GREATER COLUMBUS INFANT MORTALITY TASK FORCE

FINAL REPORT AND IMPLEMENTATION PLAN

THE CITY OF COLUMBUS
CITY COUNCIL

JUNE 2014

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LETTER TO THE COMMUNITY: COLUMBUS CITY COUNCIL PRESIDENT ANDREW GINTHER

Columbus has one of the highest infant mortality rates of America's 50 largest cities. Our rate is twice that of New York City.

Every year in Franklin County, approximately 150 babies – enough children to fill five kindergarten classes – die before reaching the age of one. That means that each week in our community, an average of three babies die before their first birthday. Franklin County's infant mortality rate is among the worst of Ohio's 88 counties.

That is why, with the support of the entire Columbus City Council, Mayor Michael Coleman and the Franklin County Board of Commissioners, I formed the Greater Columbus Infant Mortality Task Force.

I charged this diverse coalition of community leaders to turn the tide of infant deaths by reducing infant mortality by 40 percent and cutting the racial disparity rate in half by 2020. The goal is ambitious, but we must be bold to achieve our vision of a community where all children thrive in their first years of life and where health is not determined by race or ZIP code.

Now, after much deliberation, the Task Force has developed community recommendations and an implementation plan to meet our goals. They are contained in the enclosed report. The plan, like our goal, is ambitious, but I'm confident that the community will come together to implement these recommendations and address this public health crisis.

The development of this plan would not have been possible without the sustained and focused commitment of the Task Force members, the leadership of Co-chairs Michael Fiorile and Donna James, and the support of our honorary co-chair, Ohio First Lady Karen Kasich. I want to express my deep appreciation to the co-chairs for their hard work, commitment to finding answers and their outstanding leadership of this important work. To each and every Task Force member: Your engagement was inspiring and invaluable.

In addition, Columbus Public Health, Nationwide Children's Hospital, Franklin County Commissioners, The Columbus Foundation and a host of community partners were instrumental in supporting the work of the Task Force, and we are enormously grateful for their contributions.

Andrew J. Ginther, President
Columbus City Council

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Infant mortality rates are a globally accepted measure of a community's well-being. And, while Columbus is widely considered to be one of our nation's more prosperous, well-educated and progressive communities, we have one of the highest infant mortality rates in the country. Consider:

- Every week in Franklin County, two to three families experience the death of a baby before his or her first birthday.
- Franklin County's infant mortality rate for 2013 is as high as the national rate from the early 1990s.
- The infant mortality rate for black babies is two-and-a-half times that of white babies in Franklin County.

Not only are too many babies dying before they reach their first birthdays, too many – 13 percent of babies in Franklin County – are born too early. Disorders related to prematurity and low birth weights are the leading causes of infant deaths, but those same disorders can cause ongoing challenges for babies who survive.

This stark reality led to the formation of the Greater Columbus Infant Mortality Task Force. This Task Force was charged with developing a community plan to reduce infant mortality by 40 percent and cut the racial disparity gap in half.

Over the last six months, the Task Force members have extensively studied the evidence on what works and the experiences of other communities. They have considered how these practices and approaches can best be adapted to address the unique challenges – and build on the distinct strengths – of our own community. The Task Force also asked the community for its ideas about how we can turn the tide. Below are key findings from this process and an overview of the plan and recommendations.

WHAT WE LEARNED

The leading causes of infant mortality are being born prematurely, congenital anomalies, sleep-related infant deaths and maternal complications of pregnancy. Racial disparities persist for all causes of infant deaths, especially those due to prematurity or sleep-related causes.

More broadly, however, we know that our infant mortality rates, and our persistent disparities, are largely affected by the unjust distribution of conditions that support health – the social determinants of health – which include factors such as adequate income; access to healthy foods, transportation, jobs, stable housing and quality schools; strong social networks; and access to health care. Families whose situations present barriers to these life-enhancing resources are at an increased risk of losing a child before his or her first birthday. We know that in our community, black families are disproportionately and negatively affected by high rates of poverty, unemployment and low educational attainment.

Addressing these disparities requires us to consider both place and race. Studies show that health outcomes are influenced by a "neighborhood effect," in which outcomes vary based on where an individual lives. For many in our community, the disadvantages of place are the result of a long history of racially biased policies and practices. A geographic analysis of infant mortality in Columbus identified eight "hot spots" – neighborhoods disproportionately affected by key social determinants, including poverty, food insecurity, cost-burdened households, safety and transportation barriers – that have infant mortality rates up to three times that of Franklin County overall. These neighborhoods comprise less than 10 percent of Franklin County births, but account for nearly 1 in 4 infant deaths and 1 in 3 non-white infant deaths in Franklin County.

ENGAGING THE COMMUNITY

Infant mortality is not a problem that can be solved simply by analyzing the numbers or reading the research. Nor will a solution implemented successfully in one community always be right for another. That is why the Greater Columbus Infant Mortality Task Force pursued a robust community engagement effort to educate the community about the problem and to gain a better understanding of local obstacles and opportunities for change.

