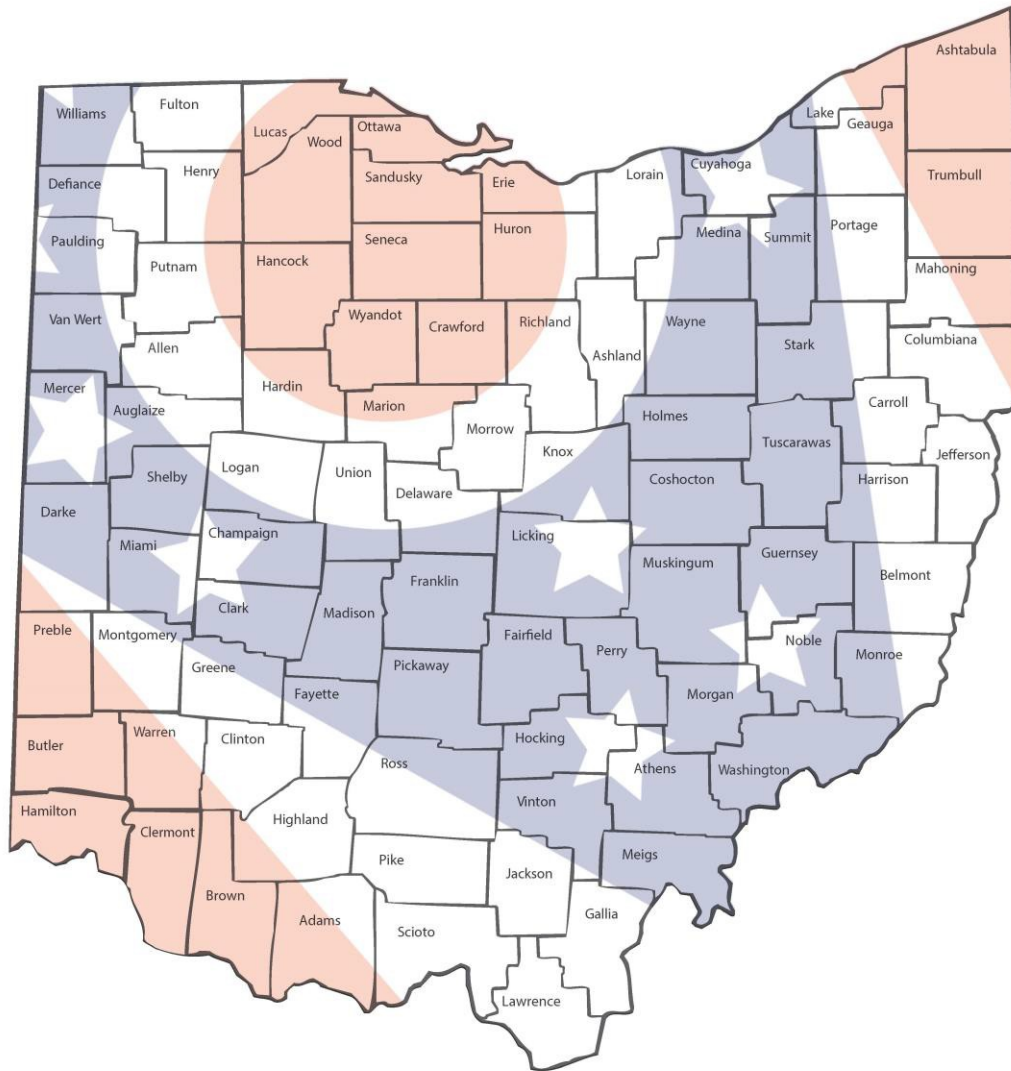


**OHIO'S UPDATED HEALTH CARE
OVERSIGHT and COORDINATION PLAN
for
Children in the Child Welfare System**



**Ohio Department of Job and Family Services
Office of Families and Children**

June 2018

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* form. 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).

PCSAAs 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, whenever the form is updated, and at the time agency custody is terminated. 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 for certain crimes (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.

PCSA’s 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 the Plan for Practice Advancement (PPA). 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:
 - o Health and developmental histories;
 - o A comprehensive physical examination;
 - o Developmental, nutritional, vision, hearing, immunization and dental screenings;
 - o A lead toxicity screening;
 - o Lab tests; and
 - o 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

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 18th birthday, ODJFS continues to provide PCSAs guidance about how to assist youth in completing this process once they reach the age of majority.

Appropriate Diagnoses and Placement

Ohio has established various procedures and protocols to ensure children in foster care are not misdiagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions or developmental disabilities, and placed in settings that are inappropriate based on those diagnoses. Five of these are highlighted below.

- Ohio law requires independent licensure of professionals qualified to diagnose medical and behavioral health conditions. In addition, licensure boards of the various professional disciplines require on-going continuing education to maintain one's ability to diagnose and treat.
- In recognition that histories of trauma can often result in symptoms mimicking psychiatric conditions, Ohio has undertaken multiple efforts to increase training on trauma informed care, and implementation of evidence-based trauma informed practices. These are described below.
- In designing the Ohio Minds Matter project, the Statewide Clinical Advisory Panel developed best practice guidelines. These guidelines recommend use of specific tools to facilitate appropriate diagnosis and treatment of syndromic characteristics (rather than diagnostic) for attention, mood, and aggression. Related algorithms also provide step-by-step instructions regarding assessment and evaluation, patient engagement and consent, selection of appropriate treatment regimens, and recommended monitoring (e.g., metabolic testing). For example, here is the algorithm for Inattention, Hyperactivity, and Impulsivity: [Algorithm D: ADHD](#). Those for the other conditions are included in the Psychotropic Medication section of this report.
- The OhioMHAS operates the Pediatric Psychiatry Network (PPN) to provide clinical decision support for Ohio physicians. In recognition that pediatricians, primary care doctors, and other general practitioners often address behavioral health conditions, the PPN provides psychiatry-led case consultation, training, information about symptom management. In addition, the PPN has established common standards of care and treatment protocols to guide clinical assessments and interventions., including but not limited to use of psychotropic medications:
 - Screening Tools: <http://www.ppn.mh.ohio.gov/ProviderResources/ScreeningTools.aspx>;
 - Behavioral Health Conditions: <http://www.ppn.mh.ohio.gov/ProviderResources/BehavioralHealthConditions.aspx>;
 - Medications: <http://www.ppn.mh.ohio.gov/ProviderResources/Medications.aspx>.

The PPN also provides web-based resources for patients and family members, including information about trauma-informed care, counseling, mental health conditions, prevention, and recovery: <http://www.ppn.mh.ohio.gov/FamilyEducation.aspx>.

For additional information about the PPN, go to: <http://www.ppn.mh.ohio.gov/Home.aspx>.

- State child welfare policies require that children be placed in the least restrictive, most family-like environment necessary to meet their individual needs. A PCSA or PCPA may only place a child in a more restrictive setting, when a child's mental, physical or emotional needs indicate that such a placement is necessary to effectively meet his or her needs. In these cases, the custodial agency must document the following in the child's case plan:

- The educational, medical, psychological and social information used by the agency to select the placement setting;
- How the setting constitutes a safe and appropriate placement; and
- Why a less-restrictive placement was not utilized.

Such settings must also be licensed, certified or approved by the state agency responsible for the type of facility in which the child is placed.

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.

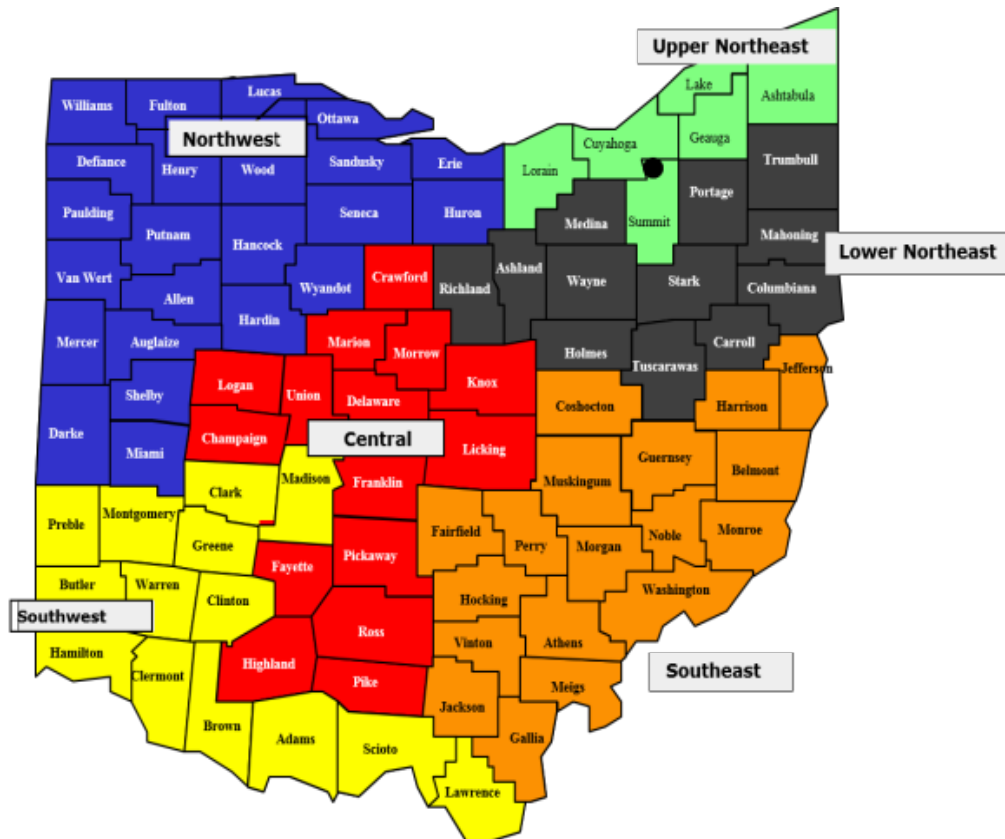
Team members of this public-private partnership reflect a broad range of constituencies. Representatives include the: Ohio Hospital Association; Public Children Services Association of Ohio (PCSAO); Ohio Association of County Behavioral Health Authorities; Ohio Association of Child Caring Agencies; County 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 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 Trauma Informed Care 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 fifth annual Statewide Summit on Trauma, *Creating Environments of Resiliency and Hope* in May 2018.

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. During this past year, IHS offered the following trauma-related courses:

Beyond the Bruises: An Overview of DV

Child welfare workers often encounter families in which domestic violence is present. This workshop will provide participants with the most recent statistical data regarding the occurrence of domestic violence. The facilitator will discuss tactics of power and control in violent relationships, as developed by the Domestic Abuse Intervention Project in Duluth, Minnesota. Likewise, a review of the cycle of violence will be provided.

Beyond the Bruises: Effects of DV on Children

This workshop will provide participants with the most recent statistical data regarding children affected by domestic violence. Likewise, a review of the cycle of violence will be provided, as well as discussions of how children may react to the cycle of violence. Participants will be exposed to the wide range of psychopathology that domestic violence may precipitate for children. A review of treatment modalities will be offered as resources for children impacted by domestic violence.

Helping Children Heal Through Books

This workshop will help participants to identify the power that children's books have to help them heal from pain and trauma. Participants will interact with books, participate in discussions, share in group work, and watch videos to learn the various methods that can help treat a child's pain. A closing activity will provide resources to the participants.

The Impact of Emotional Abuse

This workshop will define emotional abuse and address the impact that emotional maltreatment can have on a child's development. Participants will be exposed to the various forms of emotional abuse. Similarly, many signs of the emotionally abused child will be discussed. Specific strategies will be provided to assist participants in advocating for children who have experienced emotional maltreatment.

Children Grieve, Too

This workshop will begin by taking class participants on the journey our children often face being removed from their families. Participants will discuss the different things that children grieve for when coming into foster care and will discover ways to help children through those trying times. Participants will be engaged in a hands-on activity that they can use to help children verbalize and release the sense of grief they might be feeling. Participants will also look at how age may impact the grief process.

