documentation of healthcare needs and services:

- Person Characteristics, previously listed globally under Medical/Mental Health Characteristics, have been divided into the following categories to make it easier to navigate: Medical, Mental Health/Substance Abuse, Developmental/Intellectual, and Prenatal/Birth. Names of diagnoses align with changes in the DSM 5. Characteristics can no longer be deleted, but may be marked "created in error."
- Person Medical pages have been improved to streamline data entry. Health Care Providers for the child are recorded once on the Provider tab, and then pull forward to the Treatment Detail records, which is where all medical, dental, mental health, and vision treatments for a child are recorded. Narrative fields on the Treatment Detail records have been consolidated, and a copy feature was added so recurring treatments can be documented more efficiently. In addition, Diagnosed Characteristics can now be recorded from and linked to a Treatment Detail Record. The user can navigate directly from the Treatment record to the Characteristic Details page (some fields are prepopulated based on the Treatment Record) where they can record the diagnoses and then return to the Treatment record. By selecting from a list of all the child's current Characteristics, the user can 'link' the diagnoses resulting from a specific screening, assessment, or examination. Medical records can no longer be deleted, but may be marked "created in error."

- Medication records have been enhanced by including the most commonly prescribed medications in a drop-down field for selection, instead of the user having to type the name into a text field. This provides better data consistency as well as efficiency for the user. Psychotropic medications in the list are automatically flagged, and users can manually flag any “Other” psychotropic medications prescribed. The administrative Medication Detail Report was developed to improve monitoring of use for each child in PCSA custody. The fields include: the medication names, total number of medications, and total number of psychotropic medications recorded.
- The Pregnancy Detail Report allows PCSAs to record Estimated Due Dates, End Dates, and Outcomes to ensure retention of gestational-related historical records. In addition, Ohio’s SACWIS contains the following indicators to the Person Profile page: Pregnant, Pregnant/Parenting Minor, and Pregnant/Parenting Youth in Custody. To improve documentation of relatives, Ohio’s SACWIS also enables PCSAs to record the number of children each parent (both male and female) has, even those who are not involved in the child welfare system.

PCSAs are monitored on documentation of medical information, and on ensuring that examinations are completed within required timeframes. ODJFS determines agency compliance with health care mandates via Child Protection Oversight and Evaluation (CPOE) reviews. Should a PCSA be found to be non-compliant, the agency must complete a Quality Improvement Plan. The Department subsequently provides ongoing monitoring to assess the PCSA’s progress toward achieving compliance.

Screenings, Assessments and Treatment:

In Ohio, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is known as the HealthChek program. Pursuant to state child welfare policy, the custodial agency is required to complete the following activities for all Medicaid eligible children:

- Work with the county department of job and family services (CDJFS) Healthchek Coordinator to secure a health care screening. The examination components must include, but are not limited to:
  - Health and developmental histories;
  - A comprehensive physical examination;
  - Developmental, nutritional, vision, hearing, immunization and dental screenings;
  - A lead toxicity screening;
  - Lab tests; and
  - Health education and counseling.

The agency may authorize the substitute caregiver, managed care coordinator, medical providers, and custodial parents to serve as a liaison with the CDJFS Healthchek Coordinator for the purposes of scheduling and arranging transportation.

- Complete the *Healthchek and Pregnancy Services Assessment* form and return it to the CDJFS Coordinator.

EPSDT also covers necessary treatment of conditions identified through HealthChek screenings and chronic care for Medicaid-eligible children and teens. OFC works with the Ohio Department of Medicaid to maintain resource listings of local EPSDT providers for use by the PCSAs.

Per statute, a comprehensive health care screening or exam is not required when:

- A child has received a comprehensive health care screening or examination within three months prior to placement in substitute care and the results are filed in the case record;
- The child in custody is a newborn who was placed directly from the hospital; or
- If the child's placement episode is less than 60 days.

The PCSA or PCPA shall, however, coordinate health care whenever the child has a condition which indicates a need for treatment at any time during the placement episode.

### Bright Futures

To increase workers' awareness of recommended timeframes for child health assessments, ODJFS promotes use of the American Academy of Pediatrics' *Bright Futures* periodicity schedule. With support from the Maternal and Child Health Bureau, Health Resources and Services Administration, *Bright Futures* provides evidence-driven guidance for all preventive care screenings and wellness visits, for children birth - age 21. To view the guide, go to: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

### **Medicaid Enrollment of Youth Aging Out of Care**

Effective January 1, 2014, youth who emancipate from foster care at age 18 became eligible for categorically-based Medicaid coverage until age 26. Face-to-face interviews are not required for application; re-determination is completed annually; and eligibility cannot be terminated without a pre-termination review.

Youth who emancipate from Ohio's foster care system enroll in a Medicaid Managed Care plan of their choosing. Ohio's Medicaid Managed Care Benefit Package includes primary and acute care:

- Inpatient hospital services;
- Outpatient hospital services (including those provided by rural health clinics and Federally Qualified Health Centers (FQHCs));
- Physician services;
- Laboratory and X-ray services;
- Immunizations;
- Family planning services and supplies;
- Home health and private duty nursing services;

- Podiatry;
- Chiropractic services;
- Physical, occupational, developmental, and speech therapy services;
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services;
- Prescription drugs;
- Ambulance and ambulette services;
- Dental services;
- Durable medical equipment and medical supplies;
- Vision care services, including eyeglasses;
- Nursing facility services;
- Hospice care; and
- Behavioral health care (via carved-out operations through community behavioral health boards).

Ohio's Medicaid Managed Care Plans (MCPs) also provide value-added services that exceed those traditionally offered in a fee-for-service program. Some of these include:

- Care management;
- Access to a toll-free 24/7 nurse hotline for medical advice;
- Preventive care reminders;
- Health education materials; and
- Expanded benefits including additional transportation options, and other incentives (varies among MCPs).

The Departments continue to jointly analyze enrollment data. This past year, the Ohio Department of Medicaid (ODM) Bureau of Technical Assistance and Compliance worked collaboratively with the ODJFS, Office of Families and Children to increase Medicaid enrollment of former foster youth. Marketing strategies included:

- Updates to the Ohio Department of Medicaid website;
- Streamlined application processes through the Ohio Benefit Bank; and
- Kiosk-based applications.

To view the revised ODM webpage specifically designed for former foster youth, go to:

<http://medicaid.ohio.gov/FOROHIOANS/Programs/FosterCare.aspx>.

### **Health Care Power of Attorney**

PCSA caseworkers are required to educate youth who are aging out of care about how to establish health care powers of attorney (POA). This information is a component of the youth's transition plan and must be completed at least 90 days prior to the date of emancipation. Because Ohio law prohibits youth from formally establishing a durable POA prior to their 18<sup>th</sup> birthday, ODJFS continues to provide PCSAs guidance about how to assist youth in completing this process once they reach the age of majority.

# TRAUMA-INFORMED CARE

## STATE LEVEL INITIATIVES

### Data Analyses

ODJFS continues to contrast data from the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS) with state census data to determine prevalence of child abuse and neglect across numerous demographic variables. Ohio's rates of maltreatment reports and out-of-home placement remain higher for younger children indicating a need for early childhood interventions and family-based, trauma-focused treatment. A subsequent increase in maltreatment rates during early-mid adolescence illustrates the need to expand trauma-focused, cognitive-behavior therapy (TF-CBT) interventions for the older children. Disproportional minority representation within the child welfare system also clearly illustrates the need for culturally relevant interventions.

In recognition that families in the child welfare system typically experience multiple and complex traumas, Ohio has launched multiple strategic initiatives designed to improve access to a continuum of effective behavioral health care services. A summary of these projects follows.

### Ohio's Trauma Informed Care Initiative

In 2013, OhioMHAS established a statewide project designed to expand availability of effective services by increasing practitioners' competency in trauma informed care practices. The objectives of this work remain to:

- Increase awareness of trauma as a public health concern;
- Enhance the array of local services by identifying gaps in programming, promoting best practices, and fostering use of community linkages; and
- Establish regional learning communities through on-going training and facilitation of promotion of peer-based technical assistance.

Team members of this public-private partnership reflect a broad range of constituencies. Representatives include the: Ohio Hospital Association; Public Children Services Association of Ohio (PCSAO); Ohio Association of County Behavioral Health Authorities; Ohio Association of Child Caring Agencies; County Boards of Developmental Disabilities; Ohio Provider Resource Association; Ohio Human Trafficking Commission; Center for Innovative Practices; Center for the Treatment and Study of Traumatic Stress; Ohio Primary Parent Advisory Council; Ohio Women's Network; Ohio Board of Regents; OhioMHAS; DODD; ODH; ODJFS; ODM; and the Ohio Departments of Aging, Education (ODE), and Youth Services (DYS).

Activities to date include:

- Partnering with the Ohio Department of Health’s Early Childhood Comprehensive Systems (ECCS) Grant to present training on *Understanding Toxic Stress: Protecting Infants and Young Children From Life-Long Impacts of Prolonged Adversity*.
- Working with the Ohio Attorney General’s Office to address issues identified in programming supported through the Crime Victim’s Fund.
- Collaborating with the Ohio Attorney General’s Office and the Ohio Peace Officer Training Academy to develop and implement a six-hour curriculum entitled, *Trauma-Informed Policing*. Through this initiative, all sworn and commissioned law enforcement officers (approximately 34,000) were required to complete this training in order to meet reimbursement requirements for their agencies.
- Providing training to private agency providers on *Alternatives to Seclusion and Restraint in Children’s Residential Treatment Facilities*.
- Training over 10,000 professionals from various disciplines (e.g., behavioral health, developmental disabilities, child welfare) in trauma-informed approaches to treatment and intervention throughout the state.
- Conducting combined TIC training for ODJFS and OhioMHAS Licensure and Certification staff.
- Providing training for 200 staff from OhioMHAS, DODD, the Ohio Attorney General’s Office, ODJFS, ODE and ODH staff on *Trauma-Informed Approach: Key Assumptions and Principles*.
- Partnering with Department of Aging to roll out *Trauma-Informed Approach: Key Assumptions and Principles* to programming serving Ohio’s older adults.
- Hosting the fourth annual Statewide Summit on Trauma, *Creating Environments of Resiliency and Hope* in June 2017.

Regional Collaboratives:

In 2015, Ohio established six Regional Trauma-Informed Care (TIC) collaboratives. The map below illustrates how the regions are configured.



These sites serve to:

- Identify regional strengths, champions and areas of excellence to facilitate TIC implementation;
- Identify regional gaps, weaknesses and barriers for TIC implementation;
- Develop a repository of expertise and shared resources within the region to facilitate local and statewide TIC implementation;
- Train individuals to disseminate TIC principles and best practices; and
- Develop specific implementation strategies to effectively address the needs of specialty populations (e.g., the developmentally disabled, children, older adults, and those challenged by addiction).

For additional information about Ohio's Trauma Informed Care Initiative, visit the OhioMHAS website: <http://mha.ohio.gov/traumacare>

### **Systemic Trauma Training for Child Welfare**

The Institute for Human Services (IHS) is the coordinator of the Ohio Child Welfare Training Program (OCWTP). IHS develops and implements competency-based training for Ohio's foster and adoptive parents, caseworkers, supervisors, and administrators.

In partnership with OhioMHAS, IHS modified the National Child Traumatic Stress Network's (NCTSN) Child Welfare Training Toolkit to meet established timelines of the state's program. In addition, revisions to both the foster care and adoption assessor curricula were made this past year to increase awareness of the impact of trauma on child development, as well as child receptiveness to adoption processes. Three (3) new trauma-related trainings were also developed in 2016-2017:

- A 12- hour series for caregivers, caseworkers, and supervisors based on Dr. Karyn Purvis' Trust Based Relational Intervention Model;
- A nine-hour training for caseworkers entitled, *Promoting Successful Futures by Addressing Child Traumatic Stress in the Child Welfare System*; and
- A three-hour training for caregivers and caseworkers entitled, *Living Out the Essential Elements of Trauma Informed Care*.

In effort to further build competency in Trauma Informed Care (TIC) practices:

- The theme of the 2017 IHS conference was *Training Through a Trauma Informed Lens*;
- A three part article on TIC was featured in the February 2017 newsletter, *Common Ground*; and
- IHS vetted and entered into E-Track NCTSN's online course, *Adolescent Trauma and Substance Abuse*.

To build capacity of child welfare staff, IHS regularly offers the following sessions:

- *Overview of Trauma and Its Effect on Children*;

- *The Impact of Trauma and the Importance of Safety;*
- *Identifying Trauma-Related Needs and Enhancing Well-Being;*
- *Worker Well-Being and the Importance of Partnering;*
- *Baby Brain Science Basics;*
- *Wounded Child, Healing Homes: The Impact of Parenting Traumatized Children;*
- *The Power of Healing Connections;*
- *Removed: Strategies for Hope and Healing for Youth;*
- *Working with Traumatized Adolescents;*
- *Working with an Adolescent with a History of Trauma;*
- *A New Paradigm in Substance Abuse Counseling;*
- *Beyond the Bruises: An Overview of Domestic Violence;*
- *Interventions for Children Who Have Suffered Trauma;*
- *The Impact of Emotional Abuse;*
- *Helping children Heal Through Books;*
- *Building Partnerships: Providing TF-CBT to Youth In Care;*
- *Achieving Better Outcomes by Building Relationships with Children;*
- *Fostering Healing, Resiliency, and Hope for Traumatized Children;*
- *Trauma-Informed Case Management;*
- *Lessons in Loss: Children and Grief;*
- *A Layman’s Guide to Brain Research.*

The OCWTP also offers the NCTSN’s companion training for foster caregivers, *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents*. This series consists of the following three-hour modules:

- *Trauma 101;*
- *Understanding Trauma’s Effects and Building a Safe Place;*
- *Feelings, Behaviors, Connections, and Healing;* and
- *Becoming an Advocate and Taking Care of Yourself.*

In addition, the OCWTP offered the following specialized training sessions to caregivers in response to requests for further education on how to effectively address trauma-related needs of children in their care:

