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ACT SUMMARY

COMMISSION ON INFANT MORTALITY RECOMMENDATIONS

- Provides for implementation of recommendations made by the Commission on Infant Mortality in a March 2016 report.

Data collection and sharing

Perinatal services and vital statistics

- Requires the Ohio Department of Medicaid (ODM) to make summary data regarding perinatal services available to local infant mortality reduction initiative organizations and grant recipients.
- Requires ODM to include information about Medicaid recipients' races, ethnicities, and primary languages in data that it shares with Medicaid managed care organizations and requires the organizations to share this information with providers.
- Requires the State Registrar of Vital Statistics to ensure that local boards of health have access to preliminary birth and death data.

- Requires the State Registrar to offer to provide training for hospital and freestanding birthing center staff, as well as funeral service workers, on their responsibilities under the vital statistics law.

Pregnancy- and birth-related data

- Requires the Ohio Department of Health (ODH) and ODM to create infant mortality scorecards that report quarterly data regarding pregnancy- and birth-related health measures and outcomes.
- Requires ODH, on a quarterly basis, to make publicly available preliminary infant mortality and preterm birth rates, as well as the stillbirth rate, delineated by race and ethnic group.

Requires the Director of Health to publish stillbirth data compiled from ODH's fetal death statistical file and to disseminate educational materials on stillbirths to the State Medical Board, statewide medical associations, and the public.

Medicaid reports

- Requires the annual report that ODM must complete on the effectiveness of the Medicaid program to include additional information related to perinatal care and infant mortality initiatives.
- Requires ODM to conduct periodic reviews to determine barriers that Medicaid recipients face in gaining access to interventions intended to reduce tobacco use, prevent prematurity, and achieve optimal birth spacing.
- Requires ODM to submit a report to the General Assembly and the Joint Medicaid Oversight Committee regarding each Medicaid managed care organization's progress, during fiscal years 2016 and 2017, in improving infant mortality measures through enhanced care management and targeted initiatives in infant mortality hot spots.

Survey of maternal behaviors related to pregnancy

- Requires ODH to create a population-based questionnaire designed to examine maternal behaviors related to pregnancy similar to the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire that was discontinued.

Assessment of Shaken Baby Syndrome Education Program

- Adds to the responsibilities the Director of Health must fulfill in assessing the effectiveness of the Shaken Baby Syndrome Education Program.



Targeted interventions

Crib bumper pad and mesh liners

- Prohibits crib bumper pad sales and certain sales of mesh crib liners and specifies penalties for violations.

Safe sleep education

- Requires ODH to provide annual safe sleep training at no cost to parents and infant caregivers who reside in infant mortality hot spots.
- Requires facilities that procure safe cribs for at-risk families, as well as ODH, to ensure that crib recipients receive safe sleep education and crib assembly instructions.
- Requires ODH to include in a report on safe sleep initiatives an assessment of whether at-risk families are being served sufficiently by its crib distribution and referral system.

Tobacco cessation

- Requires ODH's tobacco use and cessation plan to emphasize reducing tobacco use by Medicaid recipients, account for the increasing use of electronic health records, and ensure that ODH collaborates with organizations in infant mortality hot spots to help them secure tobacco cessation grants.
- Requires ODM to enter into an interagency agreement with ODH under which ODM pays the federal and nonfederal shares of Ohio Tobacco Quit Line services provided to Medicaid recipients.

Birth spacing and prematurity prevention

- Generally requires each hospital and freestanding birthing center to ensure that a woman giving birth has the option of having a long-acting reversible contraceptive (LARC) device placed after delivery and before discharge.
- Authorizes a hospital or freestanding birthing center to submit a Medicaid claim for a LARC device provided to a Medicaid recipient after giving birth that is separate from the claim for inpatient care.
- Requires the Directors of Health and Medicaid to coordinate technical assistance and grants to federally qualified health centers (FQHCs) and FQHC look-alikes that seek to include the practice of a prescriber who promotes awareness and use of LARC devices (a "LARC First practice").



- Requires the Director of Health, with participation from the State Medical and Nursing Boards, to collaborate with health professional schools to develop curricula on counseling patients regarding efficacy-based contraceptives, including LARC devices.
- Requires ODM, when contracting with a Medicaid managed care organization, to use a uniform prior approval form that is not more than one page for progesterone prescribed for pregnant women.

Restructuring health systems for improved outcomes

- Permits any entity that is eligible to be, and requests to serve as, a qualified provider to make presumptive Medicaid eligibility determinations for pregnant women if ODM determines that the entity is capable of making the determinations.
- Requires ODM to contractually require Medicaid managed care organizations, and ODH to contractually require Women, Infant, and Children (WIC) clinics, to promote use of technology-based resources that offer tips on having a healthy pregnancy and healthy baby.
- Requires the Executive Director of the Office of Health Transformation to establish goals for continuous quality improvement pertaining to episode-based payments for prenatal care and to promote the adoption of best practices on family planning options, reducing poor pregnancy outcomes, and wellness activities.
- Requires certain health care professional licensing boards to consider the problems of race- and gender-based disparities in health care treatment decisions and to annually provide licensees with a list of relevant continuing education and experiential learning opportunities.

Social determinants of health for pregnant and at-risk women

Qualified community hubs

- Requires Medicaid managed care organizations to provide or arrange for certain Medicaid recipients to receive services by certified community health workers who work for, or are under contract with, a qualified community hub.
- Requires ODH to establish a qualified community hub in each community that lacks one, and requires the Commission on Minority Health to convene quarterly meetings with the hubs to discuss performance data and best practices.



Home visiting

- Requires that, to the extent possible, Help Me Grow program goals be consistent with the Federal Home Visiting Program's goals.
- Creates the Ohio Home Visiting Consortium to ensure that home visiting services are high-quality and delivered through evidenced-based or innovative, promising home visiting models.
- Requires ODH and the Department of Developmental Disabilities to create a central intake and referral system for the state's Part C Early Intervention Program and all home visiting programs.
- Requires that families be referred to appropriate home visiting services through the central intake and referral system.
- Requires ODH rules to specify that families residing in infant mortality hot spots are to receive priority for Help Me Grow home visiting services.
- Requires ODH, after considering recommendations of the Home Visiting Consortium, to allocate funds for home visiting pilot projects targeted at families with the most challenging needs.
- Requires ODH to transition to paying for home visiting services based on outcomes rather than processes.
- Requires home visiting service providers to promote certain technology-based resources and report program performance data as a condition of receiving payment.
- Requires ODH to facilitate and allocate funds for a biannual home visiting summit.

Evaluation of state policies and programs

- Requires the Legislative Service Commission to contract with a nonprofit organization to convene and lead a stakeholder group concerned with evaluating social determinants of health for infants and women of child-bearing age.

Housing

- Requires the Ohio Housing Finance Agency (OHFA) to include reducing infant mortality as a priority housing need in its annual plan.
- Requires OHFA and the Ohio Development Services Agency to include pregnancy as a priority in their housing assistance and local emergency shelter programs.



- Permits OHFA to establish a housing assistance pilot program for extremely low-income households that include pregnant women or new mothers.
- Requires the Commission on Infant Mortality to work with the Ohio Housing and Homelessness Collaborative to develop a plan for a rental assistance housing program.

Commission on Infant Mortality membership

- Adds to the Commission on Infant Mortality's membership the Director of Developmental Disabilities or the Director's designee.

ADMINISTRATION OF INJECTABLE DRUGS BY PHARMACISTS

- Authorizes a pharmacist to administer by injection any of the following drugs if certain conditions are met: opioid antagonists, antipsychotics, specified drugs related to preterm birth risk and contraception, and vitamin B12.
- Requires a pharmacist to notify the prescribing physician each time a drug is administered by injection and to observe the recipient for any adverse reactions.
- Requires the State Board of Pharmacy to adopt rules implementing these provisions.
- Requires the Medical Board to adopt rules to be followed by a physician when prescribing a drug that may be administered by injection by a pharmacist.

