hpio health policy institute of ohio ™

Health **Policy** Brief

Strategies to prevent Adverse Childhood Experiences (ACEs) in Ohio

1 Ensuring a strong start for children and strengthening economic supports for families

The health and well-being of Ohioans can be improved by ensuring that children have a strong start and that families are financially stable. Providing and implementing evidence-informed programs and policies, such as high-quality early childhood education, home visiting, medical-legal partnerships and a refundable state Earned Income Tax Credit, can both prevent and mitigate the impacts of childhood adversity and trauma.[1] Policymakers and partners across the state are taking action to make sure that Ohio children and families have what they need to thrive.

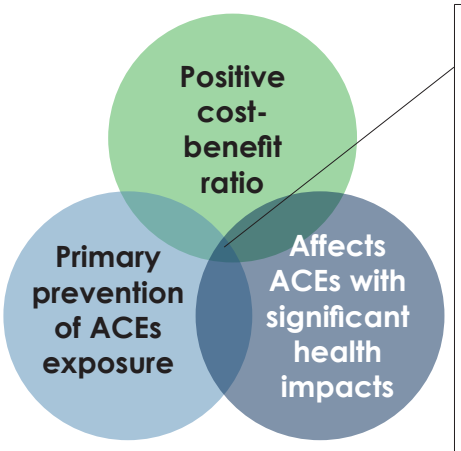
Roughly 20% of Ohio children are exposed to one or more adverse childhood experiences (ACEs), which have both immediate and long-term effects on health.[2] By focusing on the implementation of evidence-informed strategies, state and local partners can ensure that every child has a fair chance for a long and healthy life.

In 2020 and 2021, the Health Policy Institute of Ohio released a **series of policy briefs** on the health and economic impacts of ACEs and elevated 12 evidence-based, cost-effective strategies (programs, policies and practices) that prevent ACEs before they happen and improve health. This brief examines the implementation status of four of those strategies in Ohio. These four strategies are effective at ensuring a strong start for children and strengthening economic supports for families. Figure 1 outlines the 12 strategies and highlights the four that will be discussed in this brief.

3 key findings for policymakers

- **Actions to prevent ACEs are already underway.** There are many opportunities to support partners across the state who are implementing **cost-effective, evidence-based strategies** to prevent ACEs.
- **ACEs prevention efforts must meet the needs of children and families.** To maximize impact, strategies should be scaled up and tailored towards those most at risk for experiencing adversity.
- **Supporting evidence-based strategies can reduce healthcare spending and other costs.** By increasing funding and sustaining support for evidence-based strategies, policymakers can effectively prevent ACEs in Ohio and reduce long-term costs.

Figure 1. **Key strategies for preventing ACEs in Ohio**



For more information on the key strategies identified, please see **A strategic approach to prevent ACEs in Ohio**

12 key strategies

This brief	• **Early childhood education programs** • **Early childhood home visiting**	Ensuring a strong start for children
	• **Medical-legal partnerships** • **Family income supports**	Strengthening economic supports for families
	• School-based violence, bullying and intimate partner violence prevention programs • Parent/caregiver and family skills training • School-based social and emotional instruction	Enhancing skills so that parents and youth can handle stress, manage emotions and tackle everyday challenges
	• Community-based violence prevention	Promoting social norms that protect against violence and adversity
	• Mentoring programs for delinquency	Connecting youth to caring adults
	• Drug courts • Trauma-informed care • Behavioral health treatment	Intervening to lessen immediate and long-term harms

This brief:
- Describes strategies that ensure a strong start for children and strengthen economic supports for families
- Provides examples of strategy implementation in Ohio
- Identifies strengths, gaps and recommendations for strengthening ACEs prevention strategies

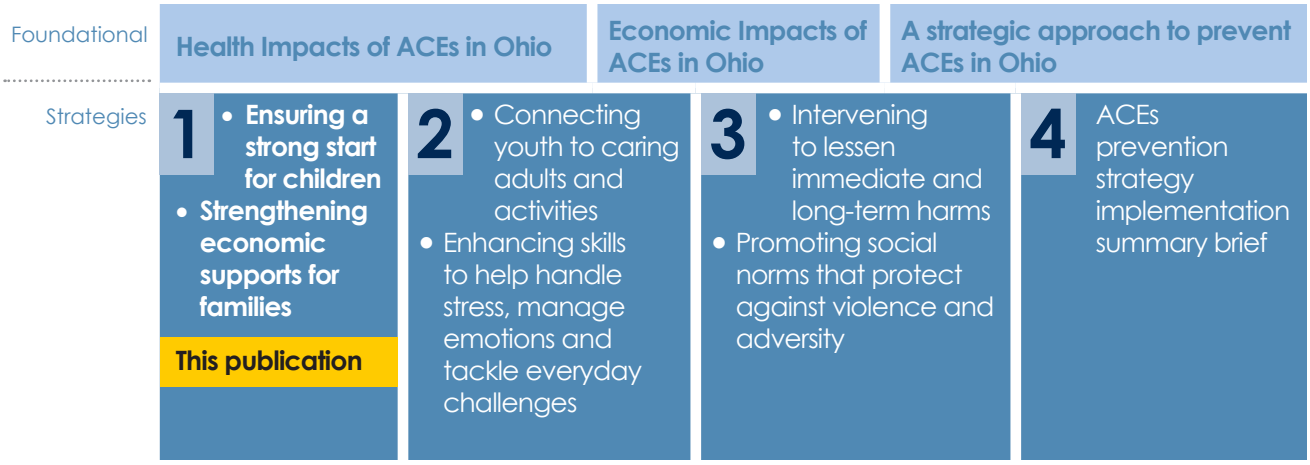
Background

Ohio ACEs Impact Project

Building upon the first three publications of the **Ohio ACEs Impact Project**, HPIO is developing three additional policy briefs that will describe and assess the implementation of 12 evidence-informed and cost-effective strategies at the state and local level that prevent ACEs exposure.

Figure 2 displays the policy briefs in both phases of the Ohio ACEs Impact Project, including the CDC ACEs prevention strategy categories that will be explored in each of the upcoming briefs.[3] This work will culminate in a final brief that will summarize policy recommendations for enhancing implementation efforts of all 12 key strategies.

