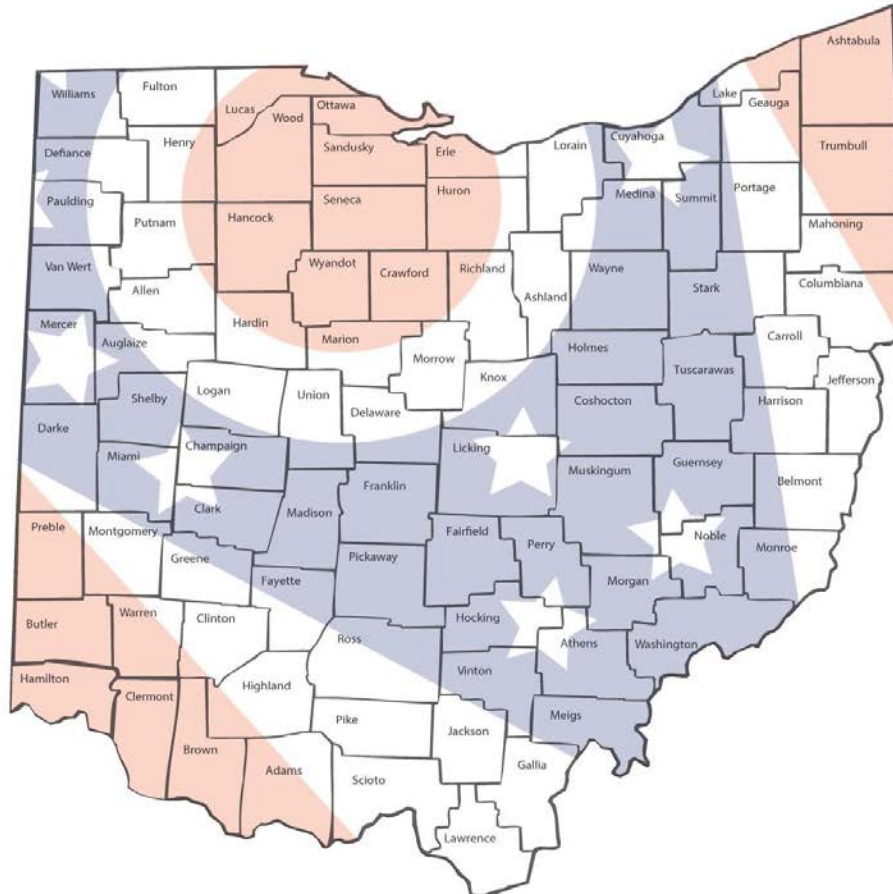


Appendix C

OHIO'S 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 2019

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).

PCSAs are required to provide parents, guardians, custodians, pre-finalized adoptive parents (if applicable) and the substitute caregivers a copy of the JFS 01443 at the time the case plan is completed, 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). ODJFS has made the following enhancements to SACWIS to improve documentation of healthcare needs and services:

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

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

PCSAs are monitored on documentation of medical information, and on ensuring that examinations are completed within required timeframes. ODJFS determines agency compliance with health care mandates via Child Protection Oversight and Evaluation (CPOE) reviews. Should a PCSA be found to be non-compliant, the agency must complete a 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:
 - Health and developmental histories;
 - A comprehensive physical examination;
 - Developmental, nutritional, vision, hearing, immunization and dental screenings;
 - A lead toxicity screening;
 - Lab tests; and
 - Health education and counseling.

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

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

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

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

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

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

Bright Futures

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

Medicaid Enrollment of Youth Aging Out of Care

Youth who emancipate from foster care at age 18 are 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.

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 ODM Bureau of Technical Assistance and Compliance continues to work with the ODJFS, Office of Families and Children Departments to jointly analyze enrollment data, and to increase Medicaid enrollment of former foster youth. Marketing strategies include:

- 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: http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/D_QuickReferenceGuide.pdf. (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

OhioMHAS has established a statewide project to expand availability of effective services by increasing practitioners' competency in trauma informed care practices. The objectives of this work are 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 peer-

based technical assistance.

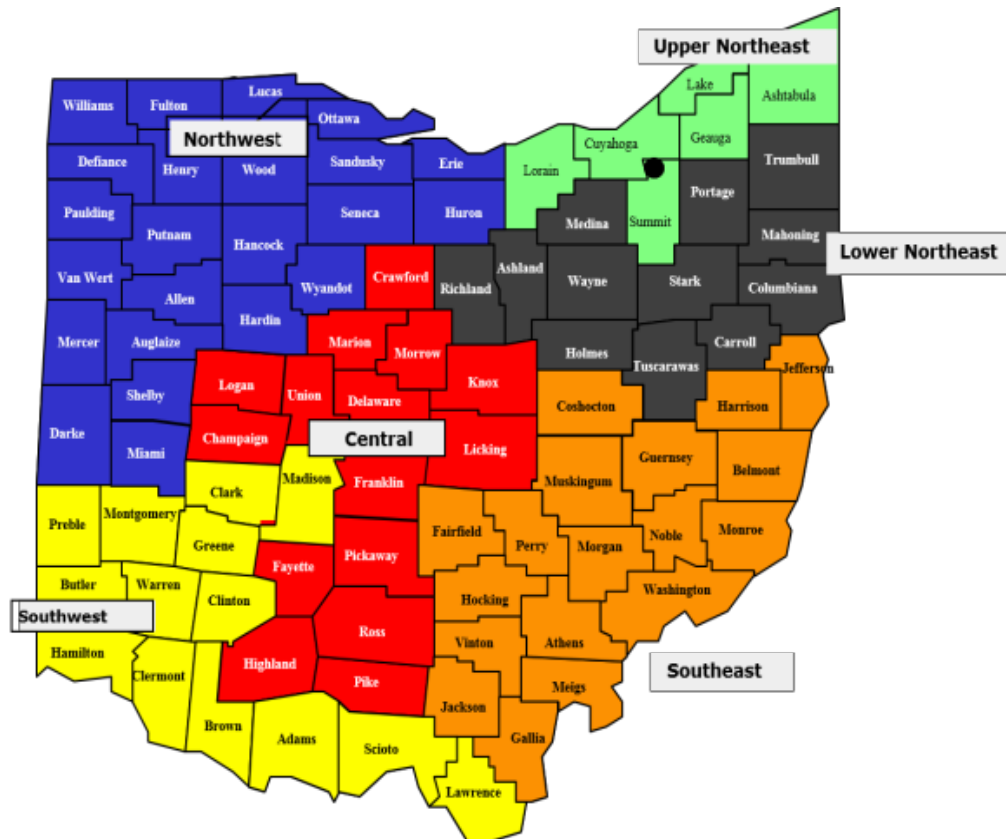
Team members of this public-private partnership reflect a broad range of constituencies. Representatives include the: Ohio Hospital Association; Public Children Services Association of Ohio (PCSAO); Ohio Association of County Behavioral Health Authorities; Ohio Association of Child Caring Agencies; County 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).

Past activities conducted during the CFSP implementation period have included, but were not limited to:

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

Regional Collaboratives:

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



These sites serve to:

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

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

Systemic Trauma Training for Child Welfare

The Institute for Human Services (IHS) is the coordinator of the Ohio Child Welfare Training Program (OCWTP). IHS develops and implements competency-based training for Ohio's foster and adoptive parents, caseworkers, supervisors, and administrators. In partnership with OhioMHAS, IHS has modified the National Child Traumatic Stress Network (NCTSN) Child Welfare Training Toolkit to meet established timelines of the state's program. The NCTSN Child Welfare Trauma Training Toolkit consists of four, three-hour modules. The chart below depicts implementation of this training throughout the last CFSP period.

NCTSN Child Welfare Trauma Toolkit	Sessions Offered	Attendance
<i>Overview of Trauma and Its Effect on Children</i>	20	253
<i>The Impact of Trauma and the Importance of Safety</i>	20	195
<i>Identifying Trauma-related Needs and Enhancing Well-Being</i>	17	150
<i>Worker Well-Being and the Importance of Partnering</i>	14	132

In addition to the Toolkit, the OCWTP made revisions to both the foster care and adoption assessor curricula in 2016-2017 to increase awareness of the impact of trauma on child development, as well as child receptiveness to adoption processes.

Most recently, the Trust Based Relational Intervention (TBRI) series was incorporated into OCWTP's menu of offerings for staff and caregivers. TBRI is an attachment-based, trauma-informed intervention that uses empowering, connecting, and correcting principles to meet the needs of vulnerable children.

- Trust-Based Relational Intervention: Introduction**
 This training focuses on understanding the meaning behind child behaviors, the brain chemistry of a traumatized child, and helping the child (and his/her family) heal and connect. Participants 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 guides participants through the attachment cycle, describes attachment styles, and identifies what to do when things go wrong in attachment. Participants learn to use the TBRI® connecting strategies of mindful engagement, choices, compromises, and life value terms.
- Trust-Based Relational Intervention: Empowering Principles**
 This module provides understanding of the importance of meeting the child's ecological and physiological needs to ensure healthy conditions exist as the basis positive future change.
- Trust-Based Relational Intervention: Correcting Principles**
 This module focuses on understanding and implementing proactive and responsive strategies within the corrective principles of TBRI®. The benefits of balancing nurture and structure are identified, and four parenting styles are introduced and explored. The benefits of the nurture group are examined, as well as strategies for teaching social and behavioral skills. In the responsive strategies, the *IDEAL Response*® and the *Levels of Response*™ are explored
- The Power of Healing: Connections Using TBRI**
 Trust-Based Parenting, by Dr. Karyn Purvis serves as the foundation for this module. Concepts of TBRI are examined, and participants' skills are enhanced through application of the principles via interactive practice. A pre-training worksheet is delivered prior to the workshop and completed before the session. Caregivers leave the workshop with a toolkit of ideas and strategies for managing the behavioral and emotional issues of children in their care.

Other OCWTP trauma training sessions provided include:

A Layman's Guide to Understanding the Brain

Research is discovering new things about the human brain on a daily basis. 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.

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 guides parents in exploring seven skills and six characteristics essential for caring for traumatized children. Participants leave this workshop with new tools and strategies to enhance their skills for parenting children who have experienced trauma.

Becoming a Trauma-Competent Caregiver Part II

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

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 highlights the ongoing challenges involved in caring for children impacted by trauma. Specifically, this program addresses nighttime behaviors of traumatized children and offers specific strategies to empower children in gaining adaptive coping skills over bedtime struggles.

Beyond the Bruises: An Overview of DV

Child welfare workers often encounter families in which domestic violence is present. This workshop provides participants with the most recent statistical data regarding the occurrence of domestic violence. The facilitator discusses tactics of power and control in violent relationships, as developed by the Domestic Abuse Intervention Project in Duluth, Minnesota. The cycle of violence is also reviewed.

Beyond the Bruises: Effects of DV on Children

This workshop provides participants with the most recent statistical data regarding children affected by domestic violence. The cycle of violence is reviewed, and how children may react to the cycle of violence is discussed. Participants are exposed to the wide range of psychopathology that domestic violence may precipitate for children. Various treatment modalities and resources for children impacted by domestic violence are presented.

Building a Teen's Capacity for Relationships

This workshop identifies six essential skills of trauma informed care through the lens/needs of a teen. It guides 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.

Children Grieve, Too

This workshop begins by taking class participants on the journey our children often face when being removed from their families. Participants discuss the different things for which children grieve when coming into foster care, and discover ways to help children through those trying times. Participants engage in a hands-on activities they can use to help children verbalize and release the sense of grief they might be feeling. Participants also examine how age impacts 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, the latest trauma research is turned into interventions caregivers, and those working with caregivers, can use every day. Through real-life case examples and experiential learning, trauma-based strategies that address the most challenging behaviors are identified.