SAFE HAVEN LAW

- Allows a parent to deliver his or her child who is 30 days old or younger, without the intent to return for the child, to a designated newborn safety incubator.
- Requires children who are dropped off in newborn safety incubators to be subject to the same Safe Haven Law requirements as children who are handed to designated individuals under continuing law.
- Requires the Director of the Department of Health to adopt rules governing newborn safety incubators in accordance with the criteria established in the bill.
- Requires juvenile courts to give hearing notice to parents in accordance with Rule 16 of the Ohio Rules of Juvenile Procedure with respect to a public children services agency's temporary custody motion regarding a deserted child.



- Changes the term "governmental entity" to "entity" under the Safe Haven Law when referring to a law enforcement agency, hospital, or emergency medical services organization that receives a deserted child.
- Clarifies that medical and other information forms are to be made available to the parents and expands the persons subject to certain prohibitions under the Safe Haven Law, including the prohibition against coercion of parents to take forms and fill them out.

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CONTENT AND OPERATION

COMMISSION ON INFANT MORTALITY RECOMMENDATIONS

Background

The Commission on Infant Mortality was created by S.B. 276 of the 130th General Assembly, enacted in late 2014. In addition to 15 members specified in statute,¹ the Commission designated other persons to participate in its meetings depending on the

¹ R.C. 3701.68(C).



topic of a particular meeting.² On March 22, 2016, the Commission issued its first report after a series of meetings that began in August 2015. That report, *Committee Report, Recommendations, and Data Inventory – March 2016*, is available at this website: <http://cim.legislature.ohio.gov/documents>. The act largely enacts recommendations in the report.

Data collection and sharing

Data availability to local organizations and boards of health

The act requires the Ohio Department of Medicaid (ODM) to make summary data regarding perinatal services available on request to local organizations concerned with infant mortality reduction initiatives and recipients of grants administered by the Division of Family and Community Health Services in the Ohio Department of Health (ODH). The data must be made available at least once each year in accordance with state and federal laws governing the confidentiality of patient-identifying information.³

The act also requires the State Registrar of Vital Statistics to ensure that each local board of health has access to preliminary birth and death data maintained by ODH, as well as access to any electronic system of vital records the State Registrar or ODH maintains, including the Ohio Public Health Information Warehouse (also known as the Integrated Perinatal Health Information System, or "IPHIS").⁴ (IPHIS automates the collection of pregnancy and newborn data, permits authorized users to print draft and final versions of a birth certificate, and facilitates the distribution of data to multiple end user systems.⁵) To the extent possible, the preliminary data must be provided in a format that permits geocoding. (The act defines "geocoding" as a geographic information system operation for converting street addresses into spatial data that can be displayed as features on a map, usually by referencing address information from a street segment data layer.) Further, the State Registrar must provide users with a data analysis tool kit that assists them with using the data in a manner that promotes consistency and accuracy among users. The tool kit must include a data dictionary and sample data analyses.⁶

² Commission on Infant Mortality, *Committee Report, Recommendations, and Data Inventory – March 2016*, p. 8, available at <http://cim.legislature.ohio.gov/documents>.

³ R.C. 5164.471.

⁴ R.C. 3705.40(B).

⁵ Ohio Department of Health, *Integrated Perinatal Health Information System*, available at https://www.odh.ohio.gov/odhprograms/cfhs/cf_hlth/datasystems/iphis.aspx.

⁶ R.C. 3705.40.



If the State Registrar requires a local board of health to enter into a data use agreement before accessing the data or systems, the State Registrar must provide each board with an application for this purpose and, if requested, assist with the application's completion.⁷

Data availability to Medicaid managed care organizations

The act requires ODM to include information about Medicaid recipients' races, ethnicities, and primary languages in data that ODM shares with Medicaid managed care organizations. This information must be included in the data the organizations share with providers.⁸

Training for birthing facilities and funeral services workers

The act requires the State Registrar of Vital Statistics, at least annually, to offer to provide training for appropriate staff of hospitals and freestanding birthing centers, as well as funeral services workers, on their responsibilities under vital records law. If provided, the training must cover correct data entry procedures and time limits for reporting vital statistics information to ensure accuracy and consistency of the vital statistics system. For purposes of this requirement, the act defines a "hospital" as one that has a maternity unit or that receives care for infants who have been transferred from other facilities and who have never been discharged to their residences following birth. A "funeral services worker" is defined as a licensed funeral director or embalmer or an individual responsible for the direct final disposition of a deceased person.⁹

New reports to track progress and identify areas for focus

ODH infant mortality scorecard

The act requires ODH to create an infant mortality scorecard. The scorecard must report:¹⁰

(1) The state's performance on population health measures, including the infant mortality rate, preterm birth rate, and low-birthweight rate, delineated by race, ethnic group, region of the state, and the state as a whole;

⁷ R.C. 3705.40(B).

⁸ R.C. 5167.45.

⁹ R.C. 3705.41.

¹⁰ R.C. 3701.953(A).



(2) Preliminary data that ODH possesses on the state's unexpected infant death rate;

(3) To the extent the information is available, the state's performance on outcome measures identified by ODH related to preconception health, reproductive health, prenatal care, labor and delivery, smoking, infant safe sleep practices, breastfeeding, and behavioral health delineated by race, ethnic group, region of the state, and state as a whole;

(4) A comparison of the state's performance on the population measures specified in (1) and, to the extent the information is available, the state's performance on the outcome measures specified in (3), with targets for the measures, or the targets for the objectives similar to the measures, that are established by the U.S. Department of Health and Human Services through the Healthy People 2020 Initiative (see **COMMENT 1**, below);

(5) Any other information on maternal and child health that ODH considers appropriate.

The scorecard must be updated each calendar quarter and made available on ODH's website. In addition, it must include a description of the data sources and methodology used to complete the scorecard.¹¹

ODM infant mortality scorecard

The act also requires ODM to create an infant mortality scorecard. The scorecard must report:¹²

(1) The performance of the fee-for-service component of Medicaid and each Medicaid managed care organization on population health measures, including the infant mortality rate, preterm birth rate, low-birthweight rate, and stillbirth rate;

(2) The performance of the fee-for-service component of Medicaid and each Medicaid managed care organization on service utilization and outcome measures using claims data and data from vital records;

(3) The number and percentage of women ages 15 to 43 who are Medicaid recipients;

¹¹ R.C. 3701.953(B) and (C).

¹² R.C. 5162.135(B).



(4) The number of Medicaid recipients who delivered a newborn and the percentage of those who reported tobacco use at the time of delivery;

(5) The number of prenatal, postpartum, and adolescent wellness visits made by Medicaid recipients;

(6) The percentage of pregnant Medicaid recipients who initiated progesterone therapy during pregnancy;

(7) The percentage of female Medicaid recipients of child bearing age who participate in a tobacco cessation program or use a tobacco cessation product;

(8) The percentage of female Medicaid recipients of childbearing age who use long-acting reversible contraception;

(9) A comparison of the low-birthweight rate of Medicaid recipients with the low-birthweight rate of women who are not Medicaid recipients; and

(10) Any other information on maternal and child health that ODM considers appropriate.

To the extent possible, the performance measures described above must be delineated in the scorecard as follows:¹³

--For each region of the state and the state as a whole, by race and ethnic group; and

--For the urban and rural communities specified by the Director of Health (in consultation with the Medicaid Director) with the highest rates of infant mortality, as well for any other communities that are the subject of targeted infant mortality reduction administered by the state, by race, ethnic group, and census tract. These communities are referred to as "infant mortality hot spots."

The scorecard must be updated each calendar quarter and made available on ODM's website. ODM must make available to any person or government entity on request the data sources and methodology used to complete the scorecard.¹⁴

¹³ R.C. 5162.135(C).

