Appendix C

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

Update

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

June 2021
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 the Ohio Administrative Code (OAC).

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 for 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 with 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; and
- 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 information system (SACWIS). To improve documentation of healthcare needs and services, SACWIS fields are designed to:

- Ease system navigation by dividing Person Characteristics into the following categories: Medical, Mental Health/Substance Abuse, Developmental/Intellectual, and Prenatal/Birth. Diagnoses align with those in the DSM 5. Characteristics can no longer be deleted, but may be marked “created in error.”

- Streamline the individual’s Medical Page 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 is available to facilitate more efficient documentation of recurring treatments. In addition, Diagnosed Characteristics can 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.”
• Improve medication monitoring and enhance record keeping capability by including the most commonly prescribed medications in a drop-down field for selection, rather than requiring the user to type each name into a text field. This provides better data consistency and greater efficiency for the user. Psychotropic medications in the list are automatically flagged, and users can manually flag any “Other” medications prescribed used as off-label psychotropics. The fields include: the medication names, total number of medications, and total number of psychotropic medications recorded.

• Record Estimated Due Dates, End Dates, and Outcomes to ensure retention of gestational-related historical records in the Pregnancy Detail Reports. In addition, Ohio’s SACWIS contains the following indicators to the Person Profile page: Pregnant, Pregnant/Parenting Minor, and Pregnant/Parenting Youth in Custody. To improve documentation of relatives, Ohio’s SACWIS also enables PCSAs to record the number of children each parent (both male and female) has, even those who are not involved in the child welfare system.

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

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

• Complete the Healthchek and Pregnancy Services Assessment form and return it to the CDJFS Coordinator.
EPSDT also covers necessary treatment of conditions identified through HeathChek screenings and chronic care for Medicaid-eligible children and teens. OFC works with the Ohio Department of Medicaid to maintain resource listings of local EPSDT providers for use by the PCSAs. Per statute, a comprehensive health care screening or exam is not required when:

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

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

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

**Medicaid Enrollment of Youth Aging Out of Care**
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 choice. 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 ambulance 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.

During this reporting period, Multi-System Services and Supports Bureau staff worked with members of the Ohio Youth Advisory Board to develop a Medicaid Roadmap as a reference for youth and young adults who are/have been in foster care. This Roadmap contains guidance about healthcare eligibility, working with one’s managed care plan to obtain case management and assistance, self-advocacy skills regarding one’s health care needs, and other resources. To view the Roadmap, go to: https://fosteractionohio.org/medicaid-roadmap-for-foster-youth-and-alumni/

**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. Six 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 appropriately 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):
  - Inattention, Hyperactivity, and Impulsivity:
    - [http://ohiomindsmatter.org/resources-d](http://ohiomindsmatter.org/resources-d)
  - Moodiness and Irritability:
    - [http://ohiomindsmatter.org/resources-f](http://ohiomindsmatter.org/resources-f)
  - Disruptive Behavior and Aggression:
    - [http://ohiomindsmatter.org/resources-e](http://ohiomindsmatter.org/resources-e)

- 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;

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 the 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.

- As of October 1, 2021 when the state implements the Family First Prevention Services Act, children’s initial placements and continued stay determinations in Qualified Residential Treatment Centers will be guided by the results of regularly administered level of care assessments. In preparation for this change, ODJFS has worked with the Ohio Department of Mental Health and Addiction Services, private providers, and stakeholders to facilitate use of appropriate assessment tools. In addition, the Department continues to design effective strategies by which to monitor the status of these assessments within Ohio’s SACWIS system.
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 demonstrates the need for trauma-focused, cognitive-behavior therapy (TF-CBT) interventions appropriate for older children. Disproportional minority representation within the child welfare system also clearly illustrates provision of culturally relevant interventions remains essential.

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 network to expand availability of effective services by increasing practitioners’ competency in trauma informed care (TIC) 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; the Ohio Children’s Alliance; 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).

Some of this work includes, but is not limited to:

- Working with ODJFS and the QRTP Workgroup to align Trauma-Informed Care practice expectations in preparation for Ohio’s implementation of the FFPSA.
• Partnering with the ODH’s Early Childhood Comprehensive Systems (ECCS) to present training on *Understanding Toxic Stress: Protecting Infants and Young Children from Life-Long Impacts of Prolonged Adversity.*

• Providing training to private agency providers on *Alternatives to Seclusion and Restraint in Children’s Residential Treatment Facilities.*

• Training 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.

Regional Collaboratives:
Ohio has established six Regional 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](http://mha.ohio.gov/traumacare).