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. Strategies to advocate for girls across systems and empower them by helping them to build protective factors to refrain from delinquent behaviors are also discussed.

The Healing Power of Connection

In this training, 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 are discussed. How the brain heals itself will be presented and brain-based interventions to help individuals of all ages and ability work to replace challenging behaviors with safe, healing connection identified.

Helping Children Heal Through Books

This workshop helps participants identify ways books can help children heal from pain and trauma. Participants 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 provides participants with resources.

The Impact of Emotional Abuse

This workshop defines emotional abuse and addresses the impact emotional maltreatment can have on a child's development. Participants are exposed to various forms of emotional abuse, and learn about the many signs of an emotionally abused child. Specific strategies are provided to assist participants in advocating for children who have experienced emotional maltreatment

Interventions for Children Who Have Suffered Trauma

Children in foster care have a vastly higher rate of trauma than their non-foster peers. Some estimate 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 -that each child will manifest it differently. Participants in this session learn ways to help improve the child's functioning, as well as how to work with the mental health system.

Promoting Successful Futures by Addressing Child Traumatic Stress

This 9-hour workshop helps child welfare professionals who have little or no experience and training in child traumatic stress and trauma-informed care, integrate trauma-informed practices into their daily work. It includes an overview of types of trauma, including complex, intergenerational, cultural, and historic trauma; describes the impact of trauma on child development; identifies how to engage youth and families using Donna Hick's Dignity Model; and, using a case study and participants' own case experiences, puts the NCTNS's (1st edition) Nine Essential Elements of Trauma-informed care into practice. A significant portion of the workshop addresses 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 are used throughout the training sessions.

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 highlights the effects trauma can have on children. An overview of the recent changes in the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD) is offered. Diagnostic indicators and appropriate assessment are further discussed to empower professionals when serving traumatized children. Specific strategies are provided to assist social service professionals in advocating for provision of competent services to these vulnerable children.

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, practical ways to educate foster parents on how to bring hope and healing to children are provided 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 are also 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?

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 is emphasized. This training enhances skills in: identifying signs and symptoms of trauma, recognizing how systems and helping professionals can unknowingly contribute to re-traumatization, and developing 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.

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. 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 developed a video series to highlight perspectives of compassion fatigue often experienced by first responders in effort to reduce stigma, promote normalcy, and provide opportunities for sharing personal recommendations about self-care techniques. OCWTP staff also consulted with OhioMHAS to develop two distance learning courses on secondary trauma: *Self-Care for Foster Caregivers*, and *Secondary Trauma for Administrators* as part of the state's Opioid Project.

Lastly, the OCWTP North Central Region has begun to provide trauma-responsive environments for learning, including a wellness room at their supervisory conference and Mindfulness training through the county employee assistance program. OCWTP staff are currently working with three RTCs to develop three classroom learning opportunities related to trauma-informed supervision.

The National Child Traumatic Stress Network

Over the past several years, Ohio has been selected to implement numerous 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.

Administration for Children and Families Grant

The Gateway CALL Project, Franklin County Children's Services

Franklin County Children's Services (FCCS) was awarded a grant from the Administration for Children and Families to support expansion of its *Gateway CALL* (Consultation, Assessment, Linkage, Liaison) project during the course of the last CFSP implementation period. 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, screening and assessment instruments were standardized to detect children's trauma issues and behavioral health concerns and utilization of the tools were standardized.

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 over-arching strategy 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: the Ohio Academy of Family Physicians; the Ohio Chapter of the American Academy of Pediatrics; Voices for Ohio's Children; the 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; ODH, ODM, ODJFS, OhioMHAS, DODD; local child welfare agencies; child health care providers; juvenile justice personnel; and representatives of local school districts.

To advance appropriate use of psychotropic medications, Ohio has:

- Established prescription guidelines.
- Implemented *Ohio Minds Matter*, the state's targeted investment toward improving safe use of psychotropic medications:
 - o Established 3 pilot sites to examine effective cross-system practices;
 - o Enhanced tele-medicine options and provision of prescriber peer support;
 - o Developed clinical guidelines based on aggression, attention, and mood symptomology;
 - o Established a website, www.Ohiomindsmatter.org to increase knowledge and promote best practices; and
 - o Co-developed with foster youth and disseminated a shared decision-making toolkit to facilitate effective patient-provider discussions regarding health care: <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/decision-guide-for-foster-care-F1.pdf>.
- Enhanced data analyses to improve prescribing practices.
- Co-developed with clinicians, county agency representatives, and ODM pharmacists a Psychotropic Medication Toolkit to assist PCSAs with development of local policies and procedures, and facilitate informed consent practices.
- Promoted evidence-based, non-pharmacological treatment.

Ohio's efforts toward promoting appropriate use of psychotropic medications, began 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, Ohio set a goal of a 25% reduction in:

- 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.

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:

- http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/D_QuickReferenceGuide.pdf
- <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/AlgorithmD.pdf>
- <http://ohiomindsmatter.org/resources-d>

○ Mood:

- <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/FQuickReferenceGuide.pdf>
- <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/AlgorithmF.pdf>;
- <http://ohiomindsmatter.org/resources-f>

○ Aggression:

- <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/EQuickReferenceGuide.pdf>
- <http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/AlgorithmE.pdf>
- <http://ohiomindsmatter.org/resources-e>

Through *Ohio Minds Matter*, the state also:

- Developed technical resources and clinical guidelines to advance safe and effective prescribing practices <http://ohiomindsmatter.org/prescribing-guidelines>
- 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 <http://ohiomindsmatter.org/parents-consumers>

In addition, child psychiatrists participating in this effort continue to promote the following principles for safe 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.

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, Doctor 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.

To review the *Ohio Minds Matter* Training Modules for continuing education credit, go to: <http://ohiomindsmatter.org/prescribers>

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/toolkit/>

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

Another component of *Ohio Minds Matter* 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:

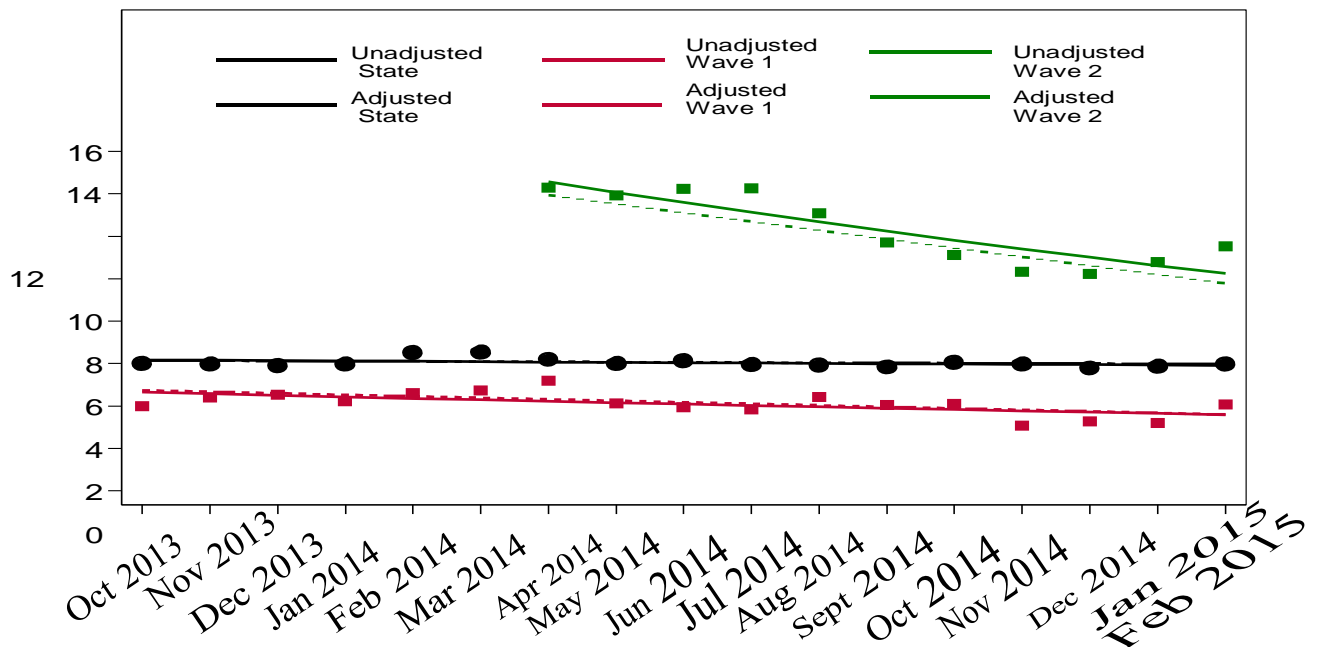
- Summit, Portage, Trumbull, and Stark Counties;
- Franklin, Licking, Fairfield, Muskingum and Perry Counties; and
- Montgomery, Greene, Miami and Clark Counties.

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:

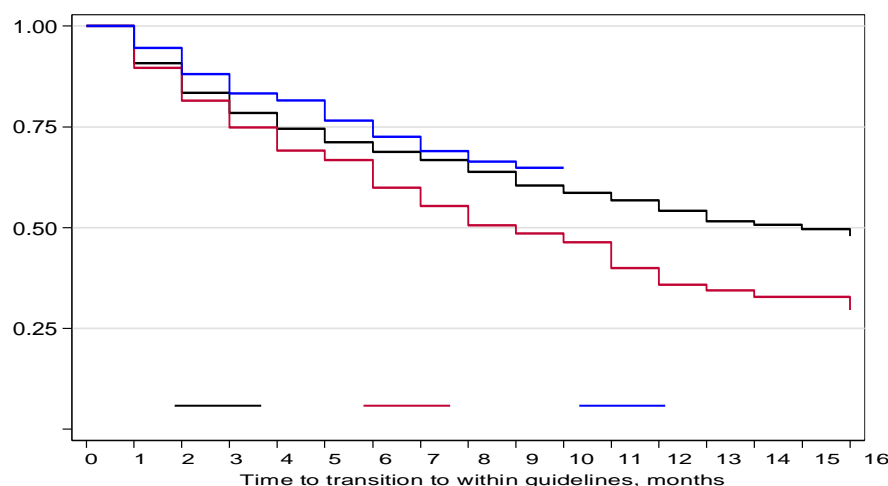
- Improve care among clinicians through training, data feedback and rapid cycle quality improvement interventions;
- Advance consumer empowerment through education and shared decision-making; and
- Improve access to care and service coordination through community collaboration.

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



Ohio Minds Matter has been nationally recognized for its approach to improve prescribing practices, its holistic design, and collaborative inter-system implementation model. Staff from Ohio were invited to present at SAMHSA conferences, and Center for Health Care Strategies events. In addition, at the requests of Senators Orrin Hatch, Ron Wyden, Tom Carper, and Claire McCaskill, the federal Government Accountability Office conducted a multi-state comparative study on child welfare oversight of medication use by foster children. The goal of this work was to determine:

- How Medicaid and child welfare agencies in selected states worked to ensure the appropriate use of psychotropic drugs for children in foster care?
- What steps, if any, did selected states take to measure the results of their efforts to ensure appropriate use of psychotropic drugs for children in foster care?
- To what extent has HHS taken steps to help states ensure appropriate prescriptions of these drugs to children in foster care?

