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
  - Columbus Neighborhood Health Centers
  - Partners (may include more as identified)
  - Alcohol, Drug, and Mental Health Board
  - Boys & Girls Club
  - Center for Healthy Families
  - 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
**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
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.
**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