¹⁴ R.C. 5162.135(C) and (D).

Preliminary infant mortality and preterm birth rates; stillbirth rate

Under the act, ODH must determine (quarterly) the state's preliminary infant mortality and preterm birth rates, as well as the stillbirth rate, delineated by race and ethnic group. The rates must be determined using a simple rolling average. ODH must publish the rates in a quarterly report, which also must include a description of the data sources and methodology used. ODH must make each report available on its website within five business days after the rates are determined.¹⁵

The act defines "preliminary infant mortality and preterm birth rates" as the infant mortality and preterm birth rates that are derived from vital records, are not considered finalized by ODH, and are subject to modification as additional birth and death data are received by ODH and added to vital records.¹⁶ It defines a "stillbirth" as death before the complete expulsion or extraction from its mother of a product of human conception of at least 20 weeks of gestation, which after the expulsion or extraction does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.¹⁷

Stillborn data and education

In addition to determining the state's stillbirth rate, the act requires the Director of Health to do all of the following related to data on stillbirths and education on stillbirths:¹⁸

(1) Publish stillbirth data compiled from ODH's fetal death statistical file and make it available on ODH's website;

(2) Review the stillbirth data and identify potential trends in the incidence of stillbirth and the possible causes of, and conditions that could lead to or indicate the possible occurrence of, stillbirth;

(3) Develop educational materials in conjunction with statewide medical associations that may be used to apprise health care providers of trends, if any, that were identified through that review; and

¹⁵ R.C. 3701.951(B).

¹⁶ R.C. 3701.951(A).

¹⁷ R.C. 3701.97(A).

¹⁸ R.C. 3701.97(B).



(4) Electronically disseminate the educational materials to the Medical Board and statewide medical associations and make them available on ODH's website in an easily accessible format.

Additions to annual Medicaid effectiveness report

Under continuing law, ODM must complete an annual report on the effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children. The act requires all data included in the report to be delineated by race and ethnic group. In addition, it requires that the report include:¹⁹

--The average number of days between a pregnant woman's application for Medicaid and enrollment in the fee-for-service component of Medicaid or in a Medicaid managed care organization. (This information also must be delineated by county and infant mortality hot spot.)

--The estimated number of enrolled women of child-bearing age who use a tobacco product;

--The estimated number of enrolled women of child-bearing age who participate in a tobacco cessation program or use a tobacco cessation product;

--A report on performance data generated by the component of the State Innovation Model (SIM) grant pertaining to episode-based payments for perinatal care that was awarded to Ohio by the U.S. Centers for Medicare and Medicaid Services;²⁰

--A report on funds allocated for infant mortality reduction initiatives in the infant mortality hot spots;

--A report on client responses to questions related to pregnancy services and Healthcheck (see **COMMENT 2**, below) that are asked by county department of job and family services personnel; and

¹⁹ R.C. 5162.13.

²⁰ In December 2014, Ohio was awarded a federal State Innovation Model (SIM) test grant to implement an episode-based payment model statewide, in which a single payment is made for all services needed by a patient for an entire episode of care. Office of Health Transformation, *Implement Episode-based Payments*, available at www.healthtransformation.ohio.gov/CurrentInitiatives/ImplementEpisodeBasedPayments.aspx.

--A comparison of the performance of the fee-for-service component of Medicaid with the performance of each Medicaid managed care organization on perinatal health metrics.

Periodic reviews on access to certain interventions

The act requires ODM to conduct periodic reviews to determine the barriers that Medicaid recipients face in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing. The first review must occur by June 5, 2017. Thereafter, reviews must be conducted every six months.²¹

ODM must prepare a report that summarizes the results of each review. Each report must be submitted to the Commission on Infant Mortality, the Joint Medicaid Oversight Committee, and the General Assembly:²²

(1) The first report must:

- Identify the access barriers described above, the individuals affected by them, and whether the barriers result from policies implemented by ODM, Medicaid managed care organizations, providers, or others;
- Make recommendations for the expedient removal of the access barriers; and
- Include an analysis of the performance of the fee-for-service component of Medicaid and the performance of each Medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing.

(2) All subsequent reports must:

- Address the progress on removing the access barriers and its impact on reducing the infant mortality rate;
- Include a performance analysis of the fee-for-service component of Medicaid and each Medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing; and
- Include any other information ODM considers to be pertinent.

²¹ R.C. 5162.136(A).

²² R.C. 5162.136(A).



ODM must make a presentation on each report at the first meeting of the Commission on Infant Mortality that follows the report's submission to the Commission.²³

Fiscal years 2016 and 2017 report

The act requires ODM to prepare a report that:²⁴

(1) Evaluates each Medicaid managed care organization's progress, during fiscal year 2016 and fiscal year 2017, toward (a) decreasing the incidence of prematurity, low birthweight, and infant mortality and (b) improving the overall health status of women capable of becoming pregnant through provision of enhanced care management services and implementation of other initiatives targeted in the infant mortality hot spots (including those that use community health workers); and

(2) Describes, in detail, the uses and amounts spent of, and outcomes from, the \$13.4 million appropriated in fiscal years 2016 and 2017 for the ODM initiative designed to engage leaders in high-risk neighborhoods for the purpose of connecting women to health care.²⁵

ODM must submit the report to the Joint Medicaid Oversight Committee and the General Assembly by April 1, 2017.²⁶

Population-based questionnaire – maternal behaviors

The act requires ODH to create a population-based questionnaire designed to examine maternal behaviors and experiences before, during, and after pregnancy, as well as during the early infancy of the woman's child. The questionnaire must collect information that is similar to the information collected by the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire that ODH most recently used, as well as any additional information suggested by the U.S. Centers for Disease Control and Prevention (CDC) for PRAMS questionnaires (see **COMMENT 3**, below).

The act requires ODH to implement and use the questionnaires in a manner consistent with the standardized data collection methodology for PRAMS questionnaires prescribed by the CDC model surveillance protocol. In addition, for the purpose of having statistically valid data for local analyses, ODH must oversample

²³ R.C. 5162.136(B).

²⁴ Section 3(A).

²⁵ See Office of Health Transformation, *Reduce Infant Mortality*, available at <<http://bit.ly/1QRK9u8>>.

²⁶ Section 3(B).



women in Cuyahoga, Franklin, and Hamilton counties annually, and oversample women in the remaining counties that constitute the Ohio Equity Institute cohort (Butler, Stark, Mahoning, Montgomery, Summit, and Lucas counties) biennially (see **COMMENT 4**, below).

ODH must report results from the questionnaires at least annually in a manner consistent with guidelines established by the CDC for the reporting of PRAMS questionnaire results.²⁷

Shaken Baby Syndrome prevention

The act adds to the Director of Health's responsibilities in assessing the effectiveness of the Shaken Baby Syndrome Education Program that ODH administers under continuing law. Under that law, ODH must annually evaluate reports it receives from the Director of Job and Family Services concerning the number of child abuse cases that were entered in the Statewide Automated Child Welfare Information System (SACWIS) indicating that the abuse arose from an act that caused the child to suffer from, or resulted in the child suffering from, Shaken Baby Syndrome. The act requires, in addition, that the Director review (1) the content of the educational materials to determine if updates or improvements should be made and (2) the manner in which the educational materials are distributed to determine if modifications should be made.²⁸

Targeted interventions

Safe sleep initiatives

Prohibition on crib bumper pad sales

The act prohibits a person from recklessly manufacturing, offering for sale, selling, delivering, or possessing for the purpose of manufacturing, selling, or delivering, a crib bumper pad.²⁹ It defines a "crib bumper pad" as any padding materials, including a roll of stuffed fabric, that is designed for placement within a crib to cushion one or more of the crib's inner sides adjacent to the mattress. However, it excludes a mesh crib liner intended for placement between a crib mattress and one or more of the crib's inner sides, regardless of whether consumer product safety standards

²⁷ R.C. 3701.952.

