Senate Bill 332: Access Barrier Assessment

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Access Barrier Assessment

Initial Review & Proposed Strategy

Introduction

The Ohio Department of Medicaid (ODM) provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, elderly, parents, and other adults. In 2016, ODM, insured approximately three million individuals[1] and paid for fifty–two percent of all Ohio births. As the largest payer for health care services in Ohio, ODM is committed to ensuring that all Medicaid insured women of reproductive age (15 – 44 years old) have access to evidence-based interventions aimed at optimizing birth and other health outcomes. This includes reducing the percentage of infants born prematurely, and the associated risk of mortality during the first year of life.

Although, the state Infant mortality rate (IMR) has declined since 1990, Ohio still ranks higher than 38 other states in the nation. The infant mortality rate among African American infants is even higher than the state IMR: in 2015, African American infants died at nearly three times the rate of white infants (IMRs of 15.1 and 5.5, respectively)[2]. The Ohio Department of Medicaid is dedicated to reducing this health disparity and offer programming that systemically removes barriers.

Pursuant to the Ohio Infant Mortality Bill – Senate Bill 332 – ODM is required to assess barriers that women of reproductive age experience when accessing interventions intended to reduce tobacco use, prevent prematurity, and promote birth spacing. ODM will submit this initial report of findings and then semiannually thereafter to the Ohio Commission on Infant Mortality, Joint Medicaid oversight committee and general assembly.

Individuals insured by ODM are currently covered through one of two delivery systems: fee-for-service (FFS), in which providers receive reimbursement for each service delivered, or through a capitated arrangement in which Medicaid contracts with managed care plans (MCPs) to coordinate services in order to optimize patient outcomes. In 2017, approximately ninety-five percent of Medicaid beneficiaries were enrolled in one of Ohio's Medicaid's six contracted MCPs[3], allowing them access to value-add benefits, such as care management, health and wellness programs, and transportation.

Based on the high percentage of individuals enrolled with an MCP, ODM and its contracted managed care plans are uniquely situated to partner with clinicians, local health districts, community workers and other entities in efforts to remove barriers to interventions those aimed at reducing tobacco use, preventing prematurity, and promoting optimal birth spacing. Ohio Medicaid and its six contracted managed care plans recognize that Social Determinants of Health (SDOH) will be captured in addressing root cause barriers to interventions. This barriers assessment is an opportunity to systematically identify and report the specific socioeconomic conditions Medicaid beneficiaries experience when trying to gain full access to tobacco cessation, birth spacing and prenatal care interventions. Housing, food security,

[1] The Ohio Department of Medicaid Report on Pregnant Women, Infants, and Children (Submitted February 14, 2017).

[2] MMCP Progress in Infant Mortality Initiatives in Priority Communities and Implementing Enhanced Care Management Services –SY 2016 and 2017 Update http://medicaid.ohio.gov/Portals/0/Resources/Reports/Medicaid-Infant-Mortality-Report-SFY16-17.pdf?ver=2017-04-04-083510-400

[3] The Ohio Department of Medicaid Statewide Managed Care Enrollment & Eligibility Summary, http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx. Accessed 4 January 2018.

transportation, family and social support, employment, education, intimate partner violence and criminal justice involvement are all major socioeconomic conditions we know individual members experience. Capturing population and intervention specific SDOH provides both the MCPs and ODM the opportunity to continue to work collaboratively to address community needs. In order to best target efforts at barrier reduction, ODM must first obtain information regarding the prevalence and distribution of barriers, as well as their root cause(s).

Methods to Identify Access to Care Barriers

Historically, ODM has learned about barriers to care through several different sources, including: feedback from Medicaid providers and provider associations, surveys, sister agency and other stakeholder input, and administrative data. These methods have provided ODM with a vast amount of information regarding access to general Medicaid services, but have not organized that information in a structured or analyzable framework. In addition, the amount of information specific to the barriers encountered by women of reproductive age, particularly in relation to their access to interventions aimed at reducing tobacco use, preventing prematurity and promoting optimal birth spacing has been limited with few opportunities to drill down to root cause.