Figure 2. **Ohio ACEs Impact Project Phases**



To inform examples of ACEs prevention strategies implemented in Ohio for this policy brief, HPIO conducted five key-informant interviews with staff from these organizations:

- Community Legal Aid Services, Inc. (Northeast Ohio)
- CoStars by the Children's Home (now Best Point Education and Behavioral Health; Cincinnati)
- Ohio Head Start Association, Inc. (statewide)
- Preschool Promise (Dayton and Montgomery County)
- SPARK Ohio (Northeast Ohio)

What are ACEs?

Adverse childhood experiences (ACEs) are "potentially traumatic events" that occur during childhood (ages 0-17). The research literature generally groups ACEs into three categories: abuse, household challenges and neglect, as outlined in figure 3. There is also emerging research on the negative effects of other forms of childhood adversity and trauma, such as experiencing racism and discrimination, war, community violence, poverty and frequent mobility.[4]

Figure 3. **What is considered an ACE?**

Abuse	Household challenges	Neglect
• Emotional abuse • Physical abuse • Sexual abuse	• Witnessing domestic violence • Substance use in the household • Mental illness in the household • Parental separation or divorce • Incarcerated member of the household	• Emotional neglect • Physical neglect

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention

What is Ohio doing to prevent and mitigate the impact of ACEs?

Public and private partners across the state are implementing many of the 12 key strategies identified in HPIO's policy brief, **A Strategic Approach to Prevent ACEs in Ohio**. These strategies are focused on preventing ACEs in children by tackling the underlying causes (i.e., social and economic factors) of adverse and traumatic events before they occur. Funding for these strategies is supported by federal grants, state general revenue fund dollars, private sector funding, philanthropy and individual donors. Additionally, **House Bill 428** of the 134th General Assembly seeks to establish an Adverse Childhood Experiences Study Commission to study the effects of ACEs and recommend legislative strategies for addressing ACEs.[5]

Ensuring a strong start for children

A critical aspect of ACEs prevention is ensuring that children have a strong start in life. Two key ACEs prevention strategies fall into this category: early childhood education and early childhood home visiting programs. By fully implementing these strategies through sustainable funding and by making them accessible across the state, Ohio policymakers and other stakeholders can support resiliency in young children and prevent trauma before it occurs.

Strategy No. 1: Early childhood education

Evidence-based early childhood education (ECE) programs lay the foundation for Ohio's youngest learners to succeed throughout their lives. These programs typically serve children ages five and under and provide enriching activities, experiences and services to support healthy cognitive and social development before kindergarten.

ECE programs have been found to prevent and mitigate ACEs, such as mental illness in the home, and have strong evidence of return on investment, with an estimated cost-benefit ratio of $3.15.[6] There is also strong evidence that high-quality programs are likely to reduce disparities in educational attainment between students from low-income backgrounds and high-income backgrounds.[7] Additionally, research has shown ECE programs lead to:

- Improved cognitive and emotional development
- Improved academic achievement
- Savings in healthcare costs, better jobs and higher earnings[8]

There are multiple publicly funded ECE programs in Ohio. These programs include state-funded preschool (the Ohio Department of Education's early childhood education program), state preschool special education, Head Start, Early Head Start and publicly funded child care (PFCC). Other locally and/or privately funded programs across the state also leverage these state programs and investments to increase the quality of and access to programs in their communities (e.g., Preschool Promise, which serves Dayton and Montgomery County).

How is Ohio improving the quality of early childhood education?

Not all early childhood education programs are equally effective at producing positive outcomes for children and their families. To promote and recognize programs that meet quality standards and exceed health and safety regulations, Ohio's Step Up to Quality (SUTQ) rating system classifies providers based on a five-star scale. A rating of three to five stars is considered "high-quality," but even one- and two-start programs (considered "quality") exceed state licensing regulations. All state-funded ECE programs in Ohio must participate in SUTQ.

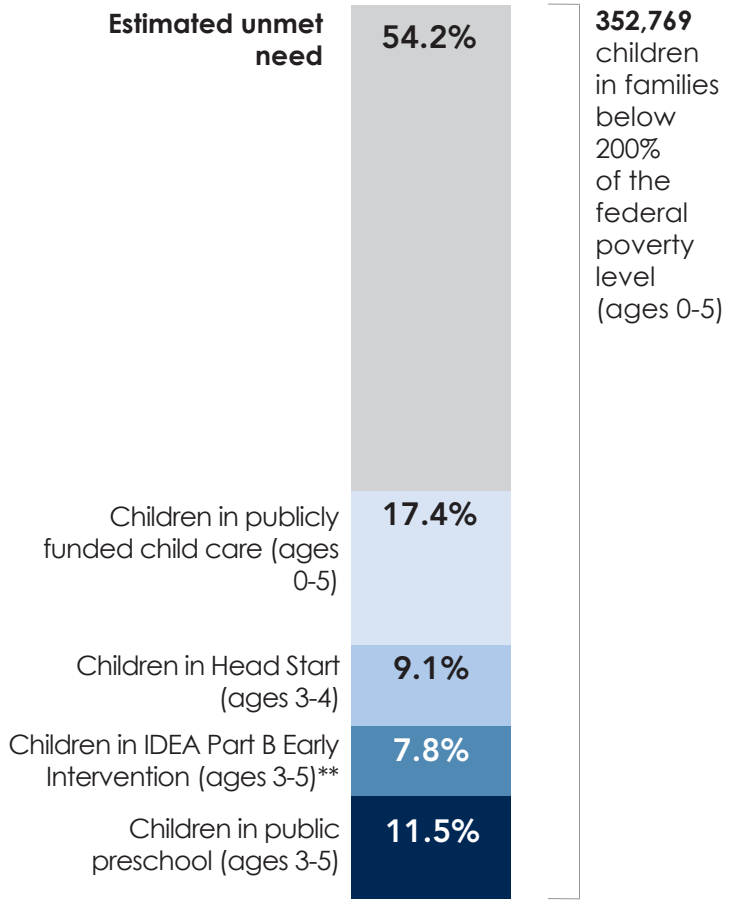
A **2020 independent evaluation** of the SUTQ rating system found that children enrolled in a program rated five-stars performed better on kindergarten readiness assessments than children enrolled in one-star programs, though one-star programs are still shown to improve early learning outcomes. Additionally, children enrolled in three- and four-star programs performed better on the Third Grade English Language Arts test than children in one-star programs.[9] As of July 2021, 49.7% of Ohio children using PFCC were enrolled in a high-quality (three to five stars) program, and an additional 43% were in a quality (one or two star) program.[10]