- *Preservice for Foster and Kinship Caregivers and Adoptive Parents:*
  - *Childhood Trauma and Its Effects, and*
  - *Minimizing the Trauma of Placement: A Layman's Guide to Brain Research;*
- *Babies' Brains: The Basics for Caregivers;*
- *Fostering Healing Resilience, and Hope for Traumatized Children;*
- *RAD: Reactive Attachment Disorder or Really Afraid Disorder;*
- *The Building Blocks of Trust;*
- *Trauma Lab for Caregivers;*
- *When Aggression is Their Profession;*
- *GAP: Meeting the Needs of the Newly Placed Child;*
- *Helping Teens Build Resilience;*
- *The Treatment of Sexually Abused Males;*
- *Wounded Child Healing Homes: The Impact of Parenting Traumatized Children;*
- *Trauma Systems Therapy for Foster Caregivers;*
- *Effects of Domestic Violence;*
- *Making Sense of Living with Sensory Processing Disorders;*
- *Living Out the Essential Elements of Trauma Informed Care;*
- *Interventions for Children Who Have Suffered Trauma;*
- *The Impact of Emotional Abuse;*
- *Bedtime Behaviors of Traumatized Children;*
- *Removed: Strategies for Hope and Healing for Youth In Care;*
- *Understanding Trauma and Trauma Bonding;*
- *Becoming a Trauma-Competent Caregiver (Parts I and II);*
- *Helping Teens Build Resiliency;*
- *Overcoming Trauma; and*
- *Self-Care for Caregivers Who Are Parenting Traumatized Children.*

## **Personal Responsibility and Education Program (PREP) Trauma Training**

During this reporting period, ODJFS partnered with the ODH and ODYS to present six-hour trauma trainings in various regions of the state. (Combined with the sessions presented the previous year, this training was made available statewide.) *Think Trauma: A Training for Staff in Juvenile Justice and Residential Settings* combined with *Essential Elements* from *The National Child Trauma Stress Network Child Welfare Training* were offered free of charge to facilitators of the Personal Responsibility and Education Program (PREP), child welfare staff, and foster parents affiliated with PREP provider agencies. In addition, biological parents were welcomed to attend with agency approval. The sessions were specifically tailored for front-line caregivers and staff. Components of the training included:

- Think Trauma - Trauma and Youth in Child Caring Systems:
  - Defining trauma and traumatic stress;
  - Recognizing how trauma reminders trigger behavior and their relationship to violence;
  - Identifying the role of resiliency;
  - Knowing what can happen when we take a trauma-informed approach to care with youth.
- Trauma's impact on development:
  - Identifying the key developmental tasks at each stage and the impact of trauma;
  - Learning methods to get development "back on track."
- Survival coping strategies:
  - Defining coping strategies - reframing violence, substance use and self-injury;
  - Understanding survival coping;
  - Learning alternative strategies;
  - Building a safety plan.

Continuing education credits as well as certificates toward meeting foster parent ongoing training requirements were issued to participants. Monique Marrow, Ph.D., who co-authored the curriculum, was the presenter for all sessions.

Dr. Marrow is a clinical child psychologist and a training specialist for the Center on Trauma and Children. She serves on several NCTSN committees, including; the National Steering Committee, the Affiliate Advisory Board, Community Violence, Complex Trauma, the Justice Consortium, and is Co-Chair of the Juvenile Justice Sub-Committee.

## **LOCAL INITIATIVES**

### **The National Child Traumatic Stress Network**

Over the past several years, Ohio has been selected to implement seven separate initiatives through the National Child Traumatic Stress Network (NCTSN). The projects have been located in metropolitan areas of the state: Cuyahoga, Franklin, Hamilton, Lucas, and Summit counties. Although these projects have been completed, the NCTSN work continues to serve as a foundation for Ohio's development of trauma-informed child welfare practices and expansion of traumatic focused treatment within the behavioral health system. Descriptions of the specific projects follow.

- ***The Regional Center of Excellence for the Treatment and Study of Adverse Childhood Events*** prepared communities to screen, assess, and treat traumatized children in a 9 county area of Northeast Ohio. Through this project, standardized screening for adverse childhood events (ACEs) was implemented at targeted points of entry throughout Akron Children's Hospital's continuum of care. Children who had been exposed to ACEs were then referred for trauma-focused treatment in their communities. In addition, the Center educated medical and children's mental health providers on use of evidence-based trauma-informed interventions.
- ***Transforming Care for Traumatized Youth in Child Welfare*** served children, aged 4-18 years, believed to be at risk for traumatic stress disorders, and provided evidence-based interventions when indicated. In addition, the grantee, Mental Health Services, Inc. (MHS), provided training to child welfare line staff and supervisors to promote use of trauma-informed practices. Previously, this site was also awarded NCTSN funding to implement the ***Children Who Witness Violence Program***. That project provided 24- hour/day trauma response services to children and families referred to MHS by police officers following incidents of domestic or community violence.
- ***The Mayerson Center*** adapted two evidence-based interventions to serve young children in **deployed military families and traumatized adolescents in juvenile justice and residential treatment centers**. This work addressed complex trauma via adaptation of the *Parent-Child Interaction Therapy (PCIT)* model and *Trauma and Grief Focused Component Therapy for Adolescents*. Project implementation included: training protocols and resources, train-the-trainer toolkits, and web-based training opportunities. Previously, the Mayerson Center, located in The Children's Hospital of Cincinnati, also received NCTSN funding as a **Trauma Treatment Replication Center** for child abuse evaluation, treatment, and research. The Center continues to train community providers on evidence-based child and adolescent trauma treatment.
- ***Nationwide Children's Hospital*** developed a trauma-informed service delivery system that served youth with severe psychiatric disorders and complex trauma. Specialized training conducted to implement this work included: *Dialectical Behavior Therapy, Trauma-Focused Cognitive Behavior Therapy with Selective Serotonin Reuptake Inhibitor Medication Treatment*; care management; expansion of evidence-based practices within the community; and evaluation of cultural appropriateness of strategies.
- ***The Cullen Center for Children, Adolescents, and Families*** provided evidence-based, multisensory trauma-focused therapies. Services were targeted to youth and families who had experienced community violence, child abuse, traumatic loss, serious illness and injury, and domestic violence.

### **The Gateway CALL Project, Franklin County Children's Services**

In October 2012, Franklin County Children's Services (FCCS) was awarded a five-year grant from the Administration for Children and Families to support expansion of its *Gateway CALL* (Consultation, Assessment, Linkage, Liaison) project. This initiative, a collaboration between FCCS and Nationwide Children's Hospital, is designed to improve access to evidence-based/evidence-informed behavioral health (BH) care services for youth involved in the child welfare system. The project seeks to standardize implementation of screening and assessment instruments to detect children's trauma issues and behavioral health concerns.

## PSYCHOTROPIC MEDICATION

### STATE LEVEL INITIATIVES

Over the past several years, Ohio has undertaken a multi-faceted approach to addressing the issue of psychotropic medication use within the foster care population. Ohio Administrative Code requires that PCSAs establish local policies and procedures to oversee and monitor the use of psychotropic medications by children in care. ODJFS reviews the local policies and procedures when conducting on-site agency reviews. In addition, Ohio's strategy also includes: advancing utilization of prescribing guidelines; promoting use of trauma-related developmental screening; and improving access to evidence-based treatments as essential components of increasing safety and reducing inappropriate use of medication. Partners in this effort include, but are not limited to: OhioMHAS, ODM, and ODH; local child welfare agencies; child health care providers; juvenile justice personnel; and representatives of local school districts.

The five major initiatives Ohio launched to advance the appropriate use of psychotropic medication have been:

- Establishment of prescription guidelines (see: BEACON, below).
- *Ohio Minds Matter*, the Administration's investment toward improving safe use of psychotropic medications:
  - Establishment of 3 pilot sites to examine effective cross-system practices;
  - Enhancement of tele-medicine options and provision of prescriber peer support;
  - Development of clinical guidelines based on aggression, attention, and mood symptomology;
  - Establishment of a website, [www.Ohiomindsmatter.org](http://www.Ohiomindsmatter.org) to increase knowledge and promote best practices; and
  - Development and dissemination of shared decision-making toolkits to facilitate effective patient-provider discussions regarding health care.
- Enhanced data analyses and use of data to improve prescribing practices.
- A Psychotropic Medication Toolkit for PCSAs to assist with development of local policies and procedures, and to facilitate informed consent practices.
- Promotion of evidence-based, non-pharmacological treatment.

### **Best Evidence for Advancing Childhealth in Ohio NOW! (BEACON)**

BEACON is a statewide public-private partnership which facilitates collaboration among more than 21 key children's provider organizations, five state agencies, and several children's advocacy groups. Partners include: the Ohio Academy of Family Physicians; the Ohio Chapter of the American Academy of Pediatrics; Voices for Ohio's Children; Ohio Children's Hospital Association; the American College of Obstetricians and Gynecologists; The National Alliance for the Mentally Ill-Ohio Chapter; The Ohio State University, Government Resource Center; and ODH, ODM, ODJFS, OhioMHAS, and DODD. BEACON's mission is to increase quality of care, improve child health outcomes and reduce costs.

BEACON initiated Ohio's efforts toward appropriate use of psychotropic medication by prioritizing:

- Timely access to safe and effective psychotropic medications, including atypical antipsychotics, in the context of evidence-based therapies;
- Improved health outcomes for Medicaid-eligible children, particularly those in foster care; and
- Reduced medication-related adverse effects.

As part of this process, BEACON set a goal of a 25% reduction in the following target areas by July 30, 2014:

- The use of atypical antipsychotic (AAP) medications in children less than 6 years of age;
- The use of 2 or more concomitant AAP medications for over 2 months duration; and
- The use of 4 or more psychotropic medications in youth less than 18 years of age.

For progress and impact to date, see *Ohio Minds Matter* below.

For additional information about the BEACON project design, refer to the **Key Driver Diagram** in **Appendix B1**.

In addition, child psychiatrists participating in BEACON continue to promote the following principles for prescribing AAPs:

- AAPs are to be prescribed in the context of the overall status of the patient's health.
- The lowest effective dose is to be used.
- Prescribers are to use caution with polypharmacy given limited data on long-term combination treatments.
- Prescribers are to carefully monitor potential adverse side-effects (e.g., body mass index, fasting glucose, lipids).
- AAPs are to be prescribed for a determined duration of treatment.
- Abrupt discontinuation is to be avoided.

### ***Ohio Minds Matter***

In September 2012, the Kasich Administration announced the unveiling of *Ohio Minds Matter*, a three-year project designed to:

- Increase timely access to safe and effective psychotropic medications and other treatments for children;
- Improve pediatric patient health outcomes; and
- Reduce potential medication-related adverse effects.

This \$1 million investment was targeted to those who provide services to Medicaid-eligible children, including those in foster care. Through this quality improvement initiative, Ohio:

- Developed technical resources and clinical guidelines to advance safe and effective prescribing practices.
- Provided second opinion consultation, educational outreach, and technical assistance to encourage supportive peer learning environments.
- Increased knowledge and understanding of parents/ caregivers, child-serving systems (e.g., child welfare, schools, juvenile courts) and pediatric patients about safe and effective use of psychotropic medications.

To achieve these goals, a Statewide Clinical Advisory Panel developed best practice guidelines. Members of the panel included child psychiatrists, pediatricians, pharmacists, and the state Medical Directors for ODM and OhioMHAS. Meeting bi-weekly, this group developed a medication guide, treatment guidelines, and tools for prescribers to use based on syndromic (rather than diagnostic) characteristics for: attention, mood, and aggression. Links to these resources are listed below.

- **Psychotropic Medication Guide:**
  - [Algorithm A: Antipsychotic Medication Management in Children Under 6 Years of Age](#)
  - [Algorithm B: Avoiding Use of More than One Atypical Antipsychotic \(AAP\) Medication in Children Under 18 Years of Age](#)
  - [Algorithm C: Avoiding Polypharmacy](#)
  - [Psychotropic Medication Parent Fact Sheet](#)
- **Psychotropic Medication Treatment Guidelines:**
  - [Psychotropic Medication List](#)
  - [Evidence-Based Treatments](#)
  - [Screening & Monitoring Tool](#)
  - [Informed Consent Process](#)
  - [AAP Adverse Effects Table](#)
  - [Psychotropic Medication Contraindications and Interactions Table Case Study](#)
- **Inattention, Hyperactivity, Impulsivity:**
  - [Algorithm D: ADHD](#)
  - **Treatment Guide**
    - [Criteria and Evidence Based Treatment](#)
    - [ADHD Medication Table](#)
    - [ADHD Medication Duration Table](#)
  - **ADHD Rating Scales:**
    - [Parent](#)
    - [Teacher](#)
    - [Follow Up](#)
    - [Scoring Instructions](#)
  - [Duration of Medication Effect Chart](#)
  - [ADHD Medication Side Effects and Intervention Chart](#)
  - [Resources](#)

- **Disruptive Behavior and Aggression**
  - [Algorithm E: Disruptive Behavior and Aggression](#)
  - [Treatment Guide](#)
  - [Modified Overt Aggression Scale](#)
  - [Resources](#)
- **Moodiness and Irritability**
  - [Algorithm F: Moodiness and Irritability](#)
  - [Patient Health Questionnaire](#)
  - [Ask Suicide-Screening Questions](#)
  - [Depression Treatment Guide](#)
  - [Substance Abuse Treatment Guide](#)
  - [BiPolar Treatment Guide](#)
  - [Resources](#)

Through the course of the project, *Ohio Minds Matter* continued to refine and develop additional resources for clinicians to use to further advance these efforts. These materials included:

- **A Quick Reference Guide:**  
[http://ohiomindsmatter.org/documents/Algorithm%20G\\_Page%20Break\\_with%20Links.pdf](http://ohiomindsmatter.org/documents/Algorithm%20G_Page%20Break_with%20Links.pdf)
- **Antipsychotic medication Management for children under 6 years of age:**  
[http://ohiomindsmatter.org/documents/Algorithm%20A\\_link\\_with%20page%20breaks.pdf](http://ohiomindsmatter.org/documents/Algorithm%20A_link_with%20page%20breaks.pdf)
- **Avoiding use of more than 1 atypical antipsychotic medication in children under 18:**  
[http://ohiomindsmatter.org/documents/Algorithm%20B\\_Link\\_with%20page%20breaks.pdf](http://ohiomindsmatter.org/documents/Algorithm%20B_Link_with%20page%20breaks.pdf)
- **Avoiding polypharmacy:**  
[http://ohiomindsmatter.org/documents/Algorithm%20C\\_link\\_with%20page%20breaks.pdf](http://ohiomindsmatter.org/documents/Algorithm%20C_link_with%20page%20breaks.pdf)
- **Psychotropic medication lists:**  
<http://ohiomindsmatter.org/documents/Psychotropic%20Medication%20List.pdf>
- **Evidence-based treatments by disorders:**  
<http://ohiomindsmatter.org/documents/5c%20Evidence-Based%20Treatments.pdf>
- **A screening and monitoring tool:**  
<http://ohiomindsmatter.org/documents/6%20Screening%20and%20Monitoring%20Tool.pdf>
- **Informed consent:**  
<http://ohiomindsmatter.org/documents/Informed%20Consent%20Process.pdf>
- **Adverse effects table:**  
<http://ohiomindsmatter.org/documents/AAP%20Adverse%20Effects%20Table.pdf>
- **Contraindications and interactions table:**  
<http://ohiomindsmatter.org/documents/9%20Drug%20Contraindications%20and%20Interaction%20Tables.pdf>
- **Case study:** <http://ohiomindsmatter.org/documents/10%20Case%20Study.pdf>
- **Behavioral symptom reference- Inattention, Hyperactivity, and Impulsivity:**  
[http://ohiomindsmatter.org/Inattention\\_Hyp\\_Imp.html](http://ohiomindsmatter.org/Inattention_Hyp_Imp.html)