**Family First Prevention Services Act (FFPSA) Planning**

**Model Selection:**
As previously noted in the APSR, Ohio’s FFPSA Workgroup sought guidance from Ohio’s TIC Care Coordinator and statewide Care Collaborative Network in order to thoroughly evaluate proposed intervention models. Through this process, stakeholders provided examples of practices currently being implemented in Ohio and other recognized TIC approaches for consideration, along with those promoted by the National Childhood Traumatic Stress Network or listed on the California Evidence-Based Clearinghouse for Child Welfare.

Utilizing input from trauma experts, ODJFS and OhioMHAS jointly created a list of TIC competencies to be used in congregate care settings. The list was shared with both the statewide TIC committee and the ODJFS TIC treatment model workgroup. Both groups are comprised of representatives from various stakeholder groups, including congregate care centers, private child serving agencies, public children services agencies, DODD, ODE, child advocacy groups, and individuals with lived experience. Feedback and input were received from both groups before finalizing the training competencies list. As Ohio moves toward FFPSA implementation, this list ([https://jfs.ohio.gov/ocf/FFPSA-Competencies.stm](https://jfs.ohio.gov/ocf/FFPSA-Competencies.stm)) will guide agencies’ model selections. To ensure practices meet nationally recommended implementation domains and principles, ODJFS also included SAMHSA’s *Concept of Trauma and Guidance for a Trauma-Informed Approach* on its website. The concept features the following six principles and ten domains of an effective TIC approach:

**Key Principles:**
- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical, and Gender Issues
Implementation Domains:
- Governance and Leadership
- Policy
- Physical Environment
- Engagement and Involvement
- Cross Sector Collaboration
- Screening, Assessment, Treatment Services
- Training and Workforce Development
- Progress Monitoring and Quality Assurance
- Financing
- Evaluation

Ohio also revised OAC during this reporting period to include SAMHSA’s trauma informed treatment model definition, along with references to Ohio’s approved TIC models and the SAMHSA guidance document. To view the revised rule, go to: https://codes.ohio.gov/ohio-administrative-code/rule-5101:2-9-42

In addition, ODJFS, in conjunction with its QRTP Workgroup members, developed the following tools to assist agencies’ development of trauma-informed treatment models:
- Trauma Requirement Flow Chart
- Trauma Training Directory
- Treatment Model Infosheet
- Trauma Models
- Trauma Model Application

Capacity Building and Training:
ODJFS and OhioMHAS are committed to ensuring providers are adequately trained in TIC principles and techniques. To this end, the departments are jointly developing a survey to be used routinely by those who work in congregate care settings, including residential treatment facilities, to assess workforce development needs on an on-going basis.

To advance this work, Ohio’s FFSPA Workgroup also identified appropriate TIC training models as part of the state’s planning process. To view these, go to: https://jfs.ohio.gov/ocf/FFPSA-TraumaProgramIntervention.stm

In addition, TIC training resources and technical assistance documents are available through the OhioMHAS E-based Academy. Agencies interested in obtaining in-person trainings also have access to local experts and resources through: https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/Trauma-informed-Care/TIC-Regional-Collaboratives.
Systemic Trauma Training for Child Welfare
Ohio’s University Consortium for Child and Adult Services (OUCCAS) is the coordinator of the Ohio Child Welfare Training Program (OCWTP). OUCCAS develops and implements competency-based training for Ohio’s foster and adoptive parents, caseworkers, supervisors, and administrators. In partnership with OhioMHAS, the OCWTP modified the National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Training Toolkit and the NCTSN Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents to meet established timelines of the state’s program. The NCTSN recently updated the Toolkit and plans are being made to incorporate these revisions into the OCWTP.

The NCTSN Child Welfare Trauma Training Toolkit consists of the following four, three-hour modules:

<table>
<thead>
<tr>
<th>NCTSN Child Welfare Trauma Training Toolkit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Trauma and Its Effect on Children</td>
</tr>
<tr>
<td>The Impact of Trauma and the Importance of Safety</td>
</tr>
<tr>
<td>Identifying Trauma-related Needs and Enhancing Well-Being</td>
</tr>
<tr>
<td>Worker Well-Being and the Importance of Partnering</td>
</tr>
</tbody>
</table>

The Workshop for Resource Parents consists of the following four, three-hour modules:

<table>
<thead>
<tr>
<th>NCTSN Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma 101</td>
</tr>
<tr>
<td>Understanding Trauma’s Effects and Building a Safe Place</td>
</tr>
<tr>
<td>Feelings, Behaviors, Connections, and Healing</td>
</tr>
<tr>
<td>Advocating and Self-Care</td>
</tr>
</tbody>
</table>

Since July 1, 2020 through March 2021:
- Three full rounds and one half round of the NCTSN Child Welfare Trauma Training Toolkit have been offered through the OCWTP.
- Two sessions of the Workshop for Resource Parents have been offered.
The OCWTP has also incorporated other standardized trauma informed care series into its menu of offerings, including *Trust-Based Relational Intervention* (TBRI).