Children in families with low incomes are an important priority population for ECE programs. Research indicates that family income in early childhood is a predictor of health outcomes later in life and that childhood poverty is linked to diminished educational and employment opportunities across the life course.[11]

There are a wide variety of ECE programs that serve low-income families in Ohio with varying enrollment criteria. For example, children in families with incomes below the federal poverty level (FPL) are eligible for Head Start (ages 3-5) and Early Head Start (birth to age 3). Children in foster care and children who are experiencing homelessness are also eligible regardless of income. Ohio's state-funded preschool program serves 4-year-olds and some 3-year-olds with family incomes up to 200% FPL, with no work requirement. Child care subsidies (i.e., PFCC) are available to families with incomes up to 142% FPL (at initial enrollment) during a qualifying parental event (work or school). Ohio's PFCC income eligibility limit is among the lowest in the country.[12]

However, despite the well-documented benefits and presence of ECE across the state, many Ohio children in need do not have access to these programs.[13] Figure 4 shows the reach of early childhood education programs for Ohio children whose families earn below 200% FPL.

Figure 4. **Reach of publicly funded early childhood education programs in Ohio, 2019-2021***



*Data for Early Head Start is not included.
** IDEA Part B Early Intervention provides services through public school systems, including special education, to children with developmental delays.
Note: There is potential for overlap among children served because data for these programs come from multiple sources. This likely results in an underestimate of unmet need.
Sources: Adapted from Groundwork Ohio's 2022 Early Childhood Dashboard Preview. Data from Ohio Department of Job and Family Services (2021); U.S. Office of Head Start data as reported by the Annie E. Casey Kids Count Data Center (2019); U.S. Department of Education (2019-2020); Ohio Department of Education (2020)

ECE programs are funded by a variety of sources. For example, Head Start programs are solely funded by the federal government; while the PFCC program is predominantly funded by federal dollars, in addition to some state dollars per federal matching requirements. Additionally, eligibility for different ECE programs in Ohio varies based on participant income and other requirements. Examples of implementation of ECE programs for low-income families are described below.

Implementation examples: Head Start and Preschool Promise

Program descriptions

- **Head Start:** A federal program that promotes school readiness of children ages 3 to 5 from low-income families by supporting their development in a comprehensive way. In addition to early childhood education, Head Start provides health services, parent engagement, parenting education and services for children with disabilities.[14] Prior to age 3, children can be enrolled in Early Head Start.
- **Preschool Promise:** An ECE program in Montgomery County, Ohio, that provides high-quality preschool, preparing young children for kindergarten. All families in the county are eligible for tuition assistance, but the amount received depends on household income, family size and their selected program's quality rating, with higher amounts allocated for the highest-rated providers.[15]

Population served

- **Head Start:** Operates in all 88 counties throughout Ohio and served 30,071 children in 2021[16]
- **Preschool Promise:** Operates in Montgomery County in multiple Dayton-area school districts and serves 2,644 students, many of whom come from low-income families[17]

Budget and funding streams

- **Head Start:** Majority of funding comes from the federal government and goes to local grant recipients, but some programs also receive local dollars
- **Preschool Promise:** Majority of funding comes from Montgomery County and the city of Dayton (via a .25% local income tax increase passed in 2016), but also receives private funding from local philanthropy

Outcome evaluation

- **Head Start:** Has been evaluated multiple times, with **findings** showing that participation in the program enhances educational achievement, behavioral outcomes and leads to other positive benefits, such as improved health status.[18] Other evaluations have found that children up to age 5 in the child welfare system who participated in Head Start were 93% less likely to be placed in foster care than children who did not participate in any kind of ECE, and the first multigenerational study of Head Start displayed significant gains for second generation participants.[19]
- **Preschool Promise:** Had an **outcome evaluation report** published in 2017, which included metrics on improving child outcomes (i.e., certain skills and attendance), access to preschool and quality improvement. The outcome evaluation found that children enrolled in Preschool Promise classrooms made substantial gains in math, literacy and social skills that outpaced national averages.[20] Researchers at the University of Dayton manage data evaluation and analysis for the program.

Child-Parent Centers

Child-Parent Centers (CPCs) are another evidence-based, cost-beneficial method of early childhood education shown to be effective at preventing and mitigating ACEs. CPCs operate at the school district level and provide comprehensive education, family support and healthcare services to low-income children, ranging from three to nine years old. The six core elements of the CPC model are:

- Effective learning experience
- A curriculum that is aligned from Pre-K to 3rd grade
- Collaborative leadership
- Professional development
- Parent involvement and engagement
- A support system that provides continuity and stability to participating students[21]

Programs are designed to meet the needs of the children and families they serve. In some iterations of the program, for example, parents attend literacy trainings to help their children become better readers while children attend ECE classes in the same building. In other iterations, parents are required to spend a half day each week in the CPC during ECE classes as a classroom aide, accompanying the class on field trips, using a parent resource room or participating in reading groups with other parents.

The Pre-K portion (for three- and four-year old children) of the CPC model has been evaluated and found to reduce special education service needs for participants, grade retention, juvenile arrests and court-reported maltreatment, as well as to increase high school completion by age 20.[22] Another evaluation of the program is underway, with preliminary results showing improvements in school readiness and parental involvement for participants.[23] Though CPCs are an evidence-based and cost-beneficial ECE strategy shown to be effective in preventing and mitigating the impacts of ACEs, Ohio currently has no formal CPCs. However, there are districts around the state offering similar types of family supports.

Ohio's early childhood education (ECE) workforce

Strengthening Ohio's ECE workforce is essential for improving ECE access and quality across the state. Compensation is a core element of workforce conditions for early learning professionals. A 2021 **report** finds that Ohio's early learning professionals earn, on average, $10.67 per hour.[24] Many early learning programs require certain qualifications among their staff, such as postsecondary degrees, certifications or years of experience.[25] Wages remain low despite such qualifications.

The childcare industry, especially, has struggled with staffing since the beginning of the COVID-19 pandemic, causing some childcare centers to close temporarily or permanently.[26] For additional recommendations on bolstering Ohio's early childhood education workforce, see **The Workforce Behind the Workforce: Advancing the Early Childhood Education Profession in Ohio's Child Care System**, a 2020 report by Groundwork Ohio.

Early childhood education programs: Next steps for Ohio

To improve the implementation of early childhood education programs across Ohio, policymakers and other stakeholders should consider the strengths, gaps and recommendations identified in Figure 5.