A key component of our community engagement was a series of facilitated workshops with key stakeholders, such as the Franklin County Community Health Coordination Infant Mortality Committee, home health care providers, educators, social service agencies, black faith leaders, neighborhood leaders from high-risk areas, and expectant and new mothers.

During the workshops, four major themes emerged:

1. Our community needs to continue improving health services and delivery for women and children.
2. Our community needs greater collaboration and coordination among agencies and providers.
3. Our community needs to address the issues that impact health beyond health care.
4. Our community needs to build and foster trust and meaningful engagement with neighborhood leaders.

While many positive things are occurring throughout Franklin County, the concerns and proposed solutions offered by stakeholders reinforce the research: Infant mortality is a multifaceted and difficult problem that has no one solution, but many. The Task Force recommendations reflect this input.

THE TASK FORCE'S RECOMMENDATIONS

The Task Force recommendations take a life course approach. This recognizes that in order to have healthy babies, we must also have healthy families and communities that set a foundation for opportunity not only for this generation but also for future generations. Taking into consideration the role that racial disparities and social determinants play in our infant mortality crisis, many activities and resources will be targeted toward the highest risk families and neighborhoods. The eight recommendations and first year strategies of the Task Force are:

1. Improve social and economic conditions that drive disparities across our community and in the highest risk neighborhoods. This recommendation includes engaging and mobilizing neighborhood-level initiatives and aligning strategies and resources to improve social and economic conditions.
2. Improve women's health before pregnancy by increasing enrollment in private and public health insurance with a focus on preventive care, starting with adolescents.
3. Improve reproductive health by emphasizing reproductive health planning in prenatal/postpartum care and increase access to, and use of, long-acting reversible contraception.
4. Improve prenatal care services and supports by increasing women's early entry into prenatal care and by ensuring prenatal care access and capacity, especially for high-risk women.

5. Ensure the highest standard of quality for perinatal care by increasing access to progesterone, decreasing early elective deliveries and ensuring neonatal intensive care quality.

6. Reduce maternal and household smoking by helping women quit smoking while pregnant and after giving birth. This recommendation also includes a call for smoke-free policies in multiunit housing facilities.

7. Promote infant safe sleep through education and awareness, with an emphasis on safe sleep and breast-feeding during prenatal care, and access to cribs for low-income families.

8. Create a collective impact and accountability structure to support strategy implementation and goal attainment.

With each of the recommendations are specific, high-impact community and neighborhood-level strategies designed to "move the needle" on the key drivers of infant mortality in our community – prematurity, sleep-related infant deaths and racial disparities. The plan specifies priorities for the first year and designates a lead entity that will be accountable for coordinating implementation of each strategy.

This is an ambitious plan. There is no single agency or entity that can accomplish these goals alone. Instead, this work will require organizations – many of which have not traditionally worked together – to collaborate to address complex social, economic and health factors that drive infant mortality and disparities in our community.

The Task Force's recommendations are based on successful collaborative efforts in other communities and are designed to ensure successful plan implementation, clear community oversight and, most importantly, accountability for results. Progress on plan implementation will be publicly reported through an annual Infant Mortality Report Card.

THE CASE FOR CHANGE

MAKING THE CASE FOR CHANGE

After the birth of her daughter, a first-time mom learned that she might be eligible for the Women, Infants and Children (WIC) program that provides food assistance to low-income women who are pregnant or have young children. When she called the local WIC program, she was given an appointment for the following week. When she arrived at her appointment, the baby was very lethargic and barely breathing. The WIC staff had the child rushed to Nationwide Children's Hospital. In talking with this mom, the staff learned she did not have money to buy food for herself or her baby. For several days she had been watering down formula to make it last longer. Doctors at Nationwide Children's Hospital indicated that the baby was severely malnourished and was close to dying.

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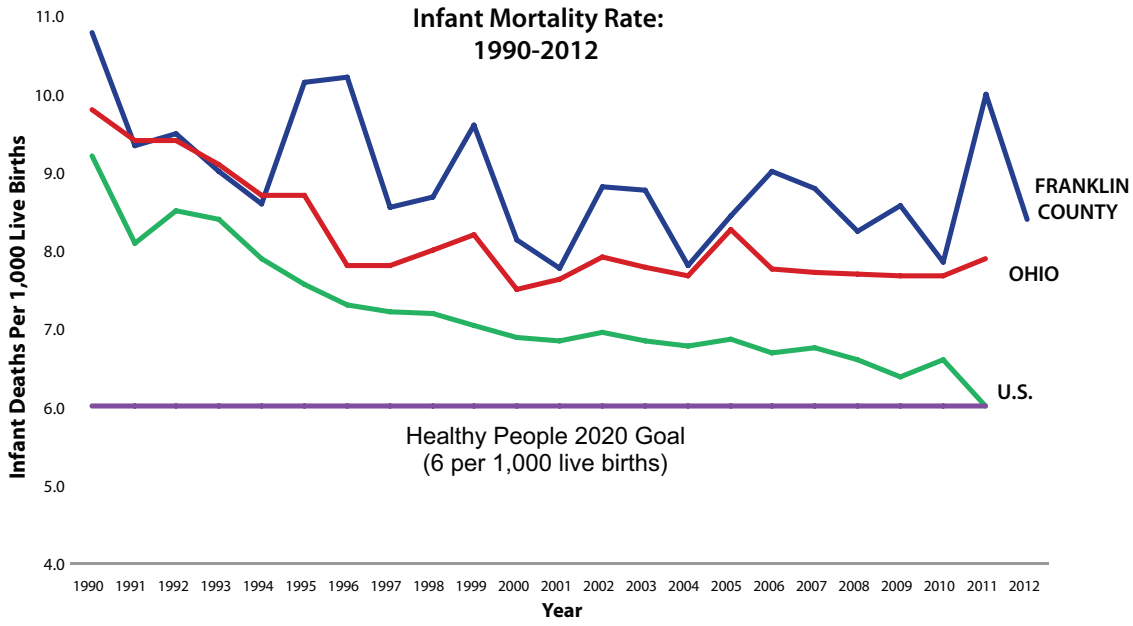
Every week, two to three families in Franklin County bury a baby before his or her first birthday. That is more than 150 babies every year – the equivalent to five kindergarten classes – who don't live long enough to realize their full potential.