Other states selected for the GAO study included: Arizona, California, Illinois, Maryland, New Jersey, and Washington. (To view the report, go to: <https://www.gao.gov/products/GAO-17-129>.) Similarly, the Patient-Centered Outcomes Research Institute (PCORI) conducted comparative study of how states monitor psychotropic medication use in the foster care population, particularly the use of atypical antipsychotics. The study included Medicaid claims data analysis, key informant interviews (with state and local level child welfare administrators, child welfare caseworkers, pharmacists, physicians, and behavioral health care treatment providers), and focus groups (with former foster youth and caregivers/ biological and foster parents.) Other selected states included: Texas, Washington, and Wisconsin. The final report has not yet been published at the time of this writing.

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.)

Also, in alignment with ODJFS' monitoring and oversight requirements for foster children's use of psychotropic medications, it is anticipated future Medicaid Managed Care provider performance measures will include the following indicators:

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

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.

- <http://ohioaap.org/BMWLearning>
- <http://ohioaap.org/projects/building-mental-wellness/building-piece-of-mind-handouts/>
- <http://ohioaap.org/parent-resource-page/>
- Since 2012, BMW has worked with nearly 60 pediatric and family medicine practices, reaching approximately 600 health care providers.
- Since 2014, BMW impacted an estimated 500,000 children throughout Ohio.
- During the most recent BMW Residency Learning Collaborative, faculty and residents completed a practitioner confidence form at three time points to assess the provider's confidence in the use of the communication skills and the assessment and management of anxiety, low mood and disruptive behaviors (such as ADHD). By the end of the nine-month learning collaborative, 99% of providers' express confidence in using the Common Factors strategies (54% very confident and 45% somewhat confident), which is an increase of 13% from Pre-Training. First line advice strategies saw an increase of 31% in confidence from Pre-Training to end of collaborative.

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.

Pediatric Psychiatry Network

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. 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 more information on the PPN, see: <http://ppn.mh.ohio.gov/>

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 Ohio's Healthcare Oversight and Coordination Plan for descriptions of initiatives designed to enhance a continuum of care for children who have experienced maltreatment.

Psychotropic Toolkit for Child Welfare:

ODJFS requires all agencies to have a written policy for monitoring the use of psychotropic medications for children in foster care. Required components of the agencies' policy include:

- Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify the child's mental health and trauma-treatment needs including a psychiatric or medical evaluation, as necessary, to identify needs for psychotropic medication;
- Informed and shared decision-making and methods for ongoing communication between the prescriber, the child, the child's parents or caregivers, other healthcare providers, and the agency case worker; and
- Effective medication monitoring for the children placed in care.

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, The Public Children's Services Association of Ohio (PCSAO) established the Behavioral Health Leadership Group (BHLG). 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 was provided by Vorys Health Care Advisors.

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). Information regarding appropriate dosages and "red flag" use was provided by ODM pharmacists.

Periodic reviews of this plan and applicable updates will be conducted every four years, unless state or federal statute require more frequent revisions. Please refer to Appendix B-2 ***Psychotropic Medication Toolkit for Public Children Service Agencies***.

COLLABORATIVE HEALTHCARE PROGRAMMING

STATE LEVEL INITIATIVES

Office of Health Transformation

During the CFSP implementation period, Governor John R. Kasich created the Office of Health Transformation (OHT) to improve health system performance and streamline health and human services. OHT coordinated 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 was committed to implementing programming which supported:

- 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 included, but were not limited to:

- 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.

RecoveryOhio

Upon taking office in January 2019, Ohio Governor Mike DeWine established the *RecoveryOhio* initiative and the *RecoveryOhio Advisory Council* to coordinate and improve how the state addresses mental health and substance use disorders. Specifically, the Executive Order tasked the Council with:

- Advancing and coordinating substance abuse and mental health prevention, treatment and recovery support services at the local, state and federal levels;
- Engaging private sector partners to align efforts to do the most good for Ohioans struggling with a mental illness or substance use disorder and their families; and
- Initiating and guiding enhancements to the behavioral health system to improve the patient's experience during treatment and treatment outcomes.

The Council was designed to represent all regions of the state. Membership was to be diverse and include those with local, state and federal governmental service; those with experience in mental health or substance abuse prevention, treatment, advocacy or support services; individuals with lived experience and family members; those in private industry, learning institutions, faith organizations, criminal justice settings, and healthcare. Appointed members to the Council include:

- Ted Strickland, Former Governor of Ohio
- Justice Evelyn Lundberg Stratton, Retired, Project Director, The Stepping Up Initiative
- John Tharp, Lucas County Sheriff
- Pastor Greg Delaney, Outreach Coordinator, Woodhaven
- Suzanne Dulaney, Executive Director, County Commissioners Association of Ohio
- Joan England, Executive Director, The Mental Health & Addiction Advocacy Coalition
- Orman Hall, High Intensity Drug Trafficking Area, Ohio University
- Dr. Navdeep Kang, Director of Operations Behavioral Health, Mercy Health Cincinnati
- Teresa Lampl, Associate Director, Ohio Council of Behavioral Health & Family Service Providers
- Jessica Nickel, Founder, Addiction Policy Forum
- Terry Russell, Executive Director, National Alliance on Mental Illness Ohio
- Dr. Shawn Ryan, Chair of Payer Relations, Ohio Society of Addiction Medicine
- Brenda Stewart, Founder, The Addict's Parent United
- Sarah Thompson, Executive Director, Ohio Citizen Advocates for Addiction Recovery
- Cheri L. Walter, CEO, Ohio Association of County Behavioral Health Authorities
- Juliet Doris Williams, Executive Director, The P.E.E.R. Center

The executive Order further mandated all Cabinet Agencies, Boards and Commissions to comply with any requests or directives issued by the RecoveryOhio Director or the RecoveryOhio Director's designee, including, but not limited to: Ohio Department of Mental Health and Addiction Services

- Ohio Department of Health
- Ohio Department of Medicaid
- Ohio Department of Job & Family Services
- Ohio Department of Rehabilitation and Correction
- Ohio Department of Public Safety
- Ohio Department of Administrative Services
- Ohio Department of Youth Services
- Ohio Developmental Services Agency

- Ohio Department of Insurance
- Ohio Bureau of Workers' Compensation
- Ohio Office of Budget and Management
- Opportunities for Ohioans with Disabilities

Structurally, the RecoveryOhio Director also holds administrative authority over the Office of Health Transformation.

In March 2019, the Council issued more than 70 recommendations in the areas of stigma, parity, workforce development, prevention, harm reduction, treatment and recovery supports, and data and outcomes measurement. The Council considered the needs of all Ohioans; however, two specialty populations were highlighted because of their unique needs – children and adults involved in the criminal justice system. A partial list of those recommendations follow:

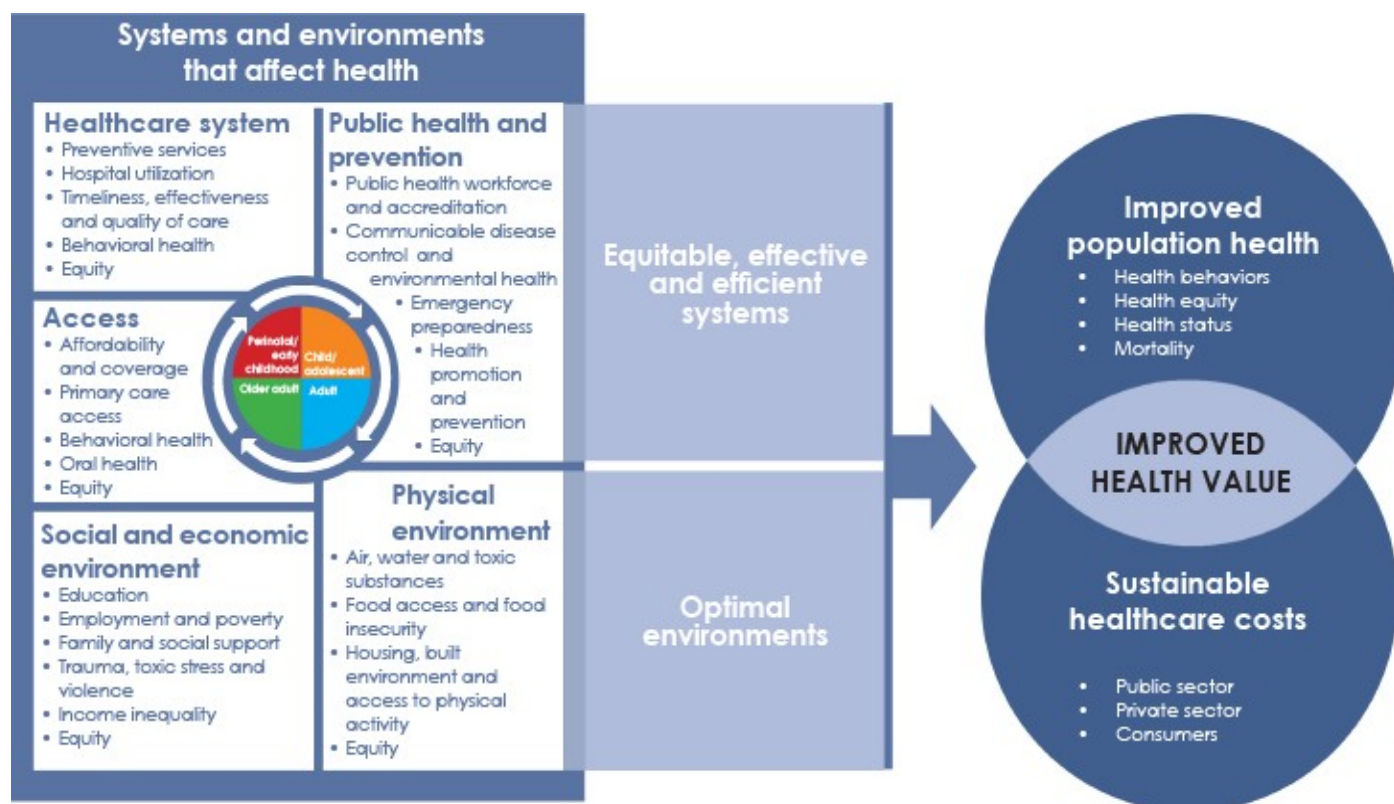
- Establish statewide prevention coordination with all state departments and agencies to ensure best practices, consistent messaging, technical assistance, and delivery of prevention services across multiple domains.
- Commission a statewide campaign to address stigma against people with mental illness and substance use disorders.
- Ensure each patient's needs and treatment recommendations are determined by a qualified clinical professional and promote insurance coverage of medically-necessary services identified by quality clinical care providers.
- Review and create a comprehensive plan for safe, affordable, and quality housing that will meet the needs of individuals with mental health and substance use disorders, including: supported housing options, transitional housing, recovery housing, adult care facilities, and short-term stabilization options.

Members of the Advisory Council continue to meet to form actionable and scalable solutions to address these recommendations.

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. ("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.) 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.



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.

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

Population health infrastructure in Ohio

Governor's Office of
Health Transformation

Ohio Department of
Health

Other state agencies
Including ODM, OMHAS, ODA, DODD,
ODJFS, ODVS, etc.

Community-level public and private partners

Hospitals and other
healthcare providers

Local health departments
and other public health
organizations

ADAMH boards and
mental health and
addiction service providers

Health insurance plans

Community-based
organizations and social
services

Local government

Law enforcement/
criminal justice

Transportation and
regional planning

Education and child care

Businesses and employers

Philanthropy/United Ways

Advocacy groups and
community action
agencies

Community residents and
healthcare consumer
groups

Family and Children First
Councils

Job and Family Services

At-risk populations

Agriculture, environmental
protection and natural
resources



For additional information about population health, go to:

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

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

At the time of this writing, Ohio is launching a new State Health Assessment. The outcome of this work will be featured in future Healthcare Oversight and Coordination Plan updates.