The table below provides a more detailed summary of current methods of determining barriers to interventions and the paragraphs that follow put forth the argument for a more structured future approach to barrier identification from the member perspective.

(Please see table below)

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Table: 1

Ohio Department of Medicaid's Current Barrier Identification Methods		
Provider Perspective		
Method	**Description**	**Limitations**
Pregnancy Risk Assessment Form (PRAF)	ODM receives information on barriers to pregnant women through the use of the pregnancy risk assessment form (PRAF). This form allows providers of prenatal services to alert the MCPs and ODM of unmet needs, both medical and social (such as the need for progesterone, tobacco cessation counseling, and transportation). It also prevents loss of Medicaid coverage during pregnancy by alerting the counties of pregnancy so that eligibility redetermination does not occur during this critical time period.	• Provides a clinical assessment of barriers to care, not the patient journey • Is not representative of post-partum or preconception health barriers to care
Provider Association Feedback	ODM takes provider feedback into consideration when assessing its policies and processes. Involvement with entities and provider associations such as Ohio Perinatal Quality Collaborative (OPQC), Ohio Collaborative to Prevent Infant Mortality (OCPIM the Ohio chapter of the American Congress of Obstetricians and Gynecologists (ACOG), and other local organizations such as, Ohio Better Birth Outcomes (OBBO) can provide ODM with insight into access barriers women of reproductive age experience to care. ODM can then work with internal and external entities to address these barriers.	• Does not capture the individual beneficiaries access barrier to care • Missing components specific to SB 332: Tobacco cessation, birth spacing and prenatal care barriers to care • No systematic record of findings
Direct Communication with ODM	ODM allows individuals to directly communicate with Medicaid through the Ohio Medicaid website. Questions are then routed to the appropriate	• Not inclusive of three intended interventions: Tobacco Cessation, birth spacing and prenatal care barriers to care

	mailbox. Examples of internal mailboxes to which questions are routed include those dealing with hospital, non-institutional, and eligibility policy. The progesterone Performance Improvement Project email box provides a direct route for providers of pregnancy services to alert ODM of any barriers to assessing progesterone for their patients. Most common barriers identified include loss of coverage and miscommunication between entities such as managed care plans, home health, and pharmacy. This email box is monitored on a daily basis and identified barriers are prioritized for resolution. ODM has many open forums. Groups convened by ODM policy and discussions with clinical entities are a few examples.	• Limited Medicaid beneficiary input
Consumer Surveys		
Method	**Description**	**Limitations**
Ohio Pregnancy Assessment Survey (OPAS) Administered by the Ohio Colleges of Medicine Government Resource Center (GRC)	Captures questions pertaining to pregnancy and pregnancy related services of the individual member before, during and after pregnancy. Data collected from OPAS provide useful information to improve the health of both the mother and infant. OPAS ask questions about lifestyle and behavioral choices associated with birth spacing, prenatal care and use of tobacco or other drugs at preconception, conception and postpartum health. In 2016, the overall response rate of the OPAS survey was at 31.4%.	• Information does not provide individual perceptions of barriers to care in assessing Medicaid services.
Ohio Medicaid Assessment Survey (OMAS)	Ohio-specific assessment that provides population health data with regard to health care access, utilization, and health status information about residential Ohioans at the state, regional and local levels, with a concentration on Ohio's Medicaid,	• Data is not specific to barriers to care women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention.