Figure 5. **Strengths, gaps and recommendations for early childhood education programs for low-income families and Child-Parent Centers**

Strengths	Gaps	Recommendations
• Many ECE programs are being implemented across Ohio, ranging in size, structure and reach • Ohio has a robust quality rating system for early care and education (Step Up To Quality) with required participation by state-funded early childhood education programs • ECE programs have federal, state and local financial support, and sometimes receive funding from philanthropy and other private entities, such as healthcare systems, in the communities they serve • The Ohio SFY 2022-2023 budget increased access to publicly funded child care (PFCC) from 130% to 142% FPL (and 150% for families with children with special needs)	• PFCC, the state program serving the largest number of young children, lacks sustainable and long-term funding[27] • Ohio's PFCC income eligibility limit (142%) is among the lowest in the U.S., and many working families with low incomes are unable to access quality ECE for their children[28] • Half of early childhood programs that are part of PFCC have not yet reached a "high quality" rating (3-5 stars)[29] • There are no formal Child-Parent Centers (CPCs) in Ohio	• Increase access to quality ECE programs for young children with working parents by increasing eligibility for Ohio's publicly funded child care from 142% to 200% FPL • Increase funding and support for early childhood education programs that have not yet achieved a high-quality rating • Invest state dollars in Early Head Start and Head Start to focus on and tailor to the needs of low-income children experiencing multiple ACEs, including children in state custody and children experiencing homelessness • Look to states such as Illinois, Wisconsin and Minnesota for guidance in implementing the CPC model

Strategy No. 2: Early childhood home visiting

Home visiting programs are an evidence-based, multi-generational strategy proven to prevent and mitigate ACEs. Trained providers (home visitors) visit expectant parents and families with infants and young children, providing one-on-one support for healthy parent and child development, early education and family needs. Participation in home visiting programs is typically voluntary.

Home visiting programs that are comprehensive and focused on high-need participants are more likely to have positive results.[30] Depending on the home visiting model, benefits may include improved child health, development and/or kindergarten readiness; enhanced parenting skills; improved family economic self-sufficiency; and decreased costs to healthcare, education, social services, criminal justice and other public systems.[31] These programs have also been shown to prevent specific ACEs, such as emotional abuse.[32]

Early childhood home visiting in Ohio

As of February 2022, there was at least one provider in every Ohio county using a home visiting model identified as "evidence-based" by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) review. There are six HomVEE home visiting models operating in Ohio, outlined in figure 6.

Figure 6. **HomVEE evidence-based home visiting models operating in Ohio**

Home visiting model	Description	Cost-benefit ratio
Early Head Start (EHS) Home-Based Option	Provides intensive, comprehensive child development and family support services to pregnant women and families with children under age three with incomes below the poverty level as well as children receiving public assistance (i.e., SNAP, TANF or SSI).	No data available
Healthy Families America (HFA)	Reduces child maltreatment, improves parent-child interactions and children's social-emotional well-being, and promotes school readiness, beginning prenatally or within a child's first three months and continuing until between ages 3 and 5.	$1.43 (2017)
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Family literacy and home visiting program for low-income families, designed for children ages 2 to 5, to improve school readiness.	$1.38 (2017)
Nurse-Family Partnership (NFP)	Improves prenatal, maternal health and birth outcomes, child health and development and families' economic self-sufficiency through trained registered nurses working with first-time, low-income parents and their children beginning prenatally and continuing until the child is age 2.	$1.37 (2018)
Parents as Teachers (PAT)	Provides parents with child development knowledge and parenting support, provides early detection of developmental delays and health issues, prevents child abuse and neglect and increases children's school readiness.	$0.18 (2017)
SafeCare Augmented	Prevents and addresses factors associated with child abuse and neglect for families with a child 0 to 5 years old.	$20.82* (2017)

* This benefit-to-cost ratio is for SafeCare. SafeCare Augmented is an adaptation of SafeCare that trains home visitors in motivational interviewing and in identifying and responding to imminent child maltreatment

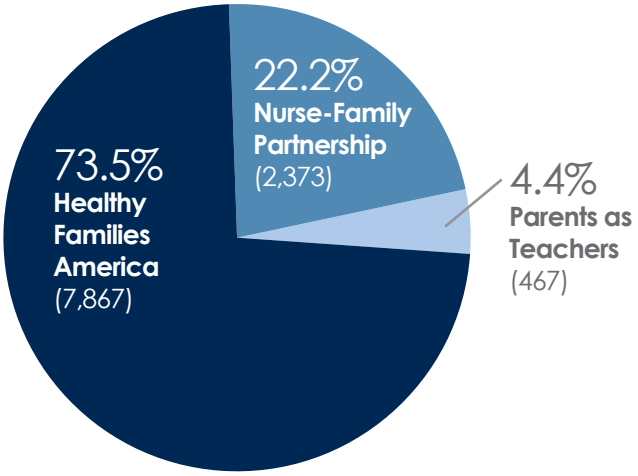
Note: A cost-benefit ratio estimates the social benefit of a strategy relative to the strategy's social cost. See **A strategic approach to prevent ACEs in Ohio** for more.

Sources: Model descriptions are from the Ohio Department of Health's June 2020 Maternal, Infant and Early Childhood Home Visiting Needs Assessment Update. Benefit-to-cost ratios are from the Washington State Institute for Public Policy. The year of each analysis is next to the ratio.

There are other programs operating throughout Ohio that provide home visiting services and related supports but are not HomVEE-designated programs. These programs serve many families, and sometimes provide additional support to pregnant women or families with young children who are also served through HomVEE models. Among them are Moms and Babies First programs[33], Certified Pathways Community HUBs[34], SPARK (Supporting Partnerships to Assure Ready Kids) and Healthy Start federal grantees.[35]

Help Me Grow Home Visiting (HMGHV) is Ohio's largest home visiting funding program.[36] It is administered by the Ohio Department of Health (ODH). Three home-visiting models are eligible for HMGHV funding: Healthy Families America, Nurse-Family Partnership and Parents as Teachers. The Ohio Department of Medicaid (ODM) also funds some home visiting services. The vast majority of Ohio households receiving home visiting services through an ODH- or ODM-funded program were served through the Healthy Families America (HFA) model, as shown in figure 7.

