OHIO’S SECRET WEAPON IN REDUCING INFANT MORTALITY IN URBAN AREAS—HEALTHY START

Lisa Matthews - MomsFirst, Cleveland – Level III Grantee
Debra Hall – My Baby and Me, Columbus -- Level II Grantee
April Snelling, Healthy Start – Toledo - Level I Grantee
Gina McFarlane-El –Healthy Start- Dayton- Level I Grantee
Lindsey Cencela – Healthy Start – Cincinnati- Level I Grantee
What Is Healthy Start?

Healthy Start is a 5 year federal grant from Health Resources Services Administration (HRSA) aim at improving perinatal health, decreasing pre-term births, reducing infant mortality, and reducing infant morbidity.

Ohio is fortunate to have 5 Healthy Start recipients funded at various levels, and each Healthy Start program has its own unique method of providing home visiting and other services to our most vulnerable pregnant clients in Ohio.

Let’s hear their stories....
MomsFirst
A helping hand for your pregnancy... and your baby
What is MomsFirst?

- MomsFirst is one of the original 15 federal Healthy Start Projects funded in 1991.
- A home-visiting, education and support program for pregnant women living in the City of Cleveland.
- Originally known as Healthy Family/Healthy Start, the Project’s purpose is to reduce disparities in infant mortality and poor birth outcomes experienced by African Americans in the City of Cleveland.
Who does MomsFirst serve?

- Pregnant women and teens in the city of Cleveland
- Women/teens who are incarcerated, residing in shelters, or enrolled in an inpatient chemical dependency treatment program
- Women/teens who have experienced a pregnancy loss

Service Delivery

- Services are provided from the prenatal period until the child’s 2nd birthday
- Each participant receives at least two face-to-face contacts and one phone call per month
- At least one of the face-to-face contacts must take place in the home
Participant Engagement

- **Community Setting**
  The *core* services of outreach, case management, health education, interconceptional care and perinatal depression screening and referral are the primary strategies used to address the Project’s objectives.

- **School Setting**
  Activities are pregnancy-prevention focused and include active Student Peer Advisory Groups.

- **High Risk Settings**
  Populations served include those incarcerated, residing in shelters, or enrolled in an inpatient chemical dependency treatment program. Focus is on healthy behaviors, family reunification, parenting, and reintegration into the community.
In 2015, we served 1,823 participants
- 58% were 17-24 years old
- 83% African American, 6% Hispanic
- 55% of participants 18 and older completed high school/GED
- 75% of participants were not working at the time of enrollment
- 91% of participants were not married
Participant Characteristics

- 64% report being in a relationship at the time of enrollment
  - 54% report that their partner is financially involved
  - 64% report that their partner is emotionally involved
- 19% report sexual abuse, trauma or physical abuse (typically under-reported)
- 90% utilize food stamps and 53% receive cash assistance
- 56% of participants report never using any form of contraception
Service Providers

- The Project funds 30 Community Health Workers and 8 Case Managers who are trained to provide the Project’s core services. These staff range from paraprofessional level to masters prepared.

- Staff are based out of six neighborhood settlement houses, one community-based social service agency (OhioGuidestone), and one Federally Qualified Health Center (Northeast Ohio Neighborhood Health Services/NEON).
MomsFirst Core Services

- Outreach - Community education and recruitment
- Case Management – Service plan development, goal setting and help navigating systems
- Health Education- Partners for a Healthy Baby Curriculum and Baby Basics
- Interconceptional Care Services – Health throughout the life course, including reproductive life planning
- Perinatal Depression Screening – All staff trained to screen Pre and post natal, addressing mental health
- Developmental Screening – ASQ & ASQ:SE
Collective Impact
Ohio Equity Institute

- Cleveland-Cuyahoga Partnership to Improve Birth Outcomes is a community driven effort to reduce infant deaths.
- Began as a 3 year approach (2013-2016) to reduce infant mortality throughout Cuyahoga County.
Ohio Equity Institute

- Upstream (LARC) and downstream (CenteringPregnancy) approaches have been successful
  - LARCS 0-90% capacity in clinics providing same day services
  - 100% of hospital systems providing Centering and by the end of 2016 100% of FQHC’s will be too
- Next phase is community engagement
- Always accepting new members that represent a variety of social determinants
Infant Mortality Rates, Cleveland by race, MomsFirst
Participant Survey Responses