Infant mortality – the death of a baby before his or her first birthday – is a globally accepted measure of a community's well-being. This is because infant mortality is not just about the health of a baby; infant mortality is affected by important economic, social, cultural and environmental factors that are also critical to the overall health and well-being of a community.

How do we compare?

- The U.S. ranks 32nd out of 34 countries in the Organization for Economic Cooperation and Development for infant mortality.
- Ohio ranks 46th out of 50 states in the U.S.
- Franklin County ranks 71st out of 88 Ohio counties.
- Columbus ranks 36th out of 50 largest U.S. cities.

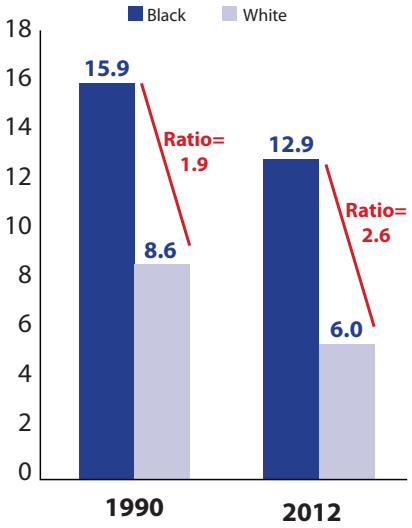
Franklin County's infant mortality rates are consistently worse than that of either the state or the nation as a whole. Over the last 20 years, infant mortality rates have steadily improved across the country. During the same period, Ohio's rates also have improved. Sadly, Franklin County has not made much progress.



GROWING DISPARITIES

Although infant mortality affects our entire community, black babies are two-and-a-half times more likely to die than white babies. Though modest, infant mortality has improved for babies of all races in our community over the last 20 years. Yet, there has been far less improvement for black babies, so the racial disparity is getting worse, not better. This gap – and worsening trend – is unacceptable.

Franklin County Infant Mortality Rates 1990-2013



UNDERSTANDING INFANT MORTALITY AND DISPARITIES

The leading direct causes of infant mortality are being born prematurely, congenital anomalies, sleep-related infant deaths and maternal complications of pregnancy. Racial disparities persist for all causes of infant deaths, especially those due to prematurity or sleep-related causes.

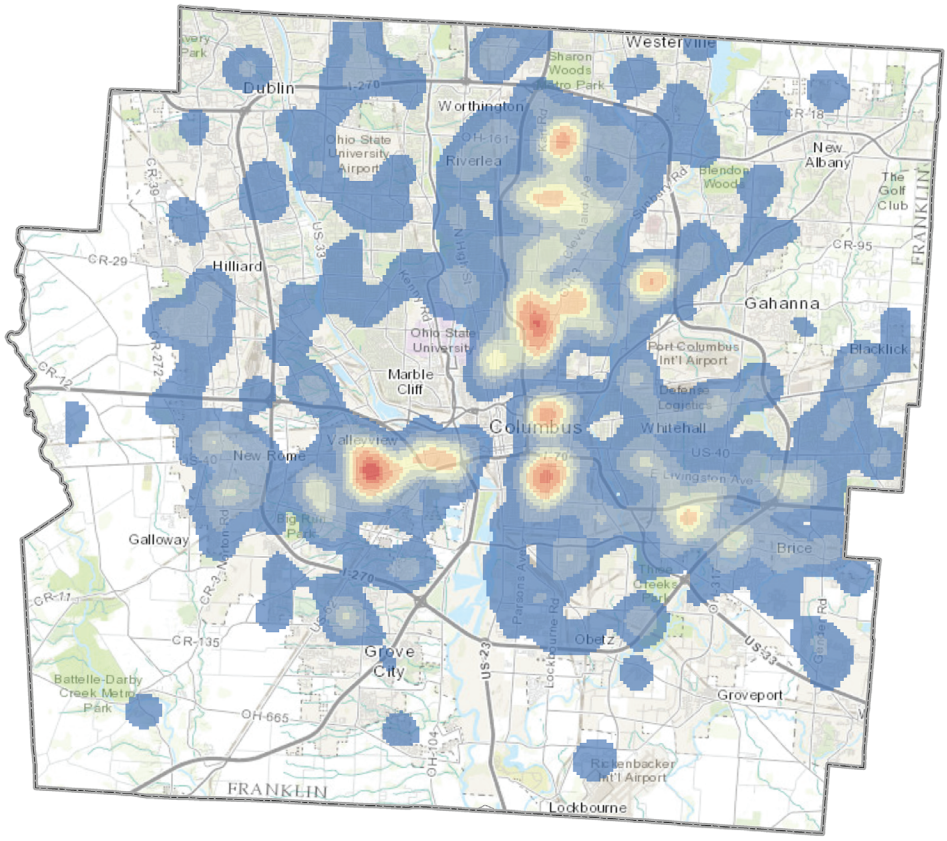
More broadly, however, we know that our infant mortality rates, and our persistent disparities, are largely affected by the unjust distribution of conditions that support health – known as the social determinants of health – which include factors such as adequate income; access to healthy foods, transportation, jobs, stable housing, quality schools; strong social networks; and access to health care. Families that live in situations in which they do not have adequate access to these life-enhancing resources are at an increased risk of losing a child before his or her first birthday. We know that in our community, black families are disproportionately and negatively affected by high rates of poverty, unemployment and low educational attainment. Consider the following statistics for black residents in Franklin County:

- Thirty-two percent live in poverty versus 13 percent of white residents.
- Fourteen percent receive food stamps versus 11 percent of white residents.
- Sixteen percent are unemployed versus 6.6 percent of white residents.
- Nearly 14 percent do not have a high school education versus 9 percent of white residents.
- Account for 71 percent of the homeless population served by the shelter system.

These statistics matter; these disparities drive a widening gap in the chance of survival between white and black infants in our community.

Place also matters. Research supports the importance of a "neighborhood effect" on health outcomes including infant mortality and its risk factors, which can vary widely based on where an individual lives. This is evident in Franklin County: A detailed geographic analysis of infant mortality identified eight neighborhoods with infant mortality rates that were up to three times higher than the community overall. These neighborhoods also had higher rates of poverty, unemployment, housing instability and transportation barriers. These "hot spot" neighborhoods account for less than 10 percent of total births, but nearly 1 in 4 of all infant deaths in our community and 1 in 3 non-white infant deaths.

FRANKLIN COUNTY INFANT DEATHS, 2007-2011



Although complex and multifaceted, social, economic and health care racial disparities have evolved and have been reinforced in our community as the result of a long history of racially biased institutional practices, such as redlining. For example, historical biases in banking practices disproportionately affected black families and neighborhoods, thus limiting opportunities for home ownership and neighborhood investment. Similarly, historical discrimination in employment practices (e.g., hiring, wages) has had a lasting impact on poverty and economic self-sufficiency. Though we have made progress, these historical policies have impacted opportunities and outcomes for certain areas of our community.

Even beyond these social and economic disparities, black women with college degrees have higher infant mortality rates than white women without a high school diploma. National studies indicate that these differences are not due to race itself, but the result of a lifetime of chronic stress brought on by living as a minority in our society.

To successfully close the racial disparity gap in birth outcomes, our community must systematically address underlying social and economic inequities and the effects of racism. We must make a long-term commitment and make investments that enhance resources and engage and support residents in our most vulnerable neighborhoods.

ENGAGING OUR COMMUNITY

ENGAGING OUR COMMUNITY

Infant mortality is not a problem that can be solved simply by analyzing the numbers or reading the research. Nor will a solution implemented successfully in one community always be right for another. The factors that affect infant deaths and maternal health are influenced by the unique attributes and resources of individual communities.

That is why the Greater Columbus Infant Mortality Task Force went to the community for a better understanding of the obstacles and opportunities for change that are specific to the Greater Columbus region. The Task Force wanted to know what is working in central Ohio and what is not working so that effective actions to reduce infant mortality can be replicated.

"We are program rich and system poor."

– Social Service Program Administrator

The Task Force had three overarching goals for community engagement:

1. To generate awareness of central Ohio's infant mortality challenges as they compare to other major metropolitan areas.
2. To reinforce the community's responsibility and commitment to reduce infant mortality.
3. To engage all stakeholders and key constituencies throughout the planning process to ensure consensus on the final community plan.

To turn these goals into action, the Task Force mobilized:

- Traditional and social media to raise awareness, share timely information and educate the public.
- A robust website to provide the community with information about infant mortality and the issues surrounding it, the Task Force itself and the collaborative steps the Task Force was taking to find solutions.
- Community presentations to build awareness of the infant mortality crisis, to gain buy-in and support for a unified approach to address it, and to build partnerships with stakeholders who could help communicate the plan and help implement it later.
- Targeted stakeholder workshops to engage in substantive dialogue with those on the frontlines of our infant mortality crisis.

This approach reached a broad and diverse segment of the population, including the business community, thought leaders, the health care community, medical and social service workers, policymakers, media and the general public.

