

Goal	Objectives	Action Steps	Measures	Timeline
Goal 2: Reduce the number of sleep related infant deaths to zero by 9/30/2025.				
A. Increase availability of safe sleep environments to 300 per year.	A1. Increase community awareness of Cribs for Kids portable crib program	A1a. Promote at community events and through social media A1b. Increase access to portable cribs at various locations	Number of new referrals sources Number of cribs distributed	
B. Reduce health disparities	B1. Increase availability of culturally appropriate resources for minority populations B2. Clark County will continue to offer implicit bias training and trauma informed care training. B3a. Continue collecting data on social determinants of health B3b. Identify a navigation process to reduce barriers to social/ health needs. B4. Education provided to father on safe sleep practices	B1a. Identify current resources B2a. Create connection with Health Equity group to provide trainings in the community and for service providers a. Clark County will write a grant to support a county navigator role to increase linkage to services. b. Clark County will continue to explore Pathways HUB community integration. Incentivize fathers to take training	B1a1. Compile a list of resources and update Local Resource page on SS website 1. Record the number of trainings provided and the number of participants 1. Number of county navigators added (aka Community Health Worker (CHW), (aka, Neighborhood Navigator) 1. Rocking Horse Community Center will provide updates on the pilot to Start Strong coalition 1. identify resources available 2. identify barriers to attending 3. connect dads to resources and mentoring opportunities	Complete 2023 Complete, ongoing
	B5. Ensure that both standardized reporting forms and social media outreach follow CLAS guidelines.			
C. Ensure accurate and comprehensive collection and distribution of data surrounding sudden unexpected infant deaths.	C1. Outline a county wide process for collection and submission of SUIDI form. C2. Develop a formal report and reporting structure for sudden unexpected infant death reviews.	C1a. Survey county agencies on awareness and current process for utilization of SUIDI forms. C1b. Identify county process for collection of SUIDI form. C2a. Identify current reporting process C2b. Research availability of standardized reporting forms. C2c. With input for Clark County Child Fatality Review committee, develop a reporting form and process.	Survey results. Document outlined process. Record current reporting process	March 2023 December 2023
E. Increase community awareness of safe sleep recommendations	E1. Social media presence	E1a. CCCHD Facebook live E1b. SS website banner promoting safe sleep E1c. Ensure social media information follows CLAS guidelines	1. Record number of views 1. Record number of views of safe sleep education page	