	Medicaid-eligible, and non-Medicaid populations . OMAS informs internal and external entities of Medicaid beneficiary health and healthcare status. Beneficiaries are randomly selected and called to answer a series of questions pertaining to their health. OMAS dashboard offers useful data on both Medicaid and non-Medicaid insured members based on age, gender, location and demographics. In 2015, 42,000 adults and 10,000 children were interviewed.	
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Ohio Medicaid MCPs are required to conduct annual surveys to assess member experience and satisfaction with care. All five MCPs randomly select and survey both adults and children regarding general access to services. CAHPS survey is useful in providing beneficiary insight about receiving tobacco cessation services. Several CAHPS survey questions ask the consumer if her provider talked to about quitting, receiving tobacco cessation counseling, medication assistance, and/or tobacco cessation strategies.	• Representative of the whole Medicaid Population • Not specific to women of reproductive age • Does not include questions pertaining barriers to care for birth spacing or prematurity prevention
Data Review and Reporting		
Methods	**Description**	**Limitations**
Pregnant Women Infants and Children (PWIC) Report	Every year, Ohio Medicaid reports on its effectiveness in meeting the healthcare needs of low-income pregnant women, infants and children. The report includes demographic information, birth outcomes and risk factors, utilization information, behavioral health, and information on the average cost of deliveries, prenatal care and the first year of infant life.	• Does not capture individual member perception of barriers to care

Maternal and Infant Health Measures: Medicaid Quarterly Dashboards	ODM creates quarterly infant mortality dashboards which include longitudinal statewide and community-specific data related to infant mortality by race and ethnic group. This data includes rates of preterm and very preterm birth, low birth weight, very low birth weight, infant mortality, prenatal care, postpartum visits, progesterone use, tobacco cessation, moderate to most effective forms of contraception, and adolescent well care visits. This data shows trends over time and is stratified by rural vs. urban, managed care plan, county and race, and can provide insight into whether outcomes are claims based nature.	• Does not capture individual member perception of barriers to care
FFS Ohio Access Monitoring Review Plan (AMRP)	Ohio developed an access monitoring review plan (AMRP) to assess FFS access to care within the following service categories: primary care services, including dental care; physician specialist services; behavioral health services; pre-and post-natal obstetric services, including labor and deliver; and home health services. The AMRP assessed FFS recipients' access to obstetrics and gynecology services by examining provider availability, Medicaid service utilization, and whether patient needs were met.	• Limited to FFS Medicaid population • Does not assess Medicaid interventions of tobacco cessation, birth spacing or prenatal care • Does not capture the individual members perspective of barriers to care
Enhanced Maternal Care File	Analyses conducted by ODM and its Managed Care plans have shown that pregnant women are often unable to access the prenatal care needed to reduce the probability of a poor birth outcome due to late identification of pregnancy. In order to aid its MCPs in more efficiently identifying women at risk of poor outcomes so that outreach and care can occur before the member becomes pregnant	• Strictly a data source and does not capture the individual's perspective of barriers to care

	again, ODM provides MCPs with monthly files that link Medicaid claims and vital statistics data. This data, along enrollment files, allow the MCPs to identify members who had a previous poor outcome and engage with them to build trust, reduce barriers to care, ensure their needs are met, assist with planning toward reproductive goals, and connect them with needed services and supports.	
Administrative Processes		
Method	**Description**	**Limitations**
Ohio Consumer Hotline	ODMs Ohio Consumer Hotline provides individuals eligible for or insured by Medicaid with direct access to a live person to provide assistance with covered services, explaining Medicaid benefits, completing Medicaid applications, and locating a Medicaid health care provider. This service is available to Ohio residents during normal business hours six days a week. The majority of calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. These calls are tracked and repeat callers seeking assistance in locating the same type of provider are flagged as this might indicate a potential access issue.	• Non categorical tracking • Not specific to tobacco cessation, birth spacing or prenatal care • Does not provide an overall annual standardized report of findings • Cumbersome • Does not capture the individual Medicaid beneficiary perspective of barriers to care
Public Comment on Medicaid Policy Changes	Ohio Administrative Code (OAC) rule filing process was designed to obtain information from providers and beneficiaries. Both have an opportunity to inform the content of Medicaid policies influencing the availability of these interventions through the Ohio Administrative Code rule filing process. Whenever a rule is considered for adoption, revision on rescission, ODM releases a public	• Does not capture individual member perspective on preventive interventions targeting tobacco cessation, prematurity prevention and safe spacing.