**Since July 1, 2020 through March 2021:**
- Nine sessions of the TBRI series have been offered.

The OCWTP continues to revise the foster care, assessor, and caseworker standardized curricula in order to increase awareness of the impact of trauma on child development and behavior, share coping and resiliency strategies, and inform caregivers and staff about secondary traumatic stress. The OCWTP has a pool of approved, independent trainers that supplement standardized trainings with training they develop. Each training is thoroughly reviewed and approved before it is added to the menu of offerings.

**Since July 1, 2020 through March 2021, the following trauma-related trainings have been added to the menu of offerings:**

**Boredom, Loneliness & Apathy: Helping Youth and Families Improve Wellness**
This virtual, instructor-led training helps participants understand the clinical descriptions of boredom, loneliness, and apathy to improve the impact of treatment interventions. These sessions also discuss the impact of the COVID-19 precautions on mental wellness, and related clinical strategies to support clients.

**Trauma: Unresolved Trauma Can be a Monster of Pain and Fire**
This virtual, instructor-led training focuses on how trauma is defined by type and symptomology. How trauma affects individuals differently is discussed, along with assessment tools and diagnostic indicators of trauma-related disorders. DSM-5 stressor-related disorders are reviewed, including: Acute Stress Disorder, Adjustment Disorder, Posttraumatic Stress Disorder (PTSD), Reactive Attachment Disorder, and Disinhibited Social Engagement Disorder. Treatment methods are described so that caseworkers can assist caregivers as they work with clinicians to treat the child’s trauma.

**Increasing Resilience: Learn, Model and Teach Resilience Skills**
This virtual, instructor-led training focuses on strategies caseworkers can use to increase personal resilience. The training recognizes that resilient behavior is often both a common occurrence and an area needing continual growth within the child welfare field. The session highlights skills that can be used to promote health and well-being and discusses the impact of personal growth on self as well as on others with whom one interacts.

**Supporting the Child in Your Care During a Pandemic**
This virtual, instructor-led training provides caregivers an opportunity to discuss challenges related to the current environment and share strategies for caregiving through the pandemic.

**Building Resilience After Childhood Trauma: Up the Spout Again**
This training underscores the tragedy of early childhood trauma, and its impact on child development. This session provides practical strategies for foster and adoptive parents to use to promote resiliency for children in their care who have been impacted by abuse.
In addition, the following chart illustrates the number of trainer-developed trauma-related trainings offered in each region since July 1, 2020 through March 2021:

<table>
<thead>
<tr>
<th>Regional Training Center</th>
<th>Staff offerings</th>
<th>Caregiver offerings</th>
<th>Joint offerings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Ohio</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>East Central Ohio</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>North Central Ohio</td>
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<td>TOTALS</td>
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<td>20</td>
<td>11 / 40 total</td>
</tr>
</tbody>
</table>

These sessions addressed the following topics:

- Increasing Resilience: Learn, Model and Teach Resilience Skills
- Adverse Childhood Experiences and Effects on Brain Architecture
- Invisible Injuries: The Impact of Trauma
- Emotional Regulation and Protective Factors
- Helping Teens Build Resiliency
- Sensory Integration and Emotional Regulation
- Bedtime Behaviors for Traumatized Children
- Becoming a Trauma-Competent Caregiver
- Build a Brain: How Trauma Affects Brain Development
- Dealing with the Effects of Complex Trauma
- Girls, Trauma, and Delinquency
- Trauma and Mental Health: Advocating for our Students
- Sensory Processing: Seeing and Meeting the Needs of Our Children
Addressing Secondary Trauma Within the Child Welfare Workforce
As part of Ohio’s application for the 21st Century Cures Act grant, 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. These materials remain available on-line for staff to easily access. 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.