- **Behavioral symptom reference- Disruptive behavior and aggression:** [http://ohiomindsmatter.org/Disruptive\\_Aggression.html](http://ohiomindsmatter.org/Disruptive_Aggression.html)
- **A Shared Decision-Making Toolkit:** [http://ohiomindsmatter.org/Phys\\_ToolKit.html](http://ohiomindsmatter.org/Phys_ToolKit.html)

For more information regarding these resources, go to: <http://ohiomindsmatter.org>

To promote on-going use of the website and increase professional knowledge about the prescribing guidelines, continuing educational credits are offered for completion of the *Ohio Minds Matter* on-line learning modules. Fields of expertise of medical professionals using this site to obtain continuing education credits include: Medical Doctors, Doctors of Osteopathic Medicine, Pediatricians, Psychiatrists, Developmental and Behavioral Pediatricians, Neurodevelopmental Pediatricians, Medical Directors, Epidemiologists, Medical School Professors, Clinical Nurses, Advance Practice Nurses, Pharmacists, Clinical Fellows, Medical Residents, and Medical Students. While most completing these training sessions were from Ohio, others were residents of: California, Florida, Georgia, Kentucky, Illinois, Nevada, New York, North Carolina, Oregon, Rhode Island, Tennessee, Texas, Washington, and West Virginia.

To review the *Ohio Minds Matter* Training Modules for continuing education credit, go to: [http://ohiomindsmatter.org/Prescribers\\_Learning.html](http://ohiomindsmatter.org/Prescribers_Learning.html)

Ohio Minds Matter also created podcasts as an alternative training method for professionals who may want additional information, but who are not interested in completing the requirements to obtain continuing educational credits. To learn more about the podcasts, go to: [http://ohiomindsmatter.org/Prescribers\\_Learning.html](http://ohiomindsmatter.org/Prescribers_Learning.html)

In addition, OhioMHAS continues to promote use of its Pediatric Psychiatry Network (PPN) as a resource for prescribers to receive peer guidance on how to treat children with difficult behavioral health issues, including but not limited to the use of psychotropic medications. For more information on the PPN, see: <http://ppn.mh.ohio.gov/>

To increase the array of clinical tools offered, *Ohio Minds Matter* developed resources to improve engagement of clinicians, families, youth, and workers in child-caring systems (including child welfare). A shared decision-making toolkit was specifically designed to address health care issues of foster children. This toolkit promotes youth involvement in health care decisions, including but not limited to the use of psychotropic medication. Issue-specific prompts are featured throughout the document to promote discussion with medical personnel regarding the patient's current issues, symptoms, treatment options, and response to chosen interventions. Current and former foster youth actively participated in the toolkit's development. To view the toolkit, go to:

[http://www.ohiomindsmatter.org/documents/decision%20guide%20for%20foster%20care\\_F1.pdf](http://www.ohiomindsmatter.org/documents/decision%20guide%20for%20foster%20care_F1.pdf)

Another component of this initiative was the establishment of three demonstration sites across the state to pilot use of the guidelines; identify local challenges; and test community-specific interventions. The following communities served as *Ohio Minds Matter* pilot sites:

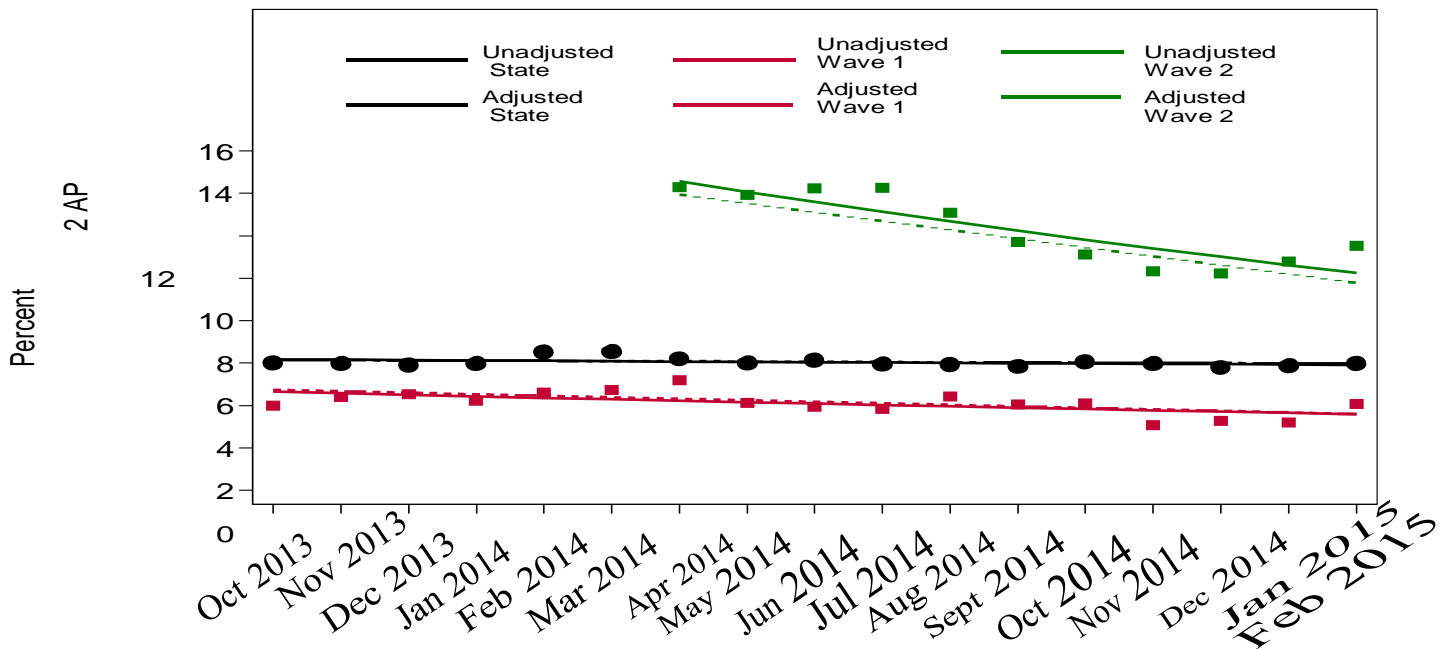
- Summit, Portage, Trumbull, and Stark Counties;
- Franklin, Licking, Fairfield, Muskingum and Perry Counties; and
- Montgomery, Greene, Miami and Clark Counties.

Each pilot site was led by a steering committee consisting of primary care and behavioral health practitioners, consumers, family members, as well as senior leadership representatives from community agencies, schools, welfare agencies, juvenile courts, youth services, medical associations and health plans. Through this effort, participating members sought to:

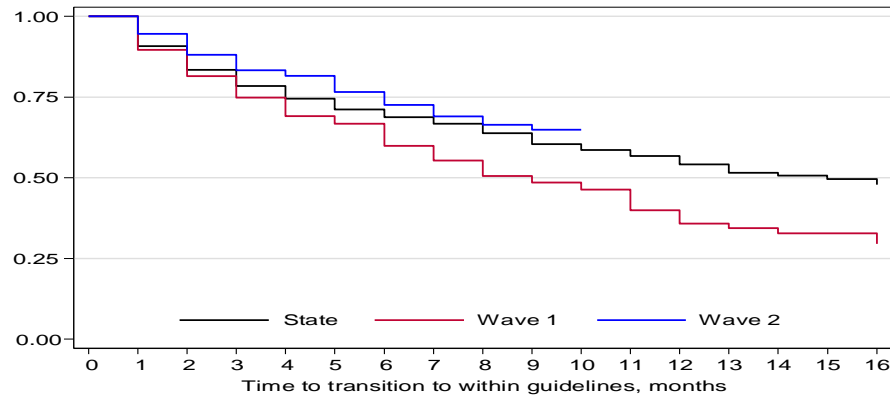
- Improve care among clinicians through training, data feedback and rapid cycle quality improvement interventions;
- Advance consumer empowerment through education and shared decision-making; and
- Improve access to care and service coordination through community collaboration.

**Clinical Results:**

***Reduced prevalence of ≥ 2 AAPs by 25%***



**Children’s length of exposure to ≥ 2 AAPs was 6 months less for Wave 1 providers  
The likelihood of transitioning to treatment within guidelines was 35% greater for Wave 1**



In March, 2015, Ohio began implementation of a strategic plan to establish a statewide learning network for clinicians and community partners. The goals of this effort were to:

- Disseminate information about tested strategies and “lessons learned” from the pilot projects;
- Advance use of the prescribing practice guidelines; and
- Increase patient participation in treatment through promotion of the shared decision-making toolkit.

At no cost, network members:

- Participated in quarterly webinars jointly facilitated by children’s services agencies and state partners to discuss engaging foster youth in treatment, and reducing barriers to treatment;
- Discussed strategies to engage foster youth in mental health treatment;
- Received diagnostic and prescribing resources specifically tailored for clinicians, families, child welfare agencies, schools and community members;
- Were provided guidance on how to facilitate shared decision-making among youth, caregivers, family members and providers through use of the *Ohio Minds Matter* Toolkits; and
- Receive Maintenance of Certification, Continuing Medical Education and Continuing Education Unit credits for completing on-line learning modules.

**Enhanced Data Analyses**

Ohio continues to improve data transparency in order to educate providers whose patients include a high volume of foster children, and those with high rates of prescribing AAPs about comparative pharmacology utilization patterns. ODM has developed the capacity to issue providers timely feedback regarding individualized prescription patterns contrasted with similar clinicians. In addition, archived Medicaid data are also being analyzed to identify clinicians who prescribe medications to children less than six years of age, and those who prescribe two or more concomitant AAPs in order to offer additional education and second opinions. (See reference to the *Pediatric Psychiatry Network* below.)

### **Building Mental Wellness and the Pediatric Psychiatry Network**

Building Mental Wellness (BMW), a Mental Health Learning Collaborative, has designed clinical resources to assist primary care physicians in effectively identifying and managing mental health issues. The scope of work for this project includes:

- Developing tools to promote screening, diagnosis, practice-based interventions, cross-system collaboration, and pharmaceutical management;
- Establishing a learning collaborative of high volume Medicaid practices; and
- Utilizing improvement science to support use of quality metrics.

BMW team members have developed clinical recommendations for key psychiatric diagnoses (including screening, diagnosis, and treatment) to help educate patients, families/caregivers, and child-serving systems about appropriate medication use. In addition, specific strategies have been implemented to improve staff competency in child welfare, courts, schools, and mental health systems that frequently interface with the children and their families/caregivers.

BMW also promotes the use of *Pediatric Psychiatry Network (PPN)* linkages. Through this effort, academic experts and faculty from Ohio's seven colleges of medicine, children's hospitals, and community mental health centers provide second opinion consultation to colleagues with high risk prescribing practices (e.g., off-label use of AAPs, concomitant prescribing, dosages outside of therapeutic ranges, and prescribing for very young children).

### **Clinical Profiles of Children with Severe Emotional Disorders**

The purpose of this project is to provide information about the clinical characteristics and needs of children with severe emotional disorders (SED); review service patterns; and identify trends in service utilization and costs. Findings guide Ohio's quality improvement efforts to support physicians treating children with SED. As part of this project, researchers work with clinical leaders to:

- Develop diagnosis-specific metrics to identify patterns of care (e.g., mental health assessments, psycho-social interventions).
- Analyze patterns of care and comorbidities associated with outcomes (e.g., emergency room visits, hospitalization, costs) that can be targeted for intervention and quality improvement.
- Determine clinical, geographical, and demographical "hot spots".
- Identify opportunities for quality improvement.

### **Non-pharmacological Treatment**

It is recognized that psychotropic medications are often prescribed when access to effective community-based behavioral health care is limited. Please refer to the trauma-informed care and collaborative healthcare programming sections of this plan for descriptions of initiatives designed to enhance a continuum of care for children who have experienced maltreatment.

### **Psychotropic Toolkit for Child Welfare:**

As the custodian for children in care, PCSAs have a profound responsibility to not only focus on safety and permanency, but also on improving the long-term well-being of children in care. Ultimately, PCSAs are required to authorize use of medication if birth/adoptive parents are unavailable to consent. Given the complexity of pharmacological interventions, consistent oversight and monitoring of medication use is critical. This responsibility requires knowledge of specific medications, effective interventions, best practices, policies, procedures and practice guidelines.

To better address this issue, PCSAO established the Behavioral Health Leadership Group (BHLG) in February 2012. BHLG membership is inclusive of state and local child welfare entities, as well as public and private providers. Representatives include: 15 Public Children Services Agencies, including both rural and urban jurisdictions; the Ohio Association of County Behavioral Health Authorities; the Ohio Association of Child Caring Agencies; the Ohio Council of Behavioral Health and Family Service Providers; and ODJFS, ODM, OhioMHAS, ODE, ODH and DODD. Technical assistance is provided by Vorys Health Care Advisors.

In 2013, the BHLG developed a toolkit to guide PCSA oversight of psychotropic medication use by children and youth in the custody of Ohio's child welfare system. The recommendations put forth were selected following review of other published works, including: *Guidelines on Managing Psychotropic Medications from the American Academy of Child and Adolescent Psychiatrists* (AACAP), other state plans (i.e. Connecticut and Texas) and local Ohio child welfare agencies' policies (i.e. Lucas, Summit). A copy of the ***Psychotropic Medication Toolkit for Public Children Services Agencies*** is found in **Appendix B2**.

During this reporting period, Ohio continued to receive national recognition for its efforts to promote safe and appropriate use of psychotropic medication for children in foster care.

