PERINATAL CASE MANAGEMENT (DOWNSTREAM)

A Perinatal Case Management Program to engage a community that is "program rich and system poor." This new program will case manage a hierarchy of services for a healthy pregnancy and lifestyle of pregnant and newly parenting women.

INPUTS

What we invest
- Program Manager
- Interns (MSW, MPH)
- Community Connectors
- Columbus Neighborhood Health Centers
- Partners (may include more as identified)
  - Alcohol, Drug, and Mental Health Board
  - Boys & Girls Club
  - Center for Healthy Families
  - Central Benefits Bank
  - Civic Associations and Area Commissions
  - Columbus City Schools
  - Community Development for All People, Ministries 4 Movement, & other Faith-Based
  - Community Shelter Board
  - Expanded Food & Nutrition Education Program
  - Hazel's House
  - Head Start
  - Health Insurance Plans
  - Hospitals
  - Job & Family Services
  - Local Matters
  - March of Dimes
  - Medicaid
  - Mid-Ohio Food Bank & Food Pantries
  - Moms2B
  - Planned Parenthood
  - Recreation Centers
  - Salvation Army
  - South Side Neighborhood Pride Center
  - United Way
  - Universities

Frameworks
- Social Determinants of Health
- Trauma Informed Care

Tools
- Pregnancy Risk Assessment
- Educational Materials on chronic stress factors
- Pre- and Post-Assessments of residents

ACTIVITIES

Target population: Pregnant women residing in zip codes 43206 and 43207, with prioritization for Non-Hispanic Black women

- Develop /Identify educational material to address chronic stress factors
- Identify and enroll participants
- Conduct a pregnancy risk assessment for participants using a standardized tool
- Provide tailored educational material to participants based on risk assessment needs
- Assist participants with attaining needed health and social services
- Complete a reproductive life plan with participants
- Follow-up with Participants
- Monitor & reassess participant's needs
- Encourage providers to write a "prescription" for case management

OUTPUTS

- # of participants enrolled
- # of pregnancy risk assessments completed
- # and type of educational materials provided
- # and type of referrals/ connections to needed health and social services
- # of reproductive life plans completed with participants
- # of follow-up visits per participants
- # of providers who write "prescriptions" for case management

OUTCOMES

Short Term:
- Pregnant women residing in zip codes 43206 and 43207, with prioritization for Non-Hispanic Black women, are enrolled in perinatal case management
- Increased knowledge of chronic risk factors

Medium Term:
Participants will have:
- Consistent prenatal care
- Lower number of chronic stress factors
- A reproductive life plan
- A safe sleep environment for infants

Long Term:
- Lower rate of low birth weight births
- Lower rate of infant mortality

"SMART" GOALS: By December 2016,
- 75% of participants receive an appropriate amount of prenatal care visits (one visit per month through 28 weeks, one visit every 2 weeks through 36 weeks, and one visit per week thereafter)
- 75% of participants have a lower number of chronic stress factors as identified using a pregnancy risk assessment tool after completion of the program
- 100% of participants develop a reproductive life plan
- 100% of participants provide safe sleep environments for their children

DOWNSTREAM

Consistent prenatal care: 75% of participants receive an appropriate amount of prenatal care visits (one visit per month through 28 weeks, one visit every 2 weeks through 36 weeks, and one visit per week thereafter)

- Numerator: Participants who received an appropriate amount of prenatal care visits based on gestation at time of enrollment
- Denominator: Participants who complete the program

Lower number of chronic stress factors: 75% of participants have a lower number of chronic stress factors as identified using a pregnancy risk assessment tool after completion of the program

- Numerator: Participants whose number of chronic stress factors, as identified using a pregnancy risk assessment tool, is lower after completion of the program when compared to before the program
- Denominator: Participants who complete the program

A reproductive life plan: 100% of participants develop a reproductive life plan

- Numerator: Participants who develop a reproductive life plan
- Denominator: Participants who complete the program