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). 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 provided training to child welfare line staff and supervisors to use of trauma-informed practices. Previously, this site was also awarded NCTSN funding to implement the Children Who Witness Violence Program which provided 24-hour/day trauma response services to children and families referred 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.
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. This initiative:
  - Comparatively examined the effectiveness of cross-system practices among 3 pilot sites;
  - Enhanced tele-medicine options and provision of prescriber peer support;
  - Established clinical treatment guidelines based on aggression, attention, and mood symptomology;
  - Launched a website, [www.Ohiomindsmatter.org](http://www.Ohiomindsmatter.org) to increase knowledge and promote best practices; and
- Enhanced data analyses to improve prescribing practices.
- Created a Psychotropic Medication Toolkit to assist PCSAs with development and implementation of local policies and procedures, including 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/resources-d](http://ohiomindsmatter.org/resources-d)

- **Mood:**
  - [http://ohiomindsmatter.org/resources-f](http://ohiomindsmatter.org/resources-f)

- **Aggression:**
  - [http://ohiomindsmatter.org/resources-e](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](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](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.

*Ohio Minds Matter* also created podcasts as an alternative training method for professionals. To learn more about the podcasts, go to: [http://ohiomindsmatter.org/toolkit/](http://ohiomindsmatter.org/toolkit/)

For more information regarding the Ohio Minds Matter project and available resources, go to: [http://ohiomindsmatter.org](http://ohiomindsmatter.org)

Another historical 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%
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 have been 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 (GAO) 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?

States selected for the GAO study included: Arizona, California, Illinois, Maryland, New Jersey, Ohio, 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 a 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.) Selected states included: Ohio, Texas, Washington, and Wisconsin. For more information about this project, go to: https://www.pcori.org/research-results/2015/comparing-effects-state-policies-monitor-mental-health-medicines-given
Enhanced Data Analyses and Technical Assistance
During this reporting period, ODM and ODIFS jointly designed and implemented a data analysis process by which to evaluate documentation of psychotropic and opioid medication use by children in foster care. The methodology requires OFC to send ODM identifying information on children in foster care in a given month. In response, Medicaid returns to OFC all pharmacy claims dispensed on those children for that month. The matched data set is then electronically analyzed to compare the medications dispensed with the information recorded in SACWIS.

The results of this comparative process are then provided to counties, and best practice strategies are discussed. The reports provide analyses on the percent of children with correctly recorded prescriptions; summary data on the number of children prescribed each medication; and detail level prescription information for each child. Contextual data is included in the report which specifies the percent of children in foster care by age who had the following psychotropic classes dispensed during the review month: ADHD Stimulants; ADHD Non-Stimulants; Antidepressants; Antipsychotics; Mood and Behavior; Opioids; and Antianxiety.

Pediatric Psychiatry Network
Ohio’s Pediatric Psychiatry Network (PPN) is 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 use of psychotropic medications:

- Screening Tools: [http://www.ppn.mh.ohio.gov/ProviderResources/ScreeningTools.aspx](http://www.ppn.mh.ohio.gov/ProviderResources/ScreeningTools.aspx);
- Behavioral Health Conditions: [http://www.ppn.mh.ohio.gov/ProviderResources/BehavioralHealthConditions.aspx](http://www.ppn.mh.ohio.gov/ProviderResources/BehavioralHealthConditions.aspx);
- Medications: [http://www.ppn.mh.ohio.gov/ProviderResources/Medications.aspx](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](http://www.ppn.mh.ohio.gov/FamilyEducation.aspx).

For more information on the PPN, see: [http://ppn.mh.ohio.gov/](http://ppn.mh.ohio.gov/)

Building Mental Wellness
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. To view these, go to the Academy of Pediatrics website:
  o http://ohioaap.org/parent-resource-page/

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).

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 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, PCSAO established the Behavioral Health Leadership Group (BHLG). 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. Recommendations 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.

During this reporting period, the Toolkit was revised to include updated information about new, commonly prescribed medications. To view the current version, go to Appendix C-1 Psychotropic Medication Toolkit for Public Children Services Agencies.
COLLABORATIVE HEALTHCARE PROGRAMMING

Ohio has a long-standing history of collaborative efforts designed to improve the delivery and effectiveness of physical and behavioral health care services throughout the state. Some of these initiatives are detailed below.

RecoveryOhio
Upon taking office in January 2019, 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 best 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 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

The Council has issued more than 70 recommendations in effort to provide a full continuum of care for Ohioans in recovery and their families. Implementation of these recommendations has been organized under the following prioritized work areas:

- Stigma and Education;
- Prevention;
- Treatment and Recovery Supports;
- Parity;
- Specialty Populations;
- Harm Reduction;
- Workforce Development; and
- Data Measurement and System Linkage.