- In April 2016, staff of the Government Accounting Office (GAO) conducted an on-site review of Ohio's medication-related practices at the state and local levels. This was part of a multi-state assessment initiated at the request Congress to determine:
  - How Medicaid and child welfare agencies in selected states have worked to ensure the appropriate use of psychotropic drugs for children in foster care?
  - What steps, if any, have selected states taken to measure the results of their efforts to ensure appropriate use of psychotropic drugs for children in foster care?
  - To what extent has HHS taken steps to help states ensure appropriate prescriptions of these drugs to children in foster care?

The GAO's report was released to Congress in January 2017. Among many recommendations, Ohio's establishment and use of prescribing guidelines for physicians, and shared decision-making tools were featured. As a result, ODJFS was contacted by Dartmouth University's Geisel School of Medicine to discuss the design and implementation of Ohio Minds Matter and potential application to their system.

- Ohio has also been selected to participate in the Patient-Centered Outcomes Research Institute's (PCORI) multi-state analysis of the impact of medication monitoring strategies on practice. PCORI is an independent nonprofit, nongovernmental organization authorized by Congress in 2010; Rutgers University is the lead investigator for this work. Other states participating in this effort include: Texas, Washington, and Wisconsin. Currently, ODJFS and ODM are working with Rutgers and other states' representatives to finalize the research design. Once that is completed, independent teams will review data sets, interview key informants, and conduct focus groups with those impacted by state policy. Proposed participants include: state and local level child welfare administrators, child welfare caseworkers, pharmacists, physicians, caregivers- including biological and foster parents, former foster youth, and treatment providers. At the time of this writing, ODJFS staff are working with the research team to finalize the arrangements for Ohio's on-site review, which will be scheduled to occur in 2017.

## **COLLABORATIVE HEALTHCARE PROGRAMMING**

### **STATE LEVEL INITIATIVES**

#### **Office of Health Transformation**

Governor John R. Kasich created the Office of Health Transformation (OHT) to improve health system performance and streamline health and human services. OHT coordinates implementation of Ohio's Medicaid program across the following state agencies: the Ohio Department of Budget and Management, The Ohio Department of Administrative Services, ODM, ODJFS, DODD, OhioMHAS, ODH, and Aging. OHT is committed to implementing programming which supports:

- Patient-centered care;
- Performance-based measurement;
- Accountable medical homes;
- Price and quality transparency;
- Streamlined income eligibility;
- Medicaid/Medicare exchanges;
- Value-based reimbursement strategies;
- Electronic information exchange;
- Continuum of care; and
- Sustainable growth over time.

OHT achievements to date have included:

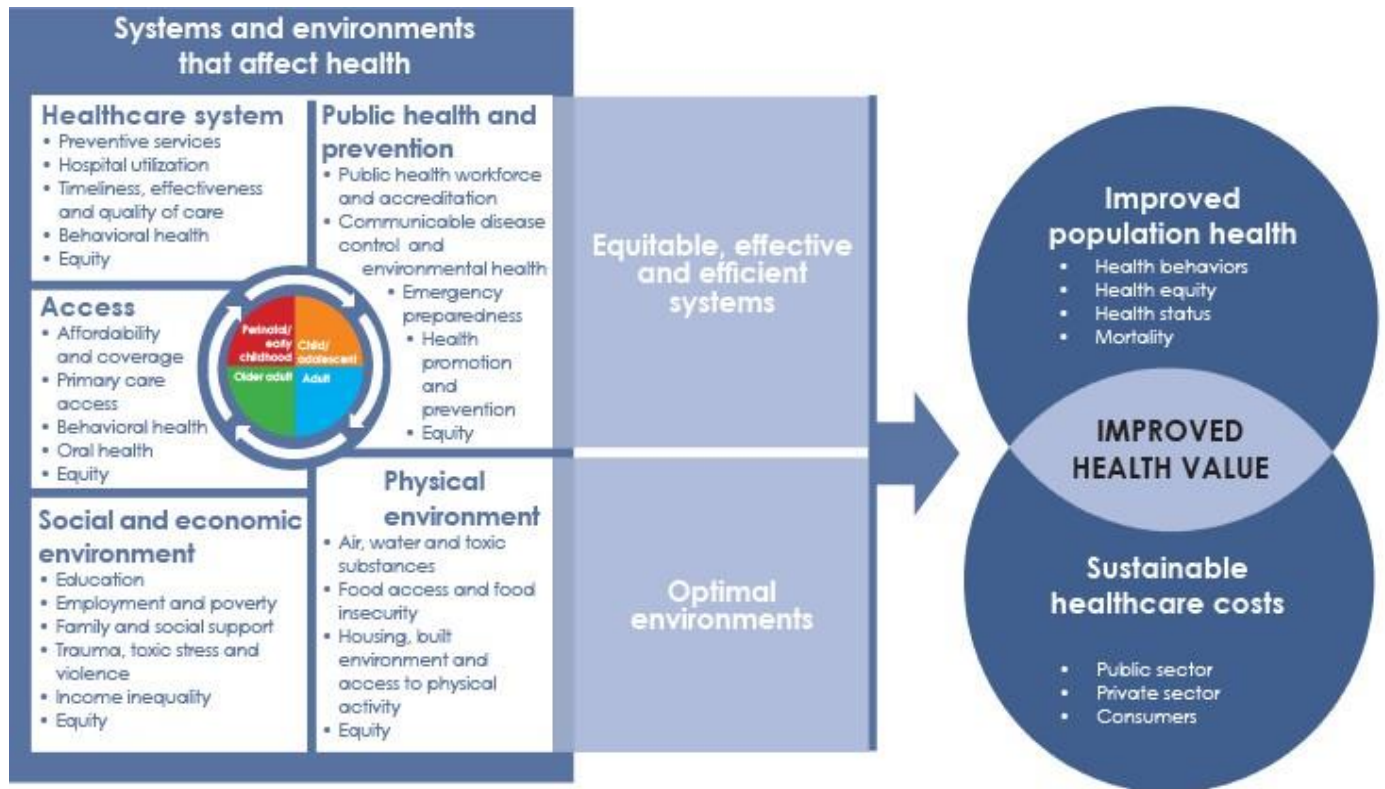
- Expanding presumptive eligibility for Medicaid to pregnant women.
- Reducing infant mortality via work with the Ohio Perinatal Quality Collaborative.
- Improving early identification and intervention for individuals with autism spectrum disorders by investing in evidence-based models.
- Increasing consumer choice by expanding waiver services for people with developmental disabilities, and consolidating Medicaid programs for people with disabilities.
- Increasing opportunities for people with developmental disabilities, including requiring that all Individual Education Plans (IEPs) for youth with disabilities include strategies for preparing for community employment after school.
- Implementing specific strategies to reduce opiate abuse.
- Integrating Medicare and Medicaid benefits through the Integrated Care Delivery System.
- Expanding use of patient-centered medical home models in primary health care practices.
- Simplifying eligibility determination systems for federal and state human services.
- Accelerating adoption of the electronic health information exchange.
- Enhancing cross-system data sharing.

### **State Plan Assessment/ State Health Improvement Plan**

In September 2015 and under the auspices of OHT, ODM and ODH contracted with the Health Policy Institute of Ohio (HPIO) to facilitate stakeholder engagement and provide guidance on improving population health planning. The primary objectives of this project are to:

- Provide recommendations to strengthen Ohio's population health planning and implementation infrastructure; and
- Align population health priority areas, measures, objectives and evidence-based strategies with the design and implementation of the Primary Care Medical Home (PCMH) model.

“Population health” requires that factors outside the traditional healthcare system (e.g., social, economic, environmental issues) be addressed in order to effectively improve health outcomes.



**World Health Organization definition of health:** Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

For additional information about population health, go to:

[http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatIsPopHealth\\_PolicyBrief.pdf](http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatIsPopHealth_PolicyBrief.pdf)

HPIO undertook a comprehensive approach to completing this work. Meetings with multi-system partners, representing both public and private partners were held monthly. In addition, HPIO conducted a series of regional forums throughout the state in order to obtain additional input from local consumers, providers, and advocacy groups. The inclusiveness of this process is illustrated in the charts below.

# Population health infrastructure in Ohio

Governor's Office of Health Transformation	Ohio Department of Health	Other state agencies Including ODM, OMHAS, ODA, DODD, ODJFS, ODVS, etc.
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## Community-level public and private partners

Hospitals and other healthcare providers	Local health departments and other public health organizations	ADAMH boards and mental health and addiction service providers	Health insurance plans
Community-based organizations and social services	Local government	Law enforcement/criminal justice	Transportation and regional planning
Education and child care	Businesses and employers	Philanthropy/United Ways	Advocacy groups and community action agencies

Community residents and healthcare consumer groups	Family and Children First Councils	Job and Family Services
At-risk populations	Agriculture, environmental protection and natural resources	



For additional information on Ohio’s approach to improving population health outcomes, go to: <http://www.healthpolicyohio.org/populationhealth/>

To view the Logic Model guiding Ohio’s development of its State Health Assessment and State Health Improvement Plan, go to: [http://www.healthpolicyohio.org/wp-content/uploads/2016/05/SHA\\_SHIP\\_LogicModel\\_04082016.pdf](http://www.healthpolicyohio.org/wp-content/uploads/2016/05/SHA_SHIP_LogicModel_04082016.pdf)

For more information about the planning process, go to: [http://www.healthpolicyohio.org/wp-content/uploads/2016/01/SIMreport\\_Final\\_SHA\\_SHIP\\_Recommendations.pdf](http://www.healthpolicyohio.org/wp-content/uploads/2016/01/SIMreport_Final_SHA_SHIP_Recommendations.pdf)

## Early Childhood Mental Health Consultation

Ohio's Early Childhood Mental Health Consultation (ECMHC) Program is designed to improve outcomes for young children (infants-six years old) who are at risk for abuse or neglect, and/or who demonstrate poor social skills or delayed emotional development. ECMHC services include:

- Clinical consultation to early childhood programs regarding:
  - Problem identification;
  - Referral processes;
  - Classroom management strategies;
  - Maternal depression;
  - Parental substance abuse;
  - Domestic violence; and
  - Other stressors on young children's well-being.
- Guidance to family members (including parents, kinship caregivers and foster parents) to increase skills in creating nurturing environments for young children.

ECMHC promotes use of evidence-based behavioral health practices as a means of delivering effective, cost-efficient care. Some of these include: *Devereux Early Childhood Assessments (DECA)*; *The Incredible Years Program for Parents, Teachers, and Children*; *The Edinburgh Postnatal Depression Screen (EPDS)*; *The Therapeutic Interagency Preschool Program*; *Trauma Focused Cognitive Behavioral Therapy*; *Positive Behavior Supports*; and *Teaching Tools for Young Children with Challenging Behaviors*. In addition, OhioMHAS, ODJFS, and ODE continue to encourage use of the core competencies, established in 2009, as a staff development tool. To view the competencies, go to:

<http://mha.ohio.gov/Portals/0/assets/Prevention/EarlyChildhood/core-competencies.pdf>

During this past year, OhioMHAS provided an additional \$9.1 million to support mental health consultants working with teachers, staff and families of at-risk children in preschools and other early learning settings. The goals of this effort were to reduce pre-school expulsion rates and promote kindergarten readiness. To this end:

- An additional 65 new FTE ECMH Credentialed Consultants were made available;
- 8 Master Trainers provided training to early learning professionals throughout the state;
- Ohio implemented a statewide Preschool Expulsion Prevention Hotline (one of only 2 in the nation); and
- The state instituted a statewide database and program evaluation.

OhioMHAS also developed and distributed *Grow Power~ Ohio Kids Matter*. This toolkit provides information to parents to promote their child's social-emotional development. To view the materials, please click on the following links below.

	<p style="text-align: center;"><b>Grow Power</b></p> <p><b>Videos:</b></p> <ul style="list-style-type: none"> <li>• Packet Overview</li> <li>• Packet Part 2</li> <li>• Packet Part 3</li> </ul> <p><b>Printable materials:</b></p> <ul style="list-style-type: none"> <li>• ECMH Consultation</li> <li>• Guide for Moms, Dads &amp; Caregivers</li> <li>• Help Me Grow Early Intervention</li> <li>• Help Me Grow Intervención Temprana</li> <li>• Safe Sleep</li> <li>• School-to-Prison Pipeline</li> <li>• FLIP IT poster</li> <li>• Healthy Eating</li> </ul>
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**School-Based Medicaid**

Ohio’s Medicaid School Program (MSP) is codified in the Ohio Revised Code. This program provides enrolled school districts the ability to obtain partial federal reimbursement for medically-necessary services identified on a Medicaid-eligible student’s Individualized Education Plan.

Eligible medically-necessary services, include, but are not limited to:

- Occupational therapy;
- Physical therapy;
- Speech therapy;
- Audiology services;
- Nursing services;
- Mental health services; and
- Psychological and neuropsychological testing.

All MSP services must be provided by a qualified professional in a specified practice field. The students' needs are identified through structured assessments and testing. Per statute, services rendered must be consistent with acceptable professional standards of medical and healing arts practice in regard to type, frequency, scope and duration.

Other covered services, supplies and equipment include:

- Specialized medical transportation services.
- Targeted case management services, including:
  - Gathering information regarding the child's preferences, needs, abilities, health status and supports;
  - Assuring case file documentation of prescribed services;
  - IEP-related care planning in coordination with the child's medical home and service providers, including making recommendations for assessments based on progress reviews; and
  - Monitoring the implementation of the child's IEP to ensure it effectively addresses the child's needs.
- Medical supplies and equipment deemed medically-necessary while the child is attending school.