- She helped me with the emotional roller coaster that you go through when you have a baby.
- Everything was less stressful.
- Gave me assurance that someone cared.
- Kept me from feeling alone.
- Made me feel more positive about my situation.
- She motivated me.
- My MomsFirst worker helped support me in many ways. Helped me understand my health information and my doctor visits. She just supported me in any way she could. I love my MomsFirst worker, she was just like a mom to me.
Lisa Matthews, MBA
Project Director
Cleveland Department of Public Health
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Cleveland Ohio 44114
(office) 216-664-4281
(fax) 216-664-2501
lmatthews@city.cleveland.oh.us
www.momsfirst.org
Healthy Start - My Baby & Me
Debra Hall, MSA, D.T.R. Project Director
Why Healthy Start Is Critical in Franklin County

- 2-3 babies die weekly
- Premature births
- Racial disparity
- High infant mortality
## Decreasing Trend in Infant Mortality Rate in the Project area

<table>
<thead>
<tr>
<th></th>
<th>Franklin County All</th>
<th>Franklin County Non-Hispanic Black</th>
<th>Franklin County Non-Hispanic White</th>
<th>Franklin County Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013</strong></td>
<td>8.3 (155)</td>
<td>13.8 (73)</td>
<td>5.5 (59)</td>
<td>8.3 (11)</td>
</tr>
<tr>
<td><strong>2014</strong></td>
<td>8.4 (158)</td>
<td>15.1 (81)</td>
<td>5.8 (61)</td>
<td>6.1 (9)</td>
</tr>
<tr>
<td><strong>2015</strong>*</td>
<td>7.7 (147)</td>
<td>10.9 (59)</td>
<td>4.9 (51)</td>
<td>6.2 (9)</td>
</tr>
</tbody>
</table>

*Data is preliminary
Source: Ohio Department of Health Vital Statistics Data Analyzed by Columbus Public Health
My Baby & Me

My Baby & Me is a home visiting program that is federally funded by Healthy Start.

The program provides in-home, family-centered service coordination and education services to pregnant women, parenting women, and their infants up to the age of 2 years, who reside in Franklin County.

Funded to serve 800 participants
- 400 pregnant
- 400 parenting and children
What We Do

- Health Education
- Reduce Risks
- Empower Residents
- Improve Access
- Provide Support and Linkage
My Baby & Me Data
November 2015 thru September 2016

- African-American, 59%
- White, 22%
- Other, 9%
- Multi-Racial, 4%
- Asian, 6%
My Baby & Me Program Data
November 2015 thru September 2016

• 100% of clients receive depression screenings and referral
• 84% of clients utilize WIC services
• 98% of clients participate in safe sleep behavior
• 77% of women report male involvement/support
• 72% of pregnant and parenting clients reside in areas that have been identified as high priority neighborhoods
  • “Neighborhoods disproportionately affected by key social determinants…”

Greater Columbus Infant Mortality Task Force (June 2014)

• Provides various items to clients with limited or no resources: Pack-N-Play, diapers, wipes, safety gates and safety kits, strollers, car seats, bus passes, developmental toys and books
Our programs provide free services which include:

- Regular home visits from our nurses, social workers and outreach workers
- Education on pregnancy, women’s health, infant health, and child development
- Support and guidance to solve problems and overcome barriers
- Free pregnancy tests
- Help with applying for Medicaid and WIC
- Help with finding care during and after pregnancy
- Help with finding a doctor for infants and toddlers
- Help with getting social services and other assistance
My Baby & Me
Table of Organization

Project Director
Debra Hall, DTR

Office Assistant
Mandy Younker

Program Manager
Stephanie Wade

Social Workers
- Donna Link
- Janet Taylor

RN's
- Patty Conway
- Kathy Murray
- Sheri Sheterom

Outreach Workers
- Darmi Daddacha
- Lily Limon
- Kara Terry

City of Columbus • Columbus Public Health
My Baby & Me
Contracted Partners

My Baby & Me

Columbus Public Health – Grantee

OhioHealth Wellness on Wheels

Mt. Carmel Health Outreach

Pregnant Clients
Parenting Clients
Children (Birth – 2yrs)
Pregnant Clients
Pregnant Clients
OIMRI
(Ohio Infant Mortality Reduction Initiative)