	hearing notice. The notice includes the date and time of public hearing. Copies of proposed rules are available on the internet at http://www.registerofohio.state.ohio.us but can also be obtained by faxing the Ohio Department of Medicaid's Office of Legal Counsel (614-995-1301) or by emailing rules@medicaid.ohio.gov.	
Managed Care Plan Grievance Systems	All ODM contracted managed care plans are required to ensure that members have and are informed of their right to file grievances, appeals or request a state hearing. This includes the process by which members may file grievances with the plan to express their dissatisfaction with any aspect of the plan's or provider's operation or provision of health services, activities or behaviors; the process by which members may file appeals with the plan to request its review of an action, and the process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS).	• Grievances are not captured in a categorical systematic method • Data is not specific to barriers women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention
Ohio's Medical Care Advisory Committee (MCAC)	The Medical Care Advisory Committee (MCAC) advises Ohio Medicaid in the development and refinement of the Medicaid program by serving as an advisory group giving Ohio Medicaid feedback on current and evolving issues in Medicaid. Advocates, service providers, and public agencies strive to work together and share their experience and knowledge to maximize the care available to low-income Ohioans.	• Does not assess individual member • Data is not specific to barriers of care women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention • Non categorical tracking

HealthChek and Pregnancy Related Services Information – County Department of Job and Family Services	Each Ohio County Department of Job and Family Services agency is required to have a Pregnancy Related Services (PRS) and Healthchek Coordinator. The Coordinator is responsible for the administration of Healthchek and Pregnancy Related Services in his/her respective county. Eligible individuals are informed of available services upon their Medicaid eligibility determination."	Does not asses access to care barriers

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Community Infant Mortality efforts

Most recently geo-mapping has been used to identify communities with higher than average infant mortality rates. The Ohio Department of Health used Geo-mapping to identify nine Ohio counties with the highest racial disparities in infant mortality.

The Ohio Institute for Equity in Birth Outcomes (OEI) is a data driven, evidence-based ODH initiative with interventions focused on addressing racial disparities in order to reduce infant mortality in these nine Ohio urban areas. Decreasing the gap between the number of Non-Hispanic Black and Non-Hispanic White babies who did not reach their first birth is required to reduce the infant mortality rate in Ohio.

In 2015, the non-Hispanic black infant mortality rate increased by 1.2 deaths per 1,000. In response, in 2016, Ohio allocated $26.8 million through the Ohio Medicaid program to support community-driven proposals to combat infant mortality at the local level[4].Through its Medicaid Managed Care Plans, ODM has funded several community efforts to address barriers to care within OEI priority communities. The efforts rely on knowledge inherent within the community itself with regard to community need. In partnership with Ohio Medicaid's five contracted Managed Care Plans, projects were funded to support the following community partner efforts:

	Akron	Butler	Canton	Cincinnati	Cleveland	Columbus	Dayton	Toledo	Youngstown
Centering (7)	X	X	X		X	X	X		X
Community Health Workers (7)		X	X	X	X	X		X	X
HUB-related (3)	X		X						X
Fatherhood (5)	X	X	X		X		XX		
Targeted Community Communication, including outreach in ZIP Codes (3)	XX			XX			X		
Racism conversation – & related activities	X							X	
Home Visiting (3)			X	X			X		
Centralized/Coordinated Intake (3)				X		X		X	
SDOH (transportation, housing counsellor, SS support)		XX					X		X
Faith-based pregnancy support		X	X				X		
Mental Health/Addiction support/MAT Medical Home						X	X	X	
Worker education, advocacy				XX					
Healthy Start/Infant focus							X		

[4] Ohio Department of Health, Number of Ohio Infant Deaths Rise in 2015; State Surging News Resources to Support local initiatives promising practices identified that help save babies' lives https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/news/news-archive/News-Release----2015-Ohio-Infant-Mortality-Report.pdf?la=en

Requests for proposals for 2018-2019 community based projects were released in 2017 and Notice of Awards will be sent quarter 1 of 2018.