### **Managed Care/Medical Home:**

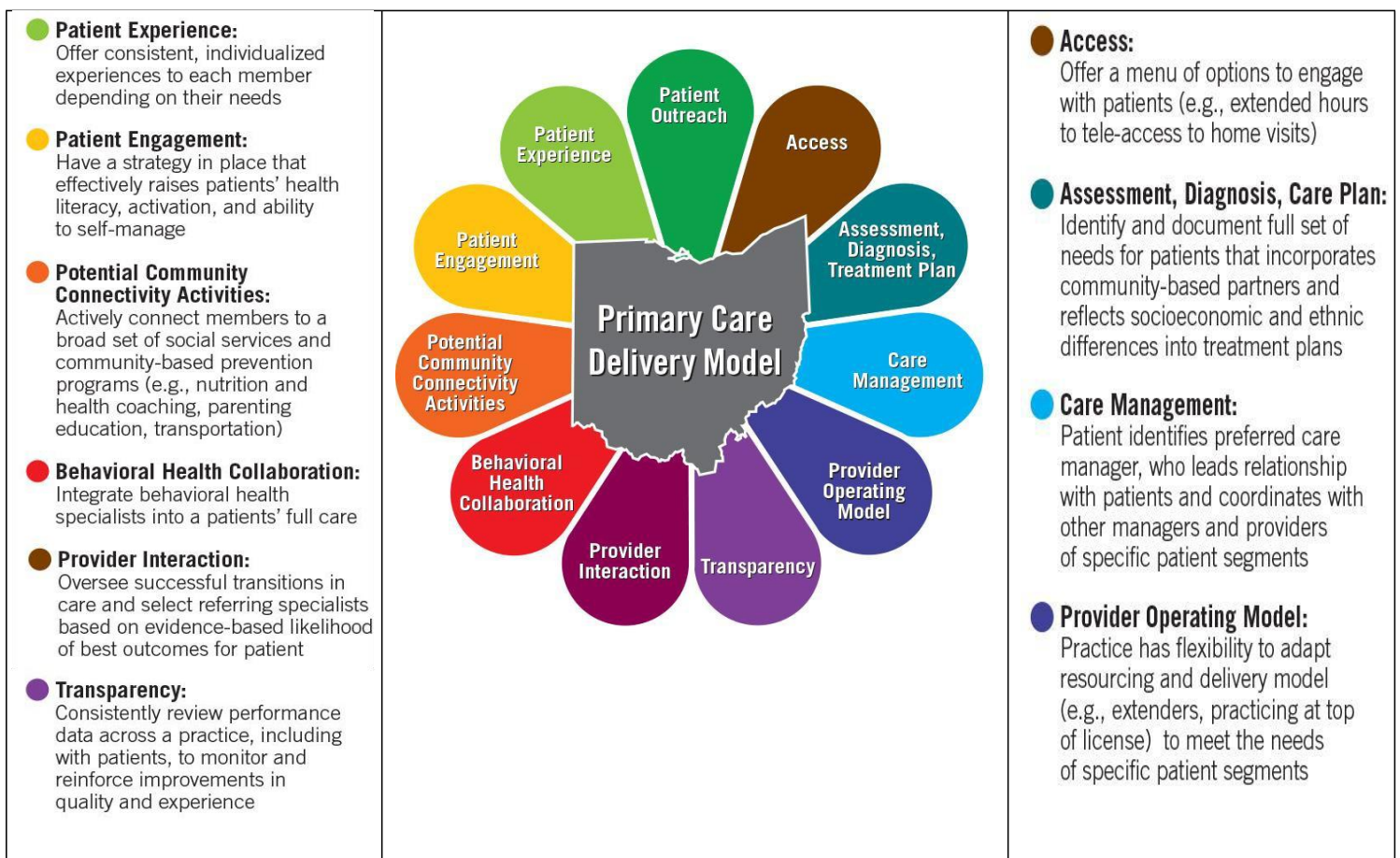
In 2005, House Bill 66 mandated statewide expansion of the Medicaid Managed Care Program for the entire Covered Family and Children population, and a portion of the Aged, Blind or Disabled population. Foster children remained on the fee-for-service option given the regional structure of the Managed Care Plan coverage areas at that time and concerns about continuity of care associated with placement moves. Over the past several years, Ohio's Medicaid Managed Care Plans have been required to ensure statewide coverage. As network coverage no longer presents a barrier to enrollment, foster youth and children who were adopted out of the foster care system began the migration to Medicaid Managed Care on January 1, 2017. To facilitate a smooth transition, regular meetings were held among ODM, ODJFS, PCSAs, MCPs and other interested parties to address emerging issues. Some of these included:

- Clarification of care management roles and responsibilities;
- Timeliness of required medical screenings and assessments for children in foster care;
- Streamlined eligibility determination;
- Simplified enrollment processes through the PCSAs;
- Flexibility in choice among the 5 Managed Care Plans;
- Access to needed services;
- Coding foster youth in the system to facilitate information sharing and expedited authorization processes; and
- Health outcome measurement.

One of the biggest advantages to transitioning the foster population from a fee-for-service to a managed care structure is the level of monitoring conducted by ODM to ensure patients receive timely and appropriate services through their contracted provider networks. Aligning with ODJFS’ monitoring and oversight requirements for foster children’s use of psychotropic medications, it is anticipated that future Medicaid Managed Care provider performance measures will include the following HEDIS indicators:

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents; and
- Metabolic Monitoring for Children and Adolescents on Antipsychotics.

The transition to a managed care system also aligns with Ohio’s vision for utilizing Primary Care Medical Homes (PCMH). This model of care offers many advantages to the youth in care, including high-quality services, individualized treatment and comprehensive care. The components of PCMH are illustrated in the graphic below.



## **Dental Care**

ODJFS-OFC continues to work with the ODH to increase utilization of public oral health care services by families involved in the child welfare system. The ODH has instituted specialized programming in an effort to increase service accessibility. These initiatives include:

- School Programs:
  - 1) The Bureau of Oral Health Services assists local agencies with implementing and maintaining school-based dental sealant programs. With parental consent, teams of dental hygienists and dental assistants place sealants on children's teeth in accordance with a dentist's written instructions.
  - 2) The Fluoride Mouth Rinse Program helps to prevent tooth decay and is available to elementary schools in non-fluoridated communities and/or those that serve a majority of students from low-income families.
- Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services) is a program offered by the Ohio Dental Association in partnership with the ODH to assist Ohioans with special health care needs and/or financial barriers to obtain dental care. Eligible patients are matched with volunteer OPTIONS dentists who have agreed to reduce fees.
- Dental Treatment Programs in Ohio are generally operated by local health departments, health centers, hospitals and other community-based organizations. These programs offer sliding fee schedules or reduced fees.
- Healthy Start/ Healthy Families is one of Ohio's Medicaid programs through which children (up to age 19) and pregnant women can obtain low cost dental care.
- Dentist Shortage Areas and Loan Repayment Programs allow dentists and dental hygienists who are working in underserved areas to apply for repayment of school loans.

## **FAMILY CENTERED SERVICES AND SUPPORTS**

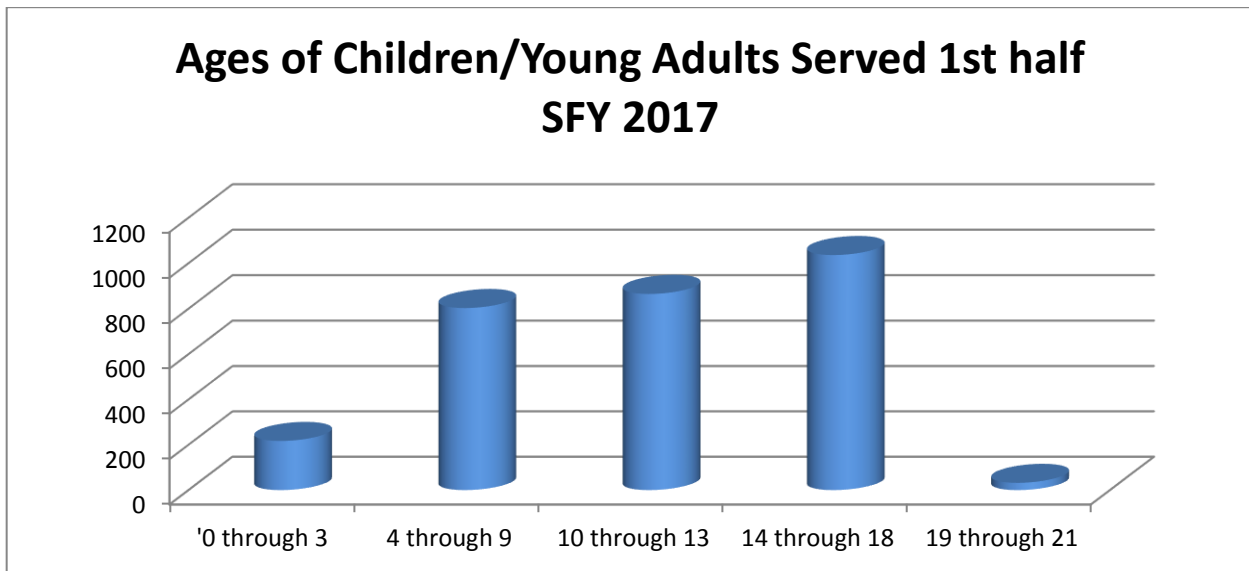
Family support services are intended to help families provide safe and nurturing environments for their children. The Cabinet's Family-Centered Services and Supports (FCSS) project reflects the state's cross-system commitment to implementing a coordinated continuum of services and supports for children, ages 0-21, with multi-system needs and their families. This initiative is jointly funded by ODJFS (Title IV-B dollars) and state funds from the Ohio Departments of Mental Health and Addiction Services, Youth Services, and Developmental Disabilities. These dollars are appropriated to local Family and Children First Councils to provide non-clinical, family-centered services and supports. Use of these funds requires that needs be specifically identified on an individualized service coordination plan which is jointly developed with the family.

Data regarding FCSS is derived from the 2017 mid-year report, released in May 2017. Findings reflect population demographics, services rendered and outcomes from July 1 – December 20, 2016.

**Number and Ages of Children Served:**

The total number of children served between the ages of 0-21 during the first half of SFY17 was **2,953**. This is **136 more children than were served during the first half of SFY16 (2,817)**.

The graph and table below show a comparison of the number of children served during the first half of SFY17 in each age group and the percent of the total children served in each age group.



Ages of Children	0 – 3	4 – 9	10 – 13	14 – 18	19 - 21	Total
Mid-SFY 2016	217	803	865	1036	32	2953
Percent of Total by Age Group	7.35%	27%	29%	35%	1%	100%

### **Total Number of Families Served**

FCFC service coordination is a family focused process, and thus, addresses the needs of the identified child(ren) and the child's family. The **total number of families served in the first 6 months of SFY17 was 2,166, compared to 2,144 families served in the first half of SFY16.**

### **Children's Service/Support Needs by Category Identified at Intake**

FCFC s are required to report the identified needs at the point of intake, regardless of whether the child was receiving services or supports to address them at that time. To be eligible for service coordination, the child must be considered to have multi-system needs, as defined by having two or more identified needs at the time of intake.

#### **At mid SFY17:**

- There were **7,700 identified needs** (average 2.63 needs per child) during the first half of SFY17. The total needs are lower than the 7,980 needs identified in the first half of SFY16, and the average needs per child are down from the average of 2.83 per child.
- The top three categories of needs identified for the past six fiscal years, including the first half of SFY17, have consistently been **Mental Health (59.7% of children had this identified need), Poverty (43.8%) and Special Education (40.7%)**. When combined, these three categories account for 4,265 of the needs identified, or 54% of the total identified needs in 13 categories.
- Beginning in SFY 2014, counties were asked to track how many children presented with a need for supports specific to those on the Autism Spectrum. In an effort to reduce duplication, they were only asked to include these children in the Developmental Disabilities category if the child/youth had additional needs above those on the Autism Spectrum. Autism Spectrum was identified in 13 % of the children/youth (384), a decrease from M-SFY 16.

The following table below illustrates number of needs identified by category. Bolded percentages indicate an increase in the percentage of children presenting with the need compared to the previous fiscal year.

Category of Service/Support Need	# Children Presenting with this Need M-SFY17	% Children with this Need M-SFY17	% Children with this Need M-SFY16	% Children with this Need M-SFY15	% Children with this Need M-SFY14	% Children with this Need M-SFY13	% Children with this Need M-SFY12
Mental Health	1765	<b>59.7%</b>	<b>57.9%</b>	<b>57.5%</b>	56%	58.5%	62.4%
Poverty	1296	43.89%	<b>48.6%</b>	45.4%	50.3%	50.3%	52.9%
Special Education	1204	40.77%	<b>43.7%</b>	39.4%	42%	<b>44.1%</b>	38%
Developmental Disability	773	<b>26.1%</b>	<b>25.5%</b>	24%	24.8%	<b>27.6%</b>	23.5%
Unruly	600	20.3%	<b>21%</b>	<b>20.1%</b>	<b>18.3%</b>	16.4%	21%
Child Neglect	342	11.5%	<b>15%</b>	<b>14%</b>	12.7%	<b>14.7%</b>	13.5%
Physical Health	296	10.2%	11.8%	<b>12.5%</b>	11.6%	<b>12.4%</b>	9.5%
Delinquent	328	11.1%	<b>11.6%</b>	11.2%	<b>12%</b>	10.5%	12.3%
Autism	384	13%	<b>15.2%</b>	<b>11%</b>	10.8% (New)	N/A	N/A
Child Abuse	294	9.9%	<b>10.5%</b>	<b>10.2%</b>	9.5%	<b>11.6%</b>	8%
Alcohol/Drug	242	<b>8.2%</b>	7.4%	7.6%	<b>8.3%</b>	7.4%	8%
Help Me Grow E.I.	132	4.4%	<b>5.3%</b>	4.6%	<b>6.1%</b>	5.4%	5.8
No Primary Care Physician	114	3.86%	<b>9.8%</b>	3.5%	5.4%	14.2% (New)	N/A
<b>Total Needs</b>	7770						

**FCSS Funded Services and Supports Provided through FCFC Service Coordination**

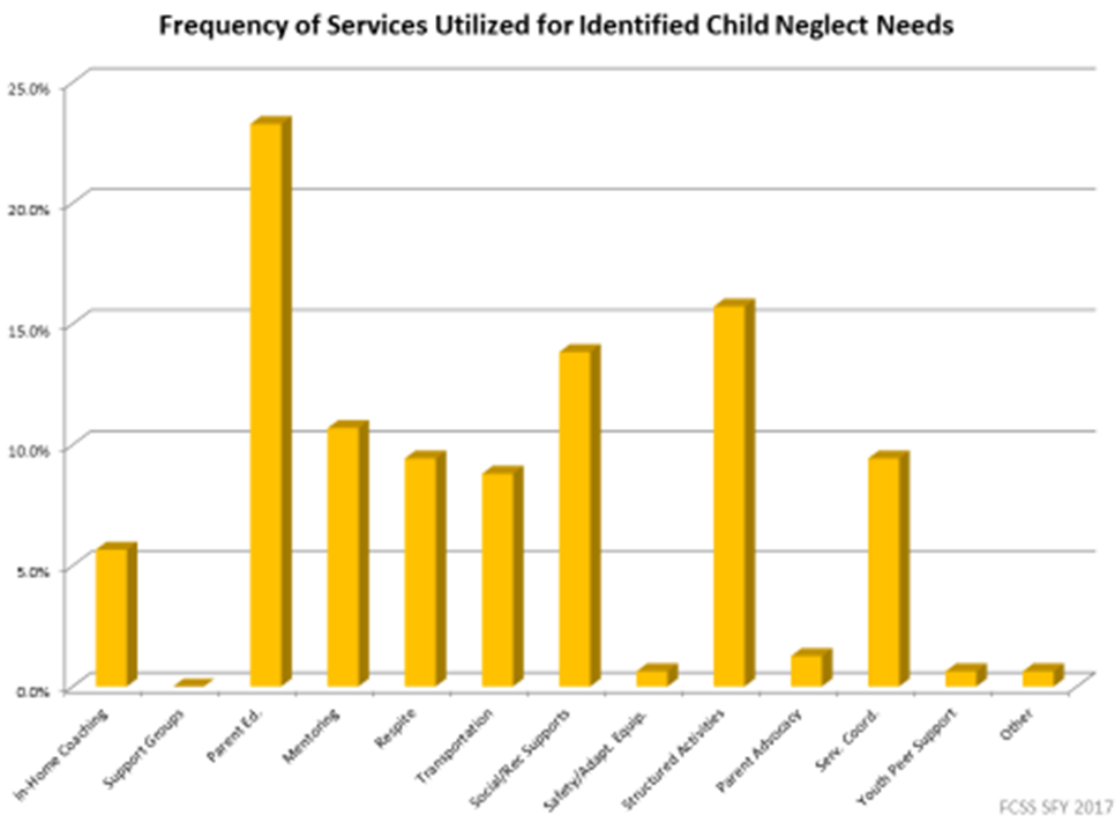
Family and Children First Councils are required to provide information about the number and different types of services and supports funded through this program. To be reimbursed, these services and supports must be written into the family’s individualized plan and processed through the local service coordination mechanism.