WHAT WE HEARD AT THE WORKSHOPS

There is no doubt that Franklin County has a number of programs in place to help improve the health of babies and mothers, support families and improve our neighborhoods. All of these are critical to successfully reducing infant mortality rates. However, what we heard was that we need to do a better job of coordinating these programs and working together as a community.

During the workshops, four major themes emerged:

1. Our community needs to continue improving health services and delivery for women and children.
2. Our community needs greater collaboration and coordination among agencies and providers.
3. Our community needs to address the issues that impact health beyond health care.
4. Our community needs to build and foster trust and meaningful community engagement with neighborhood leaders.

Stakeholders understood that this work must extend beyond the Task Force's initial engagement. Below is a summary of what the community said during 12 targeted stakeholder workshops that included health care professionals, neighborhood and faith leaders, educators and social service providers.

1. Improving the Health of Women and Children

Columbus has some of the greatest health care resources in the country. However, workshop participants identified areas of improvement and gaps in services.

The Task Force heard the following concerns about the health care of women and children from the community:

- There are currently no health education policies for middle schools.
- Women lack access to family planning resources.
- Women are facing chronic physical and mental health issues before, during and after their pregnancies.
- Substance abuse issues persist throughout pregnancies, and there are too few doctors who can treat pregnant women addicted to drugs and alcohol.
- Pregnant women are not accessing prenatal care services early enough, if at all, in their pregnancies.
- A number of factors, including transportation, call center wait times and awareness of eligibility for services, provide obstacles for women to access programs.
- Mothers-to-be, including teens, do not receive encouragement and support during their pregnancies.

Community-proposed solutions for increasing opportunities for healthy women, healthy pregnancies and healthy babies:

- Create middle school health education guidelines that include sexual health, self-esteem, healthy relationships, mental health and nutrition.
- Focus on decreasing obesity, diabetes and smoking rates in Franklin County among women of childbearing age.
- Provide easier access to family planning resources.
- Improve access to prenatal care during the first trimester by educating providers and patients about Medicaid eligibility.
- Reduce telephone wait times to access health care enrollment, programs or prenatal care.

- Provide a nurse navigator or social worker for high-risk pregnancies.
- Improve baby care education, such as breast-feeding and safe sleep.
- Engage family members to support expectant mothers.
- Provide new mothers and their families with a comprehensive book or binder of information, rather than individual pamphlets.
- Provide systematic programs for both parents and family caregivers to reinforce baby care basics.
- Provide home visits for every mother and offer case management through the child's second birthday.

2. Greater Collaboration

A social service program administrator summarized one of our greatest challenges, "We are program rich and system poor." In fact, even in a room of frontline health care providers, some of those who are serving women and children in home-based care, learned about certain programs for the first time during one of the Task Force's workshops.

"We've spent years building trust in these neighborhoods. People come to us for assistance. Help us help you."

– Faith Leader

Along those lines, workshop participants identified specific concerns and opportunities to improve collaboration among services supporting women, children and families, including:

- Too many programs are working in silos and are duplicating or contradicting programs and information.
- While some collaboration is taking place among programs, it is not at an institutional or leadership level.
- There are too few resources, and there is too much competition among programs for those resources. This does not inspire a spirit of collaboration.
- There is a lack of data about who is using the programs currently offered and the results those programs achieve.
- Even health care professionals are not aware of the breadth of programs offered in the community. Additionally, the overwhelming number of services makes it difficult for families to know where to find a point of entry.

Community-proposed solutions for improving system integration and program collaboration:

- Create a central tracking system that monitors programs, who is using the services and their outcomes.
- Create a centralized referral system through which health care and social service program providers can identify the program that will best meet the needs of an individual family.
- Link funding to successful outcomes and move away from competitive grant-based funding systems.

3. Issues that Impact Health Beyond Health Care

Throughout the process, we heard from local and national experts that health is about more than health care. The stories of those who live in our community brought this fact to life. During a series of neighborhood workshops, we heard from educators, new and expectant mothers, teen parents and neighborhood leaders that there are a multitude of factors that contribute to our community's overall health.

When asked about some of the factors that impact the health of people in their community and what creates barriers to accessing health care services, workshop participants identified specific concerns about the challenges facing mothers and children in Franklin County, including:

- Poverty and employment
- Education
- Transportation
- Neighborhood safety
- Affordable housing

To tackle some of these deep-rooted social determinants of health, workshop participants offered the following solutions for consideration:

- Improve transportation options by offering women safe, comfortable, convenient and affordable ways get to doctors' appointments, grocery stores and jobs. One specific idea was to align bus routes with low-income housing communities.
- Create one-stop locations, based in neighborhoods, for women to receive comprehensive services – from prenatal care to food assistance to employment services.
- Develop safer, more affordable housing options.
- Generate more opportunity for fresh food to be available within walking distance of families and provide training on food preparation.

4. Trust and Engagement

One of the most interesting things learned during the workshops was the recurring theme of trust and engagement. New mothers are more willing to receive information and implement it when it comes from a person they know and trust. That person is likely someone in the community with whom they already interact – a pastor, a teacher, a friend or a family member or a community leader.