A large majority of the nine communities with infant mortality reduction efforts conducted individual community assessments to determine barriers and areas of need for women and families in their communities. The most frequently identified were: on-demand transportation for pregnant women, centering programs, child care, housing, tobacco use, food insecurity, mental health, lack of education, and birth spacing.

These efforts illustrate the vast amount of information available to community-based organizations regarding the barriers experienced by Medicaid beneficiaries when accessing services. In the past, this information has not been compiled or fully shared with policy-making agencies, like ODM. Community based organizations are the "boots on the ground", reaching Medicaid beneficiaries daily to address social and economic conditions that do not fall within the realm of Medicaid covered services. Partnering with these organizations offers an opportunity to develop an organized and systematic approach to obtaining information regarding barriers from a community and member-based perspective, allowing Medicaid to better identify and partner with the community and sister agencies to address root causes.

A Path Forward: A New Barrier Assessment Methodology

Despite Ohio Medicaid's multiple methods of finding out about barriers to care, a standardized, systematic method for identification of barriers pertaining to Medicaid Interventions for women of reproductive age does currently not exist. None of the current methods fully address the requirements stated in SB 332: identification of barriers Medicaid beneficiaries experience when accessing interventions intended to reduce tobacco use, prevent prematurity and promote optimal birth spacing for women of childbearing age. Very few of the methods described above capture the direct perspective of Medicaid beneficiaries and fewer still contain the demographic information needed to determine barriers specific to women of reproductive age. Based on these findings, ODM is proposing a community based approach to understanding what Ohio Medicaid beneficiaries experience when accessing interventions intended to prevent prematurity, reduce tobacco use, and promote optimal birth spacing—The Women of Reproductive Age Barriers Assessment (WRABA).

A community based approach to assessing access barriers will uncover the perspective of individuals insured by Medicaid, allow for the determination of root cause(s) and the association, if any, to Medicaid, MCP or provider practice policies. Identifying barrier(s), root cause(s) and correlation to policies will also help inform future population health efforts at Ohio Department of Medicaid, as well as, highlight opportunities to strengthen current partnerships and develop new ones.

The WRABA methodology will take a community approach to assessing access barriers and will occur in two waves: (1.) an assessment of barriers experienced by women of reproductive age insured by Ohio Medicaid, and (2.) a review of Medicaid and its' contractors policies to assess whether they may have contributed to or reinforced the identified barriers. This assessment will allow Medicaid to identify what changes may be needed at policy and administrative levels, as well as inform any improvements in communications or partner collaboration. The assessment of barriers experienced by women of reproductive age will be composed of two parts: a set of interviews with community leaders, and focus groups with women of reproductive age insured by Ohio Medicaid and who live in communities with high-infant mortality rates.