Figure 7. **Households served by home visiting programs funded by the Ohio Department of Health and Ohio Department of Medicaid, by model, FFY 2021** (n=10,707)

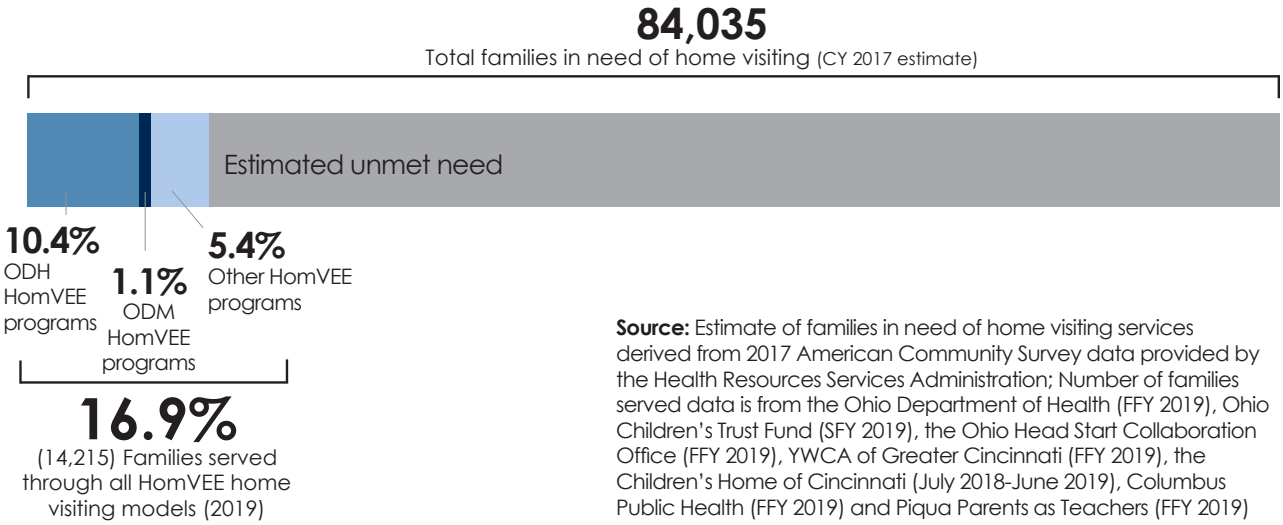


Note: Includes households that were served by and enrolled in home visiting programs
Source: Ohio Department of Health

There were 10,707 households served through ODH- and ODM-funded programs in FFY 2021. This represents 12.7% of the estimated number of Ohio families in need of home visiting services (84,035 Ohio families in 2017 as estimated by the Health Resources and Services Administration, or HRSA).

There are also other evidence-based home visiting models operating in Ohio that are not funded by ODH or ODM. One with considerable enrollment is Early Head Start (Home-Based Option). ODH's 2020 Maternal, Infant and **Early Childhood Home Visiting Needs Assessment Update** included data for these additional evidence-based programs. With these additional programs, the report found that only 16.9% of need had been met in 2019, shown in figure 8.

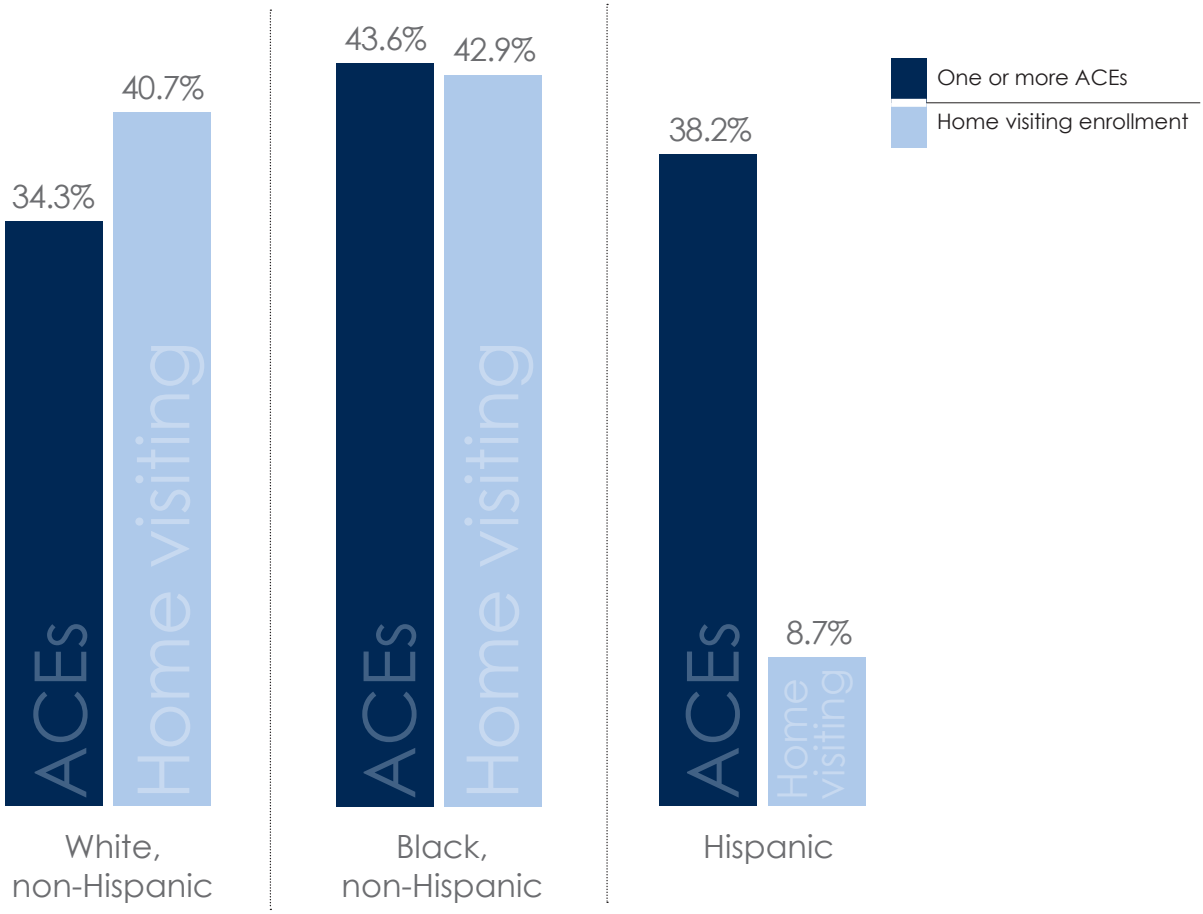
Figure 8. **Estimated percentage of Ohio need met through evidence-based, HomVEE home visiting programs, 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), the Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019), the Children's Home of Cincinnati (July 2018-June 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019)

The need for home visiting services is greater among groups of Ohioans most at risk for childhood adversity. Figure 9 contrasts the prevalence of ACEs among children, ages 0-5, with the percent of pregnant women and primary caregivers enrolled in a home visiting program funded by ODH or ODM, by race and ethnicity. For example, while 38.2% of Hispanic children, ages 0-5, in Ohio were exposed to ACEs, only 8.7% of the pregnant women and primary caregivers receiving ODH- and ODM-funded home visiting services were Hispanic in Federal fiscal year (FFY) 2021.