Fostering Healing, Resiliency, and Hope for Traumatized Children

Learn practical ways to bring hope, healing, and resiliency to children who have experienced trauma. By allowing you to experience how trauma affects the brain, development, and attachment, we will take the latest trauma research and turn it into interventions you can use every day in your caregiving or in working with caregivers. Through real-life case examples and experiential learning, you will discover trauma-based strategies that will address the most challenging behaviors you face.

Girls, Trauma, and Delinquency

This workshop first takes an exploratory view into the world of delinquent girls and the eight factors correlated to female delinquency. Secondly, the workshop reviews the root causes of female delinquency, such as trauma, victimization, social learning, and family/community strain. Also discussed are strategies to advocate for girls across systems and empower them by helping them to build protective factors to refrain from delinquent behaviors.

Interventions for Children Who Have Suffered Trauma

Children in foster care have a vastly higher rate of trauma than their non-foster peers. Some estimates are that 51% of the children in care suffer Post-Traumatic Stress Disorder. All adults in these children's lives must understand the role trauma plays in their behavior and achievement of developmental milestones. Participants need to understand that the impact of trauma is idiosyncratic - each child will manifest it differently. Participants will learn ways to help improve functioning, as well as how to work with the mental health system.

Removed: Strategies for Hope and Healing

When children are removed from their biological homes, they often experience fear, trauma, and feelings of powerlessness and hopelessness. In this class, you will learn practical ways to educate foster parents on how to bring hope and healing to children through real-life case examples and experiences. The culture of trauma, attachment, grief and loss, nurturing techniques, sibling connection, and ways to help children feel safe will be addressed.

Wounded Child, Healing Home

When a child enters a foster or adoptive home following a history of abuse, neglect, and trauma, the family *will* be transformed. This interactive workshop addresses key issues: What does a traumatized child look like? What behavioral challenges do parents face most often? What really *does* happen to the foster/adoptive family? How can workers be prepared to support and guide families from the pain to the other side?

This workshop tackles tough and realistic issues faced by families but not often recognized by the professionals who work with them.

Promoting Successful Futures by Addressing Child Traumatic Stress

This 9-hour workshop will help child welfare professionals who have little or no experience and training in child traumatic stress and trauma-informed care, advance their practices of trauma-informed care into their daily work. It includes an overview of types of trauma, including complex, intergenerational, cultural, and historic trauma, the impact of trauma on child development, how to engage youth and families using Donna Hick's Dignity Model, and using a case study and participants' own case experiences to put the NCTNS's (1st edition) Nine Essential Elements of Trauma-informed care into practice. A significant portion of the workshop will address the risks of vicarious trauma and organizational, team, and individual strategies for reducing these risks and promoting resiliency. Small group exercises, large group discussions, films, a Power Point presentation, and case examples will be used.

Trust-Based Relational Intervention: Introduction

This training, module one of the Trust-Based Relational Intervention (TBRI®) series, will focus on understanding the meanings behind child behaviors, the brain chemistry of a child from a hard place, and helping the child (and his/her family) heal and connect. Participants will learn tools they can put into action immediately. This module is a prerequisite for additional TBRI® modules.

Trust-Based Relational Intervention: Connecting Principles

This module of the Trust-Based Relational Intervention (TBRI®) series will guide participants through the attachment cycle, attachment styles, and what to do when things go wrong in attachment. Participants will learn to use the TBRI® connecting strategies of mindful engagement, choices, compromises, and life value terms.

Trust-Based Relational Intervention: Correcting Principles

This module of the Trust-Based Relational Intervention (TBRI®) series will focus on understanding and implementing the proactive and responsive strategies within the corrective principles of TBRI®. In the proactive strategies we explore the benefits of balancing nurture and structure, and introduce and explore four parenting styles. We will examine the benefits of the nurture group, as well as the necessity and strategies for teaching social and behavioral skills. In the responsive strategies we will explore the *IDEAL Response*® and the *Levels of Response*™.

The Power of Healing: Using TBRI

The foundation of this interactive workshop is the DVD based program, Trust-Based Parenting, by Dr. Karyn Purvis. The learning will involve an exploration of the concepts of trust-based relational intervention, application of the principles, and skill development through interactive practice. A pre-training worksheet will be delivered prior to the workshop and should be completed before the session. Caregivers will leave this workshop with a toolkit of ideas and strategies for managing the behavioral and emotional issues of children in their care.

Building a Teen's Capacity for Relationships

This workshop will identify six of the essential skills of trauma informed care through the lens/needs of a teen. It will guide participants in understanding the "perfect storm" of a teen's trauma history and emerging adolescent stressors, why the adult relationship is fundamental to healing, and how to recollect strategies for managing adolescents with a traumatic history.

A Layman's Guide to Understanding the Brain

Research is discovering new things about the human brain daily. Many of the discoveries have great implications to our work with children and families. This course is designed, not as a technical look into the brain research, but as a layman's guide to understanding the brain. Time is spent applying the new research to our work with kids and families.

PTSD and Children

Although childhood is supposed to be a time of laughter and joy, millions of children confront adverse experiences that profoundly impact their development. This training will highlight the effects that trauma can have on children. An overview of the recent changes in the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD) will be offered. Diagnostic indicators and appropriate assessment will further be discussed to empower professionals when serving traumatized children. Specific strategies will be provided to assist social service professionals in advocating for competent services to these vulnerable children.

Trauma-Informed Case Management

The goal of this workshop is to present an overview of trauma, including what constitutes a traumatic event, the role of adverse childhood events in the development of illness, substance abuse and mental illness, and the physiological, psychological, cognitive, and behavioral effects of trauma. The importance of understanding trauma and how it might impact casework with parents and children will be emphasized. This training will enhance skills in identifying signs and symptoms of trauma, recognizing how systems and helping professionals can unknowingly contribute to re-traumatization, and develop strategies for working more effectively with traumatized persons.

Trauma Systems Therapy for Foster Caregivers

This training reviews the impact of trauma on children and caregivers, and provides knowledge and strategies for understanding and responding to the needs of children and teens in care. Specific strategies

are provided to assist caregivers with managing their emotions as well as the emotional and behavioral responses of the children in their homes.

The Healing Power of Connection

In this training, we will examine how adverse childhood experiences (ACEs) create repeated fear responses and disrupt the "felt safety" (neuroception) needed in order for the attachment and regulation centers of the brain to work properly. Setting power struggles aside, we will explore how the brain heals itself and identify everyday brain-based interventions to help individuals of all ages and ability levels work to replace challenging behaviors with safe, healing connection. This training is a repeat of information provided in the second three hours of the training, *Fostering Healing, Resiliency and Hope for Traumatized Children*.

Bedtime Behaviors for Traumatized Children

For many foster children, nighttime may trigger a host of traumatic triggers that can include changes in a child's mood, refusal to shower or go to bed, nightmares, night terrors, and extreme anxiety responses. This workshop will highlight the ongoing challenges involved in caring for children impacted by trauma. Specifically, this program will address nighttime behaviors of traumatized children and offer specific strategies to empower children in gaining adaptive coping skills over bedtime struggles.

Becoming a Trauma-Competent Caregiver Part I

Do you, as a foster or adoptive parent, really feel ready to parent a child with a difficult history? When a child enters your foster or adoptive home following a history of abuse, neglect, and trauma, that child will greatly impact you and your family. Oftentimes the foster or adoptive family is broadsided by shattered expectations - the experience is nothing like they expected. Foster caregivers and adoptive parents can develop their understanding of what it means to be a "trauma-competent caregiver". This workshop will guide parents in exploring seven essential skills and six characteristics essential for caring for traumatized children. Participants will leave this workshop with new tools and strategies to enhance their skills for parenting children who come from hard places.

Becoming a Trauma-Competent Caregiver Part II

This workshop will build on information trained in Becoming a Trauma-Competent Caregiver (Part I). This one-day training will explore ways to help traumatized children manage overwhelming emotions and control behaviors that stem from those emotions. Caregivers will learn the importance of supporting positive connections the child already has, as well as the value of building new connections. Caregivers will also learn how to help a child develop a strength-based understanding of his trauma history. Finally, caregivers will learn to develop self-care skills to avoid secondary traumatic stress.

The National Child Traumatic Stress Network

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 in 2016-2017 to increase awareness of the impact of trauma on child development, as well as child receptiveness to adoption processes.

Over the past several years, Ohio has also 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, was designed to improve access to evidence-based/evidence-informed behavioral health (BH) care services for youth involved in the child welfare system. Through this project, implementation of screening and assessment instruments were standardized to detect children's trauma issues and behavioral health concerns.

Addressing Secondary Trauma Within the Child Welfare Workforce

As part of Ohio's application for the 21st Century Cures Act grant, the OhioMHAS emphasized the need to provide trauma resources for first responders tasked with addressing the immediate impacts of the state's opioid epidemic. Given the related demands on child welfare staff, PCSA personnel were identified as a targeted population for these efforts. To that end, OhioMHAS contracted with the Center for Innovative Practices at Case Western Reserve University to provide regional secondary trauma sessions throughout the state in the Spring of 2018. To view an example of one of the sessions, go to: <https://www.youtube.com/watch?v=M-az7cDb048&feature=youtu.be>. In addition, OhioMHAS is in the process of developing video series highlighting the perspectives of compassion fatigue often experienced by first responders to reduce stigma, promote normalcy and provide opportunities for sharing personal recommendations about self-care techniques.

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:
 - o Establishment of 3 pilot sites to examine effective cross-system practices;
 - o Enhancement of tele-medicine options and provision of prescriber peer support;
 - o Development of clinical guidelines based on aggression, attention, and mood symptomology;
 - o Establishment of a website, www.Ohiomindsmatter.org to increase knowledge and promote best practices; and
 - o 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 launched Ohio's efforts toward appropriate use of psychotropic medication 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 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
- **Antipsychotic medication Management for children under 6 years of age:**
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
- **Avoiding polypharmacy:**
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

- **Behavioral symptom reference- Disruptive behavior and aggression:**
http://ohiomindsmatter.org/Disruptive_Aggression.html
- **A Shared Decision-Making Toolkit:** 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

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

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

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:

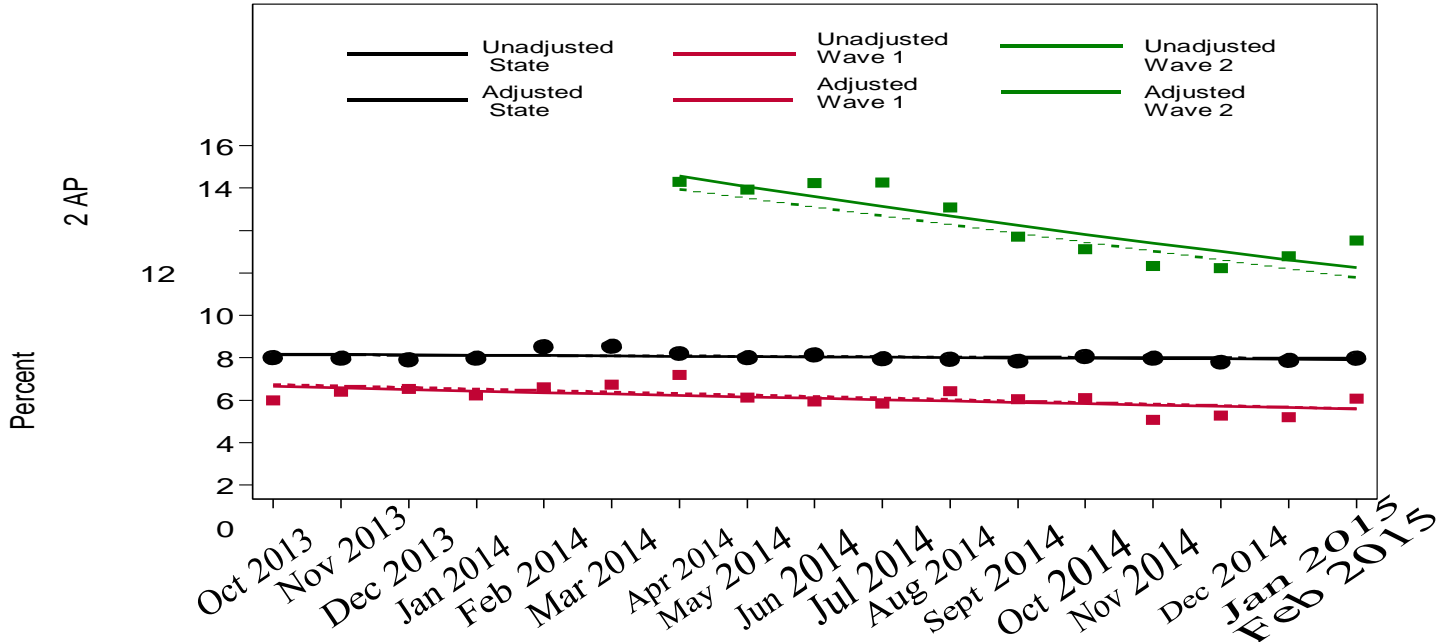
- Summit, Portage, Trumbull, and Stark Counties;
- Franklin, Licking, Fairfield, Muskingum and Perry Counties; and
- Montgomery, Greene, Miami and Clark Counties.