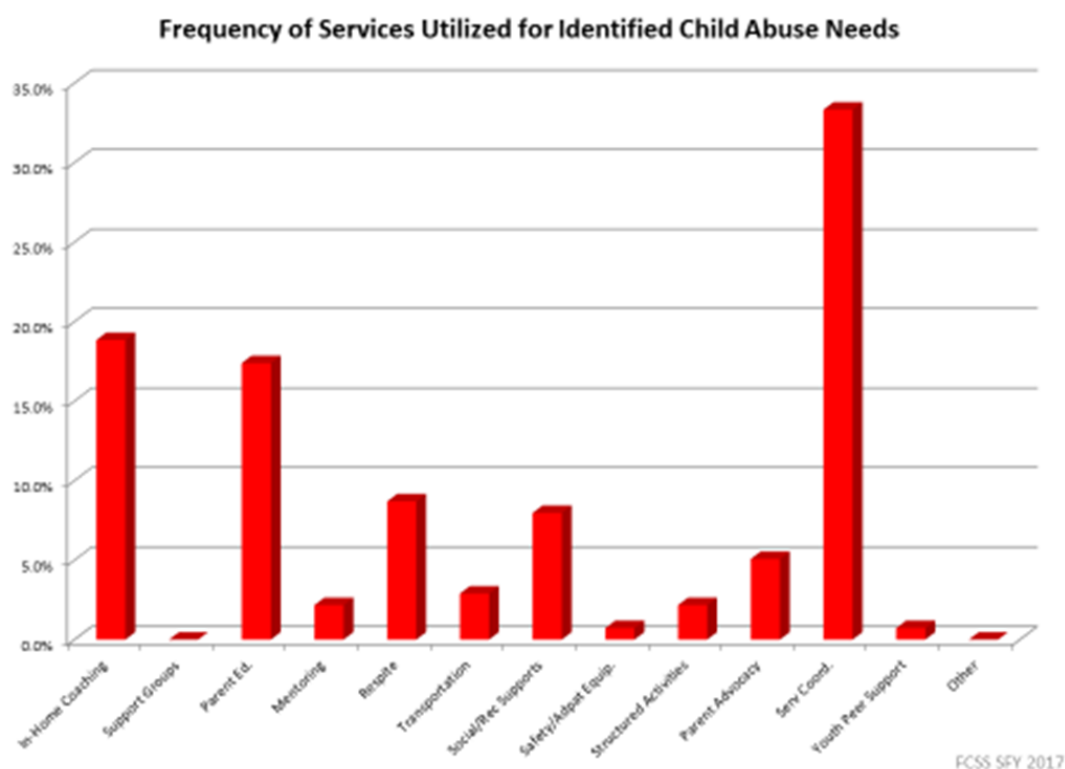
The **total number of various types of services/supports** provided with FCSS funds during the first half of SFY17 was **4,821**, an increase from the first half of SFY 16 (4,641). The chart below provides the details of the frequency of all service types reported.

Type of Service/Support Provided	% of Families Receiving This Service/Support (M-SFY17)	% of Total Services & Supports M-SFY17	% of Families Receiving This Service / Support (M-SFY16)	% of Total Services & Supports M-SFY16	% of Families Receiving This Service/Support M-SFY15	% of total Services & Supports M-SFY15
Service Coordination	63.7%	28.6%	62.8%	29%	68.3%	33.4%
Social/Recreational Supports	37.1%	16.7%	34.1%	15.8%	28.6%	14%
Respite	24.2%	10.8%	21.2%	9.8%	25.1%	12.3%
Transportation	27.1%	12.2%	23%	10.6%	22%	10.8%
Structured activities to improve family functioning	18%	8.1%	16.6%	7.7%	11%	5.4%
Non-clinical in-home parenting/coaching	10.9%	4.9%	16.7%	7.7%	12.5%	6.1%
Mentoring	12.6%	5.6%	12.8%	5.9%	10.4%	5.1%
Parent Education	9.3%	4.1%	12.8%	3.9%	8.5%	3%
Parent Advocacy	8.3%	3.7%	9.2%	4.2%	10.4%	5.1%
Safety and Adaptive Equipment	7.29%	3.2%	7%	3.3%	7.2%	3.5%
Youth/Young Adult Peer Support	0.8%	0.3%	2.1%	0.9%	0.7%	0.4%
Non-clinical Parent Support Groups	1.6%	0.7%	1.7%	0.8%	1.5%	0.7%
Other	1.6%	0.4%	0.7%	0.3%	0.8%	0.4%

### **Number of Referrals by System**

Beginning SFY 2017, analyses were conducted to determine the frequency of services and supports provided by identified categories of need/system involvement (i.e., mental health, developmental disability, poverty, child abuse, child neglect, alcohol/drug, unruly behavior, delinquency, physical health, special education, Help Me Grow-early intervention for ages 0-3 years, autism spectrum disorders, primary care physician linkage). Graphs illustrating services rendered to children and families identified as neglect and abuse follow.





**Number of Children in Out-of-Home Placement during Service Coordination**

In addition to the data captured above, the FCSS Annual Report also includes analysis of the number of children who are placed in out of home care while actively receiving FCSS funded services and supports. For purposes of this report, out-of-home placements include residential treatment facilities, local or state correctional facilities, group homes and foster care, lasting longer than 72 hours (with the exception of respite care that can be provided up to seven (7) consecutive days). The most recent Annual Report, SFY16, indicates that of the 5,091 children served, 263 (5.2%) were removed from their homes. Although no information was collected regarding the length of out of home stay, some councils reported removal was temporary, brief, and solely for the purpose of stabilization.

***94.8% of children served with FCSS funds remained in their own homes in SFY 16***

**Summary**

The children served through FCSS have complex needs, are involved with multiple systems, and require comprehensive interventions. Traditional service systems have not been effective in meeting the needs of these families; often the children are on the verge of placement. FCSS provides families the opportunity to creatively design integrated service plans with trusted and unique teams so that their children can safely remain at home with provision of community-based services. From a system perspective, FCSS have consistently demonstrated cost-effectiveness and improved outcomes for the children and families being served.

## **ENGAGE**

The Substance Abuse and Mental Health Services Administration awarded Ohio a System of Care Implementation Grant on July 1, 2013. To facilitate long-term sustainability, the original proposal was amended to refine the target population and project focus. *Engaging the New Generation to Achieve Their Goals through Empowerment* (ENGAGE) is designed to address the complex needs of multi-system youth and young adults in transition (YYAT), ages 14 – 21, with serious emotional disturbance/mental illness, including those with co-occurring disorders (substance use and/or developmental disabilities). To ensure programming for those most at risk, the population to be served through ENGAGE now also requires past, current, or risk of involvement with child welfare, juvenile/criminal justice, and/or homelessness. To ensure statewide consistency, the implementation strategy for ENGAGE has been streamlined to use of evidence-based High-Fidelity Wrap Around service coordination with incorporated components from the Transition to Independence Process (TIP) model.

Ohio's multi-level approach to statewide system of care implementation has four components:

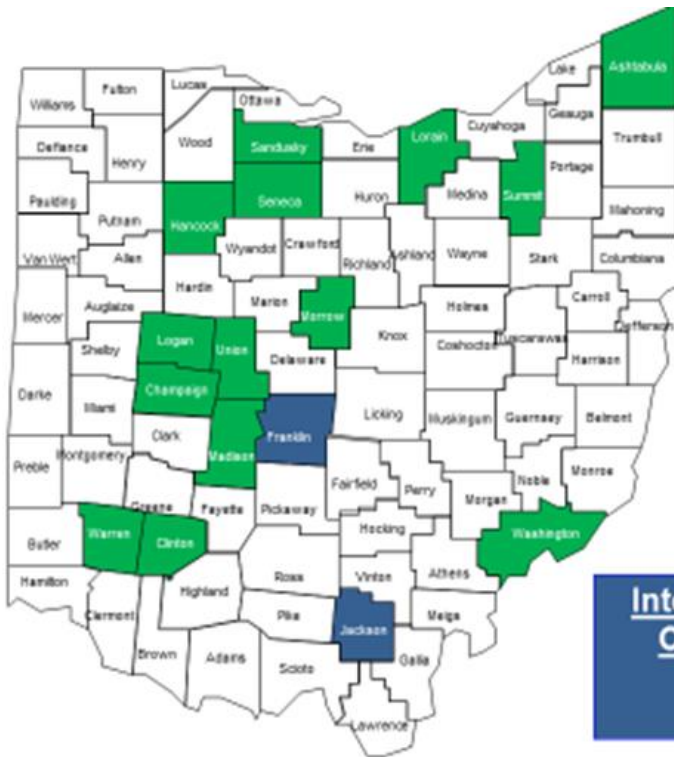
- Workforce development;
- Capacity building;
- Evaluation and continuous improvement; and
- Fidelity.

Through a competitive process, the Center for Innovative Practice at Case Western Reserve University was selected to develop the curriculum, training schedules and technical assistance processes. In 2013, a comprehensive community readiness assessment was conducted to identify counties for inclusion in the various project cohorts. To date, the following counties have completed facilitator training:

- Cohort 1: Allen, Auglaize, Butler, Champaign, Coshocton, Erie, Franklin, Guernsey, Hancock, Holmes, Logan, Lorain, Lucas, Mahoning, Putnam, Richland, Sandusky, Seneca, Summit, Trumbull, and Wayne.
- Cohort 2: Ashland, Ashtabula, Athens, Carroll, Fairfield, Gallia, Geauga, Greene, Jackson, Licking, Madison, Meigs, Morrow, Noble, Preble, Union, and Washington.
- Cohort 3: Columbiana, Clark, Clinton, Crawford, Harrison, Henry, Hocking, Jefferson, Lawrence, Marion, Morgan, Muskingum, Paulding, Pickaway, Portage, Ross, Scioto, Tuscarawas, Warren, and Wyandot.

The first map that follows illustrates active implementation as of October 24, 2016. The second map identifies sites that also received intensive coaching in effort to enhance local service capacity.

### ENGAGE Training Map



**Intensive ENGAGE  
Coaching FY17**

The ENGAGE Youth Advisory Council was formed with the intent of increasing youth voice in matters of public policy, program development and personal treatment decisions. To that end, the Council has launched several initiatives designed to increase awareness of children’s mental health issues and to decrease stigma. These include:

- Maintaining an ENGAGE Youth Facebook page;
- Implementing an ENGAGE Youth Text Alert System;
- Implementing the *Resiliency Ring* at the Ohio Statehouse (April 2017) to promote awareness of behavioral health recovery; and
- Designing and distributing a YouTube video to highlight the Council’s work. To view the video, go to: [http://www.namiohio.org/nami\\_ohio\\_mental\\_health\\_apparel](http://www.namiohio.org/nami_ohio_mental_health_apparel)

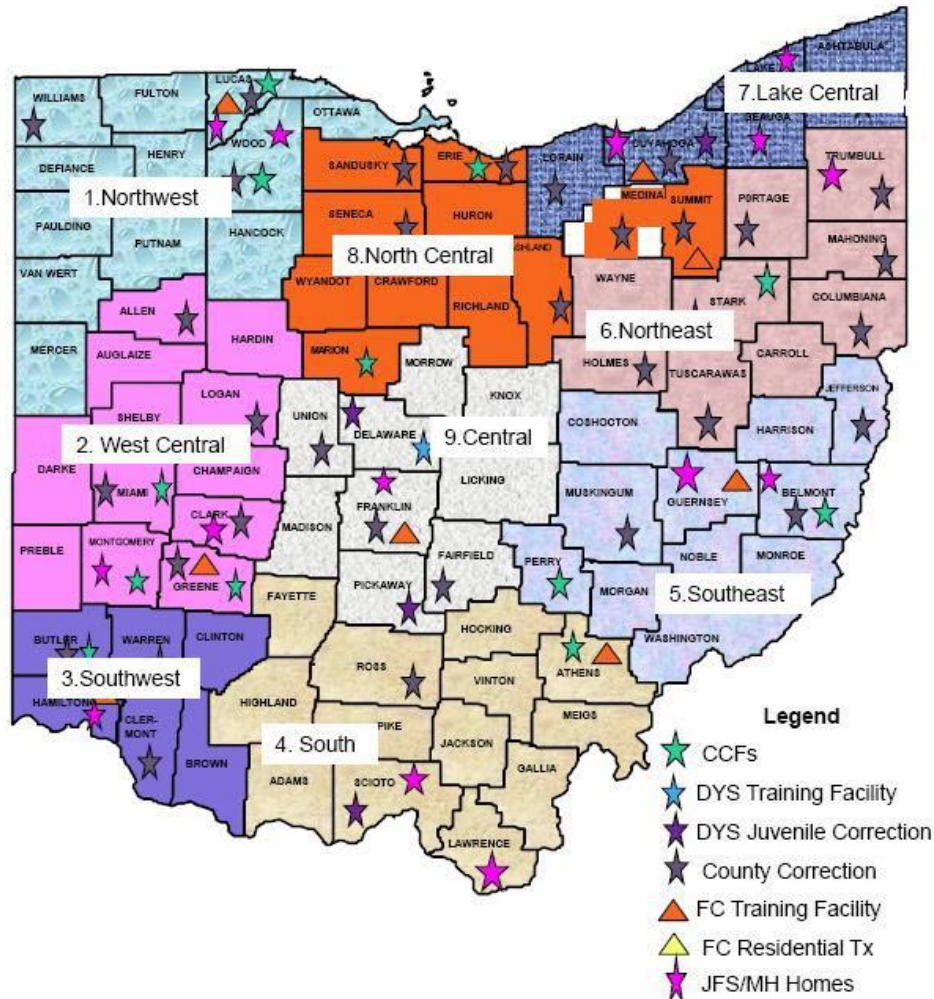
In addition, the ENGAGE Youth Advisory Council has been instrumental in testing OhioMHAS’ Peer Support Certification process, and establishing a cadre of trained individuals to assist other transition-age youth.