²⁸ R.C. 3701.63.

²⁹ R.C. 3713.021(A).



of the U.S. Consumer Product Safety Commission (CPSC) include mesh crib liners in the federal definition of "crib bumper pad."³⁰

Prohibition on certain mesh crib liner sales

The act prohibits a person from recklessly manufacturing, offering for sale, selling, delivering, or possessing for the purpose of manufacturing, selling, or delivering, a mesh crib liner intended for placement between a crib mattress and one or more of the crib's inner sides that does not comply with consumer product safety standards promulgated after October 9, 2016, by the CPSC, for the purpose of ensuring sufficient permeability and breathability so as to prevent infant suffocation.

If the CPSC does not issue those standards, the act prohibits a person, beginning April 6, 2020, from recklessly manufacturing, offering for sale, selling, delivering, or possessing for the purpose of manufacturing, selling, or delivering, any mesh crib liner.³¹

Violations

The Superintendent of Industrial Compliance must issue a notice of violation to any person found to have violated any of the provisions described above. A person who, after being issued a notice of violation, continues to violate the prohibition is subject to a fine of not more than \$500. Each day of violation constitutes a separate offense.³²

Annual safe sleep training in infant mortality hot spots

Under continuing law, ODH must establish a safe sleep education program. As part of the program, ODH must develop and make available on its website educational materials that present readily comprehensible information on safe sleeping practices for infants and possible causes of sudden unexpected infant death.

The act requires ODH to also provide annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in the infant mortality hot spots, including child care providers, hospital staff and volunteers, local health department staff, social workers, individuals who provide home visiting services, and community health workers.³³

³⁰ R.C. 3713.01(I).

³¹ R.C. 3713.022(A) and (B).

³² R.C. 3713.021(B), 3713.022(C), and 3713.99(C).

³³ R.C. 3701.66(B).

Training and crib assembly instruction at crib distribution sites

Under continuing law, hospitals and freestanding birthing centers are generally required to determine, through an infant safe sleep screening procedure before discharge, whether an infant is unlikely to have a safe crib at the infant's residence. If it is unlikely the infant will have a safe crib, the facility must make a good faith effort to arrange for the parent, guardian, or other person responsible for the infant to obtain a safe crib at no charge. There are four ways a facility can meet this requirement.

If a facility obtains a safe crib with its own resources, collaborates with or obtains assistance from persons or government entities that are able to procure a safe crib or provide money to purchase a safe crib, or refers the parent, guardian, or other person responsible for the infant to a person or government entity to obtain a safe crib free of charge, the act requires the facility to ensure that the crib recipient receives safe sleep education and crib assembly instructions from the facility or another source. If a facility refers the parent, guardian, other person to a Cribs for Kids Program site (see **COMMENT 5**, below), ODH must ensure that the Program or a successor program ODH administers provides safe sleep education and crib assembly to the crib recipient.³⁴

Assessment of safe crib distribution and referral system

Under continuing law, the Director of Health must annually submit a written report to the Governor and General Assembly summarizing information on the number of safe cribs that were obtained and distributed by facilities as described above. The act requires the report to assess whether at-risk families are being sufficiently served by the crib distribution and referral system and make suggestions for system improvements.³⁵ It also requires each recipient of a grant that ODH administers pertaining to safe crib procurement to annually report to ODH (1) demographic information specified by the Director regarding the individuals to whom safe cribs were distributed and (2) if known, the extent to which distributed cribs are being used.³⁶

The act requires that the report be submitted to the General Assembly with, and in the same manner as, ODM's annual report on the effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children.³⁷

³⁴ R.C. 3701.67.

³⁵ R.C. 3701.67(F).

³⁶ R.C. 3701.671.

³⁷ R.C. 3701.67(F).

Tobacco use and cessation

ODH plan

The act requires (rather than permits) ODH to prepare a tobacco use and cessation plan and specifies that it must emphasize reducing tobacco use by Medicaid recipients (in addition to reducing use among populations specified in continuing law: youth, minority and regional populations, pregnant women, and others who may be disproportionately affected by tobacco use). The act also requires that the plan:

--Take into account the increasing use of electronic health records by health care providers and expanded health insurance coverage for tobacco cessation products and services; and

--Require ODH to collaborate with community organizations in infant mortality hot spots for the purpose of helping them succeed in securing grants from the Moms Quit for Two Grant Program created by the 2015 biennial budget act, H.B. 64 of the 131st General Assembly, and other tobacco cessation grant programs.³⁸

Ohio Tobacco Quit Line services – Medicaid recipients

The act requires ODM, by May 8, 2017, to enter into an interagency agreement with ODH under which ODM pays the federal and nonfederal shares of Ohio Tobacco Quit Line services provided to Medicaid recipients.³⁹ ODM also must make Medicaid providers aware of the Quit Line services. The Ohio Tobacco Quit Line is a free tobacco cessation resource available to uninsured individuals, Medicaid recipients, pregnant women, and members of the Ohio Tobacco Collaborative.⁴⁰

Safe birth spacing and prematurity prevention

Option for long-acting reversible contraception (LARC) after delivery

The act generally requires each hospital that has a maternity unit, as well as each freestanding birthing center, to modify operational processes to ensure that a woman giving birth in the facility has the option of having a long-acting reversible contraceptive (LARC) placed after delivery and before the woman is discharged. A

³⁸ R.C. 3701.84(A) and (B).

³⁹ Section 6.

⁴⁰ Ohio Department of Health, *Ohio Tobacco Quit Line*, available at www.healthy.ohio.gov/healthylife/tobc2/cessation/quit.aspx.



facility is exempt if it notifies ODH in writing that it has a faith-based objection to the requirement.⁴¹

Medicaid claims for LARC devices

The act authorizes a hospital or freestanding birthing center that is a Medicaid provider to submit to ODM or ODM's fiscal agent a Medicaid claim that is both of the following:⁴²

--For a LARC device that is covered by Medicaid and provided to a Medicaid recipient after the recipient gives birth in the hospital or center and before the recipient is discharged; and

--Separate from another Medicaid claim for other inpatient care the hospital or center provides to the Medicaid recipient.

According to the American College of Obstetricians and Gynecologists, LARC devices include the intrauterine device (IUD) and birth control implant. An IUD is a small, T-shaped, plastic device that is inserted into and left inside a woman's uterus for three to five years. An IUD may or may not release hormones; it prevents fertilization of an egg by a sperm. A birth control implant is a single flexible rod about the size of a matchstick that is inserted under the skin in the upper arm. It releases hormones into the body and protects against pregnancy for up to three years.⁴³

LARC First practices

The act defines a "LARC First practice" as the practice of a prescriber who promotes awareness and use of LARC as the first-line contraception option for women, including teens. During fiscal year 2017, the act requires the Director of Health to coordinate with the Medicaid Director to both:

--Provide technical assistance to health care facilities, including federally qualified health centers (FQHCs) and federally qualified health center look-alikes (FQHC look-alikes), that seek to include a LARC First practice and that serve women residing in the infant mortality hot spots; and

--Provide grants to such health care facilities.

⁴¹ R.C. 3702.34 and 3727.20.

⁴² R.C. 5164.721.

⁴³ American College of Obstetricians and Gynecologists, *Long-Acting Reversible Contraception (LARC): IUD and Implant*, available at www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-LARC-IUD-and-Implant#methods.

