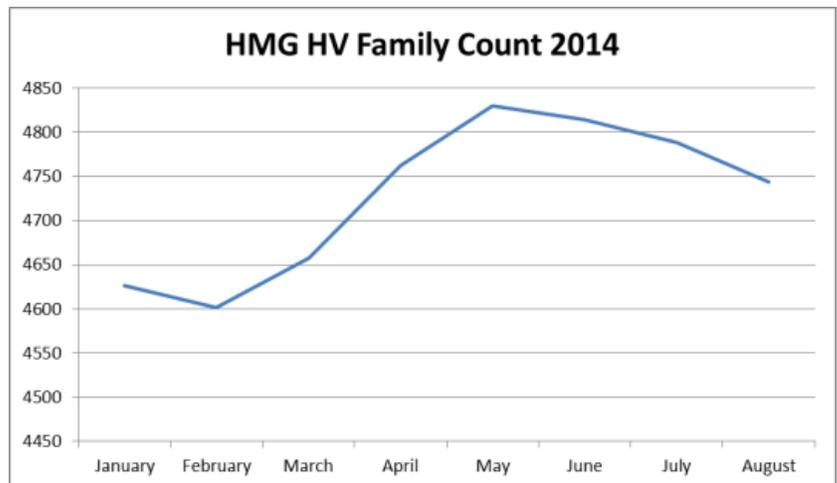


BUREAU FOR CHILDREN WITH DEVELOPMENTAL AND SPECIAL HEALTH NEEDS
HELP ME GROW HOME VISITING Technical Assistance CALL
September 25, 2015



Family Counts

- January 2014 4,626
- February 2014 4,601
- March 2014 4,657
- April 2014 4,762
- May 2014 4,830
- June 2014 4,814
- July 2014 4,788
- August 2014 4,474



“Tool Time”

Edinburgh Postnatal Depression Scale (EPDS)

Please refer to the EPDS handout.

BUREAU FOR CHILDREN WITH DEVELOPMENTAL AND SPECIAL HEALTH NEEDS
HELP ME GROW HOME VISITING Technical Assistance CALL
September 25, 2015

Supervisor's Day Summary

The Help Me Grow Home Visiting Team wants to thank all of the supervisors who attended our first (and not last) day to support the great work supervisors do every day to support the home visiting program. Over 100 people attended and provided us with a lot to think about and some action steps to take. Here is a summary of the key points ODH will be following up on in the next several months:

- Outreach vs. Capacity
- How to use ET as a tool in supervision
- Communication strategy from ODH to supervisors
- Specific outcome trainings
- Specific model quality assistance
- Doing a better job at answering “why”
- Support agency capacity building
- Individualized agency webinars
- ODH support of supervisors (reflective supervision)
- Standardized data collection forms
- TA repository (SharePoint)

By the Numbers

Program and the Research and Data team have been working to provide you with the most useful information regarding program implementation and participant outcomes. The following data will soon be available to you from ODH specific to your agency:

- Point in time family counts will also include agency capacity
- Program referrals for HMG HV only (pull out MIECHV)
- Source of program referral compared to state averages
- Tool compliance
- Days to first visit
- Months in program
- Visits per family
- Outcomes
 - Smoking Cessation
 - Preterm births
 - Low birth weight
 - Maternal Depression
 - Breastfeeding

BUREAU FOR CHILDREN WITH DEVELOPMENTAL AND SPECIAL HEALTH NEEDS
HELP ME GROW HOME VISITING Technical Assistance CALL
September 25, 2015

Technical Assistance

The Help Me Grow Home Visiting Team is here for you!!

Please access your Program Consultant to answer any implementation, eligibility, rule, or other program related question. The best and most accurate answers come from the source! While we encourage networking between sites, and recognize that there are venues for you to solicit information, these alternative information sources are not operated by ODH/HMG and are not vetted for accuracy.