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 as a staff development tool. To view the competencies, go to:

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

OhioMHAS continues 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.

	<h2 style="text-align: center;">Grow Power</h2> <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:

On January 1, 2017, Ohio's foster care and adoption (from foster care) populations began the systemic migration from a fee-for-service to a Managed Care service delivery model. 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:

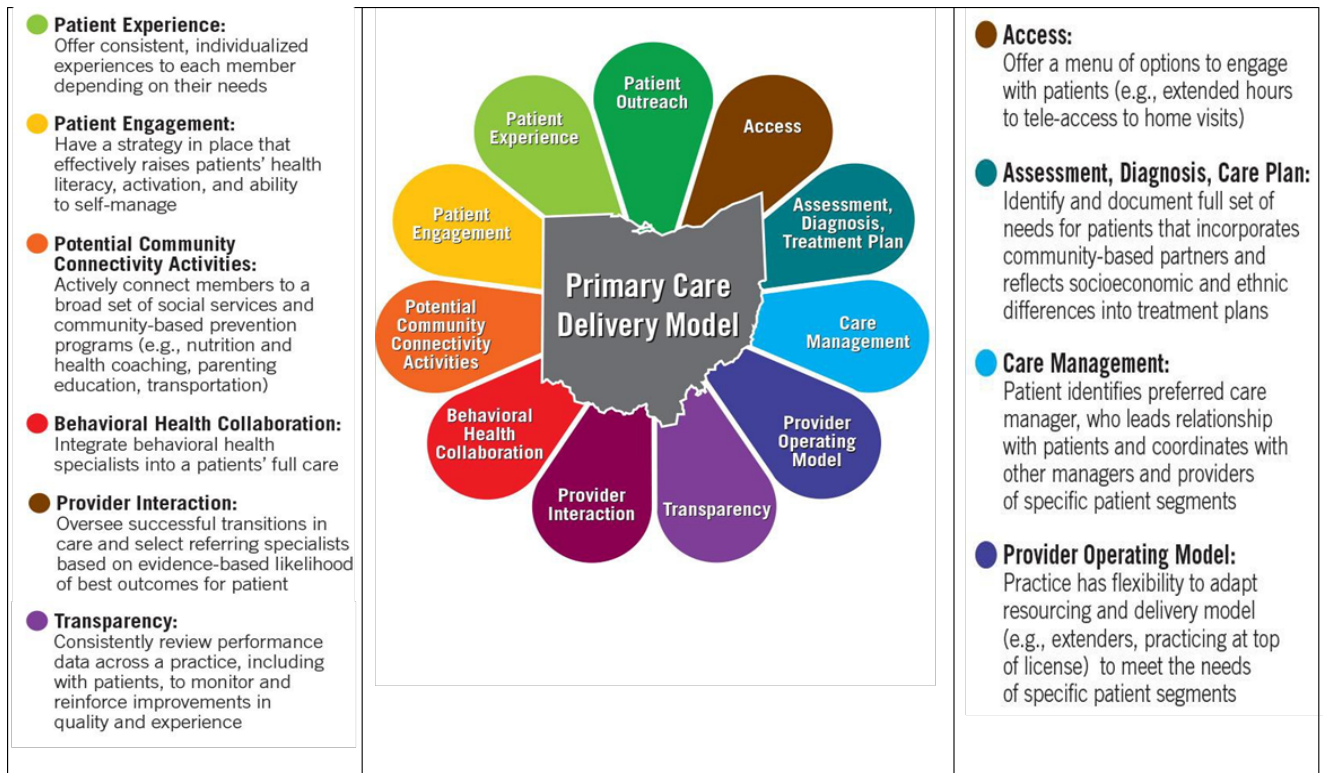
- Clarification of care management roles and responsibilities;
- Timeliness of required medical screenings and assessments for children in foster care;
- Streamlined eligibility determination;
- Simplified enrollment processes through the PCSAs;
- Flexibility in choice among the 5 Managed Care Plans;
- 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 measures 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:
 - 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.
 - 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

Throughout the CFSP implementation period, Family-Centered Services and Supports (FCSS) funds were allocated through the Ohio Department of Mental Health and Addiction Services to provide services supports to children and youth needed to safely maintain them in their own homes. The FCSS funds are comprised of ODJFS Title IV-B federal funds matched with state general revenue funds from OhioMHAS, ODODD, and ODYS. FCSS funds are available on a reimbursement basis to county Family and Children First Councils (FCFC) for services and supports that meet specific requirements.

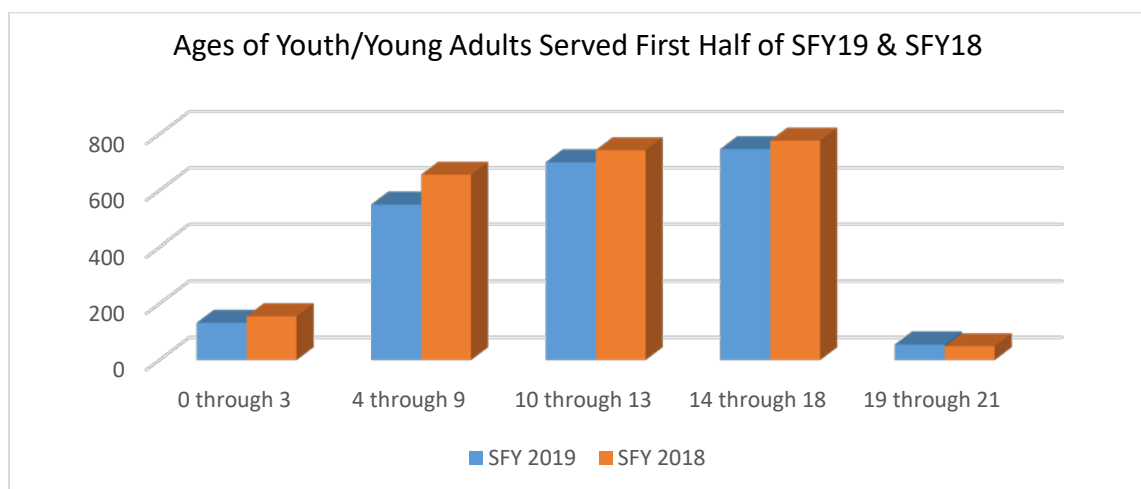
The FCSS target population are youth (ages 0 through 21) with multi-systemic needs who are receiving service coordination through the county FCFC. Service coordination is provided by FCFCs according to the Ohio Revised Code section 121.37(C) mandate, with many counties also providing Wraparound as a way of coordinating care for those with a higher complexity of needs. FCSS funding is designed to meet the unique needs of children and families identified on the county FCFC individualized family service coordination plan (IFSCP) developed through a formal service coordination process. To read more about the purpose and criteria established for use of these funds, go to: <http://www.fcf.ohio.gov/Initiatives/System-of-Care-FCSS>.

The 88 county FCFCs requesting FCSS funding were required to submit a Semi-Annual Report by February 1, 2019. The following is a brief summary of the information provided in the 87 submitted county FCSS SFY19 Semi-Annual Reports, as well as the SFY18 Annual Report.

Total Number and Ages of Children Served

The total number of children served between the ages of 0-21 during the first half of SFY19 was **2,184**. The **14 through 18-year-old age group (747 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 (700) and the age range of 4 through 9 was the third highest (550). There were more youth served in the 19 through 21-year-old age range than in the first half of SFY 18 (55).

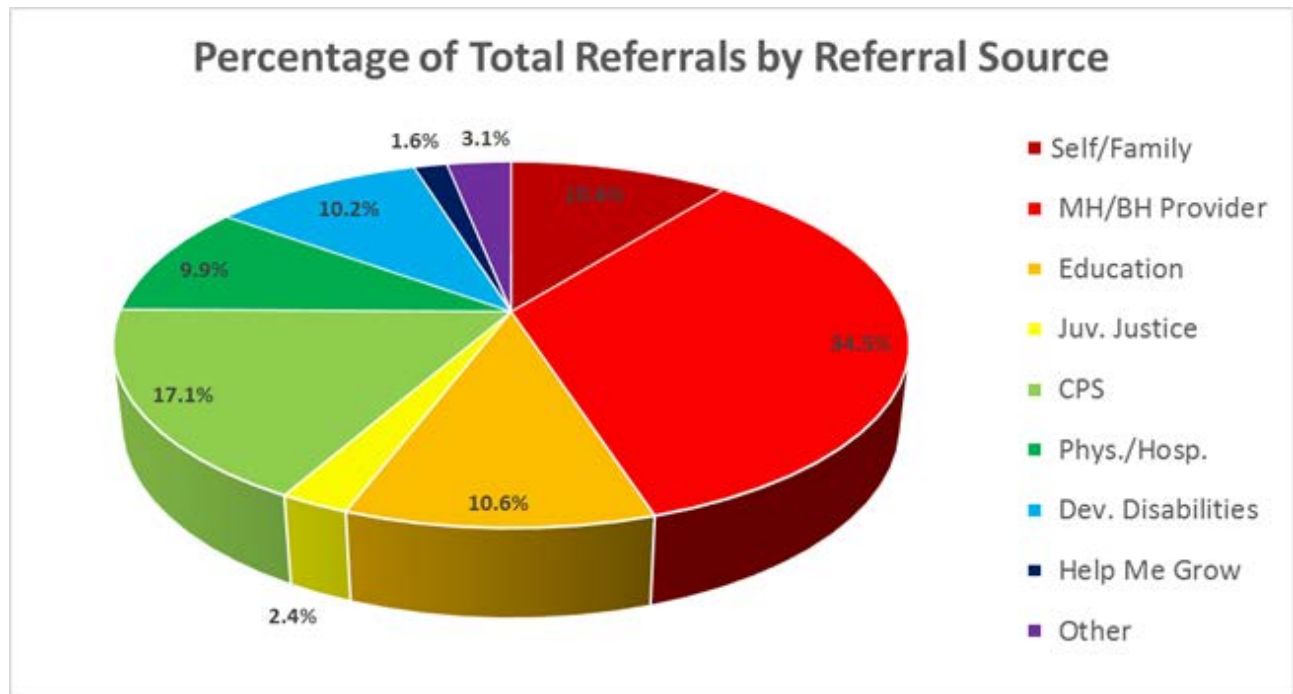
The graph and table below show a comparison of the number of children served in the first six months of SFY19 and SFY 18 in each age group and the percent of the total children served in each age group.



Ages	0 – 3	4 – 9	10 – 13	14 – 18	19 - 21	Total
SFY19	132	550	700	747	55	2184
Percent	6.0%	25.2%	32.1%	34.2%	2.5%	100%

Number of Referrals by System

Beginning with SFY17, Ohio Family and Children First began tracking referral sources to FCFC Service Coordination/Wraparound by system. This data is also used to identify the presenting needs of youth as they enter FCFC Service Coordination/Wraparound. The pie chart below indicates the percentage of referrals by system for SFY18.



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

Local FCFCs are 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 **5,785 identified needs** (average 2.65 needs/ child) during the first half of SFY19. The total needs are higher than identified in the first half of SFY18 (5,199), and the average needs per child are up from the average of 2.18 per child.
- The top three categories of needs identified for the past six fiscal years, including the first half of SFY19, have consistently been **Mental Health (66.2%)**, **Special Education (41.1%)** and **Poverty (35.2%)**. When combined, these three categories account for **53.8%** of the total identified needs in 13 categories.
- Beginning in SFY14, counties were asked to track how many children presented with a need for supports specific to those on the Autism Spectrum. This need was identified in 14.0% of the children/youth (305), which is an increase from the first half of SFY18.