A facility that is awarded a grant must use it to purchase LARC devices, as well as progesterone for pregnant women. The Medicaid Director and Director of Health must use any available funds from the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) or any unallotted General Revenue Funds within ODH's budget to fund these activities.⁴⁴

Health professional curricula

The act requires the Director of Health, with participation from the Medical Board and Board of Nursing, to collaborate with Ohio medical, nursing, and physician assistant schools or programs, as well as Ohio medical residency and fellowship programs, to develop and implement appropriate curricula in those schools and programs to prepare primary and women's health care physicians, advanced practice registered nurses, and physician assistants to provide patient counseling on efficacy-based contraceptives, including LARC devices.⁴⁵

The act also requires the Director to collaborate with health professional schools to develop appropriate curricula to prepare health professionals to practice within a patient-centered medical home model of care and specifies that a component of the curricula include preconception care and family planning.⁴⁶

Uniform form for progesterone administration

When contracting with a Medicaid managed care organization, the act requires ODM to require the organization, if it requires practitioners to obtain prior approval before administering progesterone to pregnant Medicaid recipients, to use a uniform prior approval form for progesterone that is not more than one page.⁴⁷

Restructuring of health systems for improved outcomes

Presumptive Medicaid eligibility for pregnant women

Federal law gives states an option to make ambulatory prenatal care available under the Medicaid program to pregnant women during a presumptive eligibility period. This period begins on the date a qualified provider determines, based on preliminary information, that the family income of a pregnant woman does not exceed the state's eligibility threshold and ends on the earlier of (1) the day a Medicaid

⁴⁴ Section 8.

⁴⁵ R.C. 3701.90.

⁴⁶ R.C. 3701.928.

⁴⁷ R.C. 5167.171.

eligibility determination is made or (2) the last day of the month following the month the eligibility determination is made if a Medicaid application is not filed by that day.⁴⁸ State law not modified by the act requires the Medicaid Director to implement this option.

The act authorizes any entity that is eligible to be, and requests to serve as, a qualified provider for the purpose of the presumptive eligibility for pregnant women option to serve as a qualified provider if ODM determines that the entity is capable of making the eligibility determinations. Former state law generally permitted only children's hospitals and FQHCs (including FQHC look-alikes) to serve as qualified providers.⁴⁹

Promotion of technology-based applications

When contracting with a Medicaid managed care organization, the act requires ODM to require the organization to promote the use of technology-based resources, such as mobile telephone or text messaging applications that offer tips on having a healthy pregnancy and healthy baby, among Medicaid recipients who are enrolled in the organization and are pregnant or have an infant who is less than one year old.⁵⁰

When adopting rules governing the Women, Infant, and Children (WIC) program, the act requires ODH to adopt rules requiring WIC clinics to promote the use of those same technology-based resources.⁵¹

Episode-based payments for prenatal care; promotion of best practices

The act requires the Executive Director of the Office of Health Transformation (OHT) to establish goals for continuous quality improvement pertaining to episode-based payments for prenatal care. The goals must be published on OHT's website.⁵²

In addition, the Executive Director, in consultation with the Director of Health, must identify best practices pertaining to family planning options, strategies for reducing poor pregnancy outcomes, health professional instruction on cultural competency, addressing social determinants of health, and health and wellness activities. In completing this task, the Executive Director may seek assistance from

⁴⁸ 42 United States Code (U.S.C.) 1396r-1.

⁴⁹ R.C. 5163.10(B).

⁵⁰ R.C. 5167.172.

⁵¹ R.C. 3701.132(B).

⁵² R.C. 191.09

health care providers, health professional trade associations, medical schools, nursing schools, and other health profession educational programs. The Executive Director must then inform all health care providers, health professional trade associations, medical schools, nursing schools, and other health profession educational programs of the identified best practices and encourage them to incorporate those practices in their professional practices, curricula, and continuing education programs.⁵³

Consideration of race- and gender-based disparities in health decisions

The act requires certain health profession licensing boards to consider the problems of race- and gender-based disparities in health care treatment decisions. This must be done by August 4, 2017. The boards subject to the requirement are the Dental, Nursing, Pharmacy, Medical, Psychology, and Counselor, Social Workers, and Marriage and Family Therapist Boards.

When considering these problems, the boards must consult with the Commission on Minority Health and one or more professionally relevant and nationally recognized organizations or similar entities that review the curricula and experiential learning opportunities offered by health care professional schools, colleges, and other educational institutions.

Each board must annually provide its licensees and certificate holders with a list of continuing education courses and experiential learning opportunities addressing cultural competency in health care treatment. If a state board determines that a sufficient number of courses or experiential learning opportunities does not exist, the board must collaborate with those nationally recognized organizations or similar entities to create such courses and opportunities.⁵⁴

Social determinants of health for pregnant and at-risk women

Community health worker services for Medicaid recipients

The act requires Medicaid managed care organizations to provide certain Medicaid recipients, or arrange for those recipients to receive, services provided by community health workers certified by the Board of Nursing who work for, or work under contract with, a qualified community hub. The act defines a "qualified community hub" as a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria:

⁵³ R.C. 191.10.

⁵⁴ R.C. 4743.08.

--Demonstrates to the Director of Health that it uses an evidence-based, pay-for-performance community care coordination model (endorsed by the Federal Agency for Healthcare Research and Quality, the National Institutes of Health, and the Centers for Medicare and Medicaid Services or their successors) to connect at-risk individuals to health, housing, transportation, employment, education, and other social services;

--Demonstrates to the Director that it has achieved, or is engaged in achieving, certification from a national hub certification program; and

--Has a plan (approved by the Medicaid Director) specifying how the community hub ensures that children served by it receive appropriate developmental screenings as specified in the publication titled "*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*," available from the American Academy of Pediatrics, as well as appropriate early and periodic screening, diagnostic, and treatment services.

A Medicaid recipient is eligible to receive the services if she (1) is pregnant or capable of becoming pregnant, (2) resides in a community served by a qualified community hub, (3) was recommended to receive the services by a physician or another licensed health professional specified in rules required by the act, and (4) is enrolled in the Medicaid managed care organization.

The services that must be provided or arranged for under the act are (1) community health worker services and (2) other services performed to ensure that the Medicaid recipient is linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services. "Community health worker services" includes assisting in accessing community health and supportive resources through the provision of services like education, role modeling, outreach, home visits, and referrals.

The act requires the Medicaid Director to adopt rules specifying the licensed health professionals, in addition to physicians, who may recommend that a Medicaid recipient receive the specified services.⁵⁵

Qualified community hubs in underserved areas

The act requires the Commission on Minority Health, on or before August 4, 2017, to identify each community in Ohio that is not served by a qualified community hub. Using funds ODH receives from the federal Maternal and Child Health Block Grant (see **COMMENT** 6, below), ODH must establish a qualified community hub in

⁵⁵ R.C. 5167.173.

each community the Commission has identified. In establishing the hubs, ODH must consult with the Commission.

The Commission must convene quarterly meetings with the qualified community hubs. The meetings may be held by telephone, video conference, or other electronic means. Each meeting must include a discussion on the community hubs' performance data, best practices for community hubs, and any other topics the Commission considers appropriate.⁵⁶

Home visiting

Help Me Grow Program – mission and goals

Help Me Grow is a program established by ODH to encourage early prenatal and well-baby care, provide parenting education to promote the comprehensive health and development of children, and provide early intervention services for individuals with disabilities.⁵⁷ The home visiting component of Help Me Grow operates in all 88 counties and provides first-time parents having incomes of not more than 200% of the federal poverty level (as well as families whose children are at-risk for poor birth and poor early childhood outcomes) with information, support, and encouragement in their homes.⁵⁸

The act specifies that the Help Me Grow program is established as the state's evidence-based parent support program that encourages early prenatal and well-baby care, as well as provides parenting education to promote the comprehensive health and development of children. It also requires that, to the extent possible, the goals of the Help Me Grow program must be consistent with the goals of the Federal Home Visiting Program. Such goals are specified by the Maternal and Child Health Bureau of the Health Resources and Services Administration in the U.S. Department of Health and Human Services.⁵⁹

Help Me Grow Program – priority groups

Under continuing law governing the Help Me Grow Program, the Director of Health must adopt rules establishing eligibility requirements for the Program. The act

⁵⁶ Section 4.