- Provides community-based outreach and care coordination
- Serve high-risk, low-income, African-American pregnant women and their infants to age 1-year
- Must reside in one of 14 specific Columbus zip codes
Pregnancy Support Services

• Provides in-home family-centered care coordination and education
• Serve low-income pregnant women and their infants to age 1-year
• Must reside in the Columbus city limits
Newborn Home Visiting

- A one-time home visitation for mothers and their newborns under age 6-weeks
- Nurses provide education on newborn care, infant safe sleep, and postpartum care
- Services are available in all of Franklin County
Contact Information

Debra Hall, MSA, D.T.R.
My Baby & Me Project Director
240 Parsons Ave Suite 112 B
Columbus, OH 43215
Phone: (614) 645-1697; Fax 614-645-8324

dlhall@columbus.gov
April Snelling, MPH
Supervisor of Maternal & Child Health,
Toledo-Lucas County Health Department
## Lucas County Infant Mortality

<table>
<thead>
<tr>
<th>Location</th>
<th>2014 IMR</th>
<th>10 Year IMR Average</th>
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</thead>
<tbody>
<tr>
<td>Lucas County</td>
<td>9.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Ohio</td>
<td>6.8</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Toledo-Lucas County
healthy start
Healthy women. Healthy families.
LUCAS COUNTY INFANT MORTALITY RATES BY RACE 2012 (MOST RECENT AVAILABLE)
## Lucas County Infant Mortality Rates by Zip Code 2007-2011

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Total # Live Births</th>
<th>Total # Infant Deaths</th>
<th>IMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>43604</td>
<td>1,091</td>
<td>18</td>
<td>16.5</td>
</tr>
<tr>
<td>43605</td>
<td>3,025</td>
<td>27</td>
<td>8.9</td>
</tr>
<tr>
<td>43607</td>
<td>1,366</td>
<td>13</td>
<td>9.5</td>
</tr>
<tr>
<td>43608</td>
<td>1,404</td>
<td>16</td>
<td>11.4</td>
</tr>
<tr>
<td>43623</td>
<td>960</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>6,886</strong></td>
<td><strong>84</strong></td>
<td><strong>12.2</strong></td>
</tr>
</tbody>
</table>
WHO WE SERVE

- Women ages 13-44 and their children 0-24 months
  - Focus on African American women
  - Focus on “hot spot” zip codes
- Fathers/Partners
- Recruitment:
  - Community outreach
  - Health Department clinics (FQHC)
  - Getting to 1 Referral and Assessment project

Toledo-Lucas County
healthy start
Healthy women. Healthy families.
SERVICES WE PROVIDE

- Obtaining social service needs
- Health insurance assistance
- Reproductive Life Planning
- Smoking cessation
- Safe sleep education/Cribs for Kids
- Father/partner involvement
- Breastfeeding support
- Transportation services
- Parenting support
- Well baby care and vaccinations
- Housing assistance
- Diaper Bank
HOW WE OPERATE

- Preconception Care
  - Public Health Nurse
  - Community Health Worker (CHW)

- Prenatal Care
  - Partner with Northwest Ohio Pathways HUB – 16 CHW’s

- Interconception Care
  - Public Health Nurse
  - CHW
  - Expansion of Pathways

- Health Education
  - Safe Sleep Ambassadors
  - Cribs for Kids
  - Fatherhood/Partner Involvement
GOALS

- Improve the health of women and families
- Reduce infant mortality
- Reduce the disparity in infant mortality among white and black babies
- Reduce the number of low birth weight babies
- Reduce the number of premature babies
- Increase birth spacing to at least 18 months
HEALTHY START PROGRESS 2015

819 program participants served
737 Reproductive Life Plans completed
1310 home visits
315 cribs distributed

83% initiated breastfeeding
9% low birth weight & preterm birth rate
2.0 program infant mortality rate
“The Healthy Start program has helped me understand my baby and his different expression of needs better. It has also taught me how to take care of my baby safely especially when it comes to safe sleep. By having one on one conversations with my Healthy Start case manager I have been able to work through some anger issues. She has taught me some good anger management coping skills. For me, I feel the Healthy Start program has helped me foster a healthier relationship with my husband and others. The program is a great resource for me and if I have a need they cannot meet, they’re good about getting me connected with other resources in the community.” — T.B.
QUESTIONS?