Figure 9. **Pregnant women and primary caregivers enrolled in home visiting programs funded by ODH or ODM (FFY 2021) and children, ages 0-5, who were exposed to ACEs (2019) in Ohio, by race and ethnicity**



Note: In addition to the HomVEE programs, home visiting data in this graphic also includes Moms and Babies First programs. These are community health worker-implemented infant vitality programs to reduce Black infant mortality in areas with high rates. Home visiting services and activities conducted vary by program, and there is no requirement to use a HomVEE-designated home visiting model.
Source: Home visiting program participation from the Ohio Department of Health. ACEs data from the Ohio Medicaid Assessment Survey.

Implementation example: CoStars Early Childhood Services, a division of Best Point Education and Behavioral Health Cincinnati, SPARK Ohio and HIPPY

CoStars provides families of young children with an array of early learning and support services, including home visiting through the SPARK Ohio and HIPPY models. SPARK, otherwise known as Supporting Partnerships to Assure Ready Kids, is a family-focused kindergarten readiness program that uses a home visitation model to prepare children ages 3-5 for kindergarten. As noted in Figure 6, HIPPY is a HomVEE-designated home visitation model for low-income families that helps parents prepare young children for success in school and throughout life. By engaging families in home visiting services, CoStars advances two-generation strategies (those targeted at both children and parents with low incomes from the same household to interrupt the cycle of poverty) that promote children's healthy development while advancing the overall wellness of families. Focused in communities where disparities in health, education and incomes are prevalent, CoStars also seeks to prevent ACEs.

More information about SPARK programs across Ohio is provided below.

Population served[37]

- Operates in 22 counties throughout Ohio
- Serves more than 2,000 children annually, including more than 600 children in Stark County

Budget and funding streams[38]

- Funding for different locations comes from different sources. Examples include:
  - Local private funders, including individuals, philanthropic organizations such as the United Way, and organizations such as Nationwide Children's Hospital
  - The Ohio Department of Job and Family Services
  - Local school districts

Outcome evaluation

- A **program evaluation** was published in 2016, showing significantly higher kindergarten readiness assessment scores for children enrolled in SPARK

Early childhood home visiting: Next steps for Ohio

To improve the implementation of early childhood home visiting programs across Ohio, policymakers and other stakeholders should consider the strengths, gaps and recommendations identified in Figure 10.

Figure 10. **Strengths, gaps and recommendations for early childhood home visiting**

Strengths	Gaps	Recommendations
• Every Ohio county is covered by at least one evidence-based home visiting model • State policymakers, including the administration of Governor Mike DeWine, place significant focus on early childhood home visiting programs in Ohio • Funding for home visiting has increased in the last two biennial state budgets, and Medicaid reimbursement for some nurse home visiting programs has been implemented	• The reach of evidence-based home visiting programs to families in need is relatively small in Ohio • In 2019, only 16.9% of the estimated number of Ohio families in need of home visiting services were served through HomVEE models (estimated need calculated by HRSA)	• Increase state funding for evidence-based early childhood home visiting, especially those models that are most cost-beneficial and focus on the ACEs with the largest impacts in Ohio (as defined in **Health Impacts of ACEs in Ohio**) • Integrate Early Head Start and other non-state funded evidence-based home visiting programs into Ohio's Help Me Grow Central Intake and Referral System • Collaborate with existing home visiting providers to overcome capacity limitations, including workforce challenges

Strengthening economic supports for families

Supporting family economic stability is a key method of preventing and mitigating ACEs in Ohio. Two evidence-based, cost-effective strategies that support family economic stability include medical-legal partnerships and the Earned Income Tax Credit. These strategies can support the economic well-being of Ohio families and ensure that families have access to necessary supports.

Strategy No. 3: Medical-legal partnerships

Medical-legal partnerships (MLPs) integrate legal services into healthcare settings, including hospitals and behavioral health clinics.[39] Legal aid, pro bono lawyers and law professors and students partner with health providers to address the legal needs of patients. These needs can relate to a variety of legal issues, such as landlord-tenant negotiation and mediation and navigating public assistance and government systems.[40] A few healthcare organizations directly employ attorneys while others partner with community organizations (e.g., local legal services agencies or academic legal clinics).

MLPs impact ACES by reducing stress and improving the well-being of children and their families and have a cost-benefit ratio of $6.98.[41] These programs can improve patient access to legal and social services, housing quality and stability, economic security and overall health and well-being (e.g., reduced hospitalizations).[42] Emerging research also shows that MLPs can improve asthma and other chronic condition-related outcomes for children by addressing the social drivers of health (e.g., housing and insurance access).[43]

MLPs are an effective strategy for reducing disparities. While MLPs can be effective for any person who needs legal assistance, many MLP programs focus their services on specific groups, including pregnant women and families, people with low incomes and immigrants and refugees.[44] It is recommended that healthcare systems have social workers on site alongside legal services to improve equity-related outcomes.[45]

Funding for MLPs can come from a multitude of sources, including[46]:

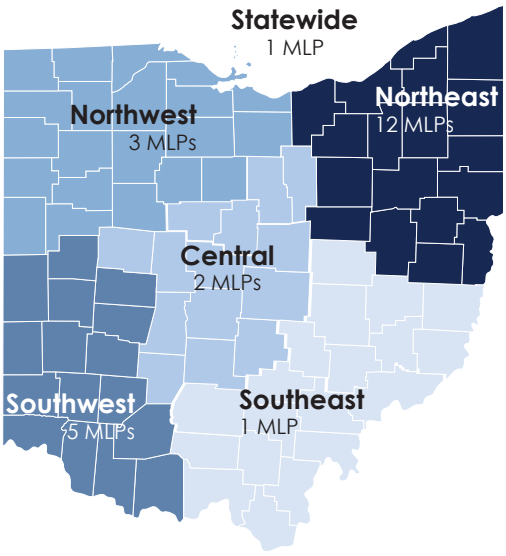
- Philanthropy, such as the Ohio Access to Justice Foundation and health foundations
- Federal and state government funding, such as Legal Services Corporation
- Law firms and schools
- Healthcare systems

Medical-legal partnerships in Ohio

There are 23 MLPs operating across Ohio serving a variety of clients.[47] Infants and children, however, are often a primary focus (11 of the partnerships have an explicit focus on this population). Equality Ohio operates the only statewide MLP, which serves LGBTQ+ clients.