Ohio Home Visiting Collaborative Learning Network

We are excited to announce the formation of the Ohio Home Visiting Collaborative Learning Network (HVCLN). Eight Help Me Grow Home Visiting providers have been invited to participate in this pilot effort to help us learn how to design and implement a collaborative network among home visiting agencies in Ohio. We will learn from shared experience and use quality improvement methods to identify strategies that can optimize:

- The time from referral to first visit
- The length of time families are enrolled
- The average number of visits per family

The Ohio Department of Health is working with the Anderson Center for Health Systems Excellence at the Cincinnati Children's Hospital Medical Center. Their project team includes talented individuals with expertise in quality improvement, home visiting, pediatrics and neonatology. The Cincinnati Children's team will design and manage the project as well as summarize learning among the home visiting agency teams.

This Collaborative pilot will begin over the next month and conclude before the end of the fiscal year.

Regional Meetings

We look forward to seeing you at one of the upcoming Help Me Grow Home Visiting regional meetings. The theme of the meetings is "Moving from TA to QA." Each meeting will be held from 9:30 a.m. to 4:00 p.m. You are welcome to choose any one of the dates that fits your schedule.

Who should attend: 1) Central Coordination Contractor Managers; 2) At least one Central Coordination Contract Worker (but as many as you wish); 3) All HMG Home Visiting Contract Managers; 4) All HMG Home Visiting Supervisors; and, 5) At least one HMG Home Visitor per agency (but as many as you

BUREAU FOR CHILDREN WITH DEVELOPMENTAL AND SPECIAL HEALTH NEEDS
HELP ME GROW HOME VISITING Technical Assistance CALL
September 25, 2015

wish). Please communicate with your staff to make sure that you have full representation. Each individual will have to register for themselves through the Survey Monkey link below.

<https://www.surveymonkey.com/s/Y7W6TMK>

Please submit your information within one week of the session you wish to attend.

Please note the changes to some of the regional meeting dates.

September 24	Butler County	CANCELLED: Please plan on attending the meeting in Montgomery County
October 9	Guernsey County	Guernsey County BODD
October 15	Summit County	Main Library
October 16	Cuyahoga County	Parma Library
October 21	Putnam County	Putnam County ESC
October 23	Holmes County	Holmes County Training Center
November 18	Franklin County	Columbus Public Health
November 20	Montgomery County	Dayton Jobs Center

In addition to ODH updates, your input on program implementation, rules updates, and strategic plans...everyone who attends will receive a fun prize!!



Prenatal Alcohol Use

Fetal alcohol exposure occurs when a woman drinks any type of alcohol (beer, wine, liquor, etc.) during pregnancy. Alcohol use during pregnancy is the only 100 percent preventable cause of birth defects, including intellectual disabilities, neuro-developmental disorders and Fetal Alcohol Spectrum Disorders (FASD). FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy, with Fetal Alcohol Syndrome (FAS) being the most severe diagnosis. The Centers for Disease Control & Prevention (CDC) report that 0.2 to 1.5 cases of FAS occur for every 1,000 live births in certain areas of the U.S. Some researchers estimate FASD rates as high as 9 or 10 per 1,000.¹

There is no cure for FASD. FASD is an irreversible, lifelong condition that can become apparent at any time during childhood. It affects every aspect of a child's life and the lives of the child's family.

How Alcohol Affects the Developing Fetus

By Trimester

- **1st:** Alcohol interferes with the formation and organization of a baby's brain cells.²
- **2nd:** Facial features related to alcohol exposure begin to appear.³
- **3rd:** Memory systems are affected, leading to problems with reading and math skills.⁴

Deficits

- **Central nervous system:** Poor fine and gross motor coordination. A range of learning disabilities, intellectual disabilities, developmental disabilities, speech and language problems, memory and processing problems, and attention problems.
- **Growth:** Low birth weight and/or short birth length and ongoing growth retardation.
- **Appearance:** Small eye openings, a flattened ridge between the mouth and nose and a thin upper lip.