Achievements made toward implementing the recommendations during this reporting period are captured under each of the individual priorities. To view them, go to: https://recoveryohio.gov/wps/portal/gov/recovery/priorities/revie\-w-2019.

RecoveryOhio also launched a series of free trainings to assist employers and employees in preventing and responding to substance abuse misuse within the workplace. The modules focus on a science-based explanation of substance use disorders to reduce stigma, and include information about how to develop effective strategies for managing it (e.g., hiring and retaining employees who are in recovery, and establishing an organizational culture which facilitates wellness). For additional information about these free trainings, go to: https://recoveryohio.gov/wps/portal/gov/recovery/resources/all-resources/recovery-friendly-employer-modules
In May 2021, Ohio Departments of Health, and Mental Health and Addiction Services, in collaboration with RecoveryOhio, implemented a targeted Naloxone distribution plan to ensure equitable access to this life-saving drug to Black and Latino Ohioans. This effort included online mail order and community outreach strategies in order to quickly address the increased rate of overdoses among minority populations.

Multi-System Youth Initiative:
Under Governor DeWine’s administration, targeted investments have been made to support the needs of families whose children struggle with multi-system needs. More than $31 Million were designated in the SFY20 and SFY21 budgets to provide services and supports for children at risk of custody relinquishment solely for the purpose of obtaining necessary treatment, and to help offset PCSAs’ responsibility for payment of costly congregate care for children already in their custody. At the time of this writing, on-going support for this work has been proposed, and is being considered through the Ohio General Assembly’s budget process.

In October 2019, Governor DeWine launched the creation of the Multi-System Youth State Program where families could apply for financial aid to cover the cost of their child’s care through their local Family and Children First Council. As of May 21, 2021, the multi-disciplinary state team, comprised of representatives from the Governor’s Office, Ohio Family and Children First, and the Ohio Departments of JFS, DD, Education, Youth Services, and Medicaid, had received 696 applications from 81 counties (93 of which were for technical assistance only). As of that date, Ohio had allocated over $18.3 Million to serve 520 families in need. As part of this initiative, investments were also made to enhance care coordination capacity via the local Family and Children First Councils.

FAMILY-CENTERED SERVICES AND SUPPORTS
The OFCF Cabinet’s Family-Centered Services and Supports (FCSS) project reflects the state’s cross-system commitment to implementing a coordinated continuum of services and supports for children, ages 0-21, with multi-system needs and their families. This initiative is jointly funded by ODJFS (Title IV-B dollars) and state funds from the Ohio Departments of Mental Health and Addiction Services, Youth Services, and Developmental Disabilities. These dollars are appropriated to local FCFCs to provide non-clinical, family-centered services and supports. Utilization of these funds requires that specific needs be identified on an individualized service coordination plan which must be jointly developed with the family. 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.

At the time of this writing, several local Family and Children First Councils were still updating service utilization reports. Based on the data available for this reporting period:

- Total Number of Families Served: 1647
- Total Number and Ages of Children Served By Age:

<table>
<thead>
<tr>
<th>Ages of Children</th>
<th>0 – 3</th>
<th>4 – 9</th>
<th>10 – 13</th>
<th>14 – 18</th>
<th>19 - 21</th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td></td>
<td>60</td>
<td>458</td>
<td>591</td>
<td>770</td>
<td>50</td>
<td>1,929</td>
</tr>
</tbody>
</table>
• **Service/Support Needs by Category Identified at Intake:**
  FCFCs report the identified child’s service or support needs at the point of intake, regardless of whether the child was receiving services or supports to address that need. To be eligible for multi-disciplinary Service Coordination through the FCFC, a child or youth must have two or more identified needs.

  In order of frequency, the presenting needs were as follows:
  - Mental Health: 1,229
  - Special Education: 819
  - Developmental Disability: 657
  - Poverty: 557
  - Autism Spectrum Disorder: 343
  - Delinquency: 190
  - Unruly Behavior: 342
  - Child Neglect: 154
  - Physical Health: Care Need: 136
  - Child Abuse: 134
  - Alcohol/Drug Disorder: 131
  - Early Intervention Need: 46
  - Primary Care Physician Linkage: 11

• **FCSS Funded Services and Supports Provided through FCFC Service Coordination:**
  Due to the COVID-19 pandemic, the services provided varied from those in the past. Because many providers closed or limited both in-home and office options for safety, efforts were taken to ensure families were able to receive needed supports remotely. To this end, FCSS funds were utilized this past year to provide: electronic equipment to assure access to needed care, structured activities that could be conducted at home, and emergency assistance so that presenting needs could be met timely. Through these vehicles, service coordination was maintained, and families were also able to continue to receive coaching and mentoring, peer support, parent education, and advocacy supports.