April Snelling, MPH
(419) 213-4263
snellina@co.lucas.oh.us
Healthy Start Reducing Infant Mortality in Montgomery County

Gina McFarlane-El, Chief Executive Officer & Project Director – Healthy Start
Program

• Five Rivers Healthy Start function within a Federally Qualified Health Center that serves over 1,400 pregnant women annually.

• By creating an incentive program, Five Rivers Healthy Start has increased prenatal visits, increased abstinence from smoking and drugs, awarded participants for participating in classes and other healthy behaviors.

• Upon completion of their prenatal care, post-partum care, and initial well-child visit, families are eligible to receive a $50 gift card, pack and play crib, layette, and/or some diapers.

• Home visits take place by Community Health Workers and RNs and patients are followed prenatally and until the child reaches the age of 2.
People

• Our staff include
  • Program Coordinator – Pam Hume
  • 3 Community Health Workers, High Risk Nurse Educator, Social Worker, Data Analyst, Dietician, Certified Nurse Midwife – Employed
  • Nurse Family Partnership (Help Me Grow/Brighter Futures – Home Visiting Nurses for High Risk OB patients – Contracted
  • Behavioral Health Consultant – Contracted
  • Program Evaluator – Contracted
Five Rivers Healthy Start – Kitchen Sink Approach

- Centering Parenting
- Engaged Community Health Workers
- Progesterone Therapy
- Behavioral Health Counselor
- Community Action Network
- Home Visiting RN (NFP)
- Data Analyst
- Dietician
- Waiting Room Education
- Extensive Incentive Program
- Centering Pregnancy
- Informing the Community

REDUCE INFANT MORTALITY
Incentives Galore!
Five Rivers Healthy Start (HS) “Kitchen Sink” Approach to Reducing the IMR

- Offering Centering Pregnancy groups – over 248 participants since January 2015-- 12.4% –Low Birth Weight; 13%– Pre-term Rate
- Offering Centering Parenting groups
- Educate Patients While In the Waiting Room on 10 different topics
- Besides the Incentive Program, Five Rivers Healthy Start created Montgomery County’s 1st Diaper Bank for parents in targeted zip codes
- HS tracks over 500 data points regarding our patients
Five Rivers Healthy Start “Kitchen Sink” Approach to Reducing the IMR

• All HS patients are visited by the team after the mother has delivered at MVH to ensure the patient has a post-partum visit scheduled and the infant has a scheduled appointment

• Educated the Staff on Toxic Stress, Life Course Theory and Trauma Informed Care

• Our Community Action Network (CAN)group will assist us in evaluating the program and developing a needs assessment for prenatal care
Total Program Participants Served
- 1,260 + 57 Men
- Feds Goal - 500

Total Births
- 561 Births -- 69% African-American
- Feds Goal 250

# of LBW Births
- 61 – (12.4%)
- FRHC 2012 – 14.4%; 2013 -13.3%; 2014-12.4%, 2015- 14.9%

# of Infant Deaths
- 3 (6.3% IMR)
- FRHC – 2014 – 15
- FRHC 2015- 10 death

Prenatal Visit by 1st Trimester
- 72%
- Ohio FQHCs – 68%
- FRHC 2012 – 50.3% -- FRHC 2015 74%
<table>
<thead>
<tr>
<th>DATA</th>
<th>January –December, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Program Participants Served</strong></td>
<td>1,260 + 57 Men</td>
</tr>
<tr>
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<tr>
<td><strong>Total Births</strong></td>
<td>561</td>
</tr>
<tr>
<td></td>
<td>69% African-American</td>
</tr>
<tr>
<td><strong># of Low Birth Weight Births</strong></td>
<td>61 (12.4%)</td>
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<tr>
<td></td>
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</tr>
<tr>
<td><strong># of Infant Deaths</strong></td>
<td>3 (6.3% IMR)</td>
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<tr>
<td></td>
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<tr>
<td><strong>Prenatal Visit By First Trimester</strong></td>
<td>72%</td>
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## Five Rivers Healthy Start Data