⁵⁷ R.C. 3701.61(A).

⁵⁸ Commission on Infant Mortality, *Data Inventory: Access to Care Initiatives*, available at <http://cim.legislature.ohio.gov/Assets/Files/access-to-care-initiatives.pdf>.

⁵⁹ R.C. 3701.61(A) and (C).



requires those rules to specify that families residing in infant mortality hot spots receive priority over other families for home visiting services provided by the Program.⁶⁰

Ohio Home Visiting Consortium

The act creates the Ohio Home Visiting Consortium. Its purpose is to ensure that services provided by home visiting programs, as well as home visiting services provided or arranged for by Medicaid managed care organizations, are high-quality and delivered through evidence-based or innovative, promising models. The act specifies that it is the General Assembly's intent that all home visiting services (1) improve health, educational, and social outcomes for expectant and new parents and young children and (2) promote safe, connected families and communities in which children are able to grow up healthy and ready to learn.⁶¹

The Consortium must:⁶²

--Make recommendations to ODH, ODM, the Ohio Department of Developmental Disabilities (ODODD), and the Ohio Department of Mental Health and Addiction Services (ODMHAS) regarding how to leverage all funding sources available for home visiting services, including Medicaid, to (1) expand the use of evidence-based home visiting models and (2) initiate, as pilot projects, innovative, promising home visiting models; and

--Make recommendations to ODM on the terms to be included in its contracts with Medicaid managed care organizations to ensure that they are providing or arranging for their Medicaid enrollees to receive home visiting services that are delivered as part of evidence-based or innovative, promising models.

In addition, the Consortium may recommend a standardized form or other mechanism to assess family risk factors and social determinants of health for purposes of the state's home visiting central intake and referral system (see below).⁶³

The Consortium's members are:⁶⁴

--The ODH Director or the Director's designee;

⁶⁰ R.C. 3701.61(F)(1) and (G).

⁶¹ R.C. 3701.612(A).

⁶² R.C. 3701.612(B)(1).

⁶³ R.C. 3701.612(B)(2).

⁶⁴ R.C. 3701.612(C).

- The Medicaid Director or the Director's designee;
- The ODMHAS Director or the Director's designee;
- The ODODD Director or the Director's Designee;
- The Executive Director of the Commission on Minority Health or the Executive Director's designee;
- A member of the Commission on Infant Mortality who is not a legislator or another individual specified in this list;
- One individual who represents Medicaid managed care organizations, recommended by the board of the Ohio Association of Health Plans;
- One individual who represents county boards of developmental disabilities, recommended by the Ohio Association of County Boards of Developmental Disabilities;
- A home visiting contractor who provides Help Me Grow services through a contract, grant, or other agreement with ODH;
- An individual who receives home visiting services from the Help Me Grow program;
- Two members of the Senate, one from the majority party and one from the minority party, each appointed by the Senate President; and
- Two members of the House of Representatives, one from the majority party and one from the minority party, each appointed by the Speaker.

Consortium members who are not members of the executive branch of government must be appointed by May 8, 2017. An appointed member holds office until a successor is appointed. A vacancy must be filled in the same manner as the original appointment.

The Director of Health must serve as the chairperson. Members serve without compensation except to the extent that serving on the Consortium is considered part of the member's regular employment duties.⁶⁵

The Consortium must meet at the call of the Director of Health, but at least once each calendar quarter. Its first meeting must convene on or before June 5, 2017. ODH

⁶⁵ R.C. 3701.612(D).

must provide meeting space and staff and administrative support. The Consortium is exempt from the Sunset Review Law.⁶⁶

Central intake and referral system

The act requires ODH and ODODD to create, by October 6, 2017, a central intake and referral system for the state's Part C Early Intervention Services Program and all home visiting programs. The system must comply with all regulations governing the federal Part C Early Intervention Program for Infants and Toddlers with Disabilities that are promulgated under the Individuals with Disabilities Education Act of 1997. Through a competitive bidding process, ODH and ODODD may select one or more persons or government entities to operate the system.⁶⁷

If ODH and ODODD choose to select one or more system operators, a contract with an operator must require that the system both:⁶⁸

--Serve as the single point of entry for access, assessment, and referral of families to appropriate home visiting services based on each family's location of residence; and

--Use a standardized form or other mechanism to assess for each family member's risk factors and social determinants of health. (If the Home Visiting Consortium has recommended a standardized form or other mechanism for this purpose, the contract may require its use.)

Families must be referred to appropriate home visiting services through the central intake and referral system.⁶⁹

Models

The act requires that home visiting services in the state be provided through evidence-based home visiting models or innovative, promising home visiting models recommended by the Home Visiting Consortium.⁷⁰

⁶⁶ R.C. 3701.612(E), (F), and (G).

⁶⁷ R.C. 3701.611(A).

⁶⁸ R.C. 3701.611(B).

⁶⁹ R.C. 3701.61(B).

⁷⁰ R.C. 3701.61(A).

Conditions for receiving payment

The act requires providers of home visiting services, as a condition of receiving payments, to do both of the following:⁷¹

--Promote the use of technology-based resources, such as mobile telephone or text messaging applications, that offer families with a pregnant woman or infant who is less than one year of age with tips on having a healthy pregnancy and healthy baby; and

--Report to the Director of Health data on program performance indicators specified by the Director in rules, which must be used to assess progress toward achieving all of the following:

(1) The benchmark domains established by the Federal Home Visiting Program, including improvement in maternal and newborn health; reduction in child injuries, abuse, and neglect; improved school readiness and achievement; reduction in crime and domestic violence; and improved family economic self-sufficiency;

(2) Improvement in birth outcomes and reduction in stillbirths; and

(3) Reduction in tobacco use by pregnant women, new parents, and others living in households with children.

Under continuing law, providers must report to the Director data on the program performance indicators that are used to assess progress toward achieving the Help Me Grow program's goals. These include data on low-birthweight and preterm births and the performance indicators specified in rules required by law not modified by the act.

The act requires that the report be made available on ODH's website.⁷²

In addition, the act requires ODH to transition to paying for home visiting services based on outcomes rather than processes. This must be done on or before January 8, 2018, after considering recommendations made by the Home Visiting Consortium.⁷³

⁷¹ R.C. 3701.61(F).

⁷² R.C. 3701.61(F).

⁷³ Section 7(B).



Allocation of funds for pilot projects

The act requires ODH, not later than January 8, 2018, and after considering recommendations made by the Home Visiting Consortium, to allocate funds for pilot projects that seek to provide home visiting services through innovative service delivery models to families with the most challenging needs who have been unsuccessful in home visiting programs that use traditional service delivery models.⁷⁴

Biannual home visiting summit

The act requires ODH, beginning in fiscal year 2018, to facilitate and allocate funds for a biannual summit on home visiting programs. The purpose of each summit is to convene persons and government entities involved with the delivery of home visiting services, as well as other interested persons, to do all of the following:⁷⁵

--Share the latest research on evidence-based and innovative, promising home visiting models;

--Discuss strategies to ensure that home visiting programs in Ohio use evidence-based or innovative, promising home visiting models;

--Discuss strategies to reduce tobacco use by families participating in home visiting programs; and

--Present successes and challenges encountered by home visiting programs.

Evaluation of state policies and programs

The act requires the Legislative Service Commission (LSC), not later than May 8, 2017, to contract with a nonprofit organization to convene and lead a stakeholder group concerned with matters regarding the social determinants of health for infants and women of child-bearing age. LSC may use up to \$500,000 for the contract.⁷⁶

The stakeholder group must do all of the following:⁷⁷

--Review state policies and programs that impact the social determinants of health for infants and for women of child-bearing age, particularly programs intended

⁷⁴ Section 7(A).

⁷⁵ R.C. 3701.613.

⁷⁶ Section 5(A) and (D).