Goal	Strategy	Objectives	Action Steps	Measures	Timeline	
Goal 3: Raise Awareness of the Importance of Preconception and 1st Trimester Health						
	A. Promote Start Strong website	A1. Promote through partner agencies, social media and county events	A1a. Distribution Start Strong promotion flyers to partner agencies A1b. Schedule presence on social media	30 flyers distributed, presented to RHC providers 5/2023, Social media analytics		
		A2. Maintain accurate, up to date information on website	A2a. CCCHD staff dedicated to maintaining website A2b. Standing agenda item for website feedback/ updates at Start Strong meetings	JAN 2024 met with social media and IT specialist to webiste improvements		
	B. Targetted efforts focusing Clark County adolescents	B1. Identify access points for adolescents B2. Maintain and increase collaborative relationships with Clark County ESC/ GRADS and Springfield City School District (SCSD) B3. Promote through social media B4. Create a pregnancy educational resource packet in partnership with GRADS program and SCSD B5. Involve fathers in classes and teen program of GRADS	B1a. Mercy Health to provide child birth classes at SCSD in process	One additional GRADS staff member hired (Candace Copeland) and placed at Springfield High School	Complete, ongoing	GRADS
		B6. Education and awareness	Health Class Guest Speaker, Brittney Bruce from Sexual Health and Wellness Clinic			
	C. Decreasing Lead Exposure	C1. Identify a baseline number of prenatal care providers using the Ohio Department of Health Prenatal Risk Assessment for Lead.	C1a. Recruit local OB provider advocate to join Start Strong C1b. CCCHD lead case management team will survey all prenatal care providers regarding use of the Prenatal Risk Assessment for Lead and tally results C1c. Obtain prenatal EBLL results from OB practices and collaborate to decrease them C1d. CCCHD lead team and Shannon Chatfield make referrals as needed for home lead assessment, ODH, WIC, food pantry, CCJFS, Project Woman, and Early Childhood services		June 2023 December 2022 December 2024	
		C2. Identify baseline number of women of childbearing age identified with an elevated blood lead level (EBLL).	C2a. Obtain lead test results of women of childbearing age to measure outcomes. C2b. Identify an existing tracking mechanism for women of childbearing age lead results or create a tracking mechanism if needed C2c. Collate women of childbearing age lead test results annually to monitor change in percent of increase or decrease of women of childbearing age with an EBLL	Submit proposal to the Ohio Department of Health requesting CCCHD access to data	March 2022 and ongoing December 2024 December 2023 September 2025	
	D. Increase Early Identification and Intervention for lead exposed mothers, infants and children	D1: Establish OB policy to lead screen pregnant women.	D1a. Investigate related polices in states that require lead screening of all pregnant women D1b. Work with local OB providers to create a mechanism for tracking prenatal blood lead lab results. D1c. Work with local OB providers to establish practice of lead screening all pregnant women at the beginning of their 2nd trimester and to retest them at the beginning of their 3rd trimester.		6/1/2023, complete December 2022 January 2024	
		D2: Establish hospital policy for lead screening cord blood of all stillborn babies prior to disposal and newborns whose mother either identified with an EBLL or was not screened for lead.	D2a. Investigate related policies in states requiring lead screening of all pregnant women D2b. Enlist OB cooperation to either establish practice of neonatologists ordering lead screening or make pediatric lead screening referrals for newborns of mothers with EBLL		December 2023 June 2025	
	E. Increasing Lead Safe Awareness	E1: Marketing efforts to increase community lead safe awareness.	E1a. CCCHD distribute lead safe literature throughout Clark County – April 2022 and ongoing E1b. CCCHD press releases E1c. CCCHD website E1d. CCCHD social media	E1b1. How lead affects the fetus in pregnancy and breastfeeding implications E1b2. Partnership with local OBs to address maternal and prenatal lead poisoning E1d1. Facebook Live session re: lead affects pregnancy and breastfeeding implications	April 2022 and ongoing January 2023 June 2023 June 2022 and ongoing October 2022	

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				E1d2. Facebook posts re: lead affects pregnancy and breastfeeding implications	October 2022 and ongoing
			E1e. Start Strong website	E1e1. Incorporate information re: lead affects pregnancy and breastfeeding implications	June 2023
		E2: Engage local prenatal care providers.	E2a. CCCHD lead case management team connect with local prenatal care providers to develop a partnership to identify and lead screen pregnant women at risk for lead exposure		
			E2b. Send letter to OBs requesting partnership		June 2022
			E2c. Disseminate lead related pregnancy and breastfeeding brochures and resources following CLAS guidelines		August 2022 and ongoing
			E2d. CCCHD lead team presentations to local prenatal care providers		December 2023
			E2e. Schedule statewide lead medical expert to address Start Strong Clinical Collaborative		June 2023
			E2f. Establish exchange of elevated blood lead level (EBLL) information between CCCHD and local OBs		August 2022 and ongoing
	F. Reduce health disparities	F1. Increase availability of culturally appropriate resources for minority populations following CLAS guidelines	F1a. Start Strong website includes culturally appropriate information following CLAS guidelines		
		F2. Clark County will continue to offer implicit bias training and trauma informed care training.	F2a. Create connection with Health Equity group to provide trainings in the community and for service providers	1. Record the number of trainings provided and the number of participants	
		F3a. Continue collecting data on social determinants of health	F3a1. Clark County will write a grant to support a county navigator role to increase linkage to services.	1. Number of county navigators added (aka Community Health Worker (CHW), (aka, Neighborhood Navigator)	
		F3b. Identify a navigation process to reduce barriers to social/ health needs.	F3b1. Clark County will continue to explore Pathways HUB community integration.	1. Rocking Horse Community Center will provide updates on the pilot to Start Strong coalition	
		Fathers learning about birth spacing		1. identify resources available	
		Fathers engaged in prenatal appointments & bonding w/unborn child		2. identify barriers to attending	
				3. connect dads to resources and mentoring opportunities	
		F4. Ensure that all flyers and social media follow CLAS guidelines			