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:

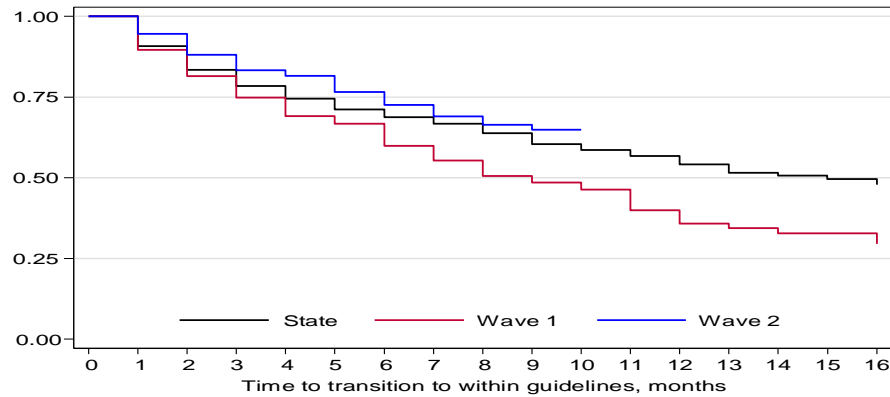
- Improve care among clinicians through training, data feedback and rapid cycle quality improvement interventions;
- Advance consumer empowerment through education and shared decision-making; and
- Improve access to care and service coordination through community collaboration.

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 was inclusive of state and local child welfare entities, as well as public and private providers. Representatives included: 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**.

National Recognition

Ohio has continued to receive national recognition for its efforts to promote safe and appropriate use of psychotropic medication for children in foster care. (The federal Government Accounting Office highlighted Ohio's programs and protocols in its January 2017 Report to Congress.) During this reporting period, Ohio has been participating 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. The work to date has included comparative reviews of Medicaid claims data sets, independent interviews with key informants (e.g., prescribers, child welfare staff, foster parents) and focus groups with former foster youth impacted by changes in state policy. At the time of this writing, Rutgers University researchers are analyzing the evaluation findings and completing the final report.

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;
- Continua 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.

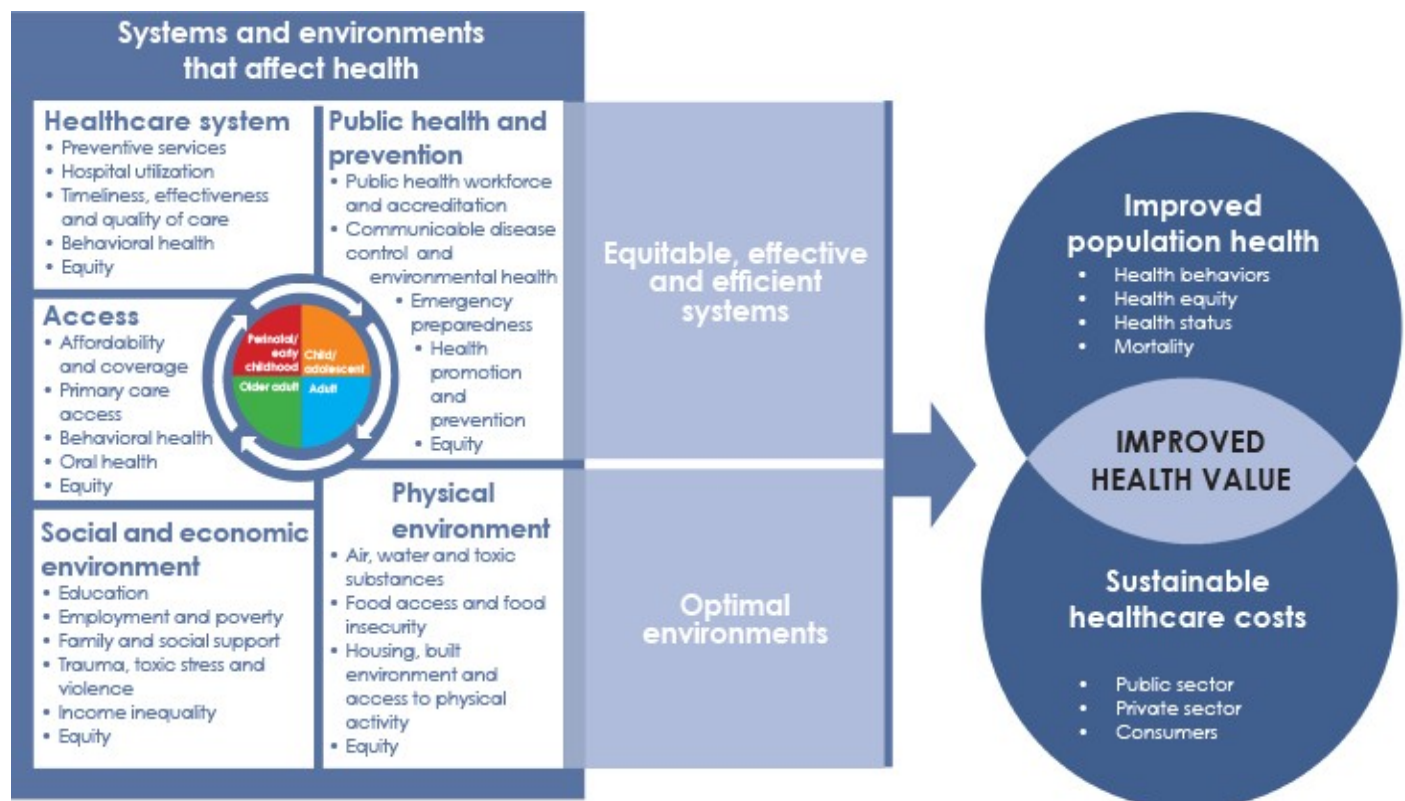
- Expanding use of patient-centered medical home models in primary health care practices.
- Simplifying eligibility determination systems for federal and state human services.
- Accelerating adoption of the electronic health information exchange.
- Enhancing cross-system data sharing.

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 were 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.