The table below shows the number of needs identified in each category by mid-year.

Category of Service/Support Need	Number of Children Presenting with this Need at Intake SFY19	% of children with this Need SFY19	% of Children with this Need SFY18	% of Children with this Need SFY17	% of Children with this Need SFY16	% of Children with this Need SFY15
Mental Health	1446	66.2%	60.5%	59.7%	57.9%	57.5%
Special Education	898	41.1%	37.6%	40.7%	43.7%	39.4%
Poverty	769	35.2%	37.6%	48.8%	48.6%	45.5%
Developmental Disability	633	29%	24.5%	26.1%	25.5%	24%
Unruly	500	22.9%	17.7%	20.3%	21%	20.1%
Autism	305	14%	12.5%	13%	15.2%	11%
Child Neglect	253	11.6%	11.5%	11.5%	15%	14%
Delinquent	231	10.6%	8%	11.1%	11.6%	11.2%
Physical Health	206	9.4%	8.5%	10.2%	11.8%	12.5%
Child Abuse	185	8.5%	7.9%	9.9%	10.5%	10.2%
Alcohol/Drug	169	7.7%	6.6%	8.2%	7.4%	7.6%
No Primary Care Physician	125	5.7%	6.6%	3.8%	9.8%	3.5%
Help Me Grow	65	3%	3.5%	4.4%	5.3%	4.6%
Total Needs	5,785					

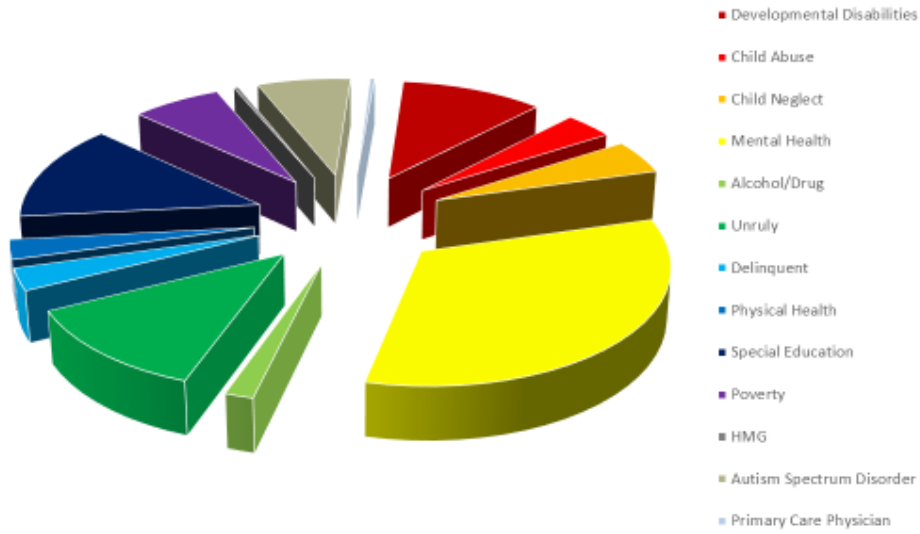
FCSS Funded Services and Supports Provided through FCFC Service Coordination

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. To ensure valid comparative analyses, the categories of service and ways services/supports were to be counted have been more clearly defined. Data from the last three years are listed below.

The charts below provide the details of the frequency of all service types reported.

Type of Service/Support Provided	Number of Families (%) Receiving Service/Support 1st half of SFY 19	% of total services and supports provided 1 st half SFY 19	% of Families Receiving Service/Support 1 st half of SFY 18	% of total services and supports provided 1 st half SFY 18	% of Families Receiving Service/Support 1 st half of SFY17	% of total services/ supports provided 1 st half SFY17
Service Coordination	1243 (67.9%)	40.8%	66.2%	34.2%	63.7%	28.6%
Social/Recreational Supports	423 (23.1%)	13.9%	35.1%	18.1%	37.1%	16.7%
Respite	335 (18.3%)	11%	25.7%	13.3%	24.2%	10.8%
Transportation	322 (17.6%)	10.6%	17.9%	9.2%	27.1%	9.2%
Structured activities to improve family functioning	188 (10.3%)	6.2%	15%	7.9%	18%	8.1%
Non-clinical in-home parenting/coaching	128 (7%)	4.2%	8.1%	4.2%	10.9%	4.9%
Mentoring	135 (7.3%)	4.4%	8.7%	4.5%	12.6%	5.6%
Parent Education	66 (3.6%)	2.2%	4.1%	2.1%	9.3%	4.1%
Parent Advocacy	92 (5%)	3%	6.4%	3.3%	8.3%	3.7%
Safety and Adaptive Equipment	91 (5%)	3%	5.5%	2.8%	7.2%	3.2%
Youth/Young Adult Peer Support (new category)	3 (0.2%)	0.1%	0.1%	0.1%	0.8%	0.3%
Non-clinical Parent Support Groups	21 (1.1%)	0.7%	0.3%	0.2%	1.6%	0.7%
Other	3 (0.2%)	0.1%	0.4%	0.2%	1.6%	0.4%
Total	3050	100%	-----	100%	-----	100%

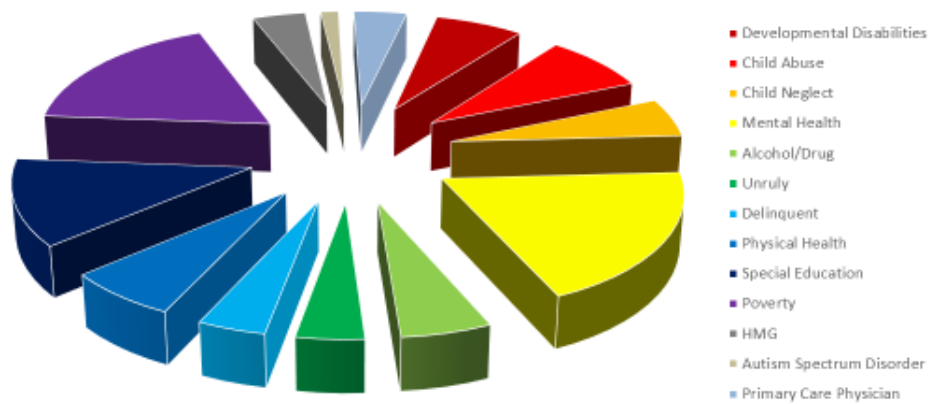
**Proportion of Needs Serviced by Utilizing Non-Clinical
In-Home Parent/Child Coaching**



FCSS SFY 2019

18

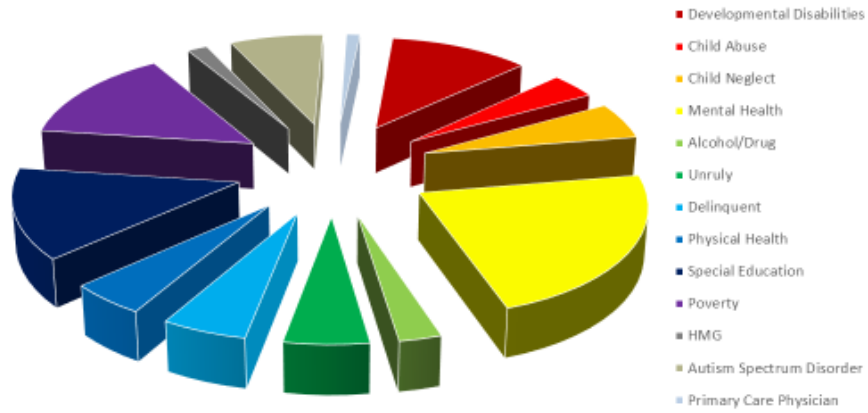
**Proportion of Needs Serviced by Utilizing Non-Clinical,
Parent Support Groups**



FCSS SFY 2019

19

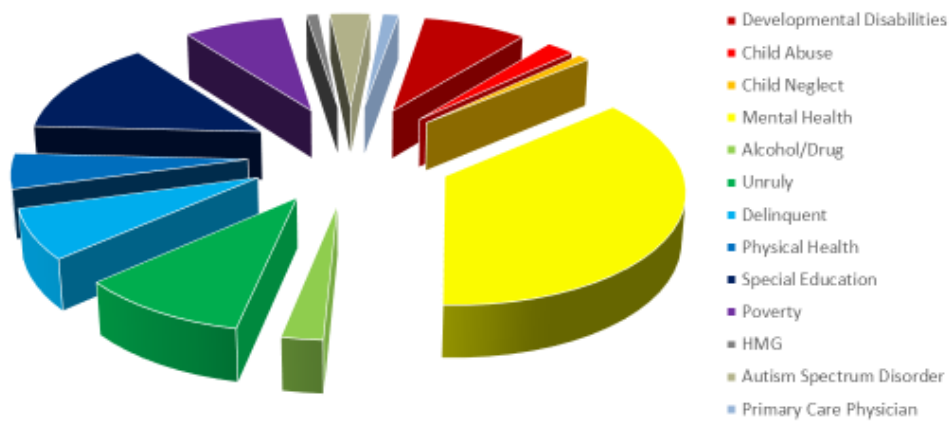
Proportion of Needs Serviced by Utilizing Parent Education



FCSS SFY 2019

20

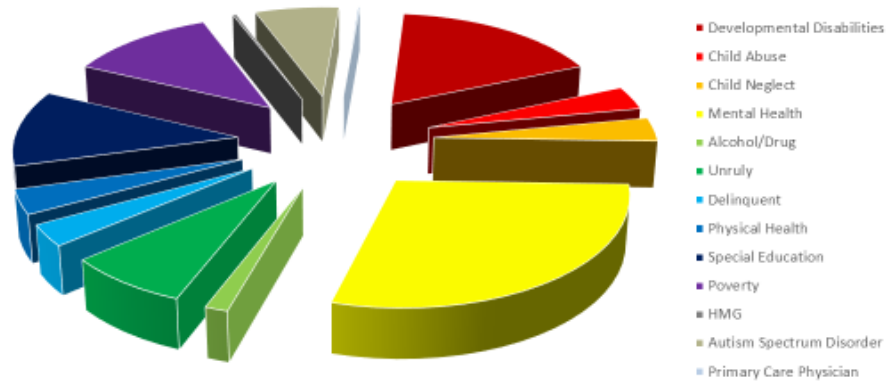
Proportion of Needs Serviced by Utilizing Mentoring



FCSS SFY 2019

21

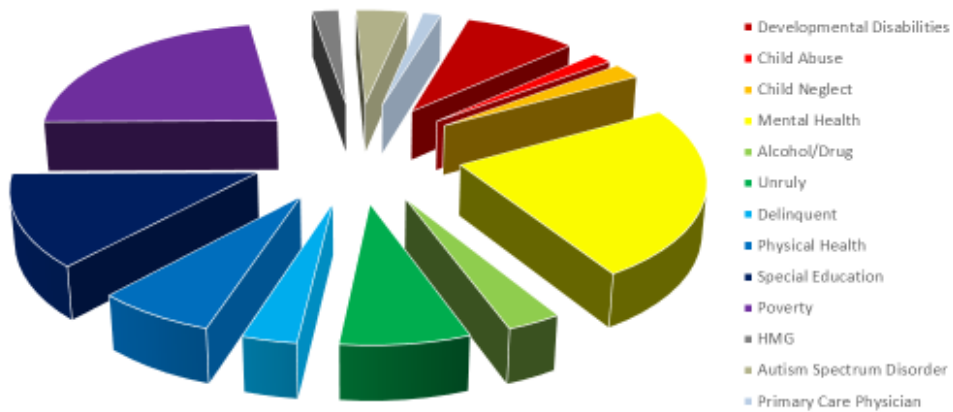
Proportion of Needs Serviced by Utilizing Respite