One insight provided during a workshop of neighborhood leaders was that if a nurse tells a woman her baby should sleep on its back, but her own mother tells her the opposite, she will follow the advice of her mother. The feedback was to take a multigenerational approach to educational and awareness efforts and deliver those messages through people from the community where people live, work, play and pray.

More specific concerns about trust and engagement in the community included:

- Lack of knowledge and understanding of available programs that community leaders can direct families to.
- Complicated jargon, such as mortality and presumed eligibility, that few families understand.
- Lack of support and encouragement for teen parents, and the shame felt by many expectant mothers.
- Overwhelming amounts of information that expectant mothers cannot easily process.
- The tendency for expectant mothers to dismiss information given in a clinical setting when it conflicts with advice given by trusted sources.
- Too little outreach to grandparents, caregivers and other family members about how to support new mothers.

Community-proposed solutions for improving trust and engagement:

- Develop neighborhood-based, peer-to-peer health and wellness mentoring programs.
- Develop materials and messages in a more understandable and accessible way.
- Take advantage of the infrastructure, trust and capacity already found within faith communities.
- Develop a sustained educational campaign.
- Provide accurate, consistent information to caregivers and supporters of young mothers.

CONCLUSIONS

While many positive efforts are occurring throughout Franklin County, the concerns and proposed solutions offered by stakeholders reinforce the research: Infant mortality is a multifaceted and difficult problem that has no one solution, but many. The insights offered by hundreds of Franklin County residents will be vital to efforts beyond the work of the Task Force. The Task Force recommendations reflect this input.

RECOMMENDATIONS

GREATER COLUMBUS INFANT MORTALITY TASK FORCE PLAN AND RECOMMENDATIONS

The factors that underlie infant deaths are multiple and complex. There is no single "magic button" to reduce infant mortality. Nor, is there a single approach from another community that could simply be replicated here.

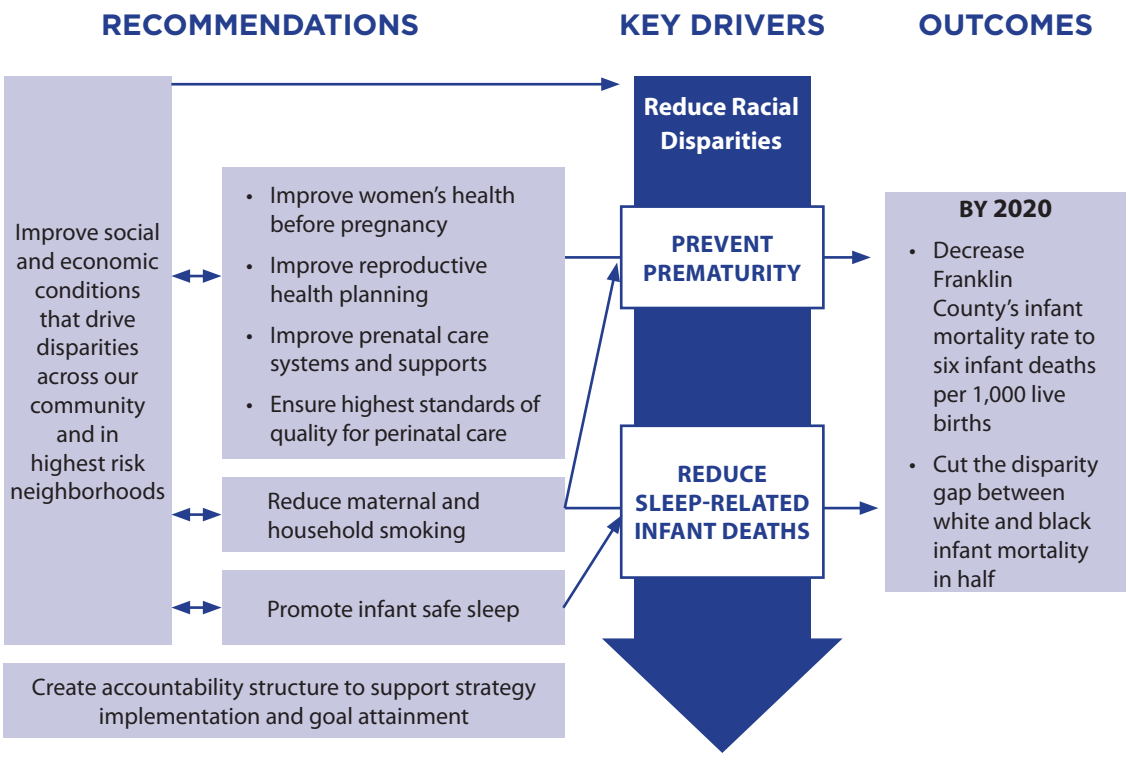
Over the last six months, the Task Force members have extensively studied the evidence on what works and the experiences of other communities. They have considered how these practices and approaches can best be adapted to address the unique challenges – and build on the distinct strengths – of our own community.