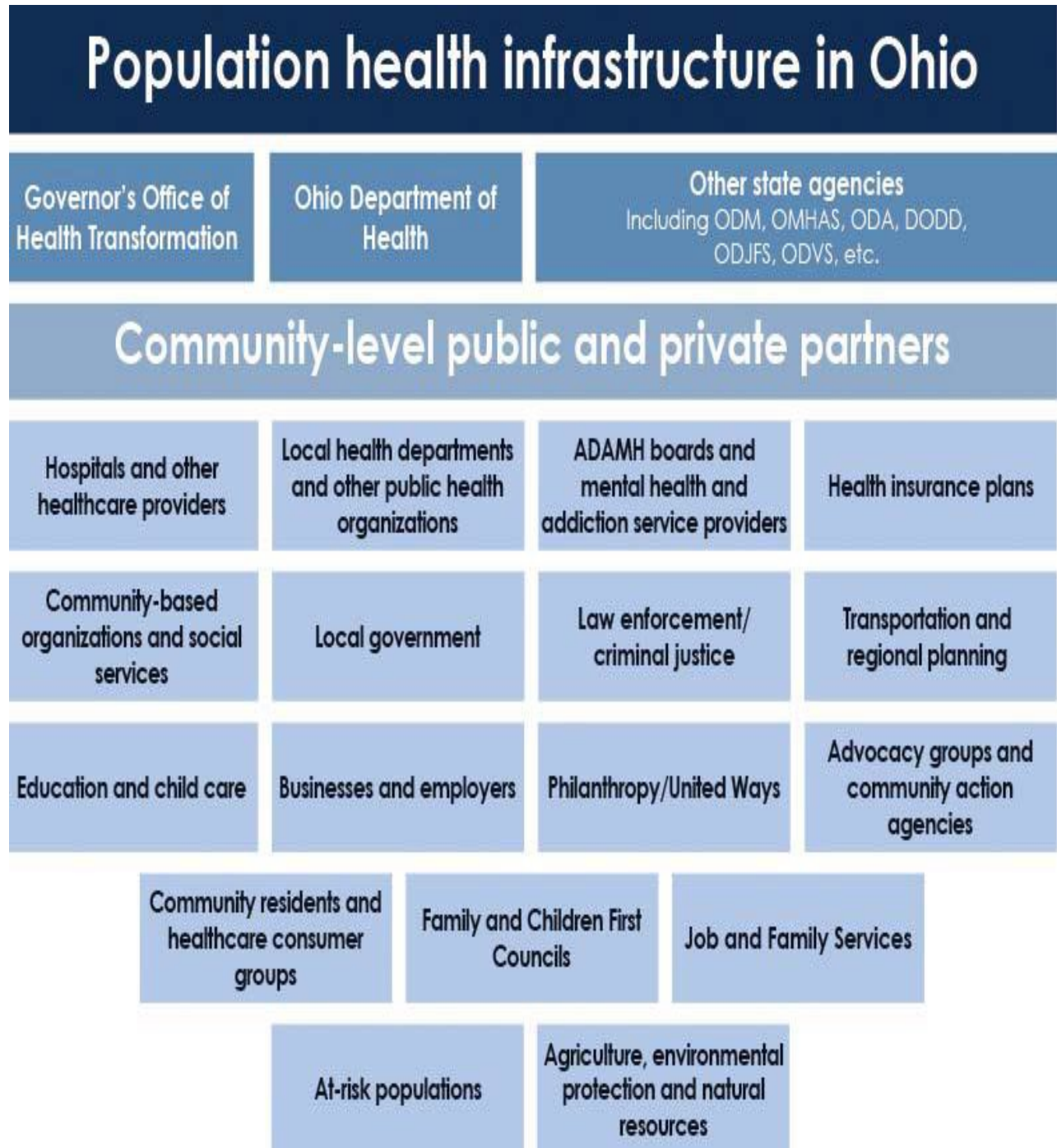


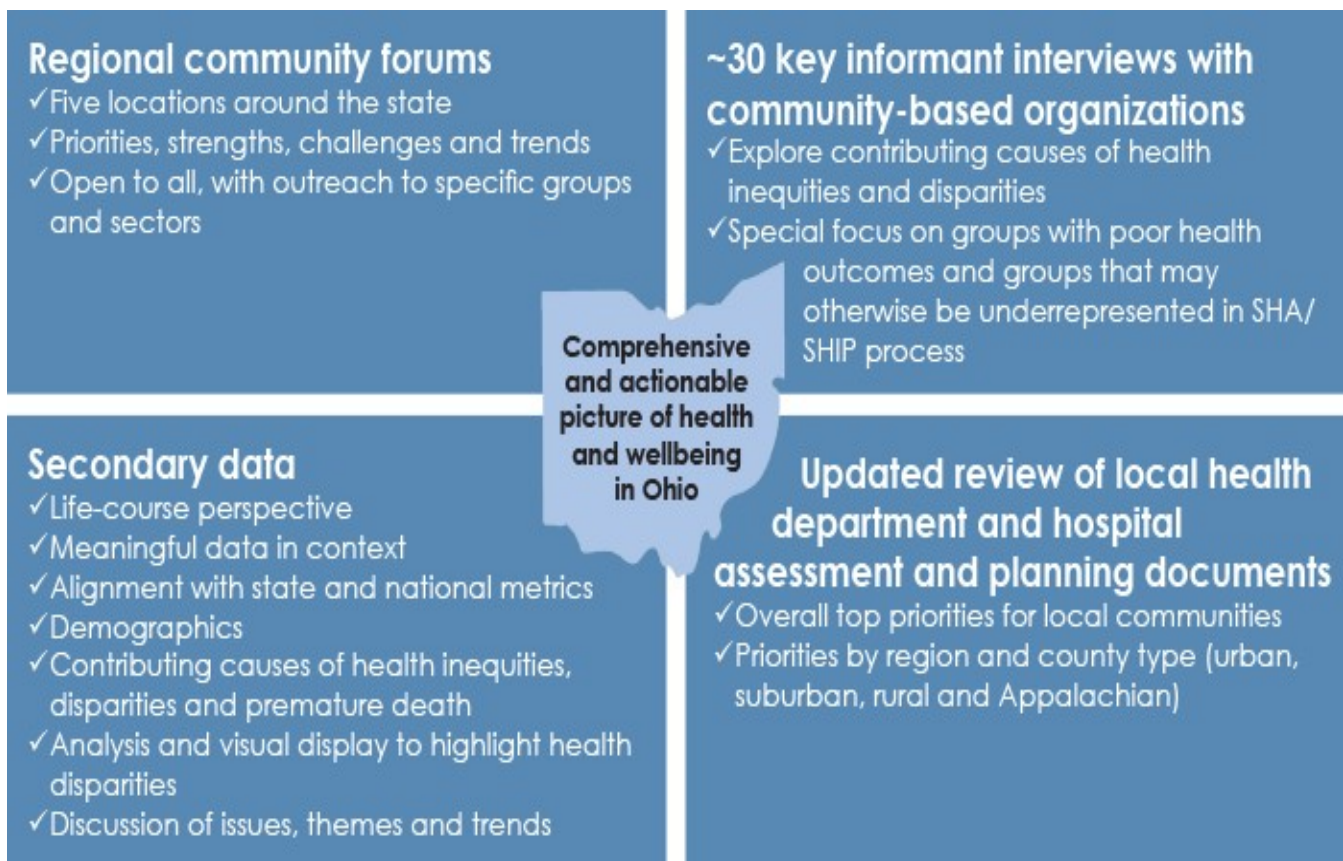
World Health Organization definition of health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

For additional information about population health, go to:

http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatIsPopHealth_PolicyBrief.pdf

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.





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

For more information about the planning process, go to: 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:
 - o Problem identification;
 - o Referral processes;
 - o Classroom management strategies;
 - o Maternal depression;
 - o Parental substance abuse;
 - o Domestic violence; and
 - o 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 continued to distribute *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;">Grow Power</p> <p>Videos:</p> <ul style="list-style-type: none"> • Packet Overview • Packet Part 2 • Packet Part 3 <p>Printable materials:</p> <ul style="list-style-type: none"> • ECMH Consultation • Guide for Moms, Dads & Caregivers • Help Me Grow Early Intervention • Help Me Grow Intervención Temprana • Safe Sleep • School-to-Prison Pipeline • FLIP IT poster • Healthy Eating
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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:
 - o Gathering information regarding the child’s preferences, needs, abilities, health status and supports;
 - o Assuring case file documentation of prescribed services;
 - o 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
 - o 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 at that time 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.

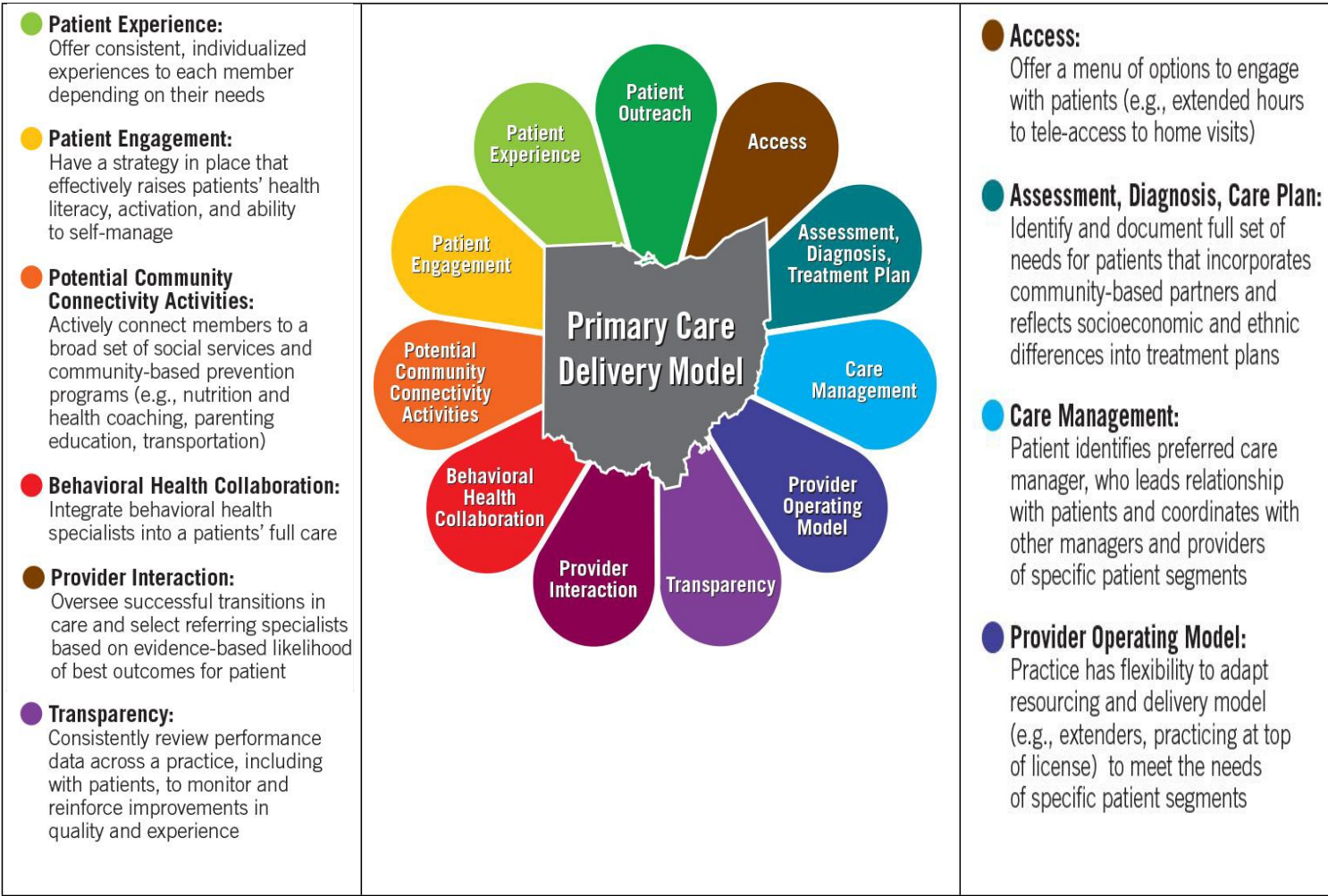
In addition, to better meet the unique needs of child welfare, ODM financially supported the establishment of a Medicaid section within the ODJFS, Office of Families and Children. The Section became fully staffed in April 2017 and has enabled the departments to work more efficiently to address systemic issues (e.g., MITS-SACWIS interface) and coverage issues impacting individual children.

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 will include the following 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.

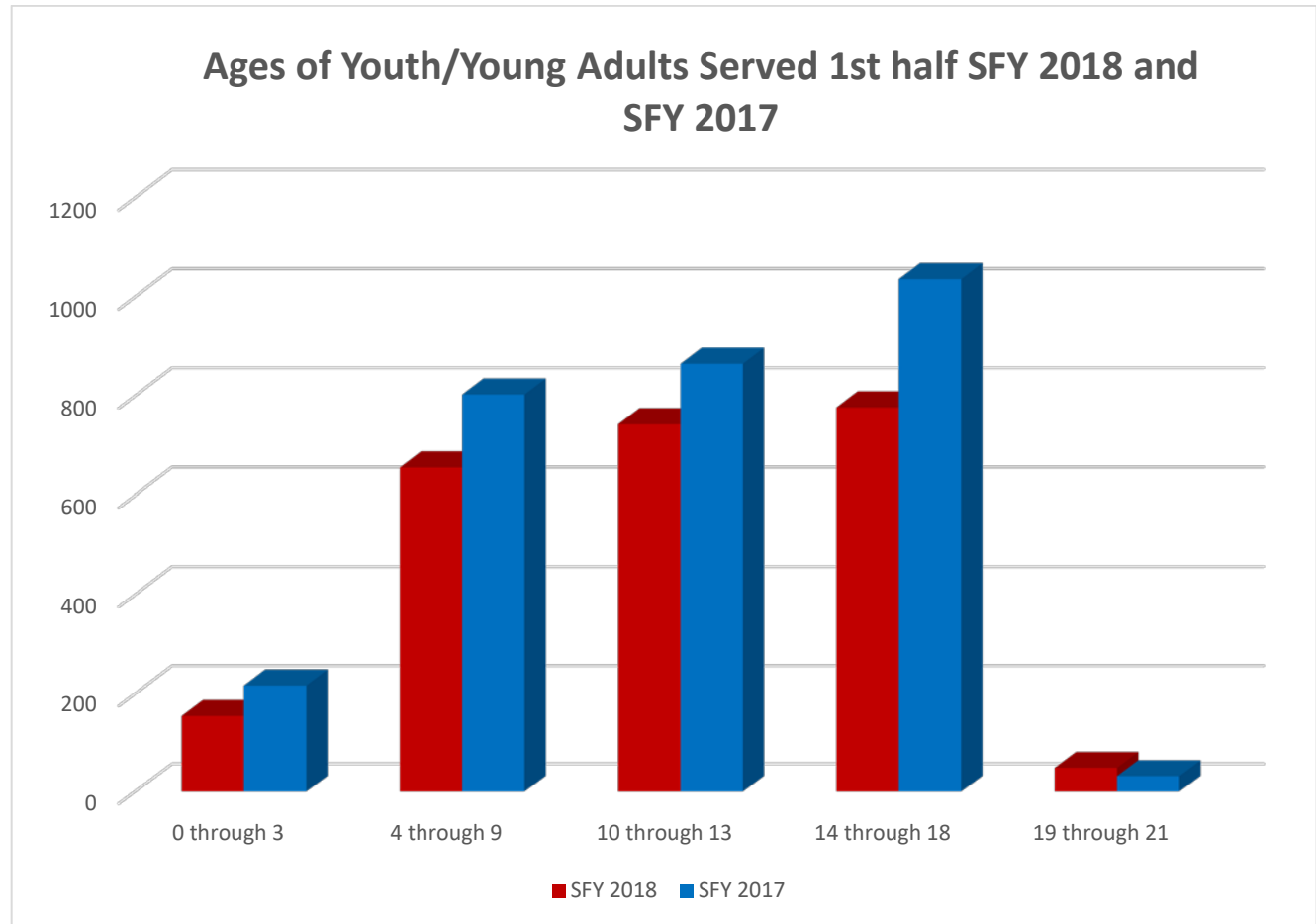
Data regarding FCSS is derived from the 2018 mid-year report, released in May 2018. Findings reflect population demographics, services rendered and outcomes from July 1 – December 31, 2017.