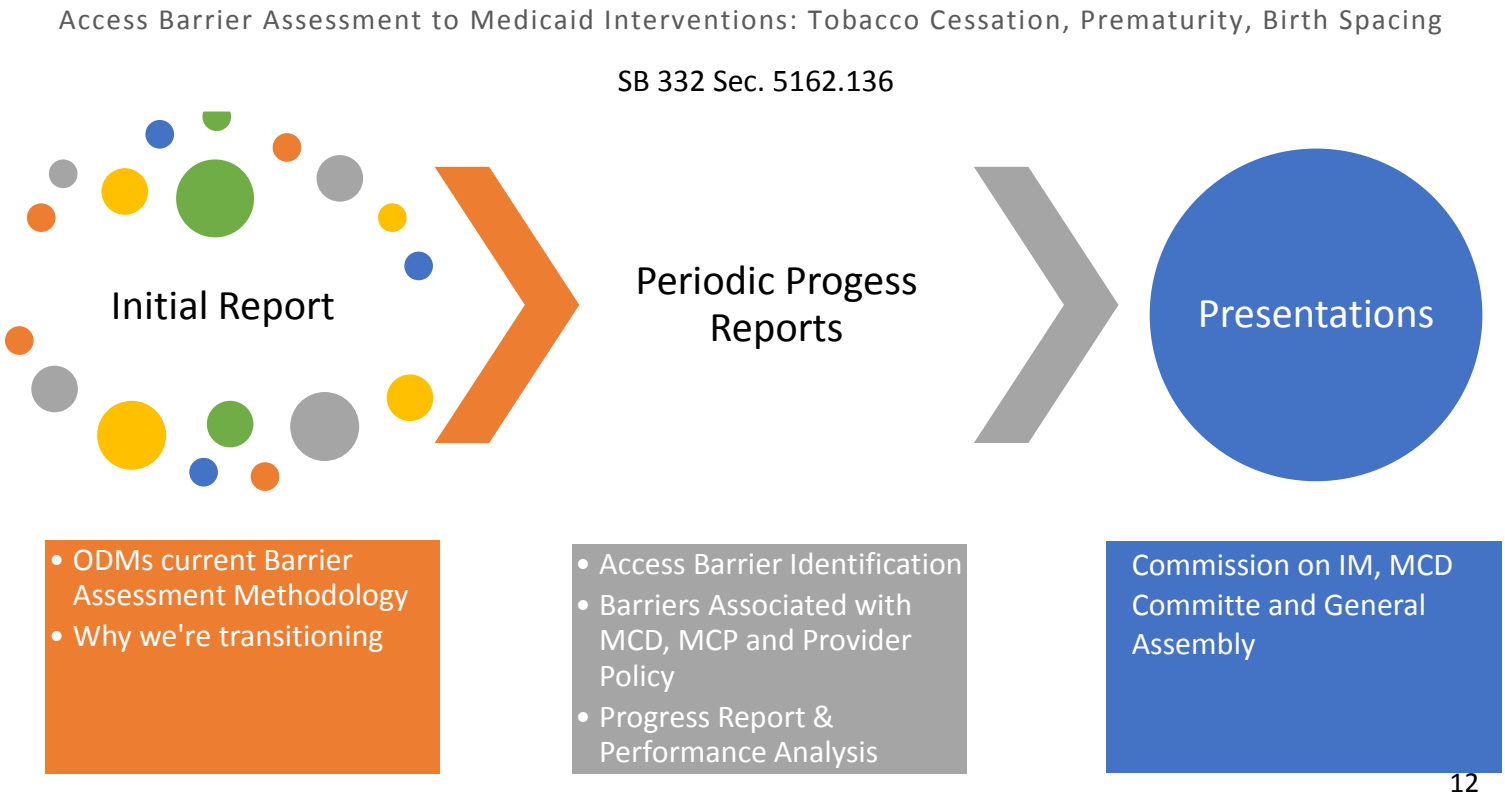
Ohio Medicaid has contracted with its external quality review organization (EQRO), Health Services Advisory Group (HSAG), to identify access barriers to Medicaid interventions through the two part community assessment. The Health Services Advisory Group will conduct a series of key informant interviews with leaders of community organizations from Cleveland, Cincinnati, Columbus, Ross county and Athens/Morgan counties, while also conducting focus groups with female Medicaid beneficiaries served by those organizations to obtain a better understanding of the of barriers they

encounter when accessing interventions intended to reduce tobacco use, prevent prematurity and promote optimal birth spacing.