The ENGAGE Youth Advisory Council continues to be an affiliate of YouthMOVE National. The decision to do so was to ensure long term sustainability following the conclusion of the ENGAGE grant. As part of this process, recruitment activities were held throughout this reporting process to establish local YouthMOVE chapters. As of March 1, 2017, YouthMOVE Chapters were active in 27 counties: Athens, Butler, Clark, Clermont, Coshocton, Cuyahoga, Erie, Franklin, Greene, Hamilton, Harrison, Hocking, Lawrence, Licking, Lucas, Madison, Meigs, Montgomery, Ross, Sandusky, Stark, Summit, Trumbull, Union, Vinton, Wood, and Williams.

### **Personal Responsibility and Education Program**

ODH, in partnership with the ODJFS and ODYS, is working to reduce teen pregnancy and sexually transmitted infection among Ohio’s youth, ages 14-19, who are in foster care or involved with the juvenile justice system. *The Personal Responsibility and Education Program (PREP) for Foster Care and Adjudicated Youth* is a five-year, federally funded project. Through this work, nine regional collaboratives have been established to comprehensively assess and address the needs of these high risk populations. The regions were specifically designed to maximize state and local resources (e.g., location of child welfare training centers, juvenile justice institutions, residential treatment centers, and community-based correction facilities). The map below illustrates the geographic service deliver areas of this statewide initiative.

## Ohio County Map—PREP Regions



PREP trains service providers on how to conduct training on the evidence-based, *Reducing the Risk* (RtR) pregnancy prevention model, as adapted for PREP. For the purposes of this initiative, three additional life skill development topics: healthy relationships, financial literacy, and education and career success were integrated into RtR. The curriculum was selected by a state level advisory council comprised of: state department representatives, association members, foster parents, advocates, and service providers. This train-the-trainer model continues to enhance professional development of direct care staff at the local level, and sustains pregnancy prevention and life skills education for youth in Ohio’s foster care and juvenile justice systems.

## Maternal Opiate Medical Support (M.O.M.S.) Project

The pervasiveness of opiate addiction in Ohio has been of epidemic proportions in recent years. The map below illustrates unduplicated admissions for opiate abuse and dependence statewide in SFY14.

### Unduplicated Admissions for Opiate Abuse and Dependence

Ohio MACSIS Data - State Fiscal Year (SFY) 2014

#### Legend

- ADAMHS Board
- Opiate Addicts (%)**
- 13.1% - 71.6%
- < 25 cases

#### Map Information:

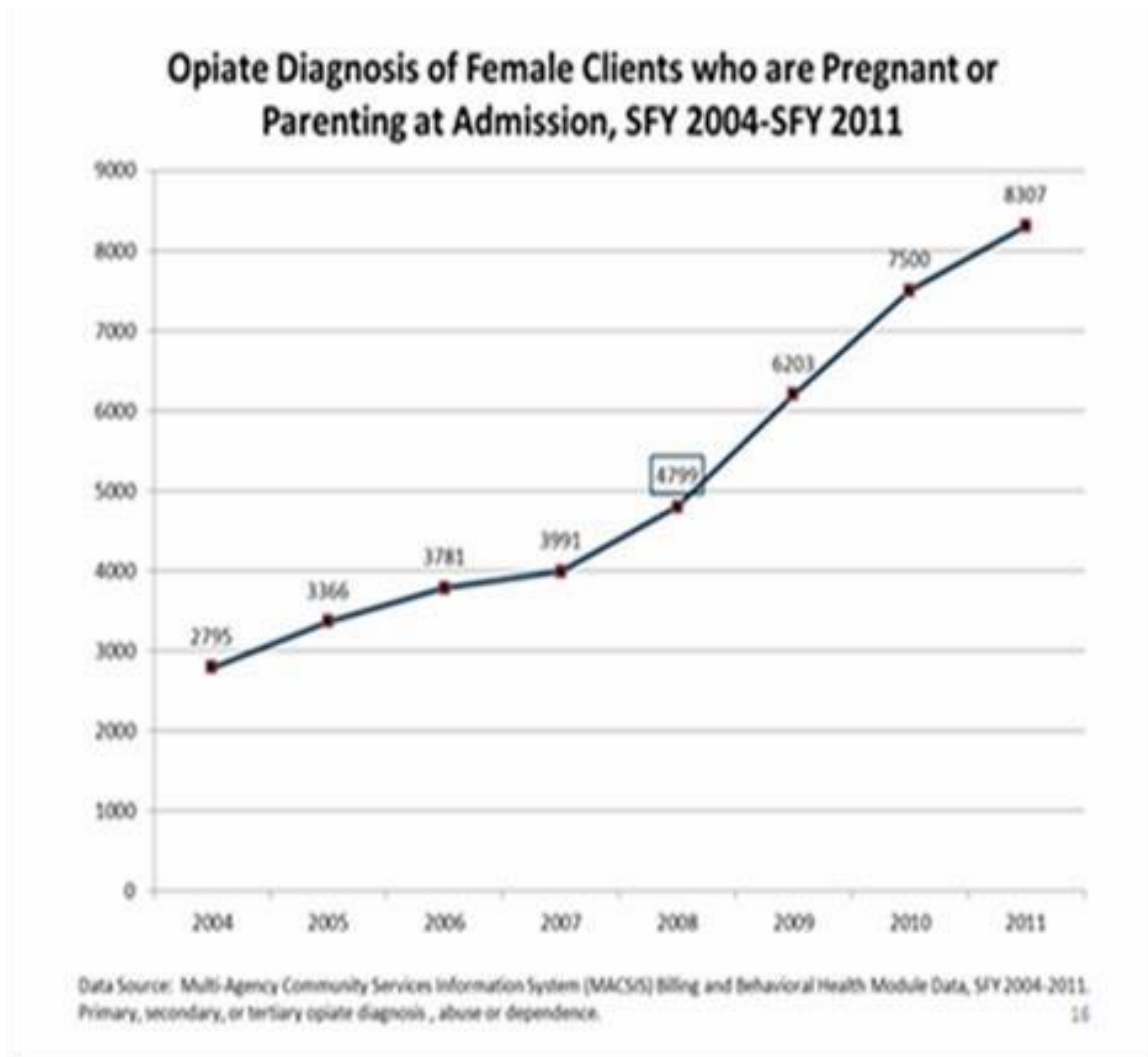
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 37.0 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2014. The highest concentrations of opiate admissions were in Marion (71.6%), Scioto (68.8%) and Vinton (68.5%) counties. The counties with the lowest concentrations of opiate-related admissions were Tuscarawas (13.1%), Coshocton (14.7%) and Henry (15.8%). Percentages are not displayed for counties with fewer than 25 admissions.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

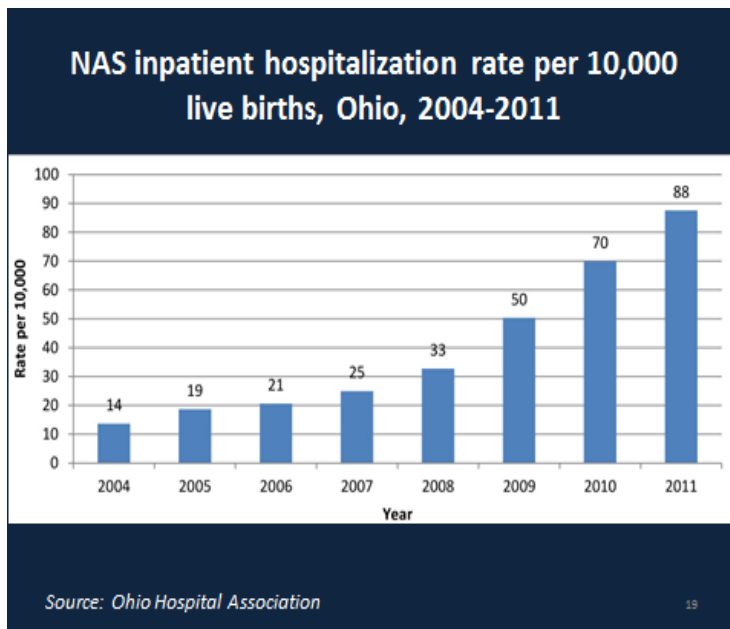
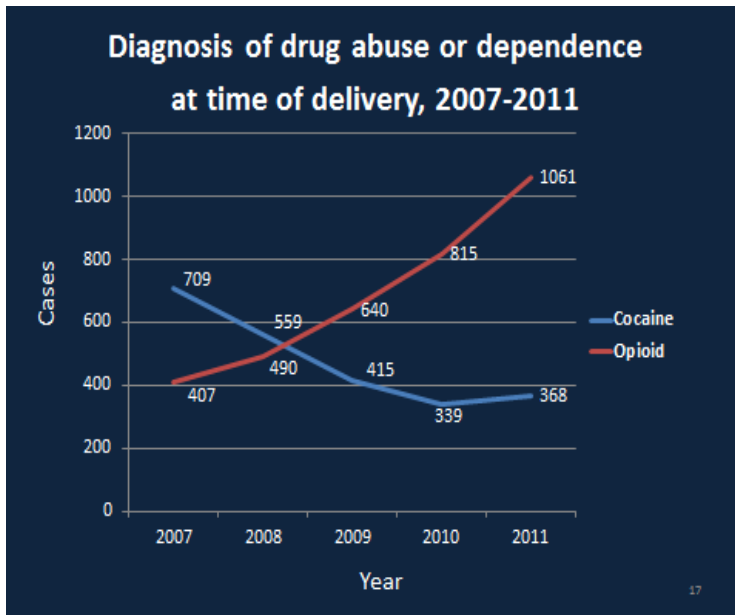
*Data Source:*  
Data from Multi Agency Community Information Systems (MACSIS)  
Map produced November 2015



Of particular concern to child welfare professionals is the growing number of pregnant and parenting women who are addicted to opiates. As indicated by the graphs below, the number of pregnant women who are addicted to opiates in Ohio has continued to rise over the past several years. In addition, analysis of statewide admission data highlights that this problem exists in all 88 counties.



Babies born under these conditions often suffer from Neonatal Abstinence Syndrome (NAS). NAS is a complex disorder with a myriad of possible symptoms found in newborns and caused by exposure to addictive illegal or prescription drugs. The most common conditions associated with NAS are withdrawal, respiratory complications, low birth weight, feeding difficulties and seizures. NAS has had a profound impact on the increased use of neonatal intensive care services for the babies following delivery.



According to the Ohio Hospital Association, the cost of care for treating these newborns was more than \$70 million and required nearly 19,000 days of inpatient care during 2011.

Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births  
Five-year Weighted Average from 2009 to 2013

Legend

ADAMHS Board

Rate per 1,000

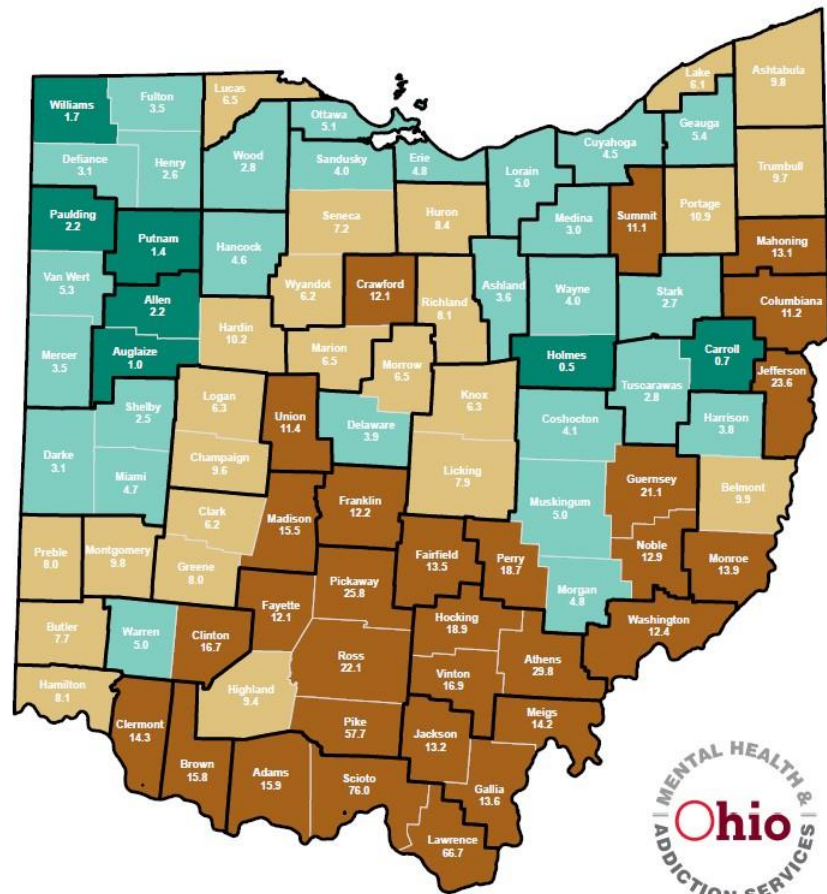


Map Information:

This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 8.8 discharges for NAS per 1,000 live births statewide between 2009 and 2013. Counties with the highest rates of NAS discharges were Scioto (76.0), Lawrence (66.7) and Pike (57.7). NAS discharge rates were lowest in Holmes (0.5), Carroll (0.7) and Auglaize (1.0) counties.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:  
Data adapted by OhioMHAS from the Ohio Hospital Association & the Ohio Department of Health  
Map produced June 2015



The majority of opioid dependent pregnant women in Ohio are not engaged in prenatal treatment. To combat this problem, OhioMHAS, ODM, and the Office of Health Transformation joined forces to launch the *Maternal Opiate Medical Support (M.O.M.S.)* project in August, 2013. This three-year initiative was designed to: improve outcomes for 300 women and babies; reduce the cost of specialized care; and shorten lengths of stay in Neo-natal Intensive Care Units (NICUs). By engaging expecting mothers in a combination of counseling, Medication-Assisted Treatment (MAT) and case management, the goal of this project was to reduce infant hospital stays by 30 percent.