Total Number and Ages of Children Served

The total number of children served between the ages of 0-21 during the first half of SFY 2018 was **2,380**. This is **573 less children than were served during the first half of SFY 2017 (2,953)**.

The **14 through 18-year-old age group (777 children)** is the largest age group of youth being served through FCFC Service Coordination with FCSS funds. The age range of 10 through 13 was the second highest (743) and the age range of 4 through 9 was the third highest (656). There were more youth served in the 19 through 21-year-old age range than in the first half of SFY 2017 (49).

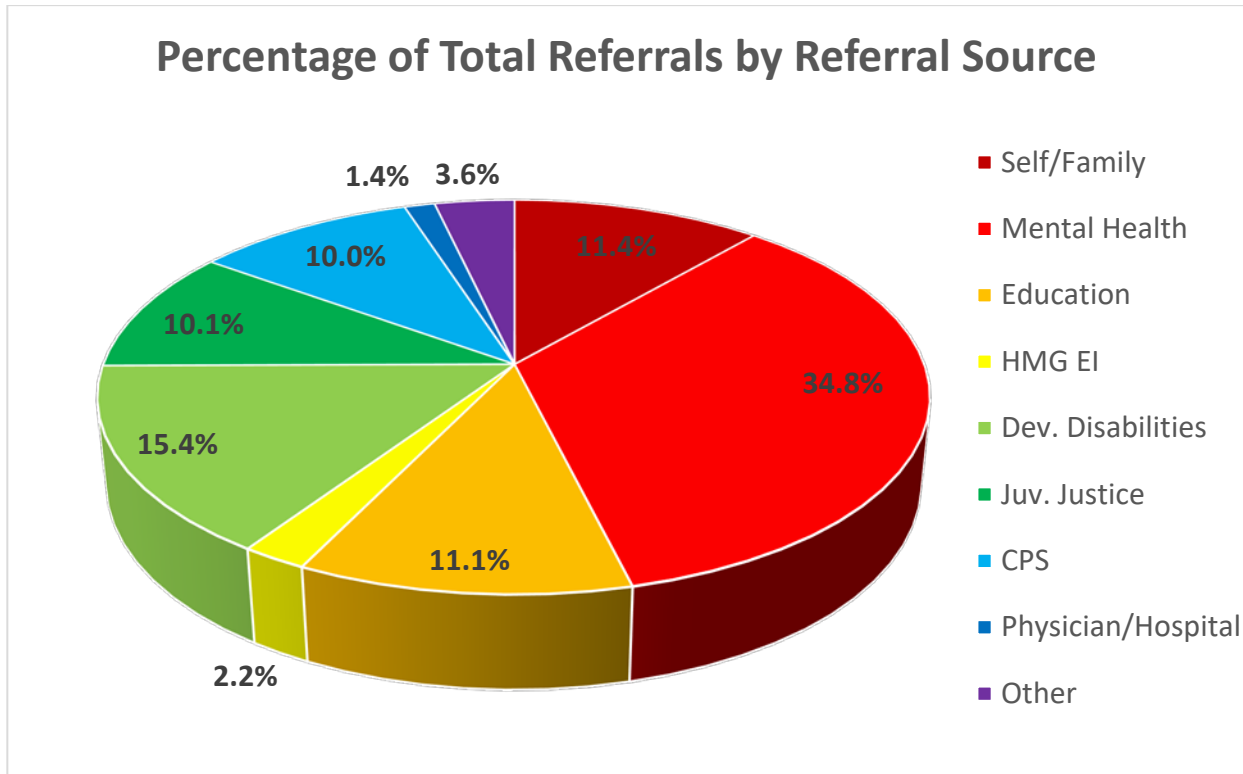
The graph and table below show a comparison of the number of children served in the first six months of SFY 2018 and SFY 2017 in each age group and the percent of the total children served in each age group during the current fiscal year.



Ages of Children	0 – 3	4 – 9	10 – 13	14 – 18	19 - 21	Total
SFY 2018	155	656	743	777	49	2,380
Percent of Total in Age Group	6.5%	27.6%	31.2%	32.6%	2.1%	100%

Number of Referrals by System

Beginning with SFY 2017, we began tracking where the referrals to FCFC Service Coordination/ Wraparound were originating by system. Data was grouped across the seven most frequent referrers to FCFC Service Coordination with all other referrers captured under “Other.”



Total Number of Families Served

FCFC service coordination is a family-focused process, and thus, addresses the needs of the identified youth and their families. The **total number of families served in the first 6 months of SFY 2018 was 1,869 compared to 2,166 families served in the first half of SFY 2017.**

Children’s Service/Support Needs by Category Identified at Intake

The FCSS guidance asked the FCFC to report the identified child’s service or support needs at the point of intake, regardless of whether the child was currently receiving services or supports to address that need at the point of intake. A child or youth must have two or more identified needs to be accepted into the service coordination process.

- There were **5,129 identified needs** (average 2.16 needs per child) during the first half of SFY 2018. The total needs are lower than the 7,770 needs identified in the first half of SFY 2017, and the average needs per child are down from the average of 2.63 per child.
- The top three identified need categories over the past six fiscal years, including the first half of SFY 2018, have consistently been: **Mental Health (60.5% of children had this identified need), Poverty (37.2%) and Special Education (37.6%)**. When combined, these three categories account for 3,219 of the identified needs, or 63% of the total identified needs among 13 categories.

- Beginning in SFY 2014, counties were asked to track the number of youth who presented with a need for supports specific to those on the Autism Spectrum. This need was identified in 12.5% of the youth (297), which is a decrease from the first half of SFY 2017.

The table below shows the number of needs identified in each category.

Category of Service/Support Need	# of Children Presenting with this Need at Intake-SFY18	% of children with this Need SFY18	% of Children with this Need SFY17	% of Children with this Need SFY16	% of Children with this Need SFY15	% of Children with this Need SFY14	% of Children with this Need SFY13
Mental Health	1439	60.5%	59.7%	57.9%	57.5%	56%	58.5%
Poverty	886	37.2%	43.8%	48.6%	45.4%	50.3%	50.3%
Special Education	894	37.6%	40.7%	43.7%	39.4%	42%	44.1%
Developmental Disability	584	24.5%	26.1%	25.5%	24%	24.8%	27.6%
Unruly	421	17.7%	20.3%	21%	20.1%	18.3%	16.4%
Child Neglect	274	11.5%	11.5%	15%	14%	12.7%	14.7%
Physical Health	202	8.5%	10.2%	11.8%	12.5%	11.6%	12.4%
Delinquent	191	8%	11.1%	11.6%	11.2%	12%	10.5%
Autism	297	12.5%	13%	15.2%	11%	10.8%	NA
Child Abuse	189	7.9%	9.9%	10.5%	10.2%	9.5%	11.6%
Alcohol/Drug	156	6.6%	8.2%	7.4%	7.6%	8.3%	7.4%
Help Me Grow	84	3.5%	4.4%	5.3%	4.6%	6.1%	5.4%
No Primary Care Physician	119	5%	3.8%	9.8%	3.5%	5.4%	14.2%
Total Needs	5129						

FCSS Funded Services and Supports Provided through FCFC Service Coordination

County FCFCs were asked to provide information about the number of different types of services and supports paid for with FCSS funds through FCFC Service Coordination when that service/support was written into a family's Individual Family Service Coordination Plan (IFSCP). The service/support categories were more clearly defined and the way the services/supports are to be counted was more clearly explained in preparation for SFY 2013 reporting. Therefore, five years of data is available for this part of the summary report to assure valid comparisons.

The **total number of various types of services/supports** provided with FCSS funding during the first half of SFY 2018 was **3,625**, which is a decrease from the first half of SFY 2017 (4,821).

- **Service coordination accounted for 34% of all types of services** provided and was the most frequently reported individual type of service/support for which FCSS funds were used. All families must be enrolled in FCFC Service Coordination in order to access FCSS funding, however, some counties have access to other funding sources to support the operational costs of service coordination and/or Wraparound.
 - 55 counties (63%) reported using FCSS funds to assist in the support of service coordination and to provide other services and supports for families in service coordination.
 - 24 counties (27%) reported that they used none of the FCSS funds to support the FCFC service coordination process and used their funds to provide services and supports to families in service coordination.
 - 7 counties (8%) used their total FCSS allocations to assist in the support of the service coordination process.
 - 2 counties (2%) reported not spending any of its allocation during the first 6 months of SFY 2018.

The chart below provides the details of the frequency of all service types reported.

Type of Service/Support Provided	Number/Percent of Families Receiving Service/Support (1st half of SFY 18)	% of total services & supports provided in 1 st half SFY 18	% of Families Receiving Service/Support t 1 st half of SFY 17	% of total services & supports provided in 1 st half SFY 17	% of Families Receiving Service/Support 1 st half of SFY16	% of total services& supports provided 1 st half SFY16
Service Coordination	1238/ (66.2%)	34.2%	63.7%	28.6%	62.8%	29%
Social/Recreational Supports	656/ (35.1%)	18.1%	37.1%	16.7%	34.1%	15.8%
Respite	481/ (25.7%)	13.3%	24.2%	10.8%	21.2%	9.8%
Transportation	334/ (17.9%)	9.2%	27.1%	12.2%	23%	10.6%
Structured activities to improve family functioning	286/ (15.3%)	7.9%	18%	8.1%	16.6%	7.7%
Non-clinical in-home parenting/coaching	151/ (8.1%)	4.2%	10.9%	4.9%	16.7%	4.9%
Mentoring	164/ (8.8%)	4.5%	12.6%	5.6%	12.8%	5.6%
Parent Education	77/ (4.1%)	2.1%	9.3%	4.1%	12.8%	3.9%

Type of Service/Support Provided	Number/Percent of Families Receiving Service/Support (1st half of SFY 18)	% of total services & supports provided in 1 st half SFY 18	% of Families Receiving Service/Support 1 st half of SFY 17	% of total services & supports provided in 1 st half SFY 17	% of Families Receiving Service/Support 1 st half of SFY16	% of total services& supports provided 1 st half SFY16
Parent Advocacy	120/ (6.4%)	3.3%	8.3%	3.7%	9.2%	4.2%
Safety and Adaptive Equipment	103/ (5.5%)	2.8%	7.2%	3.2%	7%	3.3%
Youth/Young Adult Peer Support (new category)	2/ (0.1%)	0.1%	0.8%	0.3%	2.1%	0.9%
Non-clinical Parent Support Groups	6/ (0.3%)	0.2%	1.6%	0.7%	1.7%	0.8%
Other	7/ (0.4%)	0.2%	1.6%	0.4%	0.7%	0.3%
Total	3625	100%	-----	100%	-----	100%

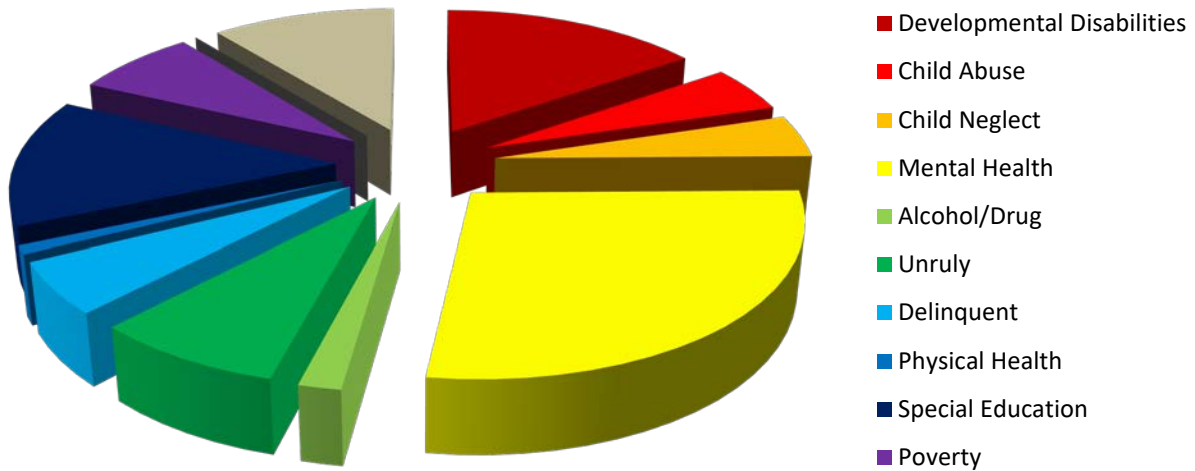
Number of Children/Families connected to a primary care physician during Service Coordination

Beginning in SFY 2013, families entering FCFC service coordination were asked if they and/or their children have a primary care physician. The families of those children without a primary care physician had the opportunity to be connected one during the service coordination process. In the first half of SFY 2018 there were 72 children identified during the intake process who did not have a primary care physician. This is 103 less than in the first half of SFY 2017 (275). Perhaps this is an indication that multi-system families are being connected to primary care earlier and at a much higher rate than in previous years. Of the 72 total children in SFY 2018 that were identified to be without a primary care physician, 66 were connected to a physician during the service coordination process. No FCSS funds were used to provide medical services. The benefit for the families is to be connected to a physician with the goal of better integrating physical and behavioral health.