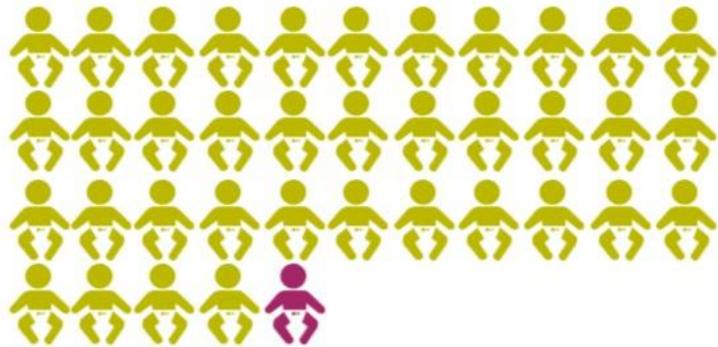
Long-term

- **Lifelong services** are often needed such as education, vocational, residential and/or social supports.
- Babies were at least **seven times more likely to die from sudden infant death syndrome** when born to mothers diagnosed with an alcohol-use disorder (while pregnant or during the baby's first year) versus born to non-alcoholic mothers.⁵

Estimated Costs of FASD in Ohio^{6*}

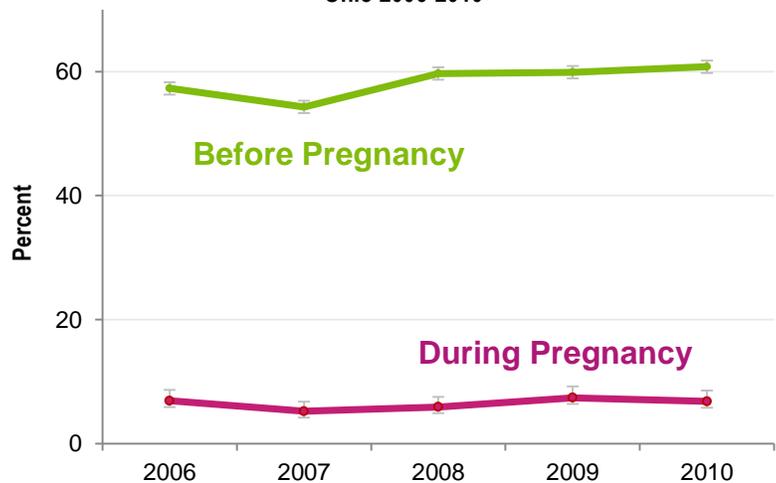
- \$50,364,720 in annual costs for special education and juvenile justice for children aged 5-18 years with FAS.
- 89 babies born with FAS each year.
- 1,193 babies are born with FASD each year.

ONLY 1 IN 38 OHIOANS LIVING WITH FASD ARE CLINICALLY DIAGNOSED



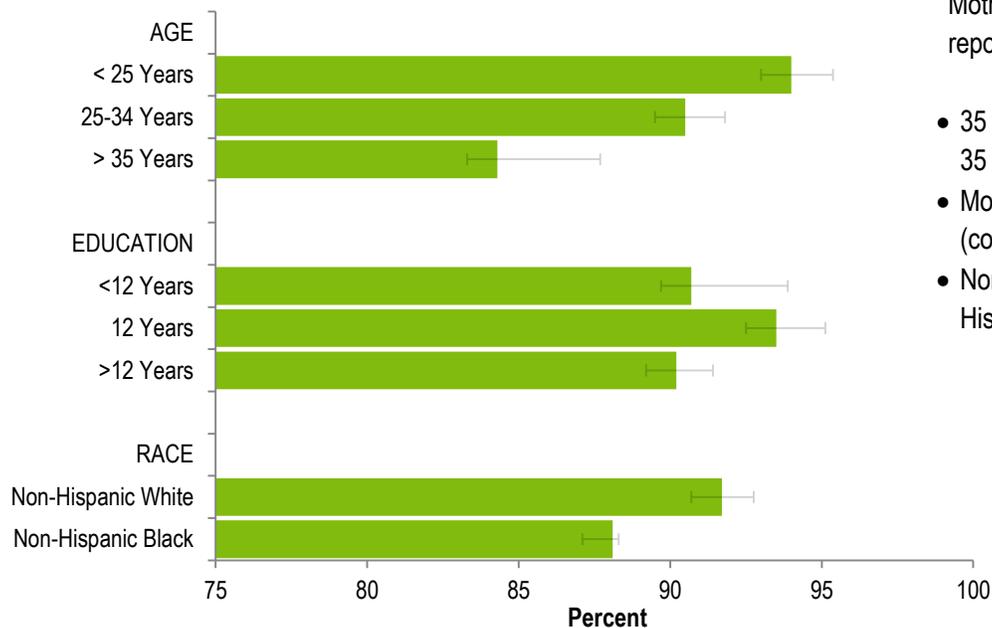
- An estimated 114,000 Ohioans live with FASD.
- Most cases of FASD go undiagnosed due to a combination of factors.

