

Hamilton County CFHS Providers SFY '12

Perinatal Health

Measure: Improve Access to Prenatal Care

Community Action Agency (CAA): Conduct outreach for perinatal clients in high risk neighborhoods through use of 1 perinatal outreach worker. Recruitment efforts will be conducted in at least 3 at risk neighborhoods. Perinatal clients will be linked with CAA's Pregnant Moms program, which is an existing program that serves high risk pregnant predominantly African American women. Benchmarks for this program will include increasing the percentage of perinatal clients from 18% to 30%. Contact: Renee Daniel: rdaniel@cincy-caa.org

Healthy Moms & Babes (HM&B): HM&B will conduct outreach for perinatal clients in high risk neighborhoods. HM&B will develop and implement a marketing message/ slogan to promote the importance of seeking prenatal care in the first trimester. Message/ slogan (mobile billboard) will be wrapped on 1- 34 foot Healthy Moms & Babes mobile unit. The neighborhoods to be targeted will be those with the highest preterm birth rates in Hamilton County: some zip codes include 45238, 45211, 45231, 45205, and 45225, 45229, 45232. Contact Kay Brogle: director@HealthyMomsandBabes.org

Child and Adolescent Health

Measure: Reduce percentage of children who are overweight

Cincinnati Children's Hospital Medical Center, Division of Adolescent Medicine: This program will address youth in Hamilton County in the elementary through high school age group with developmentally and age appropriate school-based health education programming to target behaviors related to healthy eating and physical activity that impact obesity. A train the trainer model will be used in which two experienced health educators will be master trainers who will train the school staff in delivering the curriculum at their respective schools. The master trainers will be present during the initial program delivery to provide on-site support for the school-based staff and be available for consultation throughout the entire project. For youth in elementary school (grades 5 and lower), the ODH approved evidence/ practice based curriculum Eat Smart, Play Hard will be used. For the older youth (6th-9th grade), the provider plans to request that ODH review the results of the FUN & FIT program that was developed by Children's Hospital with CFHS funding during the last grant cycle. If use of FUN & FIT curriculum is not approved by ODH, Eat Smart, Play Hard will be used at all the grade levels. The schools included in this proposal have high percentages youth at highest risk for obesity e.g. minority and economically

disadvantaged. This program builds on existing collaborative relationships with schools which will contribute to the success in program implementation. 1500 children in 10 schools in 3 different school districts will be reached through this program. Program is evaluated through pre and post tests of participating students. Contact: Dr. Paula Braverman:
paula.braverman@cchmc.org

Hamilton County Public Health (HCPH): HCPH staff will work with childcare center staff to adopt a resolution to create nutrition standards for all food and beverages provided within the center, as well as, guidelines creating daily physical activity requirements. HCPH will work with childcare staff to create an implementation plan and identify necessary resources and technical assistance opportunities needed by centers to implement their new guidelines. HCPH will work with centers to promote the new guidelines to staff and parents to build awareness and ensure compliance. HCPH will support center staff in the development of a plan for enforcing and sustaining positive change. The children who are most at risk in Hamilton County who attend childcare centers will have increased access to healthy food choices and increase the number of minutes they are physically active daily. The approved evidence based education program I am moving, I am learning will be used in the childcare setting. 1300 children will be reached through 875 visits by HCPH staff to child care centers. Parent surveys, numbers of minutes per center of increased physical activity on the daily schedule and number of improved (i.e. healthier) school menus will be conducted annually as part of the evaluation process for this program. Contact: Kathy Lordo: Kathy-lordo@hamilton-co.org

YWCA: The YWCA of Greater Cincinnati **Healthy EnerGy On the go (EGO)** program will provide nutrition education and physical activity in Cincinnati Public Schools and at the YWCA Cincinnati Early Learning Child Care Center. The program will meet bi-weekly with the school aged children during the After-school program for one hour for education on health topics and physical activity and weekly with the preschool age children. **Healthy EGO** will utilize the *My Pyramid* materials for school age children and the *Grow It, Try It, Like It!* Curriculum for preschoolers. The implementation strategies are: promotion, session presentation, and evaluation. These program strategies will be implemented each school year. The **Healthy EGO** Health/Fitness Specialist will maintain participant records that include attendance, participation, activity completion, basic information and program forms. The specific program goals beyond the CFHS benchmarks include a 60% increase in participant's knowledge of healthy eating habits evaluated with a pre-posttest administered at the beginning and end of each school year and an increase in participant's physical activity evaluated through attendance records. This information will be reviewed, approved, and used by the **Healthy EGO** Director in the preparation of YWCA monthly performance reports that are submitted to YWCA Program Directors and Board and to CFHS. 76 education and physical activity sessions will be provided and with school age children in a school and 38 education and physical activity session with preschool children in a child care center. Contact: Ami Brown:
abrown@ywcacin.org

Measure: Increase the access to child and adolescent health services

Cincinnati Health Department: The Health Check Program was established to close the gap in health services for students in poverty. Currently, the CHD public health RN Health Check program offers enrollment in Medicaid and complete comprehensive health screening services to all Cincinnati Public School students. However, only about 50% of parents return their permission forms and enroll in Medicaid for their children. This program will provide a part time coordinator to follow up with parents who do not return appropriate forms so that the children can be enrolled in Medicaid. This program plans to assist at least 50 children and their families in enrolling in Medicaid or other insurance and connecting them to a medical home. Program will be evaluated by the number of families who have enrolled in Medicaid as a result and who have a medical home. Contact: Kathy Sabin: kathy.sabin@cincinnati-oh.gov

