History of DCHD FIMR Program

Nebraska Blue Ribbon Panel formed to address high infant mortality rates (1999)
Douglas County convened Baby Blossoms Collaborative (the equivalent of CAT) in 2004
Incorporated FIMR Program 2 years later (2006)
We’re currently celebrating 10th year anniversary of Douglas County FIMR Program

What is CATS’s Role?

Develop new and creative solutions to improve services & resources for families
Enhance the credibility & visibility of issues related to women, infants & families
Work with the community to implement interventions
Assess and safeguard successful changes

Who should be on CAT?

Those who have political will/fiscal resources
Those who have a community perspective and know how to create community change

Membership Examples

- Mayor
- City council members
- Director of local medical society
- Hospital presidents
- CEO of insurance companies
- State MCH Manager
- Housing Authority manager
- Chamber of Commerce
- Local Healthy Start
- Kiwanis Club
- FQHCs
- Local home visitation agencies
- Bereavement organizations
- Local MOD
- Urban League
- Community Health Center representative
- Perinatal Data Unit
- Public school representative
- Church representative

Who is currently on DCHD CAT?

- Alegent Health
- Babies R Us
- Big Picture Productions
- Charles Drew Health Center/Omaha Healthy Start
- Children’s Hospital and Medical Center
- CityMatCH
- College of Saint Mary
- Creighton University Medical Center
- Department of Health and Human Services
- Douglas County Board of Health
- Douglas County Coroner’s Office
- Early Childhood Consortium of the Omaha Area
- Early Childhood Training Center
- Essential Pregnancy Services
- Fred Leroy Health and Wellness Center
- Girls, Inc.
- March of Dimes Nebraska Chapter
- Methodist Physicians Clinic
- Metro Omaha Medical Society
- Ministerial Alliance
- Munroe Meyer Institute
- NE Children and Families Foundation
- NE Children’s Home Society
- NE Medical Center
- NE Methodist Health System
- NE Midwives Association
- NE SIDS Foundation
- Office of Minority Health
- Omaha District Dietetic Association
- Omaha Police Department
- Omaha Public Schools
- Our Healthy Community Partnership
- Project Harmony
- Region 6 Behavioral Health Care
- Salvation Army
- Share Advantage
- Turning Point
- University of Nebraska at Omaha
- University of Nebraska Medical Center
- Urban League of Nebraska
- Visiting Nurse Association
“Around the table” can be defined in different ways. We have built relationships with people who we still utilize, but they don’t physically come to our meetings anymore.

Examples:
- Physician who was President of local medical society and currently is VP of large insurance agency
- Perinatologist who runs statewide perinatal collaborative
- Head of Psychiatry Dept. at regional medical center

How do you recruit/engage members?
- Recruit members based on agency mission or personal interest
- Pose the question “who else should be around the table”, and ask members to recruit peers
- Engage members with meaningful work
- When developing community plan, put a system in place where everyone can be involved and/or offer input
- Use the Steering Committee to recruit leaders

How do you keep them engaged?
- Common Agenda
  - Make sure members have something to take back from each meeting that’s useful to their work/agency.
  - Change it up – we’ve developed different “systems” through the years where we try to meet our members’ needs in addition to CAT’s goals.
  - Ask members to sign a 2 year contract committing to a certain percentage of meetings, committees, etc. Ask them to identify an “alternate” to attend meetings when they aren’t able.

Data Driven Plan
- Cumulative Data Set
  - Population-based data
  - Case Data
  - Prams
  - PPOR
  - Youth survey

How CAT is Developing PH Workforce
- College of Public Health
  - Health Promotion
  - Epidemiology
- Two medical schools & resident programs
- Five Nursing schools
- Recruit via mock CRT & BBC meetings
- Utilize national & local students with at least master’s degree
- Look for medical students working on MPH

Group Activity
Thank you
Guide to Developing Goals, Objectives, and Action Steps

1. **State the goal** (the what and why)

   a. **Develop (or refine) a goal statement** that includes what is to be done and why it is to be done (e.g., “Create caring communities through education and opportunities to serve.”) To do so:
      1. Describe the essential “what” of the organization or initiative by reviewing its core functions and current programs and activities (e.g., training, advocacy, support, partnerships)
      2. Explain the essential “why” of the organization or initiative by reviewing the vision statements (e.g., safe neighborhoods, healthy children)
      3. Frame the goal statement as a single sentence that captures the common through parent training and community support (the what)."