Figure 11 provides an overview of how many MLPs are operating in certain areas of the state. Northeast Ohio has the largest concentration of MLPs in the state with 12 programs operating across the region. Other regions of the state, however, do not have the same concentration of MLPs. MLPs may be further limited in their service area due to population focus (e.g., only working with families with infants or children) and/or limited capacity (e.g., funding or personnel) to provide services across multiple counties.

Figure 11. **Map of Ohio-based MLPs**



Note: Regions used are based on those defined by the Ohio Medicaid Assessment Survey and are provided to contextualize the service areas of MLPs in Ohio. MLP service areas may cross regional lines or not include every county in a region. Some MLPs operate in multiple regions and have been included in counts for all regions in which they operate.
Source: Data provided by Ohio Access to Justice Foundation. Ohio's Medical Legal Partnership Summary PDF. Provided March 1, 2022.

All MLPs in the state have a legal and medical partner; however, not all partnerships have an attorney embedded at the medical facility. Nine MLPs report having an attorney onsite in the medical facility; three additional MLPs had one before the COVID-19 pandemic began. There are also efforts underway in Cincinnati to educate health professionals and law professionals on the connections between health and the law.

Implementation example: Health, Education, Advocacy, and Law (HEAL) Project[48]
The HEAL Project is an MLP located in Northeast Ohio. HEAL's legal partner, Community Legal Aid Services, Inc., works with several healthcare providers, including Akron Children's Hospital, Summa Health and the Pathways HUB of Mahoning County.[49]

Population served

- 245 cases in 2021, involving 369 adults and 477 children
- Served clients across nine Northeast Ohio counties, with most cases from Summit County
- HEAL's clients were 49% Black, 36% white, 6% Asian or Pacific Islander, 4% Hispanic and 4% other or preferred not to answer
- 212 clients identified as female and 33 identified as male
- Most clients were referred to the program to address challenges related to housing and taxes

Budget and funding stream

- Primary funding for HEAL is provided by the federal Legal Services Corporation and the Ohio Access to Justice Foundation
- HEAL blends additional funding from the Ohio Department of Health and philanthropic organizations, such as Akron Community Foundation, to operate pieces of the MLP for specific populations (e.g., infants) and in specific healthcare systems

Outcome evaluation

As of 2021, HEAL had not evaluated the impact of the project on ACEs. The project has qualitative data from outcome surveys and client legal outcomes collected when the case is closed and detailing how the case was resolved (e.g., client received counsel and advice, counsel negotiated settlement with litigation, case received a court decision).

Medical-legal partnerships: Next steps for Ohio

To improve the implementation of MLPs across Ohio, policymakers and other stakeholders should consider the strengths, gaps and recommendations identified in Figure 12.

Figure 12. **Strengths, gaps and recommendations related to medical-legal partnerships (MLPs)**

Strengths	Gaps	Recommendations
• MLPs are being implemented across the state. As of 2021, there were 23 MLPs in Ohio. The Cleveland-Akron area has the most MLPs • MLPs have local economic support, receiving funding from philanthropy and other private entities (e.g., healthcare systems) in the communities they serve	• MLPs and legal aid services lack sustainable and long-term funding • Many medical facilities around Ohio do not have an MLP, leaving most of the state without the number of MLPs needed to meet demand	• State and local governments can allocate funding to MLPs in their budgets, including allocation of state general revenue funding and agency-specific funding (such as the Ohio Department of Health's infant vitality funding for HEAL) • Health centers can develop social determinants of health and legal need screenings to help patients get connected to necessary legal services

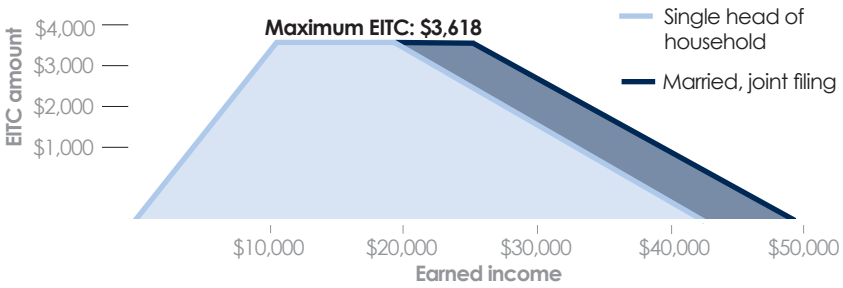
Strategy No. 4: Family income supports: Earned Income Tax Credit

Family income supports provide financial assistance to families, helping parents with low-wage jobs provide a secure, healthy and nurturing environment. These supports include several policies, such as the Earned Income Tax Credit, the Child Tax Credit, Temporary Assistance for Needy Families, unemployment insurance and living wage laws.

Family income supports reduce poverty and increase employment, among other outcomes.[50] Supports may also address many of the physical, social and economic conditions (e.g., limited economic resources, low educational attainment, poor mental health) that contribute to ACEs and the generational impacts of ACEs.[51]

The Earned Income Tax Credit (EITC) is an example of a family income support that has a positive cost-benefit ratio ($1.75) and addresses ACEs-related outcomes, including mental illness in the household.[52] The EITC is an income tax credit that increases income and employment, improves maternal and infant health and and improves financial stability for workers with low to moderate incomes.[53] A **research summary** from the Office of Planning, Research and Evaluation at the U.S. Department of Health and Human Services also reported improved quality of life outcomes for adults receiving the EITC and improved short- and long-term health and well-being outcomes (e.g., health status and academic achievement) for children.[54]

Figure 13. **Federal EITC amount for households with one child, tax year 2021**



Notes: EITC amounts displayed here exemplify how the EITC operates based on marital status and amount of earned income. Different amounts of credit are available for tax filers with no children, two children and three or more children. The data assumes that all income is from earnings (as opposed to investments, for example).
Source: Center on Budget and Policy Priorities (2022)

An EITC is available from both the federal government and 29 state governments, including Ohio.[55] The federal credit amount changes each year and depends on income, marital status and number of dependent children. The credit amount earned declines once a person's income reaches a certain point, decreasing for every additional dollar earned until no credit is available.[56] Most state EITCs (including Ohio's) are a percentage of the federal credit and can have additional eligibility criteria (e.g., income limits). Ohio's EITC is 30% of the federal EITC.[57] Figure 13 displays the amount of federal EITC available in tax year 2021 for someone with one child filing their taxes as single and joint filing for them and their spouse.