FCSS SFY 2019

22

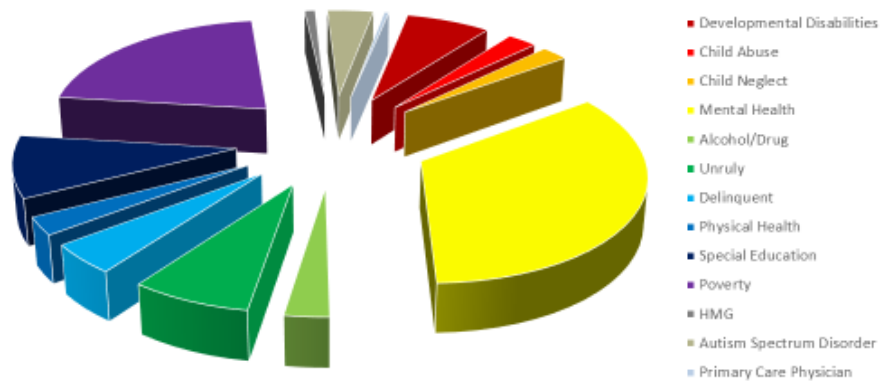
Proportion of Needs Serviced by Utilizing Transportation



FCSS SFY 2019

23

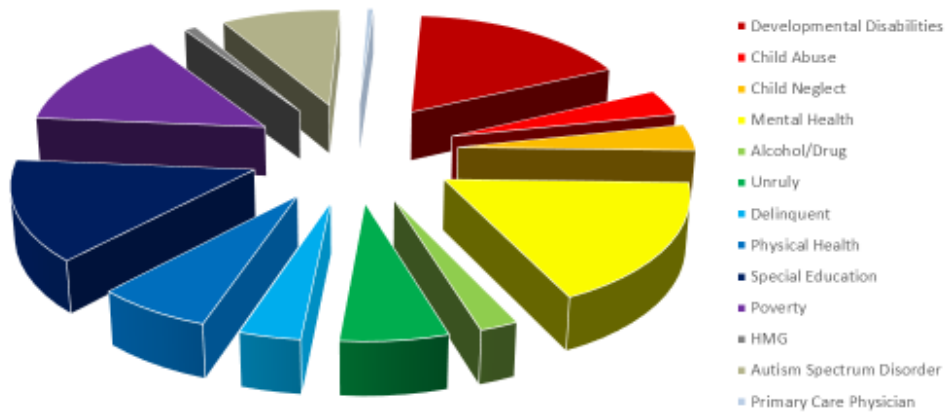
Proportion of Needs Serviced by Utilizing Social/Recreational Supports



FCSS SFY 2019

24

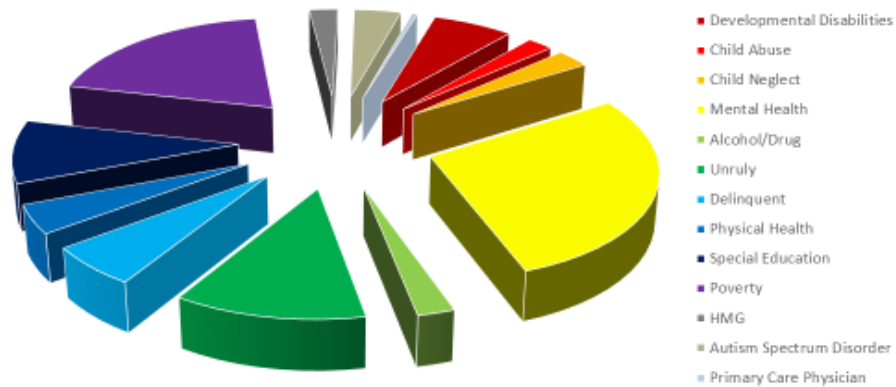
Proportion of Needs Serviced by Utilizing Safety/Adaptive Equipment



FCSS SFY 2019

25

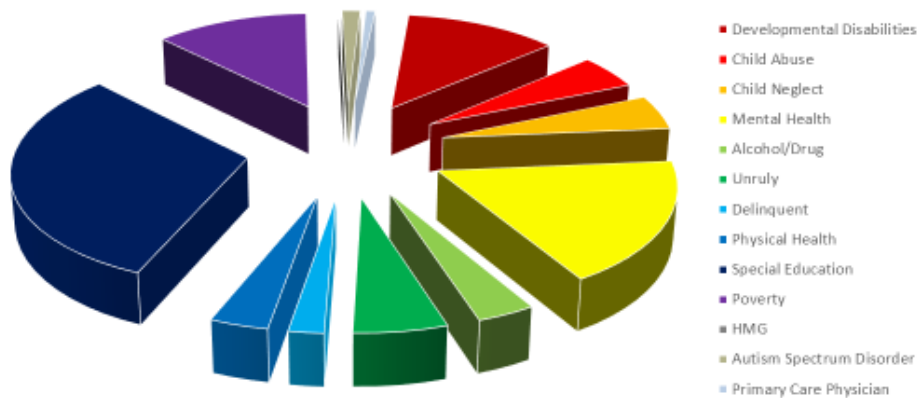
Proportion of Needs Serviced by Utilizing Structured Activities to Improve Family Functioning



FCSS SFY 2019

26

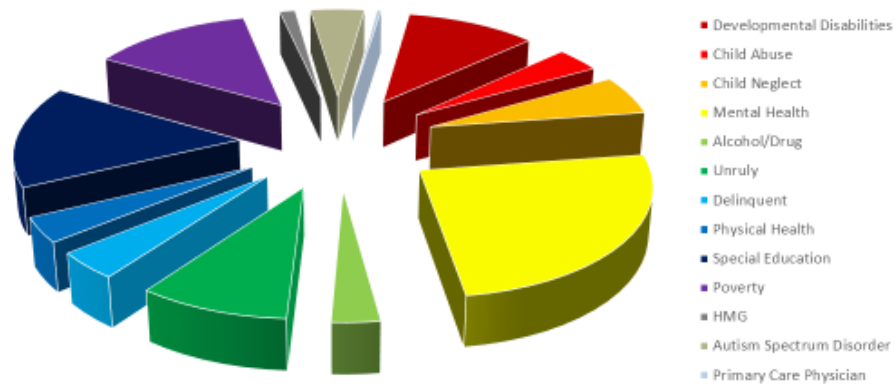
Proportion of Needs Serviced by Utilizing Parent Advocacy



FCSS SFY 2019

27

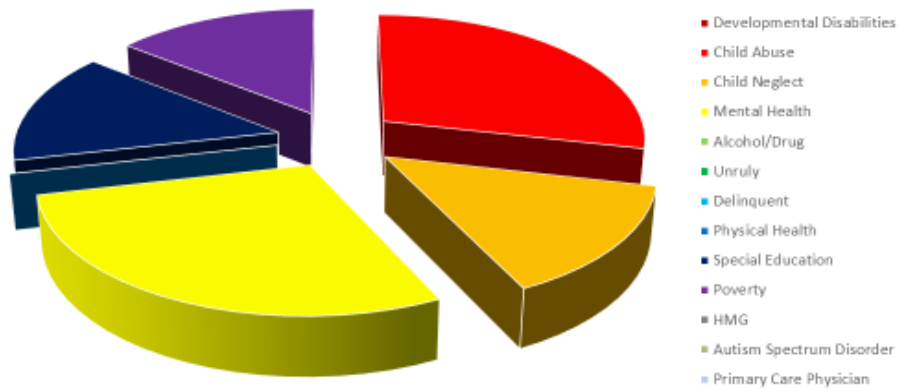
Proportion of Needs Serviced by Utilizing Service Coordination



FCSS SFY 2019

28

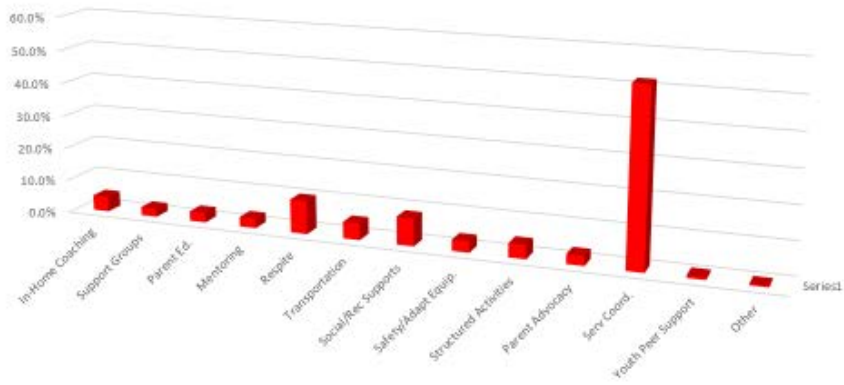
Proportion of Needs Serviced by Utilizing Youth/Young Adult Peer Support



FCSS SFY 2019

29

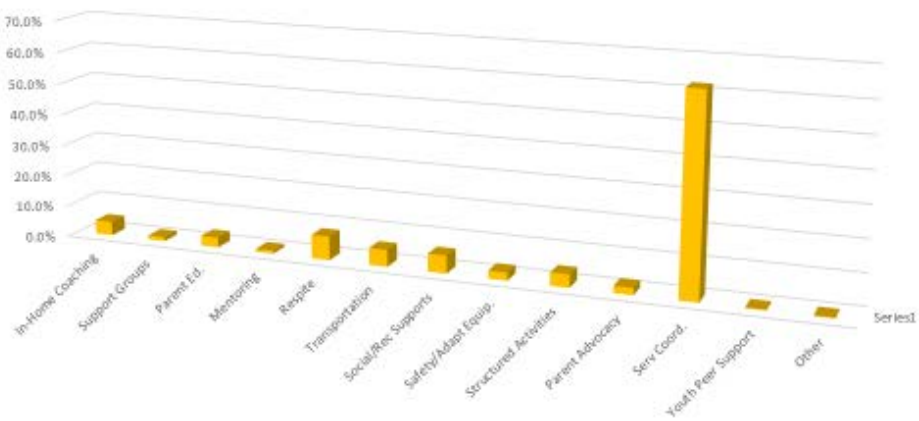
Frequency of Services Utilized for Identified Child Abuse Needs



FCSS SFY 2019

5

Frequency of Services Utilized for Identified Child Neglect Needs



FCSS SFY 2019

6

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

Beginning in SFY13, families entering FCFC Service Coordination were asked if they, and/or their children, had a primary care physician. Families without a doctor then were provided the opportunity to be connected to a primary care physician. In the first half of SFY19, 44 children were identified during the intake process as not having a doctor. Of these, 37 were connected to a primary care physician during the service coordination process.

As a point of contrast, 72 children lacked an identified doctor at the same point in time during SFY18. This decrease of 28 children may indicate that families of children with multi-system needs are being connected to primary care earlier and at a much higher rate than in previous years.

In compliance with federal funding regulations, no FCSS funds are used to provide medical services. The goal of connecting families to primary care physicians through the service coordination process is to improve outcomes via integrated physical and behavioral healthcare.

Number of Families Successfully Completing FCSS Supported Service Coordination

Data local Family and Children First Councils indicated that **81% of the families who exited FCFC Service Coordination in SFY18 successfully completed the goals** written into their Individualized Family Service Coordination Plan. This is an impressive accomplishment, considering the high level of intensive needs identified when these families enter FCFC Service Coordination/High-Fidelity Wraparound. Often, the children served are at a high level of risk of out-of-home placement, and there is a high level of transience with many of these families.