Women Having a Live Birth Who Reported Alcohol Use 3 Months Before Pregnancy** and Who Reported Alcohol Use During the Last 3 Months of Pregnancy, By Year, Ohio 2006-2010[†]



- Close to 60 percent of Ohio mothers reported drinking three months before pregnancy.
- Approximately 7 percent of mothers reported drinking during the last three months of pregnancy.
- Alcohol use has not changed significantly from 2006-2010, before or during pregnancy.

Women Having a Live Birth Who Reported NO Alcoholic Drinks in an Average Week During the Last 3 Months of Pregnancy, by Demographics, Ohio 2006-2011†



Mothers within these groups less often reported NO alcohol use during pregnancy:

- 35 years or older (compared to less than 35 years old)
- More than a high school education (compared to 12 years)
- Non-Hispanic Black (compared to non-Hispanic White)

There is no safe amount and no safe time to drink alcohol during pregnancy.

NOT A SINGLE DROP!

Source: Ohio Pregnancy Risk Assessment Monitoring System. Ohio Department of Health



State and Local Efforts to Address FASD

Not a Single Drop is Ohio's FASD initiative. The FASD Steering Committee efforts are led by the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, and the Ohio Department of Developmental Disabilities. The mission of the steering committee is to integrate FASD activities into existing agency and program systems. The goals of the initiative are to increase availability of services for those affected by FASD; increase awareness about the risks for alcohol use during pregnancy; provide FASD-specific education and training for agencies, organizations and professionals who provide services to children and families with or at risk of FASD; to adopt appropriate FASD screening tools and protocols and increase access to screening; and to create and implement a data system to track FASD risk factors, prevalence and incidence in Ohio. The website provides information, fact sheets, evidence-based practices for screening and diagnosis, living with FASD and resources: <https://notasingledrop.mh.state.oh.us/>

Alcohol Screening and Brief Intervention (ASBI): Since September 2008, Ohio's Montgomery County WIC Program has practiced the ASBI process. It is a process modeled after a similar program in California, which screens all pregnant WIC participants for alcohol use, provides brief interventions to all who screen positive, follows those receiving brief interventions during pregnancy and, if needed, refers them to treatment services. The Ohio WIC Program and the Montgomery County WIC Program developed the ASBI process for all Ohio WIC projects, which can be adapted in other maternal and child health programs and settings. The Ohio Department of Health WIC ASBI website provides information, tools, and other resources: <http://www.odh.ohio.gov/odhprograms/ns/wicn/Alcohol%20Screening%20and%20Brief%20Intervention.aspx>

Data Notes:

- * 2012 Ohio Births and Population were used in the calculations as well as the mean of CDC's FAS rates of 0.2-1.5 cases of FAS/1,000 live births
- ** Measure of alcohol use sometimes used as proxy for alcohol use during very early pregnancy
- † Grey bars within figures represent 95% confidence intervals (CI). The width of the CI gives us an idea of how certain we are about the true prevalence. The 95% CI means that if this study was repeated 100 times, 95 of the intervals generated would contain the true estimate.