M.O.M.S., a \$4.2 million program, was supported by a \$2.1 million investment from the Health Transformation Innovation Fund. (The Fund supports strategies designed to advance Ohio's health system by improving performance and creating a return on investment for taxpayers.) The balance of the project was funded from Medicaid dollars. In addition to treatment, the project supported a limited number of non-Medicaid that promoted recovery (e.g., short-term transitional housing, transportation associated with appointments, and child care needed while the parent is attending counseling sessions).

Four sites were selected to implement this project:

- First Step Home (Hamilton County);
- Comp Drug (Franklin County);
- MetroHealth Medical Center (Cuyahoga County); and
- Health Recovery Services, Inc. (Athens County).

The locations encompassed all major metropolitan areas of the state and a rural area in southeast Ohio.

Ohio contracted with The Ohio Colleges of Medicine Government Resource Center (GRC) and the Health Services Advisory Group (HSAG) to develop and implement MOMS model of care toolkits; oversee the project's quality improvement efforts, and conduct the evaluation. Performance measures related to early identification and engagement, use of clinical best practices, and treatment retention were collected. In addition, monthly webinars were held with pilot sites, state partners, and members of the clinical advisory panel to facilitate peer learning and promote practice improvement.

To this end, GRC designed a website to provide additional information to pregnant women struggling with substance use disorders, treatment providers, and those who assist at-risk families. The site contains:

- Decision trees for care of opiate-dependent women:  
[http://momsohio.org/healthcare-providers/decision-trees/decisiontree-attributes/MOMS-Decision-Tree\\_F3\\_12-8-15.pdf](http://momsohio.org/healthcare-providers/decision-trees/decisiontree-attributes/MOMS-Decision-Tree_F3_12-8-15.pdf)
- A cross-system training curriculum for medical professionals, treatment providers, and child welfare staff:  
[http://momsohio.org/healthcare-providers/providers-attributes/MOMS%20Child%20Welfare%20Training\\_Final\\_3-21-16.pdf](http://momsohio.org/healthcare-providers/providers-attributes/MOMS%20Child%20Welfare%20Training_Final_3-21-16.pdf)

To view additional information on the site, go to: <http://momsohio.org/>

The goals of MOMS were to improve maternal and fetal outcomes, increase family stability, and reduce costs associated with neonatal abstinence syndrome. Compared to a matched Medicaid comparison cohort, MOMS participants received more prenatal care and behavioral health services during pregnancy and after delivery; were more likely to receive MAT during pregnancy and after delivery; and had better outcomes with child protective services post-delivery. In recognition of these findings, MOMS was featured in a non-partisan legislative commission's [2017 Report to Congress on Medicaid and CHIP](#).

Ohio plans to expand the MOMS program over the next two years to six new sites per year of the grant, utilizing a portion of funding received through the federal [21<sup>st</sup> Century Cures Act](#). In addition, the Ohio Children's Trust Fund is seeking to prevent child abuse and neglect by supporting future components of MOMS programs in targeted regions of the state.

## **Specialized Substance Abuse Training for the Child Welfare System**

While Ohio's child welfare system has always been challenged by the impact of parental substance abuse, increasing rates of opioid addiction are of growing concern. To assist workers in developing the skills needed to effectively address the complex needs of families struggling with substance use disorders, the OCWTP developed a specific strategic cross-system training plan in recognition that effective interventions require multi-disciplinary approaches.

### **OCWTP**

In 2015, the OCWTP held a Substance Abuse Training Partnership event for building an ongoing infrastructure to align substance abuse professionals and the Regional Training Centers. Speakers from the OhioMHAS, ODJFS, the Supreme Court of Ohio, Case Western School of Addiction Medicine, PCSAO, and local child welfare administrators provided highlights of substance abuse needs and existing collaborative efforts by which to address them. At that event, 80 participants committed to serving as liaisons to the regional training centers and PCSAs. These individuals represented local ADAMHS boards, as well as prevention, treatment, and opiate-specific addiction specialists.

In addition, the OCWTP launched [www.osatg.org](http://www.osatg.org) to provide opportunities for distance learning. Topics found there include, but are not limited to: *Medication Assisted Treatment, Opioid Use During Pregnancy, Supporting Children Affected by Pre-natal Substance Exposure, Adolescent Trauma and Substance Abuse*, trauma informed care, and building collaborative practices.

The OCWTP also:

- Offered 77 trainings on substance use, including:
  - o *Overview of Medically Assisted Treatment in Substance Abuse;*
  - o *Assessment and Treatment of Opiate Addiction;*
  - o *The Dramatic Effects of Prenatal Substance Exposure: Living the Legacy;*
  - o *Born Addicted: Promoting Best Care for Substance Exposed Infants;*
  - o *Engagement and Case Planning with Opioid-Involved Families;*
  - o *The Hard Stuff- Heroin;*
  - o *Women's Substance Abuse;*
  - o *Understanding Birth Parent Addiction and the Impact on the Children in Your Home; and*
  - o *Helping Child Welfare Workers Support Families with Substance Use, Mental Health or Co-Occurring Disorders.*
- Increased the OCWTP's capacity by adding cross-system training facilitators.
- Initiated strategies for ongoing technical assistance on substance abuse issues to PCSAs and RTCs.
- Developed specialized sessions for foster and adoptive parents to better equip them to meet the needs of children whose parents are addicted.

### **MOMS Cross-System Training**

Knowing that children, especially infants, are of high risk in situations where parental substance abuse exists, the MOMS program developed a cross-system training curriculum to facilitate collaboration among medical personnel, treatment providers, child welfare and patients. The training features information about mandated reporting, development of plans of safe care, child welfare processes, use of Medication Assisted Treatment, expectations associated with recovery, and needed supports to ensure safety. To view the curriculum, go to:

[http://momsohio.org/child-welfare-worker/child-welfare-attributes/MOMS%20Child%20Welfare%20Training\\_Final\\_3-21-16.pdf](http://momsohio.org/child-welfare-worker/child-welfare-attributes/MOMS%20Child%20Welfare%20Training_Final_3-21-16.pdf)

### **LOCAL HEALTH CARE PROGRAM HIGHLIGHTS**

A report on Ohio's efforts to address the health care needs of children involved in the child welfare system would not be complete without highlighting some local initiatives designed to holistically treat youth and families. The two programs described below feature coordinated interventions and implementation of evidence-based practices.

#### **Fostering Connections Program at Nationwide Children's Hospital**

In an effort to improve the quality of health care provided to foster children, Nationwide Children's Hospital established the *Fostering Connections Program* (FCP) in partnership with Franklin County Children's Services. Housed in the Center for Child and Family Advocacy, FCP is a specialized clinic which offers comprehensive health care services to children placed in out-of-home care. The FCP program features a team approach to service delivery to reduce fragmentation and improve coordination of health care.

FCP serves as the medical home for children enrolled in the program. A care coordinator facilitates collection of prior medical information, referrals and follow-up of care. Clinic staff provide each child with an individualized treatment plan, and foster parents receive health education and support. The clinic provides initial assessments following placement, well child visits, as well as on-going treatment (as needed). Additional services include: 24-hour access to physicians who specialize in child and adolescent health, a full-scale on-site lab, access to a healthcare advocate, and trauma-focused interventions. Each child also receives mental health and developmental screenings with direct access to behavioral health care and ancillary services. This streamlined process results in improved access to timely treatment.

#### **Integrating Professionals for Appalachian Children**

Integrating Professionals for Appalachian Children (IPAC) specializes in young child health and wellness. IPAC is comprised of nineteen community agencies in Athens, Hocking, Meigs and Vinton Counties (Athens City School District; Athens County Family and Children First Council;

Athens Meigs Educational Service Center; the Appalachian Rural Health Institute; the Corporation for Appalachian Development; The Dairy Barn Arts Center; Family Healthcare, Inc.; Greater Athens Soccer Association; Health Recovery Services, Inc.; Help Me Grow; Tri-County Mental Health and Counseling, Inc.; the Ohio University: College of Osteopathic Medicine, College of Osteopathic Medicine Community Health Programs, College of Health Sciences and Professions, Hearing, Speech and Language Clinic, Psychology and Social Work Clinic, and Scripps College of Communication; University Medical Associates, Pediatrics; and the Youth Experiencing Success in School Program).

The program provides services to children (birth- eight years of age) and their families. Many of the children served have multiple developmental concerns. IPAC programming includes, but is not limited to:

- Home visitation;
- Developmental screening and assessment;
- Early childhood mental health consultation;
- Intervention services provided via a cross-disciplinary team;
- Intensive behavioral health treatment services; and
- School-based violence prevention programs.

The chart below demonstrates IPAC’s significant advancements in integrating physical and behavioral health care, improving care coordination, and ensuring continuity of treatment.

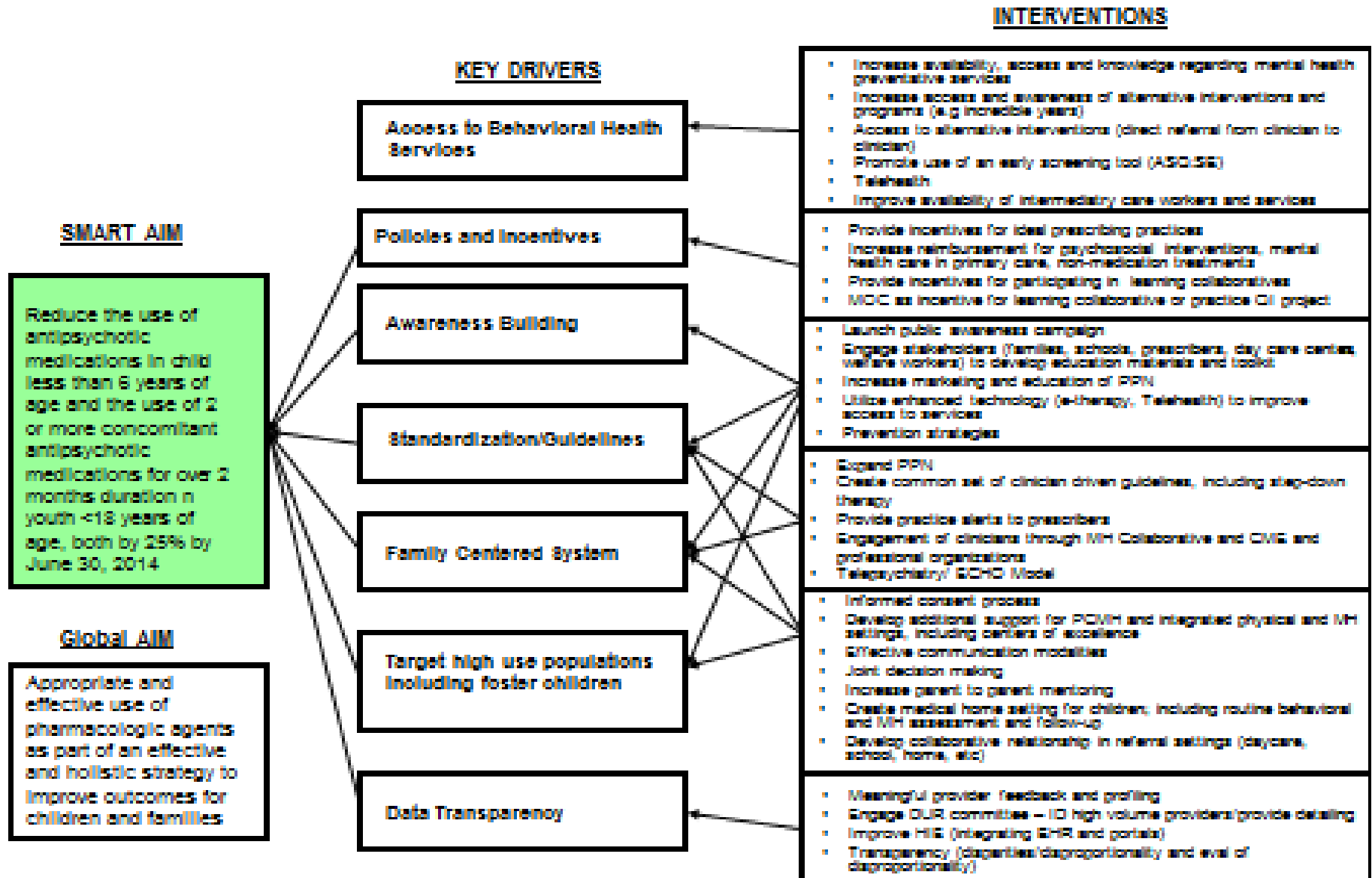
<b>Provider Type</b>	<b>Primary Care</b>	<b>Behavioral Health</b>	<b>Resource/Time</b>
Federally Qualified Health Center (FQHC)	Family Healthcare	Tri-County Mental Health and Counseling Services (Community Mental Health)	Physician contractually purchased providers from Community Mental Health Center for set number of hours per week
University Affiliated Pediatric Group	University Medical Associates	Independently Licensed Private Practitioners	“Warm Hand-off” Co-located in adjoining offices
Solo	Private Practitioner	Health Recovery Services (Community Mental Health)	Co-located two mental health providers in primary care setting in the same building
Ohio University Psychology Department	TBD	Ohio University Psychology Doctoral Student	Ohio University doctoral student supervised in specialized health psychology in co-located practices.

## **Appendix B1**

**Key Driver Diagram**

***Ohio Minds Matter***

# KEY DRIVER DIAGRAM



## **Appendix B2**

***Psychotropic Medication Toolkit  
for  
Public Children Services Agencies***