Safe sleep: 100% of participants provide safe sleep environments for their children

- Numerator: Participants who provide safe sleep environments, as identified using a safe sleep environment checklist and audit, for their children
- Denominator: Participants who complete the program

THE CITY OF
COLUMBUS
MICHAEL B. COLEMAN, MAYOR

COLUMBUS
PUBLIC HEALTH

COMMUNITY BUILDING / CIVIC ENGAGEMENT PARENTING EDUCATION / MENTORING (UPSTREAM)

A Community Connector Program to engage a community that is "program rich and system poor." Win-win: The Coalition's work is advanced through the Connectors which its members appoint to the training program; the Connectors gain information that helps them enhance their existing outreach work; residents get one-on-one parent education info from folks they recognize and trust.

INPUTS

What we invest
- Program Manager
- Columbus Public Health Social Worker
- Partners (may include more as identified)
  - Alcohol, Drug, and Mental Health Board
  - Boys & Girls Club
  - Center for Healthy Families
  - Central Benefits Bank
  - Civic Associations and Area Commissions
  - Columbus City Schools
  - Community Development for All People, Ministries 4 Movement & other Faith-Based
  - Community Shelter Board
  - Expanded Food & Nutrition Education Program
  - Hazel's House
  - Head Start
  - Health Insurance Plans
  - Hospitals
  - Job and Family Services
  - Local Matters
  - March of Dimes
  - Medicaid
  - Mid-Ohio Food Bank & Food Pantries
  - Moms2B
  - Planned Parenthood
  - Recreation Centers
  - Salvation Army
  - South Side Neighborhood Pride Center
  - United Way
  - Universities

* Community Members and Residents

ACTIVITIES

Target population: Coalition (a union between groups to work toward a common goal)
- Providers
- Social Services
- Community

Connectors (lay health advisors or community champions)
- Coalition
- Community

Coalition
- Establish coalition
- Inform coalition
- Create inventory of programs
- Identify and convene community connectors
- Develop training and program description for connectors
- Identify through the connectors areas of advocacy for improving services

Connectors
- Complete training
- Act as a liaison between coalition and community
- Connect families to services

OUTPUTS

- # of coalition members
- # of coalition meetings
- # of trainings provided
- # of trained connectors
- Inventory developed of health and social service programs for zip codes 43206 and 43207
- Identified target areas
- Reporting structure for program developed
- # of advocacy issues identified

OUTCOMES

Short Term:

Coalition
- Increased knowledge of service gaps and maternal and child health related program in Franklin County

Connectors
- Increased knowledge of leadership and health education

Medium Term:

Coalition
- Better alignment of resources
- Better understanding of successes and challenges for health and social service programs

Connectors
- Families have a better understanding of and can access health and social service programs

Long Term:
- Lower rate of infant mortality
- Increased community engagement
- Improved quality of life for residents of zip codes 43206 and 43207

"SMART" GOALS: By December 2016,
- 75% of coalition members will have increased knowledge regarding maternal and child health related programs in Franklin County
- The coalition's mean Wilder Collaboration Factors Inventory score is higher after 2 years of working together.
- 90% of connectors complete a program for leadership and health education
- 75% of community members know about connectors and what they do

UPSTREAM

Coalition has increased knowledge of service gaps: 75% of coalition increase knowledge regarding maternal and child health related programs in Franklin County

- Numerator: Coalition members who score higher in a post test for knowledge regarding maternal and child health related programs in Franklin County
- Denominator: All coalition members

Coalition is more collaborative: The coalition's mean Wilder Collaboration Factors Inventory score is higher after 2 years of working together.

Connectors earn a program certificate of completion for leadership and health education: 90% of connectors complete a program for leadership and health education

- Numerator: Connectors who complete a program for leadership and health education
- Denominator: All connectors

People know about connectors and what they do: 75% of community members know about connectors and what they do

- Numerator: Surveyed community members who know about connectors and what they do
- Denominator: Surveyed community members