References:

- 1 Fetal Alcohol Spectrum Disorders Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice, 2009
- 2 Claren, Streissguth, Journal of Pediatrics, 92(1):64-67
- 3 Early-Human-Development; 1983 Jul Vol.8(2)99-111
- 4 Coles, Neurotoxicology and Teratology, 13:357-367, 1991
- 5 O'Leary, C. Pediatrics, 2013;doi:10.1542/peds.2012-1907
- 6 Burd, L., Fetal Alcohol Syndrome Online-Clinic: Prevalence & Cost Calculator, North Dakota Fetal Alcohol Syndrome Center, 2011 May, <http://www.online-clinic.com/calcs/calc-prev-cost.aspx>

Data Contact: Sierra Mullen
sierra.mullen@odh.ohio.gov

Program Contact: Anna Starr
anna.starr@odh.ohio.gov



www.odh.ohio.gov



Information for Health Care Providers and Public Health Professionals: Preventing Tobacco Use During Pregnancy



Box 1:

CDC's Tips From Former Smokers

Watch or read real stories from mothers who quit smoking or whose children are affected by tobacco smoke at www.cdc.gov/tobacco/campaign/tips/

- » *Amanda tried hard to quit smoking while she was pregnant, but she was unable to overcome her addiction to cigarettes.*
- » *Beatrice is a mother of two boys. She has no health problems but quit smoking with support from friends and family.*
- » *Tiffany quit smoking because her mother died of cancer when Tiffany was 16. She could not bear the idea of missing out on her own daughter's life.*
- » *Jessica never smoked but her son has severe asthma triggered by secondhand smoke exposure.*

What are the health effects of tobacco use on pregnancy?

Smoking during pregnancy remains one of the most common preventable causes of pregnancy complications and of illness and death among infants. Women who quit smoking before or during pregnancy reduce their risk for poor pregnancy outcomes.

Compared with nonsmokers, women who smoke before pregnancy are about twice as likely to experience the following conditions:

- Delay in conception
- Infertility
- Ectopic pregnancy
- Premature rupture of the membranes
- Placental abruption
- Placenta previa

Compared with babies born to nonsmokers, babies born to women who smoke during pregnancy are more likely to be:

- Premature
- Low birth weight
- Small for gestational age or fetal growth restricted
- Born with a cleft lip, or cleft palate, or both
- They are also more likely to die of SIDS (Sudden Infant Death Syndrome)

All tobacco products that are burned contain nicotine and carbon monoxide. These are harmful during pregnancy. These products include cigarettes, little cigars, cigarillos, and hookah.

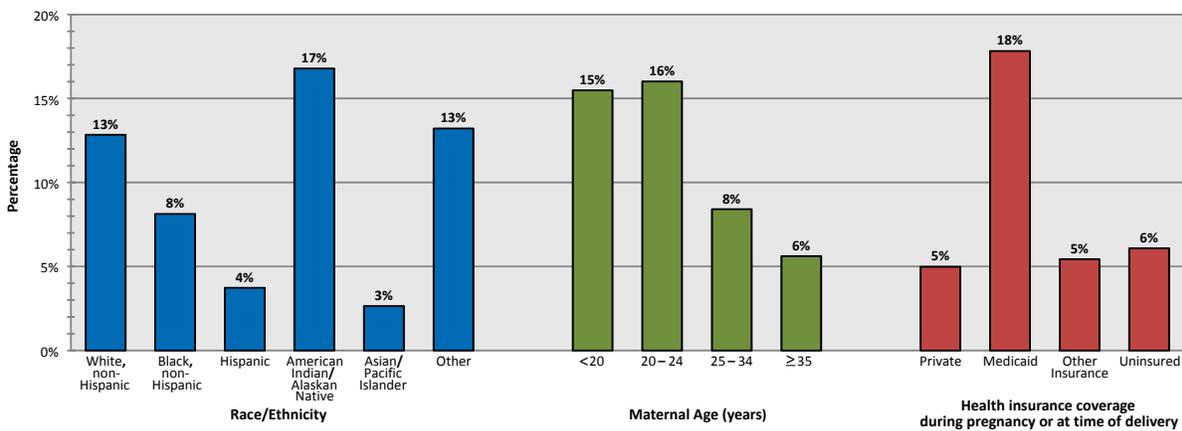
What is the prevalence of smoking before, during, and after pregnancy?

CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) monitors the prevalence of smoking before, during, and after pregnancy based on a mother's self-report. In 2011, data from 24 states (representing about 40% of US live births) showed:

Before pregnancy

- About 23% of women smoked during the 3 months before pregnancy.