⁷⁷ Section 5(A).

to improve educational attainment, public transportation options, housing, and access to employment;

--Identify opportunities to improve those programs and policies;

--Study the impact of using a state-funded rental assistance program targeted at infant mortality reduction; and

--Evaluate best practices other states have implemented to improve the social determinants of health for infants and women of child-bearing age.

The nonprofit organization must determine the stakeholder group's membership and who should be invited to participate in the group's discussions. The stakeholder group must include a representative from a metropolitan housing authority that operates at least 1,000 units in Ohio. The nonprofit organization must submit a report to the Governor and General Assembly by December 1, 2017, summarizing the stakeholder group's findings and making policy recommendations based on them.⁷⁸

Stable housing for at-risk pregnant women

Ohio Housing Finance Agency (OHFA) annual plan

The act requires the Ohio Housing Finance Agency (OHFA) to include reducing infant mortality as a priority housing need in the agency's annual plan.⁷⁹ OHFA is a state agency that administers programs to help certain individuals and families find housing.

The act also permits OHFA, not later than December 31, 2017, to establish a housing assistance pilot program intended to expand housing opportunities for extremely low-income households that include pregnant women or new mothers. If it does so, the program must (1) include rental assistance and (2) exist for at least three years. In addition, OHFA must, through a competitive bidding process, select local community entities that are involved with issues concerning housing and infant mortality reduction efforts to participate in the program. OHFA must evaluate the program's outcome and include the findings in the annual report prepared pursuant to continuing law.⁸⁰

⁷⁸ Section 5(B) and (C).

⁷⁹ R.C. 175.14(A).

⁸⁰ R.C. 175.04, not in the act, and R.C. 175.14(B).

Priority status for housing assistance and local emergency shelter

The act requires OHFA and the Ohio Development Services Agency (ODSA) to include pregnancy as a priority in its housing assistance programs and local emergency shelter programs. In consultation with ODSA, OHFA may adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) to implement this requirement.⁸¹

Commission and collaborative housing assistance program plan

The act requires that, on or before July 5, 2017, the Commission on Infant Mortality work with the Ohio Housing and Homelessness Collaborative to develop a plan for a rental housing assistance program to expand housing opportunities for extremely low-income households that include pregnant women or new mothers. (The Collaborative was established by the Governor in 2012.) The Commission and the Collaborative must submit an implementation plan to the Governor and the General Assembly by December 31, 2017.⁸²

Commission on Infant Mortality membership

The act adds to the Commission on Infant Mortality's membership the Director of Developmental Disabilities or the Director's designee. This additional member brings the Commission's total membership to 16 individuals.⁸³

ADMINISTRATION OF INJECTABLE DRUGS BY PHARMACISTS

Pharmacist authority to administer certain drugs by injection

The act authorizes a pharmacist to administer by injection any of the following drugs, if the drug has been prescribed by a physician who has an ongoing physician-patient relationship with the individual who is to receive it:

- (1) An opioid antagonist (a prescription that blocks the effects of opioids) used to treat drug addiction and administered in a long-acting or extended-release form);
- (2) An antipsychotic drug administered in a long-acting or extended-release form;

⁸¹ R.C. 175.15.

⁸² Section 9.

⁸³ R.C. 3701.68.



(3) Hydroxyprogesterone caproate (a prescription hormone used to lower the risk of preterm birth);

(4) Medroxyprogesterone acetate (a prescription contraceptive); and

(5) Cobalamin (vitamin B12).

The act also permits a pharmacist to administer epinephrine or diphenhydramine, or both, to an individual in an emergency resulting from an adverse reaction to a drug administered by injection by the pharmacist.⁸⁴ (Epinephrine is used to treat life-threatening allergic reactions, and diphenhydramine is an antihistamine used to treat allergy symptoms.)

Qualifications

To be authorized to administer drugs by injection, a pharmacist must do all of the following:⁸⁵

(1) Successfully complete a course in the administration of drugs that has been approved by the Pharmacy Board;

(2) Receive and maintain certification to perform basic life-support procedures by successfully completing a basic life-support training course certified by the American Red Cross or American Heart Association;

(3) Practice in accordance with a protocol (see below) that meets the act's requirements.

The act prohibits a pharmacist from administering drugs by injection if these requirements have not been met. It also prohibits a pharmacist from delegating to any person the pharmacist's authority to administer drugs by injection.⁸⁶

Protocol

A protocol for administration by injection must be established by a physician whose scope of practice includes treating the condition for which the individual has

⁸⁴ R.C. 4729.45(A).

⁸⁵ R.C. 4729.45(C).

⁸⁶ R.C. 4729.45(F).

been prescribed the drug. In addition, a protocol must satisfy the requirements established in rules adopted by the Pharmacy Board and must specify the following:⁸⁷

- (1) A definitive set of treatment guidelines;
- (2) Locations where a pharmacist may engage in the administration of drugs;
- (3) Procedures to be followed by a pharmacist when administering by injection, including processes for obtaining permission from the individual receiving the drug and notifying the physician who prescribed the drug, as well as the length of time and location at which the pharmacist must observe the individual receiving the drug (see below);
- (4) Procedures to be followed by a pharmacist when administering epinephrine or diphenhydramine to an individual having an adverse reaction to a drug the pharmacist administered by injection.

Requirements when administering drugs by injection

Each time the pharmacist administers a drug specified in the act by injection, the pharmacist must:⁸⁸

- (1) Obtain permission to administer the drug from the individual, the individual's parent or other person having care or charge of the individual, if the individual is under 18, or the person authorized to make health care decisions on the individual's behalf, if the individual lacks the capacity to do so;
- (2) Observe the individual to determine whether the individual has an adverse reaction to it; and
- (3) Notify the physician who prescribed the drug.

Patient tests before administering opioid antagonists

When administering an opioid antagonist, the act requires that the pharmacist obtain test results indicating that it is appropriate to administer the drug. The requirement applies when administering either (1) the initial dose or (2) any subsequent dose, if the administration occurs more than 30 days after the previous dose was administered.

⁸⁷ R.C. 4729.45(E).

⁸⁸ R.C. 4729.45(D).

The act authorizes a pharmacist to obtain the required test results as follows:⁸⁹

(1) From the prescribing physician; or

(2) By ordering blood and urine tests for the individual to whom the opioid antagonist is to be administered.

If a pharmacist orders blood and urine tests, the act requires that the pharmacist evaluate test results. It stipulates that the authority to evaluate test results does not authorize the pharmacist to make a diagnosis.⁹⁰

Pharmacy Board rulemaking

The Pharmacy Board must adopt rules governing pharmacist administration of drugs by injection, including rules addressing the following:

(1) Requirements for courses in the administration of drugs;

(2) Requirements for protocols for the administration of drugs;

(3) Procedures that a pharmacist must follow when obtaining permission from an individual to administer a drug by injection.

The rules must be adopted in accordance with the Administrative Procedure Act. The Pharmacy Board must consult with the Medical Board before adopting the rules regarding requirements for protocols.⁹¹

Medical Board rulemaking

The Medical Board must adopt rules establishing the standards and procedures that a physician must follow when prescribing a drug that may be administered by injection by a pharmacist. The rules must be adopted in accordance with the Administrative Procedure Act and in consultation with the Pharmacy Board.⁹²

⁸⁹ R.C. 4729.45(D)(2) and (E).

⁹⁰ R.C. 4729.45(E).

⁹¹ R.C. 4729.45(H).

⁹² R.C. 4731.057.