In developing this plan and recommendations, the Task Force has built on the work of other critical community collaborations to engage all sectors of the community in the long-term solutions that provide a pathway to success, from preconception to post-career. Our work has been guided by the following principles:

- Act with a sense of urgency and adopt a "no excuses" approach to the problem.
- Commit to collectively own the problem and identify solutions to this crisis.
- Identify best practices and use them as a benchmark for the work.
- Focus efforts on both clinical and human service agencies.
- Encourage and actively recruit an inclusion of ideas and engagement on the issue.
- Commit to continuous improvement with a tolerance for rapid-cycle successes and failures.
- Strive for collective impact by establishing a common agenda, shared measurement, continuous communication and a strong accountability structure.
- Support and embed change to improve infant mortality across our community and in our neighborhoods.

This report presents eight recommendations for achieving our ambitious goals to reduce infant mortality and racial disparities. With each of the recommendations are specific, high-impact strategies designed to "move the needle" on the key drivers of infant mortality in our community: prematurity, sleep-related infant deaths and racial disparities. We have taken a life course approach in our recommendations. This recognizes that in order to have healthy babies we must also have healthy families and communities and set a foundation for good health and opportunity not only for this, but also for future generations. Taking into consideration the role that racial disparities and the social determinants play in our infant mortality crisis, many activities and resources will be targeted toward the highest risk families and neighborhoods.

A visual summary of the recommendations is included on the following page.



GUIDE TO THE RECOMMENDATIONS

The report includes a brief overview of key data and learnings for each recommendation, a summary of the metrics that each recommendation will impact and a table with the following elements:

Strategies	Key Activities	Lead Entity	Year 1
Key elements of the plan to accomplish the recommendation	Specific action steps that should be taken to implement the strategy	Entity responsible for convening appropriate partners; ensuring work plan development and progress monitoring for a particular strategy	A YES in this box indicates this strategy is prioritized to begin in the first year of plan implementation

Each recommendation includes specific strategies and detailed action steps that will help us reach our 2020 goals. We have prioritized high-impact opportunities – those that have the potential to have the most significant impact on our infant mortality rate – for implementation in the first year of this effort.

Going forward, the leaders of this initiative – an Executive Committee and Project Director* – will produce an annual work plan to ensure we implement all the strategies contained in this report in subsequent years and adapt planned strategies, as necessary, based on experiences and results. Year One implementation activities are detailed on page 46.

Finally, we have developed the Greater Columbus Infant Mortality Report Card – a dashboard that will allow us to track progress on key metrics related to infant mortality, prematurity and sleep-related infant deaths. This Report Card can be found on page 41.

*Described in Recommendation 8

1

RECOMMENDATION:
Improve Social and Economic Conditions that Drive Disparities Across Our Community and In Highest Risk Neighborhoods

In Franklin County, black babies are two-and-a-half times more likely to die before their first birthdays than white babies. This disparity is the result of a myriad of health care, social and economic factors that influence the health of a woman over her lifetime.

For all races, poor nutrition; stress; abuse; use of tobacco, alcohol and drugs; poverty; access to health care; and exposure to toxins can have a devastating effect on infants and mothers. These factors more significantly impact black mothers and babies in our community.

Addressing these disparities requires us to consider both place and race. Studies show that health outcomes are influenced by a "neighborhood effect" in which health outcomes vary based on where an individual lives. These inequities stem from a long history of racially biased policies and practices. Neighborhood factors include access to "life-enhancing" resources such as health care, housing, education, employment, social relationships, transportation and food supply.

Studies also show that the lifetime stress of living as a minority in our society has an adverse effect on birth outcomes.

Planned Impact and Metrics

Key Drivers

Prematurity
Safe Sleep
Disparities

Year One Metrics

- ↓ Disparity gap for all Report Card metrics
- ↑ Neighborhood-level results for all Report Card metrics
- ↑ Neighborhood-level improvements for key social and economic factors (TBD)

WHAT WE LEARNED

- Racial disparities in overall infant mortality rates mirror similar disparities in key drivers such as prematurity and sleep-related deaths.
- The neighborhoods most affected by housing, education, hunger and food insecurity, poverty and employment issues are also those most affected by infant mortality.
  - Eight neighborhoods – Franklinton, Hilltop, Morse/161, Near East, Near South, Northeast, South Linden and Southeast account for nearly 1 in 4 infant deaths and 1 in 3 black infant deaths in Franklin County.
  - These neighborhoods have infant mortality rates that are up to three times that of Franklin County overall, and are disproportionately affected by key social determinants, including poverty, food insecurity, cost-burdened households, safety and transportation barriers.
- Across the country, communities that have reduced disparities target resources to the highest risk populations and neighborhoods, and address underlying social and economic factors.

The Task Force's recommended strategies are designed to reduce disparities by addressing social and economic determinants of health for our community's highest risk neighborhoods and populations.