**State Plan Assessment/ State Health Improvement Plan**
ODH contracted with the Health Policy Institute of Ohio (HPIO) to complete the 2020-2022 State Health Improvement Plan (SHIP), a tool to strengthen state and local efforts to improve health, well-being, and economic vitality in Ohio. The SHIP is Ohio’s roadmap to address the many challenges identified in the 2019 State Health Assessment (SHA). To view information about how the SHA was conducted and its findings, go to:
2019OhioStateHealthAssessment_SummaryReport_ES_Final.pdf (healthpolicyohio.org)

The SHIP was developed with input from hundreds of Ohioans through:
  - Regional forums;
  - An online survey completed in 2018 as part of the 2019 SHA (622 participants);
  - A Steering Committee made up of representatives from 13 state agencies, including sectors beyond health;
  - An Advisory Committee with 176 participants, including subject matter experts from
around the state who participated in work teams to set objectives and select strategies.

Though these collaborative processes, a framework and specific strategies were developed to address identified gaps in services. To view these, go to:


In April 2021, HPIO released an updated Health Value Dashboard. This document illustrates the state’s rankings for health conditions, outcomes, spending, and access to services. It also provides information about COVID impacts on Ohio’s citizens, health disparities, and strategies for improvement. To view the Dashboard, go to: [https://www.healthpolicyohio.org/wp-content/uploads/2021/04/2021_HealthValueDashboard_FINAL.pdf](https://www.healthpolicyohio.org/wp-content/uploads/2021/04/2021_HealthValueDashboard_FINAL.pdf)

**Managed Care, OhioRISE, Medical Homes:**

**Managed Care:**
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. One of the biggest advantages to this has been the opportunity for ODM to monitor provision of patient services through their contracted provider networks. In addition, a specialized Medicaid Technical Assistance Section has been established within the Office of Families and Children to specifically address the healthcare coverage needs of foster children, adoptees from the child welfare system, and young adults who have emancipated from care. This Section is jointly funded through ODM and ODJFS.

In April 2021, the ODM announced that 6 managed care plans will coordinate Medicaid-funded services for Ohio’s 3 million members, their families and service providers. The Plans selected were:

- United Healthcare Community Plan of Ohio, Inc.
- Humana Health Plan of Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- AmeriHealth Caritas Ohio, Inc.
- Anthem Blue Cross and Blue Shield
- CareSource Ohio, Inc.
OhioRISE:  
In December 2020, ODM, in partnership with the Governor’s Office of Children’s Initiatives and the Ohio Family and Children First Cabinet, announced the launch of OhioRISE (Resilience through Integrated Systems and Excellence). This initiative has been designed to better address the needs of children with complex challenges and multi-system involvement.

As noted in the graphic below, on any given day, approximately 140 Ohio children are placed in out-of-state facilities, often in Psychiatric Residential Treatment Facilities. One goal of OhioRISE is to ensure access to appropriate treatment options though intensive case management, and expansion of in-state provider networks. OhioRISE is slated to begin operations in 2022.

New services that will be available through OhioRISE include:

- **Intensive Care Coordination**: Moderate and intensive levels of care coordination will be implemented under the principles of High-Fidelity Wraparound model and delivered by a Care Management Entity-qualified agency;

- **Intensive Home-based Treatment**: Ohio’s existing IHBT services will be changed and aligned with those of the Family First Prevention Services Act;

- **Psychiatric Residential Treatment Facility**: This service will be designed to keep youth with the most intensive behavioral health needs in-state, and closer to their families and support systems.

- **Mobile Response and Stabilization Services**: This service will provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services. (Note: This service will also be available to children who are not enrolled in Ohio Medicaid.)

- **Behavioral Health Respite**: This service will provide short-term, temporary relief to the primary caregiver(s) of an OhioRISE enrolled youth.
To be eligible for OhioRISE Service, children/young adults must be:

- Enrolled in Ohio Medicaid—either under managed care or fee-for-service;
- Be under the age of 21; and
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) tool.