Community Leaders from the five representative communities will be interviewed telephonically by the external reviewer to assist in identifying root cause barriers to Medicaid interventions for women of reproductive age. HSAG will interview community based leaders with experience working with the population of maternal and child health to learn their perspective of what barriers exist. As previously identified, most community based organizations have conducted independent barriers assessments and hold a wealth of knowledge and understanding Medicaid could use on this project. HSAG will assist in capturing this information and aide in the identification of barriers. Leaders from community based organizations have been identified, by ODM leadership, to assist with these efforts and provided to HSAG for one hour telephonic interviews. In addition to being asked to provide perspective regarding barriers experienced by the Medicaid population, each CBO leader will also be asked to assist in the identification of Medicaid recipients from their communities to participate in focus groups designed to glean more in depth information from the perspective of women of reproductive age insured by Medicaid.

Open-ended questions and a facilitation guide will be developed by HSAG and approved by ODM for use in the key informant interviews and focus groups, respectively. One key informant interview and one focus group will be conducted in each of the following OEI and Appalachian communities, Cleveland, Cincinnati, Columbus, Ross County, and Athens/Morgan County Ohio initially and periodically throughout the course of two years. With assistance from the CBOs, HSAG will conduct five 90 minute focus groups with Medicaid participants each across the state. Once the initial set of key informant and focus group interviews are conducted HSAG will provide ODM with transcripts and key themes, identified barriers and findings in the form of two separate reports.

The report of interview and focus group findings will be used to inform an analysis of current Medicaid and managed care plan policy in order to determine whether policy updates can influence the identified barriers. In future years, periodic telephonic interviews will be conducted with CBO key informants to assess barrier reduction based on prior findings. The graphic below depicts this process.



Action Plan

Target population: marginalized women of reproductive age, 15 – 44 years of age who have attempted to access interventions intended to reduce tobacco use, prevent prematurity, and/or promote optimal birth spacing to improve health outcomes.
Aim: Identify barriers women of reproductive age experience when accessing interventions intended to reduce prematurity, increase tobacco cessation, or promote optimal birth spacing and determine if ODM, MCP or provider policies may contribute to any of the barriers identified.
Tasks • Conduct five key informant interviews with community based leaders from Cleveland, Cincinnati, Columbus, Ross County, Athens/Morgan counties; and five focus groups with 50 Medicaid beneficiaries from each of the 5 identified communities. • Identify key access barriers and themes based on findings from community interviews • Determine contribution of ODM and MCP policies to barriers identified. • Submit progress report and action plan for how to address identified barriers. • Submit performance analysis.
• Reassess Medicaid Beneficiaries and key Informants to determine barrier reduction • Progress report submitted to include steps towards barrier reduction, policy changes, etc. • Performance analysis submission
• Final report submission

Reporting

In accordance with SB 332, ODM will submit a report documenting the analysis provided by contractor to the required entities. HSAG is responsible for the completion of multiple reports to ODM throughout the course of their current contract period, June 2019. This includes the report of transcripts and key themes identified during each individual key informant interview and focus group, a key informant methodology report, identification of barriers, and a summary of findings based on root causes identified. HSAG's initial report of findings will assist in identifying the root causes of access barriers and recommendations as a baseline to begin addressing these concerns. HSAG's reports and ODM's analysis of policy will provide a more robust understanding of areas where Medicaid can address barriers. Every six months thereafter, HSAG will assess Medicaid's progress towards reducing these barriers to accessing interventions intended for women of childbearing age. ODM in turn will review submitted reports, assess opportunities for improvement, and provide all required documentation as stated in SB 332.

Sustainability

Ohio Department of Medicaid's Office of Health Innovation and Quality will continue to measure successful barrier reduction not only through the WRA-BA, but also through annual production of Health Effectiveness Data and Information Sets (HEDIS) measures. ODM is fully expecting improved HEDIS performance in prenatal and postpartum measures directly correlated to preterm birth and safe spacing with proper execution of the WRA – BA. By addressing root cause barriers, SDOH, ODM anticipates a positive shift in post-partum and prenatal office visits. Patients who do

not receive post-partum care are more likely not to practice safe spacing, and if members do not obtain prenatal care the likelihood of them receiving progesterone if needed is reduced. ODM also has conceptualized ideals of data use to inform programmatic changes throughout the system for specific Medicaid interventions.