Goal attainment rates for SFY18, SFY17, SFY16 and SFY15 are compared in the chart below.

	# Families Exiting Service Coordination	# Families Successfully Completing 75-99% of Family Goals	# Families Successfully Completing 100% of Family Goals	Total # Families Successfully Completing 75-100% of Family Goals
SFY 18 Number of Families Exiting	1436	586	580	1166
SFY 18 % of Total Families Exiting	100%	40.8%	40.4%	81.2%
SFY 17 Number of Families Exiting	1515	747	655	1402
SFY 17 % of Total Families Exiting	100%	49.3%	43.2%	92.5%

	# Families Exiting Service Coordination	# Families Successfully Completing 75-99% of Family Goals	# Families Successfully Completing 100% of Family Goals	Total # Families Successfully Completing 75-100% of Family Goals
SFY 16 Number of Families Exiting	1448	704	635	1339
SFY 16 % of Total Families Exiting	100%	48.6%	43.9%	92.5%
SFY 15 Number of Families Exiting	1477	567	593	1160
SFY 15 % of Total Families Exiting	100%	39%	40%	79%

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

One of the goals of providing service coordination is to prevent or reduce the incidence of out-of-home placement of children. (Out-of-home placements include residential treatment facilities, local or state correctional facilities, group homes, and foster care.) For FCSS, public agency custody status or any placement lasting longer than 72 hours, excluding respite care up to seven (7) consecutive days, is considered to be an out-of-home placement. During SFY 2018, **209 children(5.3%) were placed in an out-of-home placement** while they were actively receiving FCSS funded supports and participating in service coordination. No data were collected regarding the length of these placements, but some FCFCs reported many of these out-of-home placements were brief and for the purpose of short-term stabilization.

Approximately 95% of children who received Family-Centered Services and Supports throughout the CFSP implementation period remained in their own homes.

Conclusion

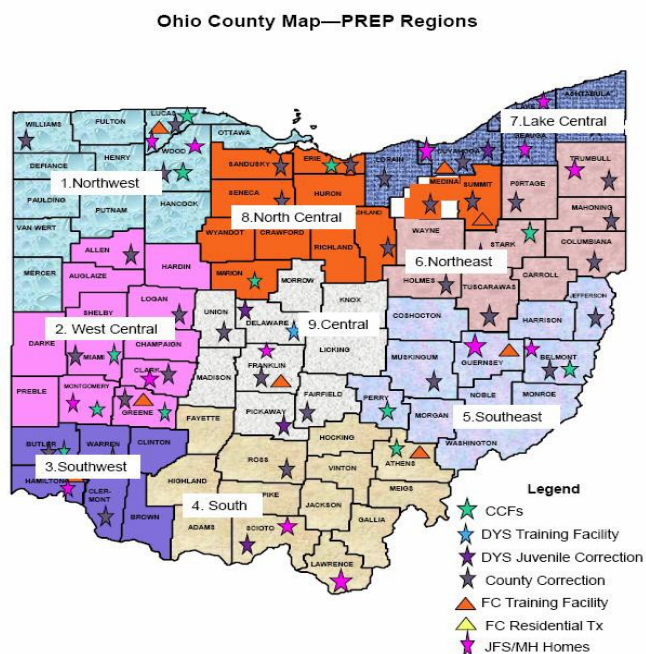
This summary provides a snapshot of how FCSS funds were used during the CFSP implementation period to serve the needs of children with multi-system needs and their families. As indicated in this report, these are not “one size fits all” children or those with a single need. These children are at the highest risk for failure within our traditional service systems, and are often on the verge of placement outside of their homes.

It should be remembered that the number of children and families served through FCFC Service Coordination/High-Fidelity Wraparound and the services and supports included in this report only include those that accessed FCSS funding. Some of the families' needs may not meet program criteria. Often, the local Councils utilize donated/ low cost community resources in addition to the program's services and supports in these instances. In addition, the FCSS funds are not used unless other resources have been exhausted.)

FCSS provides opportunities for families to creatively design integrated family service plans with trusted and unique team members. Local FCFCs report these funds are highly valued and serve as a safety net to meet the needs of families when no other funding sources are available. From a state perspective, FCSS has consistently demonstrated that this uniquely designed braided funding strategy is resulting in a cost-effective method to obtain better outcomes for the children and families being served by each of the child-serving departments.

Personal Responsibility and Education Program

ODYS, in partnership with the ODJFS and ODH, 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. Through the federally-funded *Personal Responsibility and Education Program (PREP) for Foster Care and Adjudicated Youth*, 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.



PREP trains service providers 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 also 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 youth rights 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

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 services 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:

- Service Coordination Model and Decision trees for care of opiate-dependent women: http://momsohio.org/sites/momsohio/files/2018-12/MOMS%20Decision%20Tree_F4_6-27-16.pdf
- A cross-system training curriculum for medical professionals, treatment providers, and child welfare staff: http://maofkdjs.com/sites/momsohio/files/2018-12/MOMS_Child_Welfare_Training_Final_3-21-16.pdf

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

As noted, 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 (i.e., maltreatment was 18% lower; out of home placements were 19% lower) Specific findings included:

Summary of Results



In recognition of the outcomes achieved, **MOMS** was:

- Featured in the General Accountability Office's [2017 Report to Congress on Medicaid and CHIP](#);
- Selected to be featured at learning symposia by SAMHSA, the Center for Health Care Strategies, and the National Governor's Association; and
- Featured in the Journal of Substance Abuse Treatment as a quality improvement project that demonstrated better health outcomes and family stability for pregnant women with Opioid Use Disorder and their infants.

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The Ohio Neonatal Abstinence Syndrome (NAS) Project

Six children's hospitals and their affiliates (20 hospitals total) formed an NAS Consortium.



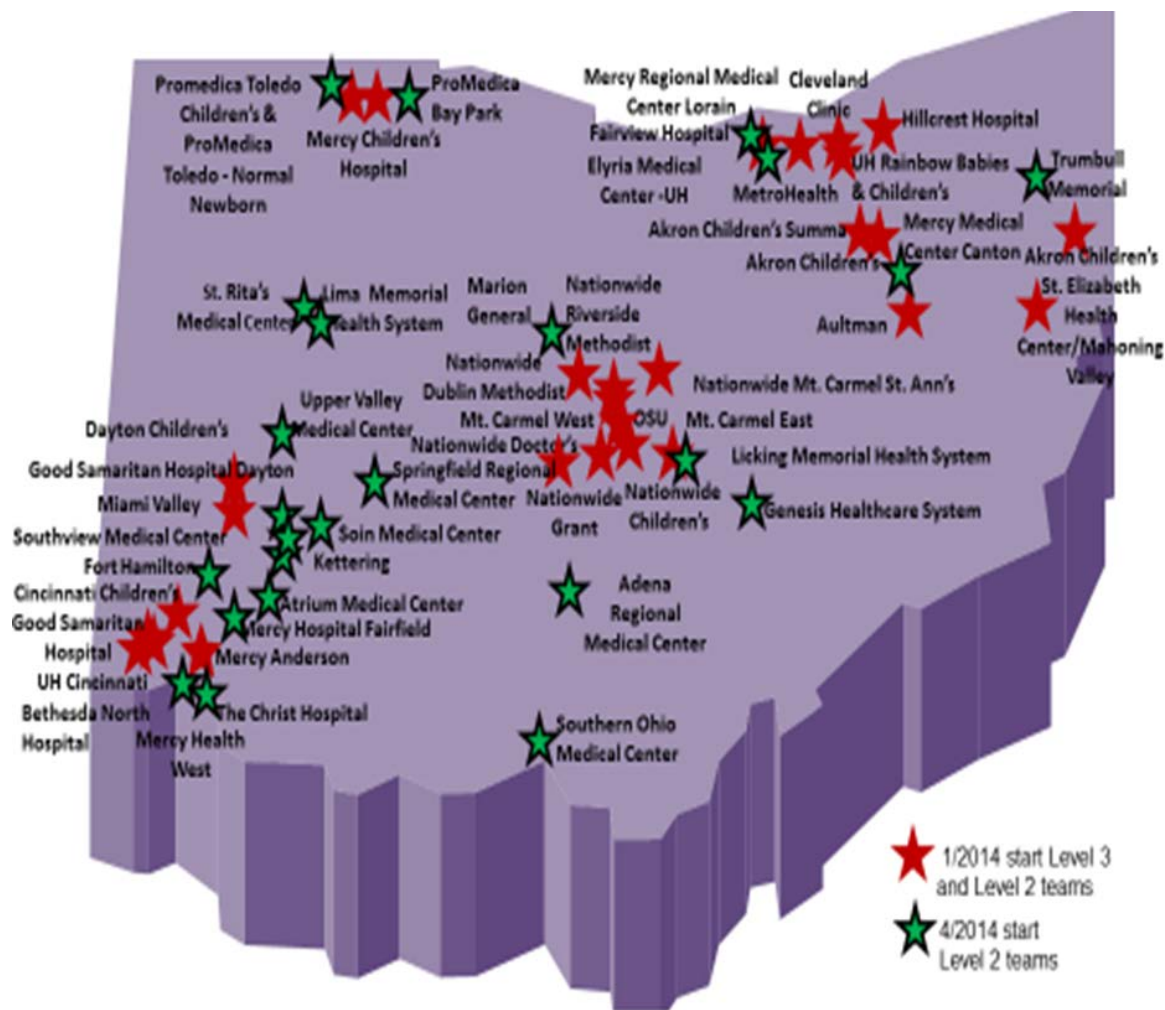
The goals of this project were to:

- 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, 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 and Scioto); NE (Cuyahoga, Summit, Trumbull and Mahoning) and West Central (Allen, Clark, Montgomery and 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.**

It takes a village...



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 impacted by substance abuse, the OCWTP developed a specific strategic training plan in Year One of the CFSP implementation period. The plan featured a cross-system training model in recognition that effective interventions require multi-disciplinary approaches. Specific activities included:

- Identifying subject matter experts in the substance abuse field who can consult with OCWTP to design a coordinated training approach.
- Finding local, state and national training information and resources that can be used in Ohio at nominal, if any, cost to the program.
- Increasing the capacity of the OCWTP trainer pool by adding trainers who can facilitate effective cross-training experiences and other high priority learning needs.
- Incorporating a continuum of different types of learning opportunities, utilizing a variety of training methodologies.
- Initiating strategies for ongoing technical assistance on substance abuse needs for PCSAs and RTCs.