To view the Governor DeWine’s and ODM Director Corcoran’s announcements about the program, go to: [https://www.youtube.com/watch?v=09KHWbyH5fU&t=237s](https://www.youtube.com/watch?v=09KHWbyH5fU&t=237s)

For Ohio Medicaid managed care youth members who are not enrolled in the OhioRISE plan, Ohio Medicaid Managed Care Organizations (MCOs) and the fee for service program will continue coverage for the Medicaid’s existing behavioral health services and Mobile Response and Stabilization Services. MCOs will manage also administrative care coordination, utilization management, and quality improvement efforts. The Ohio Medicaid MCOs also will be responsible for assuring access to the Child and Adolescent Needs and Strengths (CANS) assessment to determine when a child needs the enhanced services of the OhioRISE plan. For more information, go to: [https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/bc8bf7ac-8838-471c-9360-aa60dd9f871e/OhioRISE+MRSS+Workgroup+Meeting+1-22-21.pdf?MOD=AJPERES&CVID=nt4wjdQ](https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/bc8bf7ac-8838-471c-9360-aa60dd9f871e/OhioRISE+MRSS+Workgroup+Meeting+1-22-21.pdf?MOD=AJPERES&CVID=nt4wjdQ)

In April 2021, it was announced that Aetna was chosen as the vendor to implement OhioRISE.

**Medical Homes:**
The transition to a managed care healthcare delivery 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.
School-Based Medicaid
Ohio’s Medicaid School Program (MSP) is codified in the Ohio Revised Code. This program provides enrolled school districts the ability to obtain partial federal reimbursement for medically necessary services identified on a Medicaid-eligible student’s Individualized Education Plan.

Eligible medically necessary services include, but are not limited to:
- Occupational therapy;
- Physical therapy;
- Speech therapy;
- Audiology services;
- Nursing services;
- Mental health services; and
- Psychological and neuropsychological testing.

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

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

- Medical supplies and equipment deemed medically-necessary while the child is attending school.

Ohio’s Medicaid School Program is jointly coordinated by the Ohio Departments of Medicaid and Education. Direct MSP providers include traditional school districts and community schools; however, other entities (e.g., Educational Service Centers or private therapy clinics) may also be contractually involved in the program.

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 Some of these initiatives include:
• The Oral Health Program (OHP) provides funding to local agencies to implement and maintain school-based dental sealant programs. With parental consent, teams of dental hygienists and dental assistants place sealants on children’s teeth in schools that serve a higher proportion of children from lower income families.

• The OHP provides funding to support safety net dental programs which provide dental care to people on Medicaid, and offer sliding-fee, reduced fees or free care to patients who don’t have dental insurance or can’t afford to pay a private dentist. The dental "safety net" includes public dental clinics, dental care provided to schoolchildren, and mobile/portable dental care programs (e.g., mobile dental vans). These programs provide basic dental care such as exams, X-rays, fillings, extractions, root canals and dentures.

• The OHP provides funding to support the integration of oral health in prenatal services. Two prenatal services providers are funded to provide oral health assessment, education, and case management for dental treatment to support the oral health of prenatal patients.

• The OHP provides training and resources to non-dental health care professionals (e.g., primary care providers, WIC, Home Visiting) to help them conduct oral health assessments, provide anticipatory guidance, apply fluoride varnish and make referrals for dental treatment.

• Healthy Start/ Healthy Families is one of Ohio’s Medicaid programs through which children (up to age 19), pregnant women and families can obtain low cost dental care.

• Dentist and dental hygienist loan repayment programs allow dentists and dental hygienists who are providing dental care in underserved areas to apply for repayment of school loans.

* During the early months of the COVID-19 pandemic, many dental offices could only see patients on an emergency basis. However, the ODH identified and directed patients to alternative resources to ensure treatment needs would be addressed. Two resources included:

  • The Ohio Dental Association’s List of Emergency Dental Care Providers; and
  • The ODH Safety Net Dental Program Brochure

**Personal Responsibility and Education Program**

ODYS, in partnership with the ODYS 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.
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. To learn more about Ohio’s Early Childhood Mental Health initiative, go to: https://mha.ohio.gov/Schools-and-Communities/Educators/Early-Childhood-Mental-Health#2791880-ecmh-consultation-andServices.docx-treatment

OhioMHAS also 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.
Maternal Opiate Medical Support (MOMS) Program
Because the majority of opioid dependent pregnant women in Ohio have often not been engaged in prenatal treatment, Ohio launched the Maternal Opiate Medical Support (M.O.M.S.) project. This initiative was collaboratively designed by healthcare leaders, stakeholders, and medical professionals to improve maternal and fetal health outcomes, improve family stability, and reduce costs of Neonatal Abstinence Syndrome (NAS) to Ohio’s Medicaid program.