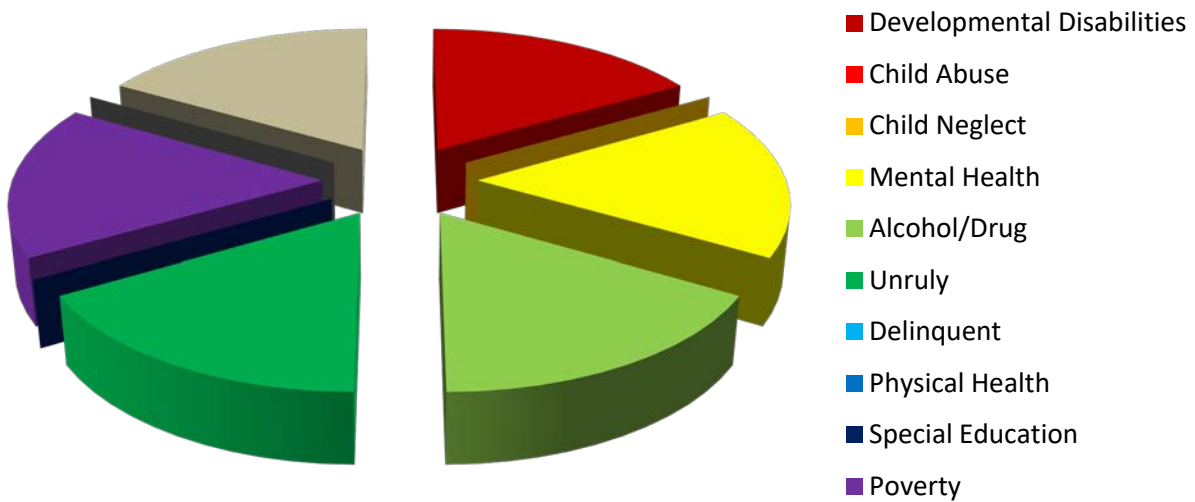
Service Utilization by System:

Beginning in SFY 2017, data collection began that supported analysis of how the needs identified at enrollment intersected with the use of the identified services and supports provided listed in the individualized family service plan. The following charts illustrate the distribution of those services and supports by primary system of care.

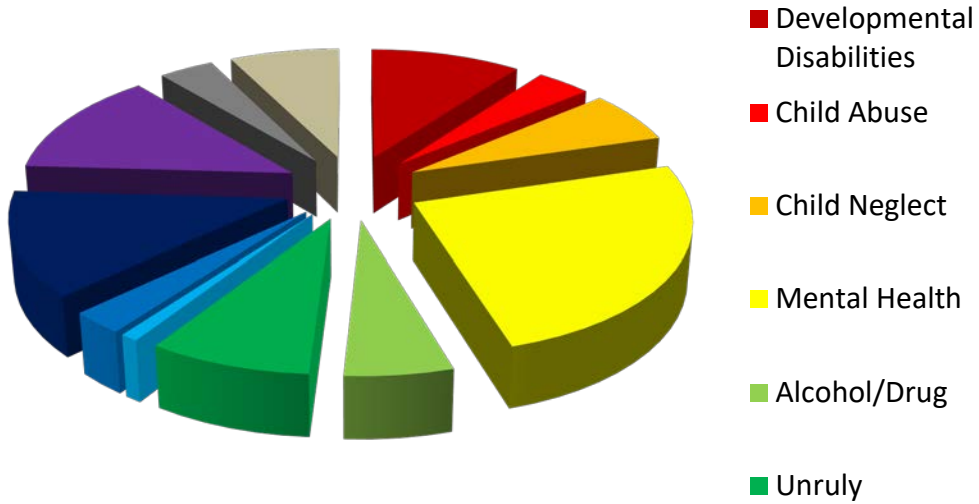
Proportion of Needs Serviced by Utilizing Non-Clinical, In-Home Parent/Child Coaching



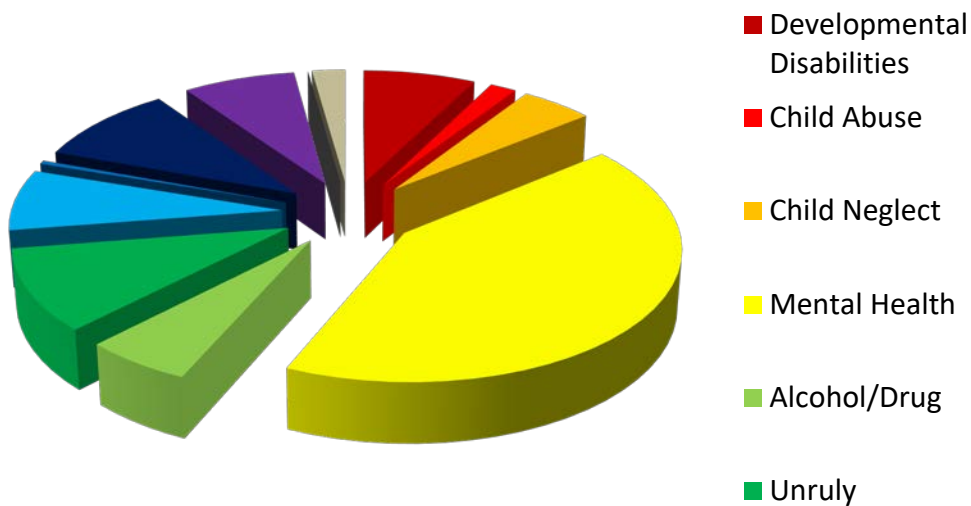
Proportion of Needs Serviced by Utilizing Parent Support Groups



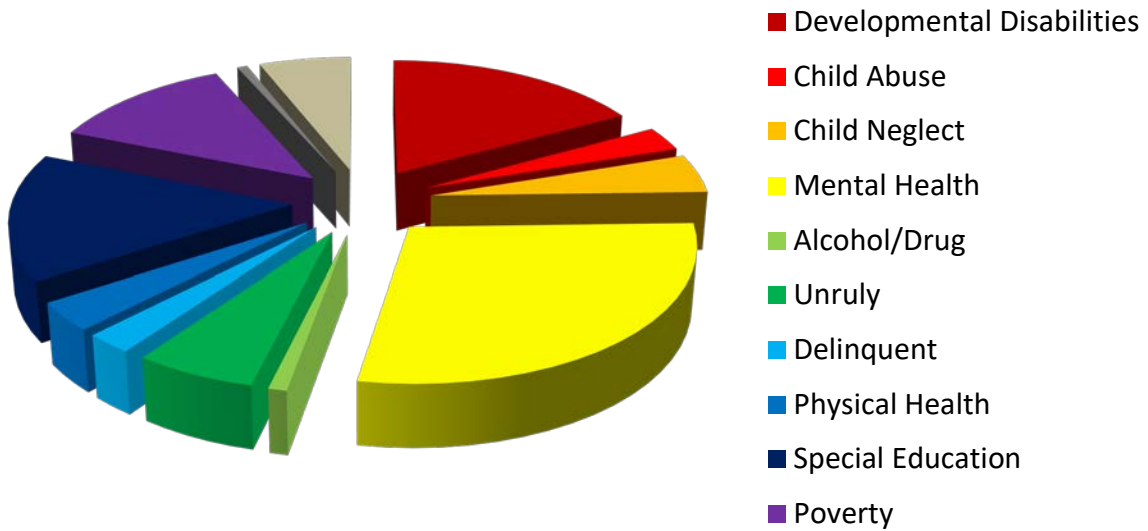
Proportion of Needs Serviced by Utilizing Parent Education



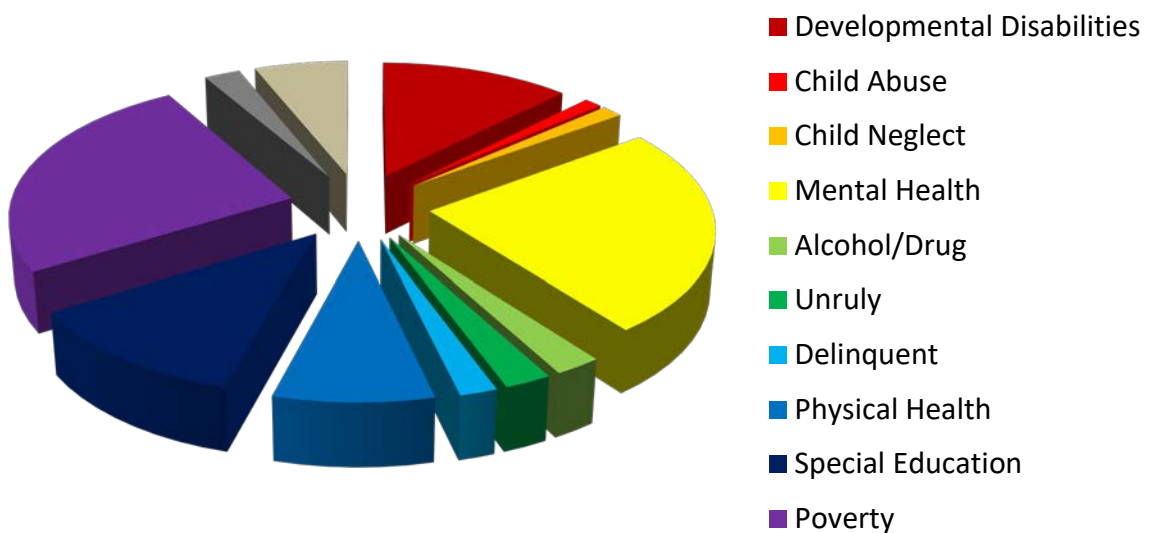
Proportion of Needs Serviced by Utilizing Mentoring



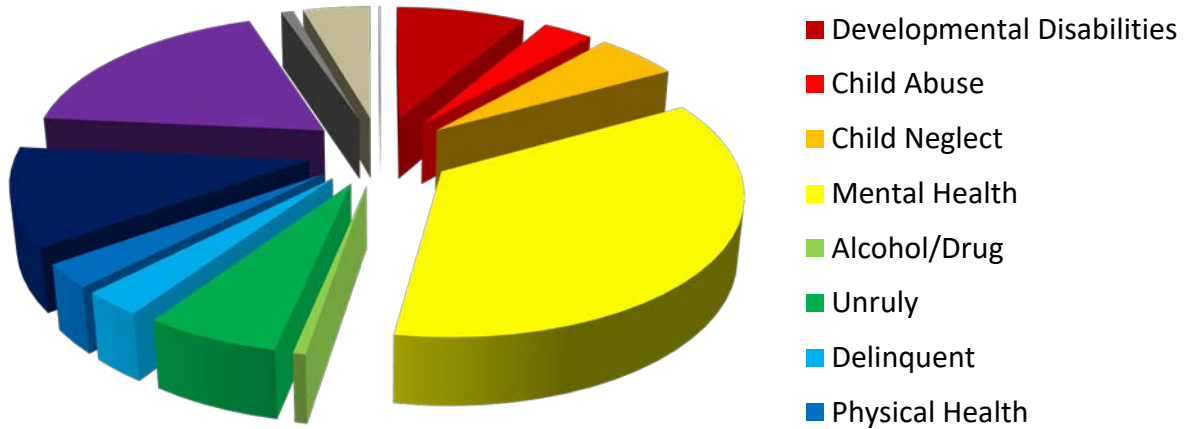
Proportion of Needs Serviced by Utilizing Respite Care