EITCs can be refundable or non-refundable. When the credit is refundable, workers receive the full credit amount, regardless of taxes owed. When a credit is non-refundable, any amount left over after being applied to taxes is not issued as a refund.[58] While the federal EITC and most state EITCs are refundable, Ohio is one of only five states with a non-refundable EITC.[59] For example, a family with a household income of $20,000 would not receive any assistance from the Ohio EITC because they do not earn enough to pay state income taxes. This family could still be eligible to receive money from the refundable federal EITC to apply to owed federal taxes. As described on page 14, EITCs that are refundable have a better chance of reaching more Ohioans, especially workers with the lowest incomes.

The research evidence is strong that EITCs decrease disparities in socioeconomic status among working-age adults. EITCs may also reduce disparities in birth outcomes for Black and Hispanic mothers and white mothers with low educational attainment.[60] The impact of EITCs on disparities is most pronounced for single-parent households, regardless of race or ethnicity, and for Black mothers when analyzing birth outcomes.

The impact of the EITC is limited by low awareness of the credit and how to apply for it. The IRS recommends that organizations refer potentially eligible people to Volunteer Income Tax Assistance

centers, which offer free assistance to people who need help in preparing their tax returns, including people who make less than $58,000, people with disabilities and people with limited English proficiency.[61] Publicizing the availability of the EITC and offering assistance to help people receive it can also increase the impact of the credit.[62]

Earned Income Tax Credit (EITC) in Ohio

In 2019, House Bill 62 of the 133rd General Assembly raised Ohio's EITC amount from 10% to 30% of the federal EITC. The state also removed the earned income cap that limited the state EITC amount to 50% of taxes due for households earning more than $20,000 a year. The bill, however, did not make Ohio's EITC refundable.

Creating a refundable state EITC would reach more people, even at a lower percentage of the federal EITC, than the current 30% non-refundable EITC. In other words, if a refundable Ohio EITC was 10% of the federal EITC, the credit could be extended to or have an increased value for roughly 609,000 Ohioans with incomes under $63,000. This includes 379,200 Ohioans in the lowest income quartile who the credit would reach or to whom the credit would be more valuable, if refundable.[63]

For example, the family earning $20,000 in the example on page 13 would receive the entirety of the state EITC as a refund in addition to any money leftover from the federal EITC after the latter was applied to owed federal income taxes.

For Tax Year 2021, Ohioans who worked and earned income under $57,414 and had investment income below $10,000 were eligible for the EITC. To be eligible, taxpayers must also[64]:

- Have a valid social security number by their tax return due date
- Be a U.S. citizen or documented resident
- Not have to file foreign earned income
- Not be claimed as a dependent or "qualifying child" on another person's tax return

Without a "qualifying child," a person must be 25-65 years old by the end of the year to claim the EITC.

Implementation example: Ohio's EITC

Note: Assessing personnel and budget for this strategy example is not applicable because the EITC is a policy, not a program.

Population served

- Approximately 877,000 Ohioans claimed the federal EITC on their 2020 tax return, and the average amount of federal EITC received by Ohioans was $2,410.[65]
- In tax year 2020, 808,751 Ohioans claimed a total of $552,815,951 in state EITC.[66]

Outcome evaluation

There is currently no outcome evaluation for Ohio's EITC. There are, however, several evaluations of EITCs, including **a research summary** from the Office of Planning, Research, and Evaluation of the U.S. Department of Health and Human Services. Key findings from the research summary show that the EITC provides both short- and long-term benefits to recipients, including improved health and educational attainment for children and improved mental health for mothers who received the EITC.[67]

Earned Income Tax Credit: Next steps for Ohio

To improve the implementation of Ohio's EITC, policymakers and other stakeholders should consider the strengths, gaps and recommendations identified in Figure 14.

Figure 14. **Strength, gap and recommendation for Ohio's EITC**

Strength	Gap	Recommendation
In 2019, Ohio raised the state credit amount to 30% of the federal EITC and removed the income cap of $20,000	Ohio is one of only five states with a state EITC that is non-refundable, limiting its ability to help all eligible Ohioans, especially those with the lowest incomes	Ohio can follow the lead of 23 other states and the District of Columbia and make the state EITC refundable

Conclusion

By acting early, policymakers can prevent childhood adversity and eliminate more than $10 billion in annual healthcare and related spending attributable to ACEs exposure in Ohio. There are many cost-effective, evidence-based strategies that ensure a strong start for children and provide economic supports for families being implemented across the state. This momentum requires additional, long-term support to achieve and sustain positive outcomes.[68]

To reduce ACEs exposure and improve outcomes for those who have already experienced childhood adversity and trauma, Ohio must do more. Public and private leaders in Ohio can improve the implementation of cost-effective, evidence-based prevention strategies by:

- Ensuring that young Ohioans most at risk for ACEs have access to programs such as high-quality early childhood education and home visiting
- Providing long-term, sustainable funding structures for programs that have been proven effective through evaluation (e.g., medical-legal partnerships), and fund evaluations for programs that show promising outcomes for children
- Enacting policies that strengthen economic supports for families, such as making Ohio's EITC refundable
- Tailoring prevention efforts to Ohioans most at risk for experiencing ACEs, including Ohioans of color, with low incomes, with disabilities and who are residents of urban or Appalachian counties

This brief analyzed the implementation of four key cost-beneficial strategies that have strong evidence for preventing ACEs with significant health impacts on Ohioans. As state and local policymakers and other partners make decisions on where to allocate resources in efforts to reduce ACEs, these four key strategies can maximize the effectiveness of public and private spending on efforts to ensure a strong start for children and strengthen economic supports for families.

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