<table>
<thead>
<tr>
<th>Objective</th>
<th>Federal Goal</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients have a documented reproductive life plan</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Patients received a postpartum visit* (Medicaid HMO – 61%)</td>
<td>80%</td>
<td>63%</td>
</tr>
<tr>
<td>Patients who engaged in safe sleep behaviors</td>
<td>80%</td>
<td>97%</td>
</tr>
<tr>
<td>Patients who have ever breastfed*</td>
<td>82%</td>
<td>54%</td>
</tr>
<tr>
<td>Abstinence from cigarette smoking*</td>
<td>90%</td>
<td>79%</td>
</tr>
<tr>
<td>No Elective Delivery before 39 weeks</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Patients that do not Conceive within 18 months of a previous birth</td>
<td>70%</td>
<td>87%</td>
</tr>
</tbody>
</table>
Through Sept. 2016, FRHC has seen 160 CenteringPregnancy© patients in 21 groups with 140 patients completed the groups with a 88% completion rate.
Five Rivers Healthy Start – Plans for the Future

• Through a grant from the Ohio Department of Medicaid, FRHC will be expanding healthy start to include **ALL** of our patients and providing most of the same resources – called **Healthy Start Expansion** --Adding 2 RNs and 3 CHWs

• This grant additionally provides funding to provide Fatherhood Education – Fathers in the community will go through Daddy Boot Camp program that will begin in October

• Finally the grant provides funding for a Community-Wide Pregnancy Housing Counselor to assist pregnant patients in dealing with housing issues – Adding 1 Counselor
Five Rivers Health Centers

Gina McFarlane-El – Gina.McFarlane-El@FRHC.org
Pam Hume – Program Coordinator – Pam.Hume@FRHC.org
Our Crisis
Hamilton County Numbers-2015

99 infant deaths
54% died on their first day of life
49 were < 25 weeks gestation
Average maternal age: 27 years old

Cause of Death 2011-2015****
- Preterm Birth: 13.8%
- Sleep-related Deaths: 16.7%
- Birth Defects: 9.7%
- Other: 59.8%

*Source: CDC Wonder, comparing our 2011-2015 rate to the 2011-2013 rate of communities throughout the US
**2011-2015; Source: Fetal and Infant Mortality Review, Ohio Department of Health Vital Statistics, 2015 data is provisional
***2014; Source: Ohio Department of Health, CDC
****Source: Fetal and Infant Mortality Review

Source: Vital Records data analyzed by Cincinnati Children’s Hospital Medical Center; CDC
Cradle Cincinnati 101
WE ARE 1
3 ways we can make a difference

SPACING
>12 months in between pregnancies decreases chances of premature birth.

SMOKING
No tobacco during pregnancy. Call 1-800-QUIT-NOW for help.

SLEEP
Babies sleep safest Alone, on their Back, in a Crib. Never share a bed with a baby.
Empowering women to make healthy choices

Women need to hear consistent messages from:

**Their medical providers.** We need quality improvement initiatives that address the ways in which health care providers talk about spacing, maternal smoking and safe sleep.

**The media.** We need simple, actionable public health messaging that addresses these issues.

**Their community.** We need to change the culture of pregnancy in Cincinnati, one block at a time.
## Partnership makes a difference

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<tbody>
<tr>
<td>Infant Deaths (Rate)</td>
<td>217 (9.8/1,000)</td>
<td>196 (8.9/1,000)</td>
<td>21 fewer infant deaths</td>
</tr>
<tr>
<td>Preterm birth rate</td>
<td>11.2%</td>
<td>10.7%</td>
<td>130 fewer babies born too soon</td>
</tr>
<tr>
<td>&lt;12 month Spacing</td>
<td>18.7%</td>
<td>17.2%</td>
<td>366 fewer short spaced pregnancies</td>
</tr>
<tr>
<td>Maternal Smoking</td>
<td>11.8%</td>
<td>9.8%</td>
<td>462 fewer maternal smokers</td>
</tr>
<tr>
<td>Sleep Related Deaths</td>
<td>35</td>
<td>21</td>
<td>14 fewer sleep related deaths</td>
</tr>
</tbody>
</table>

Source: 2011-2015 vital records data, FIMR; details available at cradlecincinnati.org
Advisory board and co-chairs