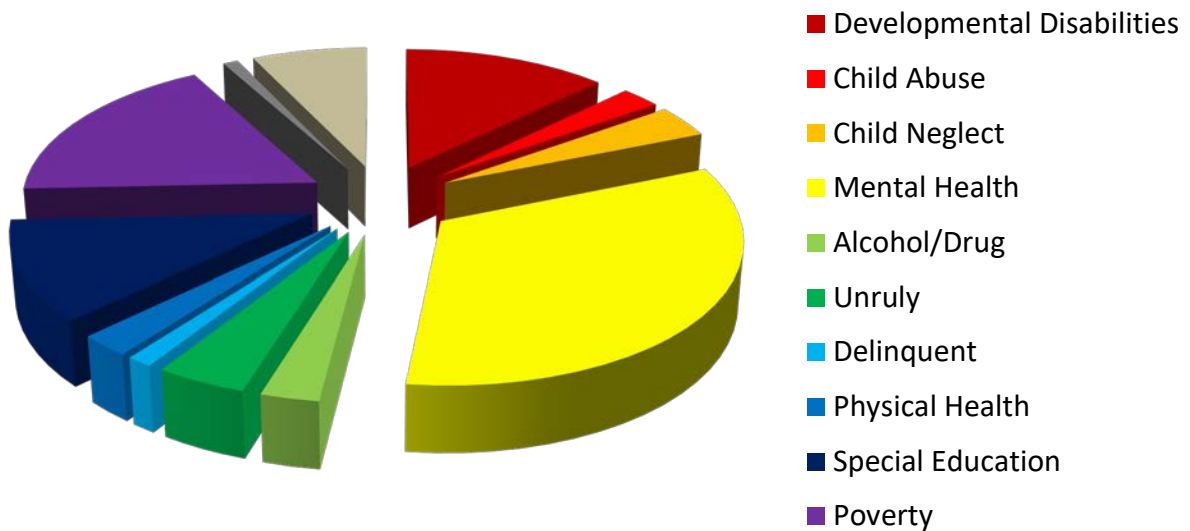
Proportion of Needs Serviced by Utilizing Transportation



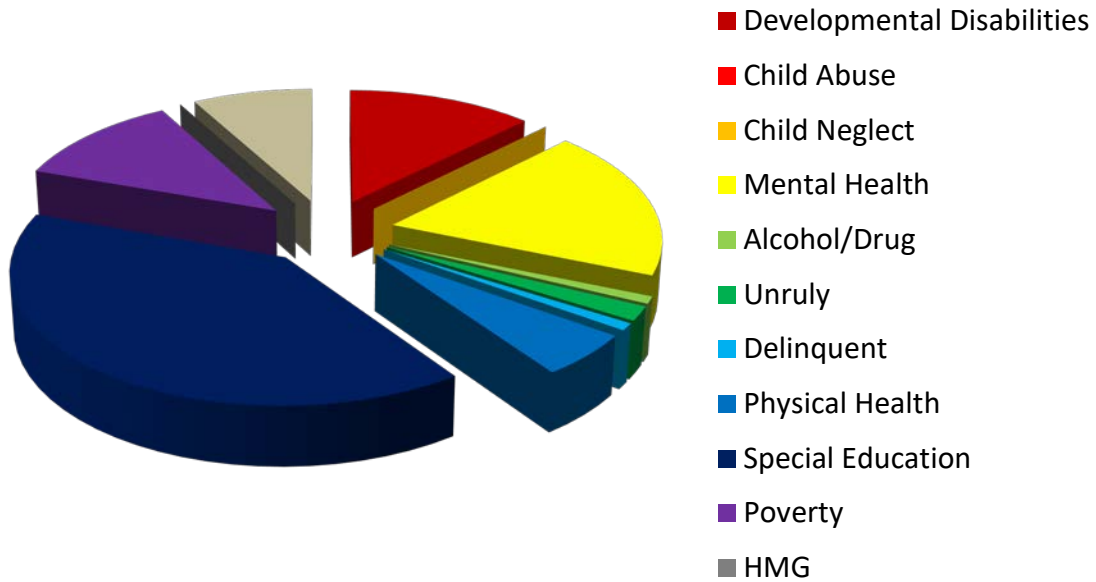
Proportion of Needs Serviced by Utilizing Social-Recreational Supports



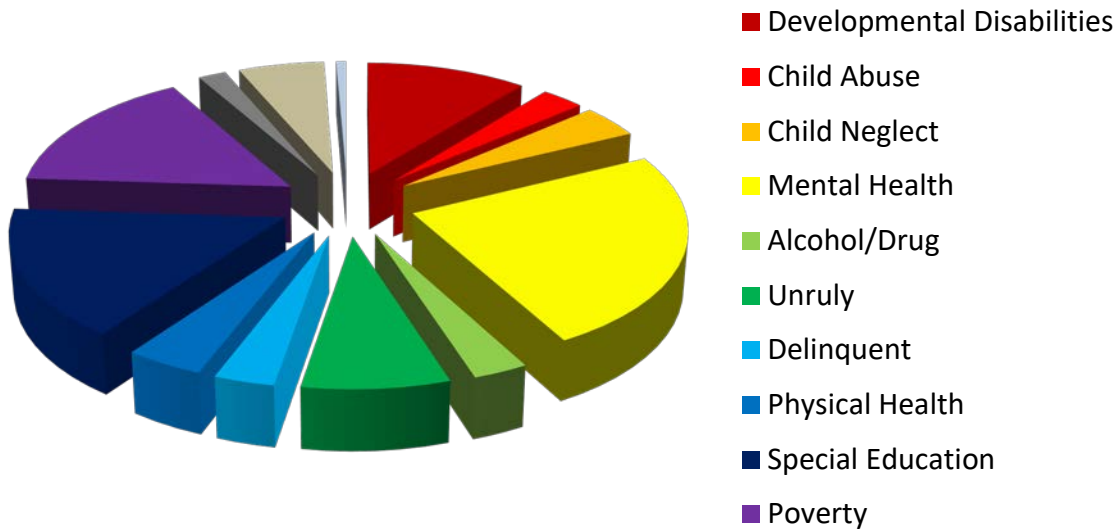
Proportion of Needs Serviced by Utilizing Structured Activities to Improve Family Functioning



Proportion of Needs Serviced by Utilizing Parent Advocacy



Proportion of Needs Serviced by Utilizing Service Coordination



Conclusion

This summary provides a snapshot of how the FCSS funds were used by counties during the first half of SFY 2018. It should be remembered that the number of youth and families served through FCFC Service Coordination/Wraparound and the services and supports included in this report only include those supported through FCSS funding. FCFCs may use other available funding, especially at the local level, to serve referred families, provide needed services and supports and to support the FCFC Service Coordination/Wraparound Process. In addition, services and supports needed by youth and families may not meet the criteria of FCSS funding. Often, the FCFC Service Coordination/Wraparound teams find community resources that are donated or have no cost associated with the service or support. In addition, FCSS funding is not used unless other resources have been exhausted. As reported by the county FCFCs, these funds are highly valued to meet the needs of families when other funding sources are unavailable to meet the unique family needs.

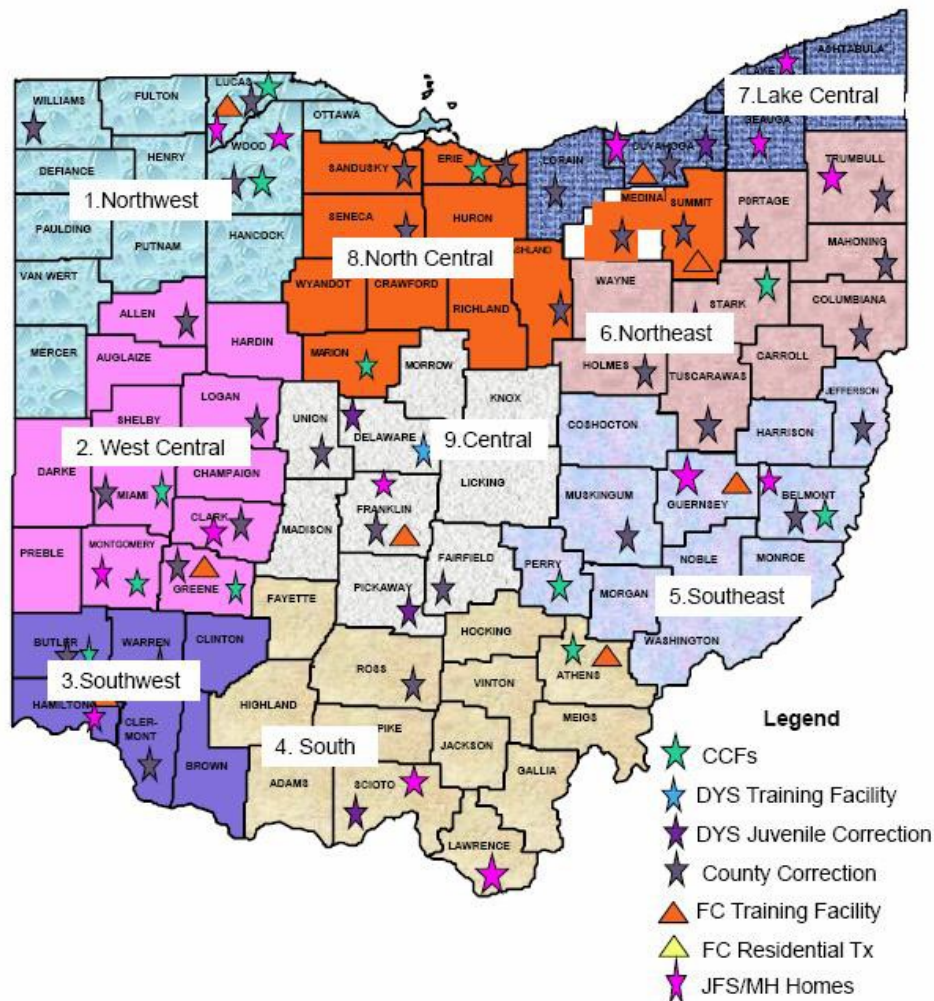
These children are at the highest risk for failure within our traditional service systems, and are often on the verge of placement outside of their homes. As indicated in this report, these are not “one size fits all” youth or with one particular need. The power of this type of service coordination/Wraparound with the support of FCSS funding is the opportunity for families to creatively design integrated family service plans with trusted and unique teams.

The reporting connected to the use of FCSS funding demonstrates how these funds and the FCFC Service Coordination Process are leading to a cost-effective method of obtaining better outcomes for the children and families being served. The required SFY 2018 FCSS Annual Report is due in August 2018. That report will contain additional information about the family goal attainment success rate and the numbers of children placed out of home while being served through FCFC Service Coordination and supported with FCSS funding.

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.

In January 2018, The Voinovich school of Leadership and Public Affairs at Ohio University released a report on the program's outcomes. Findings include:

- Since inception, 3,664 Ohio youth attended at least one PREP session.
- A total of 2,371 youth completed 75% of the 15- to 16-hour PREP programming.
- Overall, Ohio youth engaged in PREP not only show increased knowledge of sexual health, prevention of pregnancy and STIs, but they also show improved intentions to use condoms and hormone-based birth control.
- Using a train-the-trainer model, over 1,400 Ohio social service and health workers participated in PREP facilitator training or retraining from program inception through July 2017.
- Among the facilitators trained to provide the intervention, Ohio PREP is increasing knowledge of STIs and knowledge of the rights of youth related to accessing reproductive health care.