Strategies to achieve these goals included:

- Use of Medication Assisted Treatment;
- Trauma- Informed, Gender-specific Behavioral Health counseling;
- Service Delivery through a Maternity Care Home (MCH) model of care;
- Coordinated case management; and
- Provision of non-clinical services needed to promote recovery (e.g., housing, childcare, transportation, employment support).
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 (which remain in use today); 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 remains in use.

Compared to a matched Medicaid comparison cohort, evaluation outcomes demonstrated that 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.

![Summary of Results]

- **Improving Care**: MOMS participants were more likely to receive prenatal care, behavioral health care, & MAT in each trimester of pregnancy than the comparison group.
- **Aim 1: Treatment Retention**: MOMS participants were 45% more likely to continue to participate in substance abuse treatment 4 to 6 months postpartum.
- **Aim 2: Family Stability**: Maltreatment was 18% lower & out-of-home placement was 19% lower among families in the MOMS project than the comparison cohort.
- **Aim 3: Birthweight**: The rate of low birthweight was similar among infants in the MOMS cohort and the Medicaid comparison group.
- **Aim 4: NICU Length of Stay**: Mothers who received MAT in the third trimester of pregnancy had infants with a significantly shorter NICU length of stay.
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.

Ohio continued to expand the MOMS program through support from the federal 21st Century Cures Act funding. For more information about MOMS, go to: https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/MOMS-Project

**The Ohio Neonatal Abstinence Syndrome Project**

Six children’s hospitals and their affiliates (20 hospitals total) came together to form a specialized consortium to study the needs of infants with Neonatal Abstinence Syndrome (NAS) and their families. An illustration of which hospitals and their locations are depicted below.

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.
Throughout its implementation, the Ohio’s Neonatal Abstinence Syndrome Project developed clinical tools and protocols that remain in use today. These include:

- **Pause before you Prescribe:**
  [https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f80797ab5183d5330550386/1602255227541/OPQC-NAS_Provider_Handout-03b+%280000002%29.pdf](https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f80797ab5183d5330550386/1602255227541/OPQC-NAS_Provider_Handout-03b+%280000002%29.pdf)

- **Resources for Prescribing Physicians:**
  [https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8079a6c1af6d45dc042525/1602255271210/Resources+for+Prescribing+Clinicians.pdf](https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8079a6c1af6d45dc042525/1602255271210/Resources+for+Prescribing+Clinicians.pdf)

- **A Mother’s Journey Through Addiction:** [https://vimeo.com/100335753](https://vimeo.com/100335753)

- **Finnegan NAS Scoring Tool:**
  [https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f807a1671fad318c31eda40/1602255383987/Finnegan+Neonatal+Abstinence+Scoring+Tool_OPQC+w+cc.pdf](https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f807a1671fad318c31eda40/1602255383987/Finnegan+Neonatal+Abstinence+Scoring+Tool_OPQC+w+cc.pdf)

- **Medication guidelines to treat infant withdrawal:**
  [https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8876eea46ded5264d69ce9/1602778864031/OPQC+Recommended+NAS+Protocol+Changes+2017.pdf](https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8876eea46ded5264d69ce9/1602778864031/OPQC+Recommended+NAS+Protocol+Changes+2017.pdf)

- **Understanding NAS as a Chronic Illness:** [https://vimeo.com/87682516](https://vimeo.com/87682516)

- **NAS- Guide for Families:**
  [https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8079d2e1e4dd0d523cfb42/1602255325601/opqc_nas_parent_guide_092914.pdf](https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9e939/t/5f8079d2e1e4dd0d523cfb42/1602255325601/opqc_nas_parent_guide_092914.pdf)

**MOMS + (Plus)**

Based on the success of the NAS project, the Ohio Perinatal Quality Collaborative (OPQC) launched a related project, MOMS +. (The “Plus” stands for Babies.) 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.

MOMS + is designed to better coordinate care provided by obstetricians, medication assisted treatment (MAT) providers, behavioral health clinicians, and neonatal specialists/pediatricians. The project is built upon a “Mentor-Partner” strategy that utilizes the expertise of faculty who provide successful maternity medical homes for pregnant women with Opioid Use Disorders (OUD) and those who developed and implemented the NAS care protocols. Hospitals serve as the lead agencies for these projects, and the facility serve as mentors to build the skills and capacity of local maternity care practices.
The goals of MOMS + are to:

- 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;
- Improve the communication amongst OB, OP, and Community Resources;
- Increase the % of women with negative toxicology screens at delivery;
- 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.**
- Improve the hand-off for continued care following pregnancy.
It takes a village...
Appendix C1

Psychotropic Medication Toolkit
for
Public Children Services Agencies