Figure 1. Prevalence of smoking during the last 3 months of pregnancy by demographic characteristics and insurance status - 24 PRAMS states, 2011



During pregnancy

- About 10% of women smoked during the last 3 months of pregnancy.
- Groups who reported the highest prevalence of smoking during pregnancy included (Figure 1)
 - American Indians/Alaska Natives.
 - Those younger than 25 years of age.
 - Those with 12 years of education or less.
- Women enrolled in Medicaid were three times more likely to smoke than women with private insurance. (Figure 1)
- About 55% of women who smoked before pregnancy reported they quit smoking by the last 3 months of pregnancy.

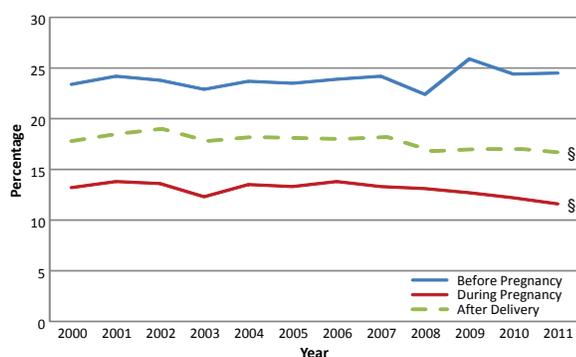
Smoking after pregnancy

- Of those who quit smoking during pregnancy, 40% relapsed within 6 months after delivery.

Trends from 2000–2011 (data from 9 states)

- The prevalence of smoking in the 3 months before pregnancy did not change. About 1 in 4 women smoked before pregnancy.
- The prevalence of smoking declined in the last 3 months of pregnancy (13.2% to 11.6%) and after delivery (17.8% to 16.6%). (Figure 2)

Figure 2. Trends of smoking before pregnancy, during pregnancy, and after delivery, 9 PRAMS states, 2000–2011



§ Significant decreased linear trend at $p \leq 0.05$.

What about products that don't burn, like electronic cigarettes and smokeless tobacco?

Women may perceive tobacco products that don't burn to be safer than smoking cigarettes. In addition, the use of electronic cigarettes —also referred to as e-pens, e-hookah, tanks, or vape pens—is increasing rapidly among youth and adults.

- All tobacco products contain nicotine, which is a reproductive toxicant and has adverse effects on fetal brain development.
- Pregnant women and women of reproductive age should be cautioned about the use of nicotine-containing products, such as electronic cigarettes, as alternatives to smoking. The health effects of using electronic cigarettes before or during pregnancy have not been studied.
- Electronic cigarettes are not regulated and have not been shown to be a safe and effective cessation aid in smokers.
- The use of smokeless tobacco products, such as snus, during pregnancy has been associated with preterm delivery, stillbirth, and infant apnea.
- There are a number of FDA-approved smoking cessation aids, including nicotine replacement therapies (NRT), that are available for the general population of smokers to use to reduce their dependence on nicotine.
- Pregnant women who haven't been able to quit smoking on their own or with counseling can discuss the risks and benefits of using cessation products, such as NRT, with their health care provider.

What works to help pregnant women quit smoking?

Counseling by health care providers

The majority of pregnant women receive prenatal care. Prenatal care visits provide a valuable opportunity to address women's smoking behavior.

- Pregnancy-specific counseling (e.g., counseling based on the 5A's model) increases smoking cessation in pregnant women. Steps of the 5A's include the following:
 - Ask the patient about tobacco use at first prenatal visit and follow up at subsequent visits.
 - Advise the patient to quit.
 - Assess the patient's willingness to quit.
 - Assist the patient by providing resources.
 - Arrange follow-up visits to track the progress of the patient's attempt to quit.
- If women are unable to quit on their own or with counseling, ACOG (American College of Obstetricians and Gynecologists) recommends that nicotine replacement therapies be considered under the close supervision of a provider.
- Quitlines can be used to support pregnant smokers in their goal to quit. Quitline counseling is available in every state, easy to use, and generally provided at no cost to the user.
- Health care system changes, such as provider reminders and documentation of tobacco status and cessation interventions, can increase the number of patients who quit.