      *What is your drafted goal statement?*

   b. **Review the goal statement**, making sure it is:
      1. Clear regarding what is to be done and why
      2. Concise (often one sentence)
      3. Outcome oriented
      4. Robust - it leaves open a variety of possible means
      5. Inclusive - reflects the voices of all people who are involved

      *What is your final goal statement?*
To develop (or refine) action steps/strategies, clearly describe how the effort will bring about the goal. Action steps are tasks you perform that contribute to the accomplishment of your goal. Action steps can be big or small, ranging from making a phone call to running a marathon. To create action steps, look at your goal and think about what you need to do to reach it. Now, brainstorm a list the actions that need to take place in order to accomplish the goal.

a. Compartmentalize actions steps/strategies for similarity/likeliness (determine the consistent themes i.e. education, social justice, lack of resources, etc.).

b. Craft each:
   1. Behavioral strategies to be used. Approaches may include:
      a. Providing information and enhancing skills (e.g., conducting a social marketing campaign to educate people about the problem or goal and how to address it)
      b. Modifying access, barriers, exposures, and opportunities (e.g., increasing availability of affordable childcare for those entering the work force)
      c. Changing the consequences (e.g., using tax incentives to encourage housing developers to create green spaces and mixed income development)
      d. Enhancing services and supports (e.g., increasing the number of public health centers that provide dental care)
      e. Modifying policies and broader systems (e.g., changing business policies so that all employees can get time off to care for their sick children)

2. Review the action steps/strategies on their appropriateness to the situation and sufficiency in addressing the mission and goal. Review the strategies for:
   a. Consistency with the overall vision, mission, and goal
   b. Goodness of fit with the resources and opportunities available
   c. Anticipated resistance and barriers and how they can be minimized
   d. Whether those who are affected are reached
   e. Whether those who can contribute are involved

Any changes?
3. **State the objectives** (how much of what the group hopes to accomplish by when).

   a. Utilizing the themes from the actions, develop objectives by clearly describing:
      
      1. Benchmarks that would help us assess where we are now (baseline or pre-intervention) and where we would be if the initiative were successful (objectives).
         
         What baseline markers could we access and how would we hope they would change if success were attained?

      2. Behavioral objectives: the changes in behaviors the group would see if the efforts were successful (What would people be saying and doing differently?) (e.g., For preventing adolescent pregnancy- “By 2012, to increase by 40% the reported level of sexual abstinence and use of contraceptives for those who are sexually active among 12-15 year olds”)

      3. Population-level objectives: the changes in community-level indicators the group would see if the objectives were met (How would changes in individuals’ behaviors add up to outcomes for all those in the community?) (e.g., For adolescent pregnancy-“By 2015, the estimated pregnancy rate among 12-15 year olds will be reduced by 30%”).

   b. Review the objectives to determine if they are: (SMART+ C)
      
      1. **Specific**
      2. **Measurable** (at least potentially)
      3. **Achievable**
      4. **Relevant** (to the mission and goal)
      5. **Timed** (date for attainment)
      6. **Challenging** (requiring extraordinary effort)

   c. Be flexible with deadlines in creating objectives. Defining objectives is time-consuming and may require second and third considerations for completeness.

   **Put together on paper and review!**
Facilitator Template
(Decision Tree)

(1) Content
(a) Review relevant data and recent interventions (placemat)

(2) Current Reality/Commitment
(Developing your goal)
(a) Utilizing the recommendation, and relevant research/data, develop a clear, compelling and concise statement utilizing the previous information (Only one goal per category)

(b) Brainstorm actions that will accomplish task.

(b) Cluster activities by themes that are related or could be done by a particular subgroup (some may already have an independent champion)

(c) Utilize the themes to draft objectives.

(d) Utilize the actions to delineate action steps

(3) Key Actions:
(Objectives and Action Steps)

(4) Draft Results
(a) Compile Goal, Objectives and Action Steps onto one document

(b) Identify Champion to report out.
Safe Sleep  Goal D

Increase awareness and access to resources to promote safe sleep practices.

Objective 1 D: Promote use of safe sleep packet at the hospital (health systems) after delivery.
Action Step 1.1: Identify and assess current safe sleep educational practices at hospitals (health systems).
Action Step 2.2: Identify and tailor best practices of Safe Sleep Education for Douglas County.
Action Step 2.3: Promote best practices of Safe Sleep Education within Douglas County hospital systems.

Objective 2 D: Promote discussion points (teachable moments) to one-to-one family providers. (IE: Physicians (OB-GYN), Nurse Practitioners, WIC etc.)
Action Step 1.2: Convene provider champions and additional stakeholders group addressing safe sleep.
Action Step 2.2: Identify current best practice model regarding one-to-one dialog.
Action Step 3.2: Implement best practice model into family provider practices in DC.

Objective 3 D: Monitor current legal standards/policies for safe sleep education for child care providers.
Action Step 1.3: Advocate for advancement for childcare rules and regulations.
Action Step 2.3: Promote current best practices for Safe Sleep.

Objective 4 D: By Dec. 31, 2014, evaluate the impact of safe sleep promotion, one-to-one family provider discussion points, and monitoring of legal standards/policies for Safe Sleep Education.
Action Step 1.4: Conduct Evaluation of Safe Sleep Initiative.
Action Step 2.4: Disseminate results of evaluation to community.
Preconception Health:
Comprehensive preconception health education shall be offered at an early age that addresses 4 umbrella concepts:
1) Need for consistent medical home, 2) Lifestyle issues,
3) Need for a culturally & religiously sensitive reproductive plan.
4) Education/management of chronic conditions including mental health, substance abuse, obesity and previous fetal loss, emphasizing that these conditions may put women of childbearing age at increased risk of negative pregnancy outcomes.