Jim Greenberg
Physician Lead

Elizabeth Kelly
Physician Lead

Ryan Adcock
Executive Director

Lindsey Cencula
Project Director

Chrissy Haslam
Project Manager

Jessica Seeberger
Proj Specialist

Beth McNeill
Assoc. Dir

Corinn Taylor
Com Dev Dir

Ryan Mulligan
Senior Specialist

Interns

Cristie Carlson
Health Ed

Perinatal Institute Support for the entire team

Janel Chriss
Eric Hall
Data Director
Karen Sparling
& business office
Jennie Parker
& development
Innovative Programs

Maternal and Infant Data Hub
Our Team

Social Worker, Registered Nurse, Dietician, and Mental Health Specialists
Healthy Start Logic Model - Cincinnati Children’s Perinatal Institute

Our goals

Promote Quality Services
Increase accountability
Achieve collective impact
Improve women’s health
Strengthen family resilience

We will partner with existing, often silo’d programs...

Existing Referral Sources
- Hospital
- Outpatient Clinics
- Churches
- Mom’s Groups

Existing Programs
- ECS Home Visitors
- CHD Home Visitors/CHW
- HCAN CHW
- HM&B

Unconnected women

...and create a resource team that addresses social determinants and encourages collaboration....

Resource team of:
- Community Coordinator
- Dietician
- Social Worker
- RN
- Therapist
- Evaluation team

...which will lead to supported, healthy families in Price Hill and surrounding communities

Decrease preterm birth by 10%
Decrease maternal smoking to 10%
Increase adequate spacing by 70%
Increase use of safe sleep practices to 80%

Supported by the partnership and the Collective Impact of:
- Cradle Cincinnati, an infant mortality collective impact collaborative;
- The Best Babies Zone in Price Hill;
- Start Strong Avondale;
- UC Health’s Community Women’s Health Program;
- Health Care Access Now;
- Every Child Succeeds;
- The Center for Closing the Health Gap;
- TriHealth;
- The Christ Hospital

Assumptions we are making:
Social determinants including issues of poverty, mental health support and nutrition support need to be addressed. A community-based resource team of health workers are a proven strategy for serving women holistically and improving outcomes. Lengthening interpregnancy intervals will be associated with a decrease in preterm birth rates. Decreased maternal smoking will be associated with improved maternal health and lower preterm birth rates. Safe sleep education will lower incidence of unsafe sleep death. A zonal approach using collective impact is needed.
Cradle Cincinnati Connections
Key Driver Diagram (KDD)

Project Leader: Lindsey Cencula
Revision Date: 08/19/2015

SMART Aim

Decrease Infant Mortality by 15% by February 2019. (15.6 deaths to 13.3 deaths per 1000 live births)
Population: Cincinnati Zip Codes: 45204, 45205, 45214, and 45225

Global Aim
To make 45204, 45205, 45214, and 45225 communities thrive and ensure healthy and safe infants.

Key Drivers

- Community Education about Infant Mortality Risks
- Community Awareness of Social Support Services
- Healthy Moms before, during and after pregnancy
- Safe Living Environments for Infants
- Healthy Infants Achieving Developmental Milestones
- Valued and Accessible Medical Home
- Interagency Collaboration
- Valued and Accessible Organizations Providing Optimal Support

Interventions (LOR #)

- Connect families with infant supplies (formula, breastfeeding supplies, cribs, car seat, diapers, etc.)
- Administer screenings and referrals (smoking, depression, intimate partner violence, early intervention).
- Facilitate connections to medical homes (insurance, prenatal care, postpartum care, and routine medical visits).
- Educate parents about family planning options through use of the Reproductive Life Plan.
- Provide encompassing solutions through case consultations with community agencies.
Cradle Cincinnati Connections is:

• Healthy Start Program supported through the Health Resources Services Administration (HRSA)
• Designed to enhance and support existing Maternal and Child Health social support programs
• Provides families and organizations with health education and screenings, case conferencing, access to supplies
• Wrap-around service model to promote better health outcomes
• Measurement of 21 Benchmarks and community level metrics
We Can Help With

- Breastfeeding support
- Safe sleep education
- Depression screenings
- Support and guidance with reproductive life planning
- Smoking cessation information
- Nutritional counseling

Let Us Connect you to

- Access to supplies (cribs, diapers, breastfeeding pumps)
- Secure housing information
- Assistance with finding a medical home
- Family/partner involvement support
- Intimate partner violence programs
- Moving Beyond Depression