Practice of pharmacy

The act defines the "practice of pharmacy" to include engaging in the administration of drugs by injection in accordance with the act's provisions.⁹³

SAFE HAVEN LAW

Newborn safety incubators

The act changes Ohio's Safe Haven Law to allow parents to voluntarily deliver a child that is not older than 30 days to a designated newborn safety incubator. Under continuing law, parents still may voluntarily deliver the child to one of the following individuals:

(1) A peace officer on behalf of the law enforcement agency employing the officer;

(2) A hospital employee on behalf of the hospital that employs or has granted practicing privileges to the person;

(3) An emergency medical service worker that is employed by or provides services to the emergency medical service organization.⁹⁴

The act also allows a parent to deliver the child to a newborn safety incubator that has been installed within a law enforcement agency, hospital, or emergency medical service organization (such as a fire department). A parent choosing to drop off a child in a newborn safety incubator would not need to interact with or physically hand the child to the individuals designated above.⁹⁵

Rulemaking

The act requires the Director of Health, by October 3, 2017, to adopt rules in accordance with the Administrative Procedure Act regarding newborn safety incubators. The rules must provide for:

- Sanitation standards;
- Procedures to provide emergency care for a child delivered to an incubator;

⁹³ R.C. 4729.01(B).

⁹⁴ R.C. 2151.3517 (R.C. 2151.3516 under former law).

⁹⁵ R.C. 2151.3516 and 2151.3517 (R.C. 2151.3516 under former law).



- Manufacturing and manufacturer standards;
- Design and function requirements that:
 - Take into account installation at a law enforcement agency, a hospital, or an emergency medical service organization;
 - Allow a child to be placed anonymously from outside the facility;
 - Lock the incubator after a child is placed in it so that a person outside the facility is unable to access the child;
 - Provide a controlled environment for the care and protection of the child;
 - Provide notification to a centralized location in the facility within 30 seconds of a child being placed in the incubator; and
 - Trigger a 9-1-1 call if a facility does not respond within a reasonable amount of time after a child is placed in the facility's incubator.
- Operating policies, supervision, and maintenance requirements for an incubator, including requirements that only a peace officer, emergency medical service worker, or hospital employee supervise the incubator and take custody of a child placed in it;
- Qualifications for persons to install incubators;
- Procedures and forms for the registration of qualified incubator installers;
- Costs for registering and regulating incubators and fees to cover those costs;
- Creating and posting signs to be placed near or on incubators to provide information about using them;
- Enforcement of and remedies for violations for failure to comply with the requirements governing incubators;
- Any other requirement the Department considers necessary to ensure the safety and welfare of a child placed in an incubator.⁹⁶

⁹⁶ R.C. 2151.3532.

Notice to parents

Under the act, before a juvenile court holds a hearing on temporary custody of a child delivered under the Safe Haven Law, the court must give notice of the hearing to the parents in *accordance with Rule 16 of the Ohio Rules of Juvenile Procedure*.⁹⁷ The Rule governs service of process (notification) and specifically provides that when the residence of a party is unknown and cannot be ascertained with reasonable diligence, service must be made by publication. This consists of newspaper publication, by posting and mail, or a combination of the two.⁹⁸ Under previous law, when the juvenile court received a motion from the public children services agency ("PCSA") for temporary custody of a delivered child, it was required to hold an emergency hearing as soon as possible, and had to give notice of the hearing to the parents *only if the court knew the names of the parents*.

Under continuing law, when a law enforcement agency, hospital, or emergency medical service organization takes possession of a child, it must fulfill several requirements, including notifying the county PCSA.⁹⁹ Upon notification, a PCSA must then fulfill several requirements, including filing a motion with the juvenile court for temporary custody of the child to the agency or to a private child placing agency.¹⁰⁰

Entities covered

The act changes the term "governmental entity" to "entity" when referring to the law enforcement agency, hospital, or emergency medical service organization, or its respective employees, that take possession of a deserted child.¹⁰¹ This change appears to clarify that nongovernmental hospitals may also take possession of a child under the Safe Haven Law.

Providing materials

The act also clarifies that medical information forms and other information forms are to be *made available* to parents who deliver their child under the Safe Haven Law. The act also provides that no *other person* employed by a law enforcement agency, hospital, or emergency medical service organization is to coerce the parents to accept or

⁹⁷ R.C. 2151.3521 (R.C. 2151.3519 under former law).

⁹⁸ Rule 16, Ohio Rules of Juvenile Procedure, is available at <https://www.supremecourt.ohio.gov/LegalResources/Rules/juvenile/JuvenileProcedure.pdf>, not in the bill.

⁹⁹ R.C. 2151.3518 (R.C. 2151.3517 under former law).

¹⁰⁰ R.C. 2151.3519 (R.C. 2151.3518 under former law).

¹⁰¹ R.C. 2151.3525 (R.C. 2151.3523 under former law).



fill out the forms, or take any other action the employing entity or designated employee is prohibited from taking.¹⁰²

COMMENT

1. **The Healthy People 2020 Initiative** was launched by U.S. Department of Health and Human Services and monitors approximately 1,200 objectives organized into 42 topic areas, each of which represents an important public health area. At the time of the December 2010 launch, 911 objectives were measurable with baseline data and established targets.¹⁰³

2. "Healthcheck" or "Healthcek" is Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for Medicaid enrollees under age 21.¹⁰⁴

3. **The Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire** is a population-based survey designed to examine maternal behaviors and experiences before, during, and after a woman's pregnancy, as well as during the early infancy of her child. The CDC initiated PRAMS in 1987 in an effort to reduce infant mortality and the incidence of low birth weight. PRAMS was implemented in Ohio in 1999,¹⁰⁵ but was discontinued at the end of 2015.¹⁰⁶

4. **The Ohio Equity Institute** is an initiative designed by CityMatCH to strengthen the scientific focus and evidence base for realizing equity in birth outcomes. (CityMatCH is a national organization that supports urban maternal and child health efforts at the local level.) The Institute is a data-driven, high-visibility movement by nine urban Ohio communities. During a three-year span, these communities will participate and receive training to support them as they select, implement, and evaluate equity-focused projects.¹⁰⁷

¹⁰² R.C. 2151.3528, 2151.3530, and 2151.3534 (R.C. 2151.3525, 2151.3527, and 2151.3529 under former law, respectively).

¹⁰³ U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, *Healthy People 2020*, available at www.cdc.gov/nchs/healthy_people/hp2020.htm.

¹⁰⁴ Ohio Department of Medicaid, *Healthcek Services for Children Younger than Age 21*, available at <http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthcek.aspx>.

¹⁰⁵ Ohio Department of Health, *Ohio Pregnancy Risk Assessment Monitoring System*, available at <https://www.odh.ohio.gov/healthstats/pramshs/prams1.aspx>.

¹⁰⁶ Electronic and telephone correspondence from ODH staff (January 8, 2016).

¹⁰⁷ Ohio Department of Health, www.odh.ohio.gov/odhprograms/cfhs/oei/Ohio%20Equity%20Institute%20Homepage.aspx.



5. **The Cribs for Kids Program**, administered by ODH, distributes cribs and infant safe sleep education materials through local and regional health departments to families who meet income eligibility requirements for the WIC program.¹⁰⁸

6. **The Maternal and Child Health (MHC) Block Grant**, authorized by Title V of the Social Security Act (42 U.S.C. 701), authorizes a wide array of direct services to individuals and population-based programs that serve everyone in a community. A formula is used to determine funding allocations based on population size and need.¹⁰⁹

HISTORY

ACTION	DATE
Introduced	05-17-16
Reported, S. Health & Human Services	09-28-16
Passed Senate (29-1)	09-28-16
Reported, H. Finance	12-07-16
Passed House (87-7)	12-07-16
Senate concurred in House amendments (31-1)	12-07-16

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¹⁰⁸ Ohio Department of Health, *Ohio Department of Health Infant Vitality: Cribs for Kids Partners*, available at www.odh.ohio.gov/~media/ODH/ASSETS/Files/infant%20safe%20sleep/ODH%20Cribs%20for%20Kids%20Partners.ashx.

¹⁰⁹ Association of Maternal and Child Health Programs, *75 Years of Title V: Maternal and Child Health Services Block Grant*, available at www.amchp.org/AboutTitleV/Documents/Celebrating-the-Legacy.pdf.