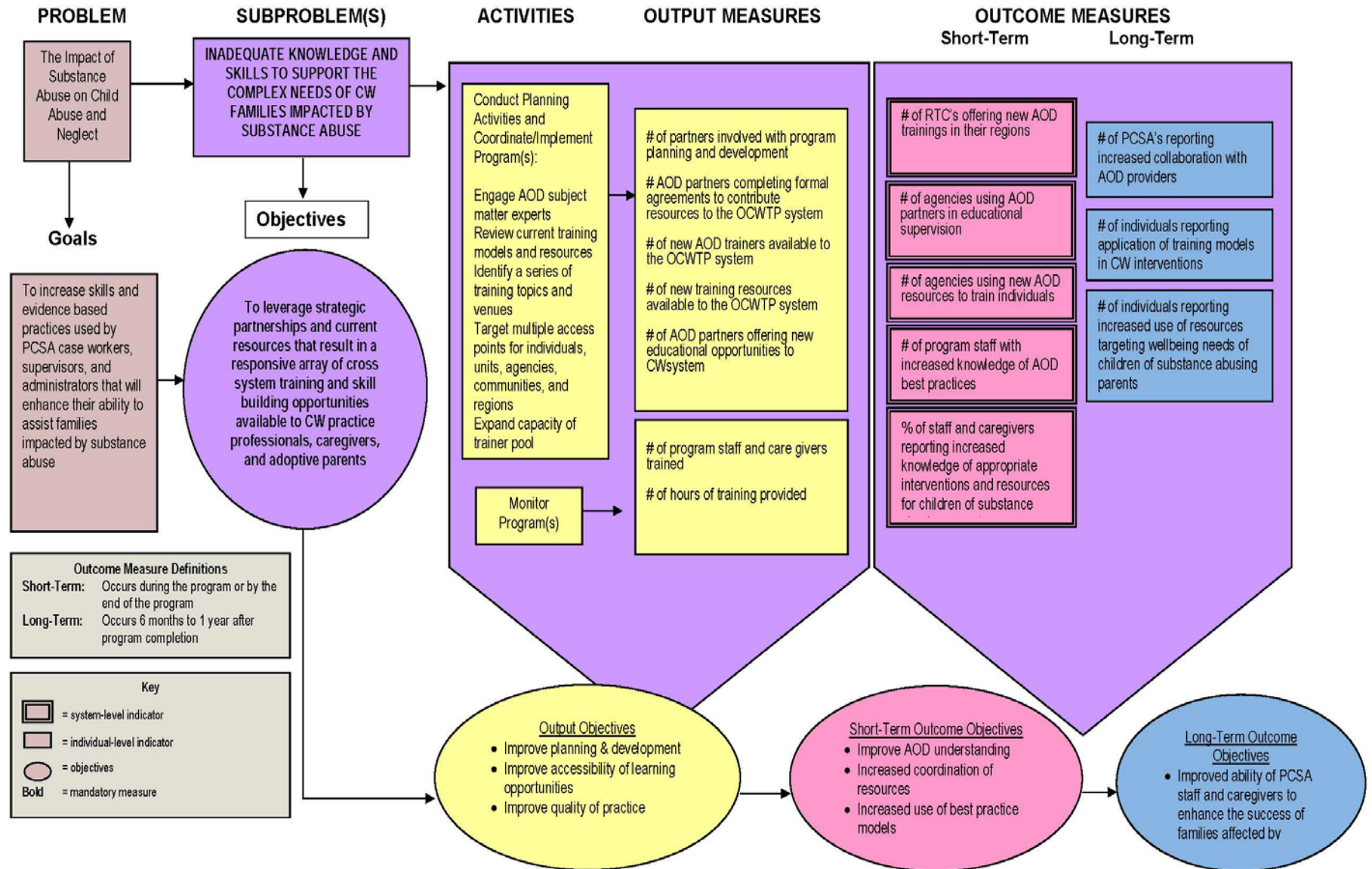
To advance this work, the OCWTP obtained commitments from a group of partners who were willing to serve as liaisons and had statewide influence and reach into the substance abuse field. This group included four statewide associations; several treatment and prevention providers; an Alcohol, Drug and Mental Health (ADAMH) Board Director; the Chemical Dependency Professionals Board; and the Supreme Court of Ohio Judicial College. The Ohio Department of Mental Health and Addiction Services also identified key individuals to provide on-going support of the effort as needed. In addition, the following training topics were identified to initially expand learnings on best practice models available to the system:

- Motivational Interviewing and Stages of Change
- Mental Health First Aid
- SAFERR Cross System Training
- Opiate Specific Case Management
- Increasing Protective Factors for Children

The OCWTP also began development of specialized sessions for foster and adoptive parents during this time to better equip them to meet the needs of children whose parents are addicted, and/or who may abuse substances themselves that year.

The Logic Model for Substance Abuse Training for this work is presented on the following page.

**OCWTP
SUBSTANCE ABUSE TRAINING: COORDINATION WITH AOD PARTNERS**



During Year 2 of the CFSP implementation period, the OCWTP held a Substance Abuse Training Partnership event for building an ongoing infrastructure of relationships between substance abuse professionals and the Regional Training Centers. The event was jointly sponsored by the Supreme Court of Ohio, ODJFS, and the Ohio Association of County Behavioral Health Authorities. Speakers from the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Job and Family Services, the Ohio Supreme Court, Case Western School of Addiction Medicine, Public Children Services Association of Ohio, and a local child welfare administrator provided highlights of current substance abuse needs and collaborative efforts. The event was attended by 80 participants.

Forty subject matter experts willing to serve as regional liaisons for the OCWTP attended the Substance Abuse Training Partnership event. These individuals represented the ADAMH boards along with prevention, treatment, and opiate-specific addiction resources. They were asked to help identify substance abuse trainers and training resources in content areas specific to child welfare system needs of caseworkers, supervisors and caregivers. These liaisons met in teams with the eight Regional Training Center Directors and staff along with a select group of public child protective services supervisors and Institute for Human Services facilitators.

Information and presentations from the Regional Substance Abuse Training Partnership event were posted on OCWTP's newly launched website (www.osatg.org). Topics featured 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.

OCWTP continues to:

- Offer regular outreach and technical assistance to Regional Training Center staff to encourage ongoing relationships with partners.
- Develop workshops for caregivers designed to foster resiliency in children whose parents are involved with substance abuse, and others to increase supervisors' knowledge about addiction.
- Participate in conversations with the Supreme Court's Statewide System Reform Program partners regarding cross training needs.
- Work with Children and Family Futures, a California-based research and policy institute that manages the National Center for Substance Abuse and Child Welfare to guide technical assistance for the Ohio START initiative.
- Provide training and technical assistance for Ohio START, managed by PCSAO, which encourages cross-system collaboration and peer recovery support in 32 counties.
- Promote use of a standardized curriculum, *Supporting Families with Substance Use, Mental, and Co-Occurring Disorders* written by the National Center of Substance Abuse and Child Welfare in June of 2017. In CFSP Year 5, the OCWTP developed and conducted two sessions of a Training on Content for new substance abuse trainers to prepare them to train the curriculum. This TOC included content on how to facilitate conversations with participants related to safety and risk around substance use disorders.

- Implement its monthly webinar series called Lunchtime LIVE (Learning Interactions with Valued Experts). This series uses state and national experts in substance abuse issues to present a topic and then examine how the topic applies to work with families across child welfare, court, and behavioral health systems. The series includes resources and tools to facilitate additional individual learning and team applications. Topics included Implementing CARA, and Fentanyl Safety Issues and Child Welfare.
- Provide training and technical assistance to counties on implementing Universal Screening protocols.
- Provide in-person training and distance learning sessions on various substance use disorder topics, including:
 - o *An Overview of Medically Assisted Treatment in Substance Abuse;*
 - o *Assessment and Treatment of Opiate Addiction;*
 - o *The Dramatic Effects of Prenatal Substance Exposure: Living the Legacy;*
 - o *Born Addicted: Promoting Best Care for Substance Exposed Infants;*
 - o *Engagement and Case Planning with Opioid-Involved Families;*
 - o *The Hard Stuff- Heroin;*
 - o *Women's Substance Abuse;*
 - o *Understanding Birth Parent Addiction and the Impact on the Children in Your Home; and*
 - o *Helping Child Welfare Workers Support Families with Substance Use, Mental Health or Co-Occurring Disorders.*
- Increase the OCWTP's capacity by adding cross-system training facilitators.
- Initiate strategies for ongoing technical assistance about substance abuse issues to PCSAs and RTCs.
- Develop 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:

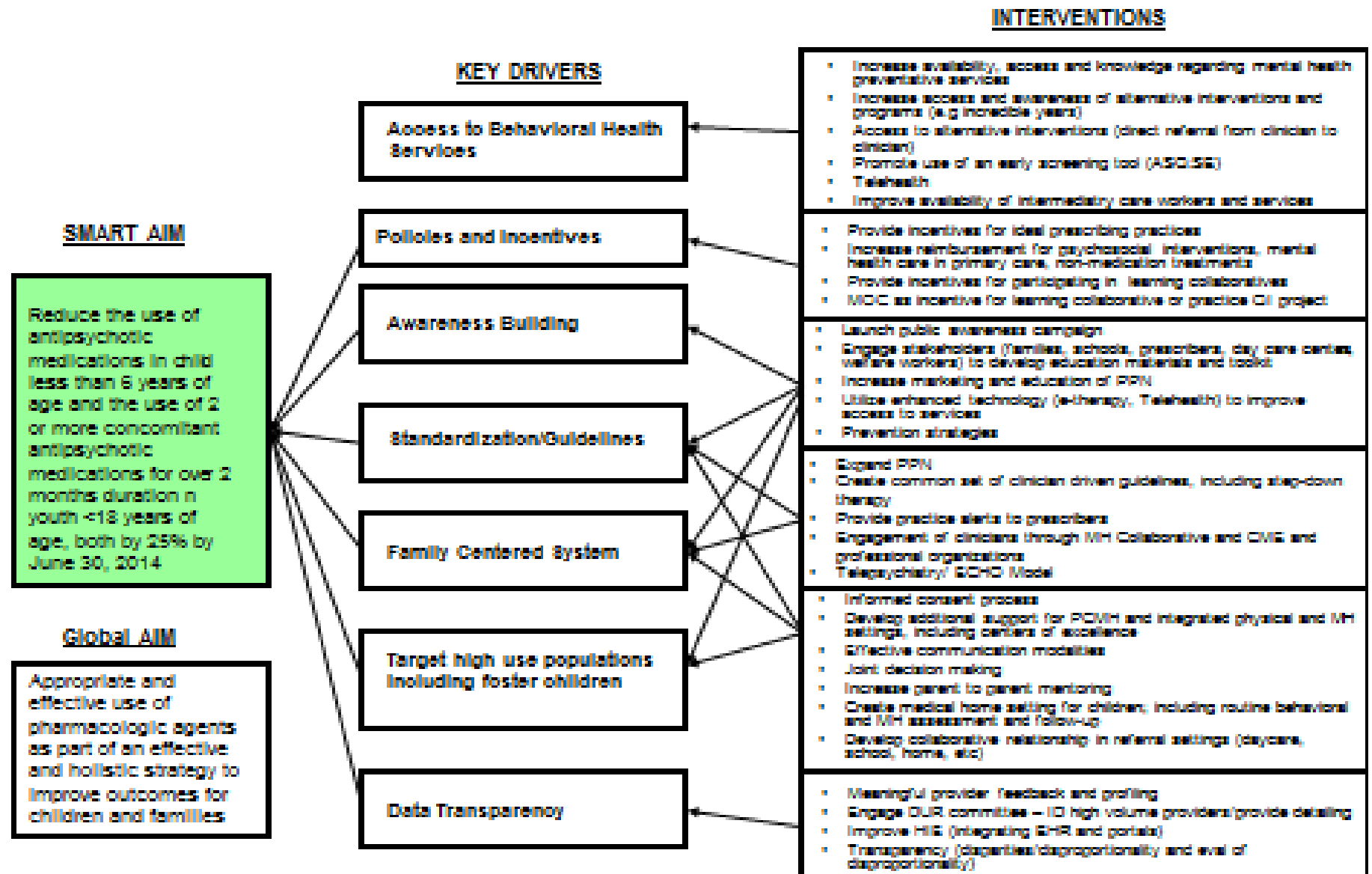
http://maofkdjs.com/sites/momsOhio/files/2018-12/MOMS_Child_Welfare_Training_Final_3-21-16.pdf

Appendix B1

Key Driver Diagram

Ohio Minds Matter

KEY DRIVER DIAGRAM



Appendix B2

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