Population-based interventions

State and community tobacco control interventions that promote tobacco cessation, prevent tobacco initiation, and reduce secondhand smoke not only reduce smoking prevalence in the general population, but also decrease prevalence in pregnant women.

- A \$1.00 increase in cigarette taxes increased quit rates among pregnant women by 5 percentage points. Higher cigarette prices also reduced the number of women who start smoking again after delivery.
- Full smoking bans in private work sites can increase the number of women who quit during pregnancy by about 5 percentage points.
- Expanded Medicaid tobacco-cessation coverage increased quitting by almost 2 percentage points in women who smoked before pregnancy.

What about cutting back the number of cigarettes smoked without quitting?

Pregnant women should be advised that complete cessation has the most health benefits by far, and any amount of smoking can be harmful to the fetus. Studies support that cutting down without quitting before the third trimester of pregnancy may improve fetal growth. However, smoking has many other health effects and the potential benefits of simply reducing the number of cigarettes smoked without quitting should be weighed against the following:

- Nicotine is a reproductive toxicant and has been found to contribute to adverse effects of smoking on pregnancy including preterm birth and stillbirth.
- Nicotine has lasting adverse effects on fetal brain development.
- Nicotine is believed to affect fetal lung development and to contribute to the risk of SIDS.
- Smoking most likely affects fetal growth through products of combustion, such as carbon monoxide (CO). There are more than 7,000 other chemicals in tobacco smoke, many of which could also affect fetal health.
- Fetal growth cannot be viewed as a measure of other health effects. It is unknown whether reducing the number of cigarettes smoked improves outcomes other than fetal growth.



What can be done?

Doctors, midwives, nurses, and other health care providers can

- Ask all pregnant women about their tobacco use (cigarettes, cigars, little cigars, cigarillos, hookah, smokeless, and electronic cigarettes) and provide nonjudgmental support for women who want to quit. An interactive Web-based program teaches best-practice approaches to help pregnant smokers and women of reproductive age to quit. This program is endorsed by CDC and ACOG and is available for continuing education credits. www.smokingcessationandpregnancy.org
- Refer pregnant women to their state quitline, **1-800-QUIT-NOW (1-800-784-8669)**. Quitlines provide special services and counseling for pregnant and postpartum women. Follow up with pregnant women to make sure they have initiated counseling.
- Share and use resources from the *Tips from Former Smokers* campaign such as posters, videos, and factsheets (see Box 1). www.cdc.gov/tobacco/campaign/tips/resources/

Public health professionals can

- Link health systems and organizations that serve women who are at high risk for smoking during pregnancy with available resources. An interactive Web-based program teaches best-practice approaches to help pregnant smokers and women of reproductive age to quit. www.smokingcessationandpregnancy.org
- Educate providers and pregnant women on tobacco cessation coverage benefits and services available in your state. As of October 2010, states are to provide tobacco cessation counseling and medication without cost sharing for pregnant Medicaid beneficiaries. www.medicaid.gov
- Monitor your state's prenatal smoking prevalence from CDC PONDER. apps.nccd.cdc.gov/cPONDER/

Women can

- Quit smoking before you get pregnant, which is best.
- If you are pregnant, quit smoking to help reduce your and your baby's risk of health problems. It's never too late to quit smoking. Don't start smoking again after your baby is born. Find tips on quitting smoking. women.smokefree.gov/
- Talk with your doctor, nurse, or health care professional about quitting. For additional support, call the quitline at **1-800-QUIT-NOW (1-800-784-8669)**. The quitline provides special resources for pregnant women.
- Watch or read real stories from mothers who quit smoking or whose children are affected by tobacco smoke (see Box 1).
- Learn more online about the effects of smoking during pregnancy. www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/



Family and friends can

- Be supportive and nonjudgmental.
- If you smoke, don't smoke around the expecting mother. Better yet, show your support and quit smoking yourself. It will benefit your health as well as hers.
- Let the expecting mother know about support from the quitline **1-800-QUIT-NOW (1-800-784-8669)**. The quitline provides special resources for pregnant women.
- Tell her about real stories from mothers who quit smoking or whose children are affected by tobacco smoke (see Box 1).
- Learn more online about the health risks of smoking. www.cdc.gov/tobacco