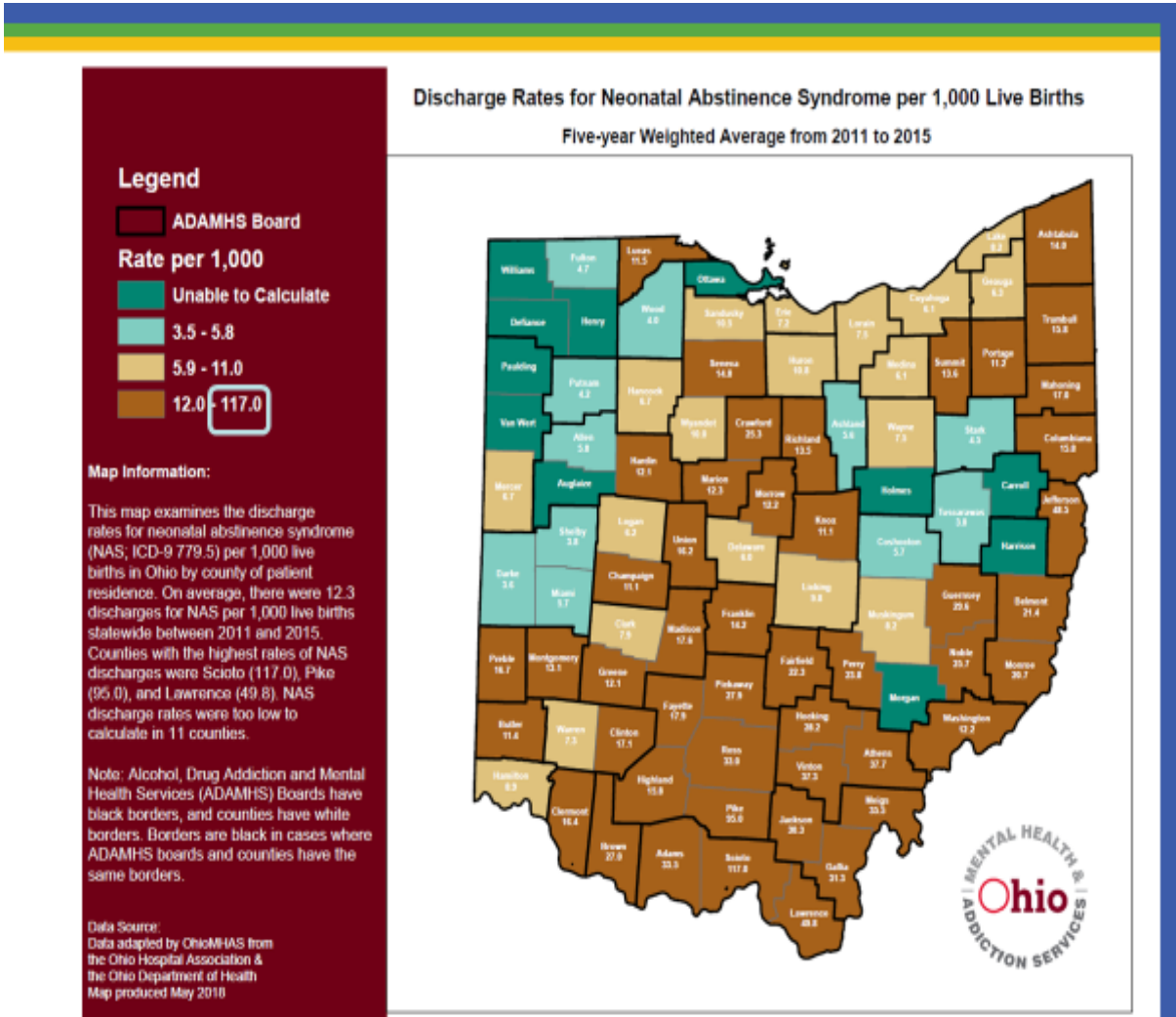
To view the entire report, go to:

<https://www.ohio.edu/voinovichschool/services/upload/Prep-Report-March-6-2018.pdf>

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

The pervasiveness of opiate addiction in Ohio has been of epidemic proportions in recent years. 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.

- **From 2004 to 2014, the rate of U.S. infants diagnosed with opioid withdrawal symptoms, known as neonatal abstinence syndrome (NAS), increased 433%, from 1.5 to 8.0 per 1,000 hospital births.**
- However, the increase was even more stark in state Medicaid programs -- rising from 2.8 to 14.4 per 1,000 hospital births. Medicaid, a public health insurance program, covered more than 80% of NAS births nationwide in 2014.
- **In Ohio, the increase in the NAS Statewide rate per 1,000 live births has risen from 1.4 in 2004 to 15.9 in 2015.**



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.

Because the majority of opioid dependent pregnant women in Ohio are not engaged in prenatal treatment, 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. 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
- 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

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 is currently expanding MOMS program through federal funding received through the federal [21st Century Cures Act](#). Over the next two years, six new sites will be added per year of the grant. The map below illustrates the MOMS 2.0 current project sites.



MOMS 2.0 Locations



The Ohio NAS Project

In September 2012, six children’s hospitals and their affiliates (20 hospitals total) formed an NAS Consortium.



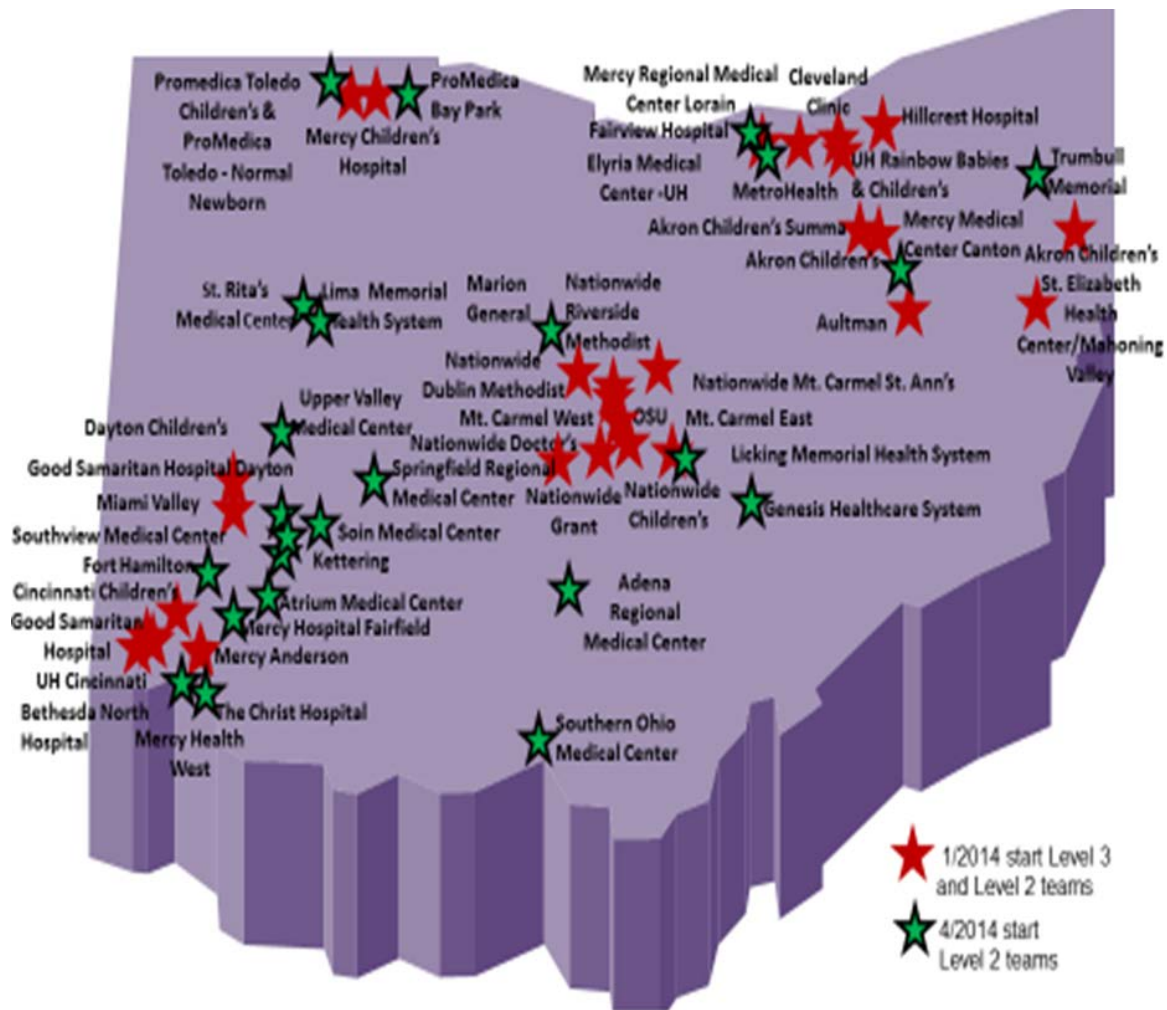
The goals of this project were to:

- Understand the epidemiology of mothers and infants with NAS by following a longitudinal cohort;
- Determine better practices for NAS treatment; and
- Identify variation and areas for future research.

Specific activities of this work included:

- Assessing and improving inter-rater reliability scoring of infant functioning in the Neonatal Intensive Care Units (NICUs);
- Improving staff attitudes about treating women with opioid use disorders;
- Standardizing pharmacological and non-pharmacological treatments across sites; and
- Partnering with stakeholders to address policy issues and promote primary prevention.

Within three quarters, significant progress was demonstrated on each of these activities. In addition, both the length of pharmacological treatment and the length of hospital stay for these infants were reduced by 9% within that time frame. By the project's end in 2014, recommendations from the NAS project had spread to 54 sites: 26 Level III NICUs; 26 level II Special Care Nurseries; and 2 General Newborn Nurseries.



MOMS Plus

Based on the success of the NAS project, the Ohio Perinatal Quality Collaborative (OPQC) is now undertaking MOMS Plus. (Members of the Collaborative include the Ohio Department of Medicaid, The Ohio Department of Health, the Ohio Association of Community Health Centers, the March of Dimes, the Centers for Disease Control and Prevention, the Ohio Colleges of Medicine Government Resource Center, and the Ohio Medical Technical Assistance and Policy Program.)

This project is designed to better coordinate care provided by obstetricians, medication assisted treatment (MAT) providers, behavioral health clinicians, and neonatal specialists/pediatricians. Hospitals serve as the lead agencies for these projects. Sites are located in the following counties, though patients served often live in neighboring areas: NW (Lucas); SW (Hamilton); SE (Athens) Central (Franklin, Muskingum, Ross, Scioto); NE (Cuyahoga, Summit, Trumbull, Mahoning) and West Central (Allen, Clark, Montgomery, Warren).

The goals of MOMS Plus are to do the following by June 30, 2019:

- Increase identification of pregnant women with Opioid Use Disorder (OUD);
- Increase the % of pregnant women with OUD who receive prenatal care, MAT, and behavioral health care each month;
- Decrease the % of full-term infants with NAS requiring pharmacological treatment; and
- **Increase the % of babies who go home with their mothers due to having an effective Plan of Safe Care established.**



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 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 trainings on substance use, including:
 - *Overview of Medically Assisted Treatment in Substance Abuse;*
 - *Assessment and Treatment of Opiate Addiction;*
 - *The Dramatic Effects of Prenatal Substance Exposure: Living the Legacy;*
 - *Born Addicted: Promoting Best Care for Substance Exposed Infants;*
 - *Engagement and Case Planning with Opioid-Involved Families;*
 - *The Hard Stuff- Heroin;*
 - *Women's Substance Abuse;*
 - *Understanding Birth Parent Addiction and the Impact on the Children in Your Home; and*
 - *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

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 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.

Provider Type	Primary Care	Behavioral Health	Resource/Time
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.