ODM has identified key billing codes, Z-Codes, to track social determinant of health risks, and the use and need of tobacco cessation services. While there is opportunity for plans to collect specific information by Z-codes (Table 2) this is not currently routine practice. Future use of Z-codes for tobacco cessation and SDOH can inform targeted strategies that are possible in barrier reduction. In addition, having access to SDOH data collected via the Ohio Department of Health's Home Visiting Centralized Intake system (OHCHIDS) will also provide a prolonged capacity to review statewide socioeconomic data.

Table: 2

Tobacco and Social Determinants of Health Z-Codes			
Measures	**Billing Code Type**	Key Billing Codes	
Tobacco Use Screening and Cessation Intervention	**CPT®** and **CPT®-II** codes to indicate tobacco screening and cessation counseling provided (numerator)	Screened for tobacco use AND received tobacco cessation intervention	4004F 1036F
		Current tobacco non-user	99406
		Smoking/tobacco counseling 3-10 minutes	99407
		Smoking/tobacco counseling >10 minutes	Z57.31
		Occupational Exposure to environmental tobacco smoke	Z71.6
		Tobacco abuse counseling (Use additional code for nicotine dependence (F17.-)	Z72.0
		Tobacco Use	Z87.891
Tobacco Use During Pregnancy, Childbirth, and Puerperium	ICD-10 codes	Use additional code from category F17 to identify type of tobacco nicotine dependence	
		Smoking (tobacco) complicating pregnancy, unspecified trimester	O99.330
		Smoking (tobacco) complicating pregnancy, first trimester	O99.331
		Smoking (tobacco) complicating pregnancy, second trimester	O99.332
		Smoking (tobacco) complicating pregnancy, third trimester	O99.333
		Smoking (tobacco) complicating childbirth	O99.334
		Smoking (tobacco) complicating puerperium	O99.335
		Exposure to (environmental) tobacco smoke in the perinatal period	P96.81
		Newborn affected by maternal use of tobacco	P04.2
		Contact with and exposure to environmental tobacco smoke	Z77.22
Social Determinants of Health	ICD-10 codes	Problems related to education and literacy	Z55
		Underachievement in school	Z55.3
		Unemployed, unspecified	Z56.0
		Lack of adequate food	Z59.4
		Homelessness	Z59.0
		Inadequate Housing	Z59.1
		Problem related to lifestyle, unspecified	Z72.9

ODM has contracted with The Ohio State University Government Resource Center for data collection for future funded community initiative projects for SFY 2018 – 2019. It is our recommendation that HSAG, the external reviewer, utilize GRC as a key Informant to obtain statewide, community level data as this will also inform ODM's work toward reducing barriers Medicaid individuals experience when accessing interventions intended to reduce infant mortality; tobacco cessation, birth spacing, and prenatal care.

ODM plans to continue the WRA – BA every biennium to ensure the data captured is representative of the entire state. The designated contractor will assess five (5) different communities every two years, in addition to continually reassessing the prior communities for barrier remediation. The WRA – BA will be conducted in Columbus, Cincinnati,

Cleveland, Athens County and Ross County Ohio for the current biennium. During the next biennium, ODM is planning to conduct the WRA – BA in Lucas, Mahoning, Butler, Adams and Belmont counties. ODM's goal is to continue conducting these assessments until we can identify the barriers that prevent members from obtaining the care they need to improve population health, and evaluate whether the number, type and intensity of the barriers identified decrease over time.

Conclusion

Ohio Medicaid is committed to improving health outcomes for women of reproductive age. Recognizing that socioeconomic barriers are quite complex and involve many different systems connected to structural influences; Ohio Department of Medicaid is dedicated to formulating solutions and is interested in partnering with other entities that can help us develop insights and programs to address Medicaid beneficiary needs. Reducing tobacco use, preventing prematurity and providing optimal birth spacing will assist ODM in decreasing prematurity, the number one driver of Ohio infant deaths.