Measure: Reduce the rate of infant mortality

Cincinnati Health Department: The CHD will offer community education on safe sleep to mothers as well populations that have not been traditionally reached by this information, namely caregivers who raised their children in a generation *before* the Back to sleep campaign and other safe sleep programs were initiated. Through the educational session, up to 6 community ambassadors will be identified and trained to spread the message among their peers. These will be mothers, grandmothers or other caregivers who show an interest in spreading the safe sleep message further. The ambassadors will be trained and mentored so that they will be able to provide the safe sleep message in additional community settings. The ambassadors will be compensated a small fee for their time and mileage to conduct these safe sleep sessions. We would anticipate each ambassador to conduct about approximately 10 sessions per year. Trainings will be offered to various community agencies sleep training. The training program use was developed from two main sources. One is the **Curriculum for Nurses: Continuing Education Program on SIDS Risk Reduction, designed by the Eunice Kennedy Shriver for National Institute for Child Health and Human Development. The other is *Reducing the Risk of SIDS in Child Care Speaker's Kit, developed by the American Academy of Pediatrics.*** Number of unsafe sleep related deaths will be tracked by Child Fatality Review Team annually. Contact: Anne Packham: anne.packham@cincinnati-oh.gov

Healthy Moms & Babes: HM&B will develop and implement a marketing message/ slogan to promote Infant Safe Sleep practices. Message/ slogan (mobile billboard) will be wrapped on 1-34 foot Healthy Moms & Babes mobile unit. The neighborhoods to be targeted will be those with the highest preterm birth and infant mortality rates in Hamilton County: some zip codes include 45238, 45211, 45231, 45205, and 45225, 45229, 45232. By implementing this Population Based Service HM&B will assure that greater than 15,000 families are reached with culturally appropriate infant safe sleep messages. Number of unsafe sleep related deaths will be tracked by Child Fatality Review Team annually. Contact: Kay Brogle, director@HealthyMomsandBabes.org

Perinatal Health

Measure: Reduce rate of preterm birth

Healthy Moms & Babes: HM&B will identify women with previous poor birth outcomes and link to appropriate care. HM&B will provide 235 free and confidential pregnancy tests (by the end of FY2012) on HM&B mobile units in order to identify pregnant women with previous poor birth outcomes in high risk zip codes. HM&B's staff will complete ODJFS prenatal risk assessments on the HM&B mobile unit on those we identify as pregnant. Those identified with previous poor birth outcomes will be linked and referred for appropriate services; such as high risk prenatal care and will also be referred into managed risk care coordination with a HM&B Community Health Worker (CHW). Memorandums of Understanding will be established to validate longstanding collaboration with area clinics in identifying and referring clients that have had previous poor birth outcomes and are in need of a HM&B CHW for care coordination. A total of two HM&B CHW's will serve approx 60 women utilizing the evidence based- Partners for a Healthy Baby Curriculum. By implementing this Enabling Service HM&B will assure that 90% of CFHS perinatal clients who are identified with a previous poor birth outcome are assessed and linked to appropriate care and followed through the pregnancy for compliance in care, education, and support by the CHW. Birth outcomes for those women enrolled will be tracked and reported in the aggregate. Contact: Kay Brogle, director@HealthyMomsandBabes.org

OIMRI

Measure: Improve birth outcomes in an at-risk, African-American community through care coordination

Healthy Moms & Babes: Ninety percent of the women in neighborhoods that HM&B serves are African American and thus are at risk of poor birth outcomes. According to the Maternal and Child Health Assessment 2010, in the most recent year for which data is available, the preterm delivery rate in Hamilton County was 13.7, with a preterm delivery rate for African American women being 18.4. In order to improve birth outcomes, Healthy Moms and Babes will provide care coordination services to at-risk African American pregnant women in neighborhoods in Hamilton County with high infant mortality and preterm birth rates. HM&B will conduct planning strategies by creating Memorandums of Understandings that will be put in place to validate longstanding collaboration with area health clinics in identifying women of child bearing age to receive information and discussion on the value of prenatal care with HMB OIMRI staff located at the clinics. Referral process will include a separate component seeking response from client on their barrier(s) to seeking prenatal care. Clients will then be assessed for needs and individual care plan will be developed. The referral process will include a separate component seeking response from client on their barrier(s) to seeking prenatal care. Clients will

then be assessed for needs and individual care plan will be developed. In order to provide culturally responsive services, 2.5FTE Community Health Workers (CHW's) will be trained and supervised in culturally appropriate service delivery. HM&B OIMRI Community Health Worker's will make home visits on a regular basis during pregnancy and through the baby's second year of life. CHWs will provide: face-to-face interaction a minimum of 2-hours a month during pregnancy and infant's first six month; face-to-face interaction a minimum of 1-hour a month during infant's 6-12 months; face-face and phone contact a minimum of 1-hour per month during child's 12-24 months. Home visits will identify and reinforce risk reduction behaviors; appropriate referrals will be made when necessary to assure positive pregnancy and infant health outcomes. Home visitors CHWs will utilize the Partners for a Healthy Baby curriculum. Home visits will identify and reinforce risk reduction behaviors; appropriate referrals will be made when necessary to assure positive pregnancy and infant health outcomes. Pathways are used to guide and validate the success of the client's care plan. Birth outcomes for clients will be tracked and reported annually. Contact: Kay Brogle, director@HealthyMomsandBabes.org