<table>
<thead>
<tr>
<th>Relevant Data</th>
<th>Proposed Activities</th>
<th>VIP’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong> - % of birth mothers who were obese 3 months prior to conception:  &lt;br&gt;<strong>Total (2010-2014) – 22.4%</strong>  &lt;br&gt;*increase from 20.5% in 2010 to 23.8% in 2014 (Source: DC Birth data)</td>
<td>Based on what stands out to you, what activities could be proposed?</td>
<td>What other organizations do you think should be at the table?</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong> - % of mothers who reported smoking cigarettes 3 months prior to conception:  &lt;br&gt;<strong>Total (2010-2014) – 13.2%</strong>  &lt;br&gt;*decrease from 14.8% in 2010 to 12.5% in 2014 (Source: DC Birth data)</td>
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<td>Factors PRAMS can’t measure well enough: obesity (missing data), alcohol &amp; drug use.</td>
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<td><strong>FIMR Case Data:</strong> Recent Interventions 3 community sites are utilizing teen-focused TOP curriculum which covers obesity &amp; substance use/abuse (along with many other lifestyle issues. Launching of the Adolescent Health Project aimed at decreasing teen STD rate in Douglas County.</td>
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<td>CDC – <em>Treating for Two Campaign</em> (educating providers/women on safe use/hazards of medication use during pregnancy. This ties in with CDC research on Opioid Use among Women of childbearing age.</td>
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</tbody>
</table>

**Piecing it together**

**Highlight what stands out to you**
Prenatal Care (1):
Throughout the prenatal period of all women, “consistent and ongoing” screening for medical & nonmedical risk factors shall occur; noting any red flags in order to signal a tiered, multidisciplinary response to include appropriate referrals.

Piecing it together
Relevant Data
In Douglas County, the no. of fetal deaths has typically been slightly higher than the number of infant deaths. The exception to this trend was 2014, where infant deaths were slightly higher.

The total no. of fetal deaths from 2010-2014 was 241 deaths. Of these deaths, 28.9% to 47.8% occurred at 28+ weeks gestation.

WIC results: Surveyed 16 women total (8 PP & 7 pregnant)
- 11 had never heard of the concept of counting kicks
- 15 had never heard of the CTK Program
- Of the 7 pregnant women, 6 were very interested in the CTK program & liked brochure/app.

Recent Interventions
Count the Kicks Program results:
- All home visitation agencies in DC have heard of CTK.
  Nebraska Children’s Home Society & VNA are utilizing info. with clients.
- CHI – purchased 7,000 brochures to get in hands of each OB provider
- Nebraska Medicine – 100 brochures
- 17 WIC clients surveyed (PP & currently pregnant)
- Program endorsed by Nebraska Perinatal Q.I Collaborative
- Information distributed at MOD Summit to OB providers
- Booth @ Omaha Baby Fair & Baby Love Essentials
- Essentials Chiropractic will be utilizing CTK in prenatal classes

Proposed Activities
Based on what stands out to you, what activities could be proposed?

VIP’s
What other organizations do you think should be at the table?

Prenatal Care (2):
Intergenerational and multicultural education shall be provided by medical, social work and other community health providers in the areas of preterm labor (warning signs during pregnancy) and prematurity (undesired outcome) in addition to the healthy signs of pregnancy.
Safe Sleep:
Safe sleep messages shall be repeated at every medical home visit (wellness and illness) for parents and other child care providers.

**Piecing it together**

**Relevant Data**

SIDS – SUIDS -

Number of SIDS/SUID cases in Douglas County over past 5 years:

- 2011 – 5 cases
- 2012 – 6 cases
- 2013 – 8 cases
- 2014 – 9 cases
- 2015 – 8 cases so far (Jan.-July)

Over the past 5 years, 83% of SIDS/SUID cases were related to unsafe sleep practices. Of these cases, 39% occurred with someone else in the bed.

**Recent Interventions**

October Media Campaign:

- Partnered with Project Harmony to do press release with total of 4 TV spots (Channels 6, 7, 3 & Fox 42). Also, online article with Omaha World Herald.
- DCHD utilized Social Media – “Sleep Safely, Douglas County”
- New Safe Sleep Brochure & Poster developed (English & Spanish versions)

**Proposed Activities**

Based on what stands out to you, what activities could be proposed?

**VIP’s**

What other organizations do you think should be at the table?
Infant Health:
All infants should have a medical home as defined as an environment in which care is accessible, continuous, comprehensive (including appropriate referrals, ex: agencies i.e. CPS), family-centered coordinated, compassionate and culturally effective. (AAP)

Piecing it together

Relevant Data
Infant mortality rate was 7.0 in 2005-2007 & dropped to 5.5 in 2012-2014. We are now avoiding 9.4 deaths/year, and this is statistically significant.

The health disparity has decreased significantly (1:1.8). Of those 9.4 deaths/yr., we are now avoiding 5.5 because of reducing black infant mortality.

*case specific info. on medical home from Carol G.

Recent Interventions
CRT has reviewed only infant cases for the past 2 years. As a result, we have compiled my infant specific data.

Proposed Activities
Based on what stands out to you, what activities could be proposed?

VIP’s
What other organizations do you think should be at the table?