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By September 30, 2025 Clark County will increase breastfeeding initiation rates from 58.2% (2019) to 75.7% (to match the rate for the state of Ohio, 2019)	A. Implement a care coordination system across the prenatal through weaning stages, including the development of formal referral systems, follow-up accountability, and handoff protocols during transitions of lactation care from one provider or setting to another.	A1. Establish community clinical linkages among healthcare providers, community-based organizations (CBCs) and other LSPs through networking and relationship building, leading to a memorandum of understanding (MOU) or other formal/informal agreements outlining each party's responsibility to ensure a seamless transition of care.	A1a. Support hospitals to strengthen evidence-based maternity care practices (such as BHFI steps 3 and 10) by outlining clear procedures for connecting to the appropriate level of care in the community (NACCHO 3.3)	BF referral system developed, 2023, beginning implementation 6/2023		
			A1b. Recruit and engage key community stakeholders to the Start Strong Breastfeeding Subcommittee.	9 community stakeholders recruited to join BF subcommittee 6/2023		
			B1. Mercy Health to continue to explore opportunity to develop a community breastfeeding support group with support being provided by a rotation of community breastfeeding support providers from various organizations.	B1a. Identify a curriculum to follow within this support group.		
	B. Increase community capacity to provide breastfeeding support.	B2. Increase the number of health care professional enrolled in the CLC/CLS training provided by WIC.			2 health care professionals enrolled in this training 6/2023, WIC in process of hiring peer helpers	
	C. Improve consistency of breastfeeding messaging by using evidence-based information and co-creating educational materials among lactation support providers and institutions within the community to avoid provision of conflicting information to breastfeeding parents. (NACCHO 3.1)	D. Reduce Health Disparities/ Increase fatherhood engagement	D1. Ensure that both curriculum and breastfeeding messaging follow CLAS guidelines		Complete a Fresh Eyes Endeavor by visiting 1-2 WIC clinics with breastfeeding initiation rates at state average or above.	
			D2. Survey parents at BAM event 1.) would you be interested in joining a BF support group 2.) Who/where do you get BF support currently			

Goal	Strategy	Objectives	Action Steps	Measures	Timeline
Goal 1: Provide evidence-based services that aid in the reduction of preterm births from 11.8% (5 year average 2015-2020) to 10.4% (state of Ohio 5 year average 2015-2020)					
	Fathers engaged in prenatal appointments and birthing classes	Mindset change to understand importance of their support to partner - reduces stress, helps mom better take care of herself	<ol style="list-style-type: none"> 1. develop survey for collecting data to identify barriers to engagement 2. Meet dads where they are - identify groups already meeting with dads in churches and other small groups to build trust & start collecting data 3. Identify barriers to father engagement (generational lack of parenting, mom won't allow, single dads run together - same mindset, no support, blame, fear of child support backlash - why pay if can't see kids) 4. Develop plan to help overcome barriers 		
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	Fathers trained in safe sleep practices	Get fathers to take training	<ol style="list-style-type: none"> 1. identify resources available 2. identify barriers to attending 3. connect dads to resources and mentoring opportunities 		
Goal 3: Raise Awareness of the importance of Preconception and 1st Trimester Health					
	Fathers learning about birth spacing		<ol style="list-style-type: none"> 1. identify resources available 		
	Fathers engaged in prenatal appointments & bonding with/room child		<ol style="list-style-type: none"> 2. identify barriers to attending 3. connect dads to resources and mentoring opportunities 		
	Increased awareness of the importance of fatherhood engagement for maternal child health		<ol style="list-style-type: none"> 1. Fathering Strong Tool kick off at Father Fest 2. Collect information to fathering tool from organizations (All members) 		
	Improve health equity	Targeted efforts for Clark County adolescents	Ensure that all survey's and identified resources and mentoring opportunities are follow 622/23, CLAS guideline overview and presentation for Start Strong coalition by Health Equity Coordinator		