Strategies	Key Activities	Lead Entity	Year 1
1. Engage, mobilize and target interventions in neighborhoods that have the highest identified risk and opportunity for improving infant mortality and reducing disparities.	Establish criteria and select two neighborhoods to pilot the approach, and develop a plan and timeline for sequencing additional neighborhoods.	City of Columbus (Health and Development)	YES
	In selected neighborhoods, identify and engage neighborhood leaders, residents, partners and anchor organizations.		
	With partners, map assets and opportunities, identify priorities and develop a plan for addressing social, economic and health factors that impact infant mortality.		
	Develop a neighborhood-level report card to monitor progress and drive results, include standardized "core" metrics across neighborhoods and initiative-specific metrics within each neighborhood.		
2. Work with City of Columbus, Franklin County, business and community leaders to align strategies and target supportive resources across sectors to improve the social and economic conditions that impact infant mortality.	Engage leaders from housing, early childhood, transportation, safety, food security, workforce development and other systems to identify opportunities to align strategies and coordinate efforts to improve conditions for high-risk populations and neighborhoods.	Executive Committee/ Project Director	YES
	As part of City and County 2015 budget processes, and annually thereafter, identify and target new resources to identified neighborhoods, implementing steps such as vacant lot/property cleanup programs, safety services, housing, transportation, employment, early childhood, education, etc.		
	Prioritize pregnant women in homeless shelter allocations, food distribution and other community programs; consider opportunities to identify pregnant women and coordinate referrals through City 211 service.		
	Target workforce development, outreach and supportive employment opportunities in high-risk communities, e.g., FastPath, Columbus' investment in career readiness.		

Strategies	Key Activities	Lead Entity	Year 1
3. Address the effects of race and racism on infant mortality.	Publicly report racial disparities on the Infant Mortality Report Card to raise awareness and accountability for closing the gap.	Executive Committee/ Project Director	YES
	Work with community leaders and organizations to provide advice and insight on ways to effectively engage the black community.		
	Build capacity among community, neighborhood leaders and service providers by offering training on structural racism designed to give leaders insight into underlying causes and strategies to change policy and practice to promote equity.		
	With trained leaders, develop neighborhood- and community-level strategies for addressing the effects of race and racism.		

2

RECOMMENDATION:
Improve Women's Health Before Pregnancy

Historically, efforts to improve birth outcomes have focused largely on ensuring that women receive adequate prenatal care. There is increasing recognition that the health of a woman before she gets pregnant has as great an impact on birth outcomes as the care she gets during the nine months of her pregnancy.

Women who smoke, abuse alcohol or other drugs, are obese or have a chronic disease, such as diabetes, are at a much higher risk of poor birth outcomes. That's why improving the health of this, and future generations, requires new prevention approaches that support women's health over a lifetime.

Planned Impact and Metrics

Key Drivers
Prematurity
Disparities

Year One Metrics

- ↑ Women of childbearing age with health insurance
- ↑ Adolescent preventive visits

WHAT WE LEARNED

- Twenty-three percent of women of childbearing age (18-44 years) do not have health insurance.
- Provisions in the federal Affordable Care Act led Ohio to expand Medicaid coverage to adults with incomes of up to 138 percent of the federal poverty level and will require providers to incorporate a greater focus on well-woman care.
- Thirty-one percent of women of childbearing age have not had a health checkup in the past year. National data suggests that people without health insurance are less likely to receive preventive health visits.
- Successful community strategies for improving preconception health include provider-level initiatives to improve screening and intervention for preconception health risks and consumer-focused health education.

The strategies for improving preconception health include a focus on increasing insurance coverage, linking high-risk populations to primary care and increasing public awareness about the importance of women's health prior to becoming pregnant.

Strategies	Key Activities	Lead Entity	Year 1
1. Increase enrollment in public and private health insurance coverage for low-income women.	Educate uninsured families about expanded insurance options. Support streamlined public insurance enrollment, including presumptive eligibility and continuous coverage.	Franklin County Department of Job and Family Services/ Local insurance navigator program	YES
2. Increase preventive health care visits for teens.	Educate teens about the importance of preventive and primary care. Link teens to providers that offer comprehensive, age-appropriate primary health care to teens.	Partners for Kids	YES
3. Expand access and use of patient-centered medical homes that include a focus on preconception and inter-conception care, starting with the highest risk women.	Educate women and families about the importance of preconception, primary and preventive health care, starting with low-income families. Identify and address barriers to primary care access and utilization among low-income women, including provider capacity and reimbursement policy. Develop a comprehensive campaign to promote preconception women's health, e.g., "Every Woman, Every Time."	Ohio Medicaid/ Medicaid Managed Care Organizations	
3. Standardize screening, risk assessment and preconception counseling for high-risk populations.	Target screening and assessment in sickle cell, drug abuse, obesity and diabetes clinics for reproductive age women; expand these to the broader population.	Ohio Better Birth Outcomes Collaborative	
4. Align patient-care medical home payments to support desired outcomes.	Engage large companies, private insurers and governments to change payment practices.	Healthcare Collaborative of Greater Columbus	

3

RECOMMENDATION:
Improve Reproductive Health Planning

Planned Impact and Metrics

Key Drivers
Prematurity
Disparities

Year One Metrics

↑ "Safely spaced" births

↓ Teenage pregnancies

Unintended pregnancy – a pregnancy that is mistimed, unplanned or unwanted – is associated with increased risks to the mother and baby, including preterm birth and low birth weight. Unplanned pregnancies often find women in less-than-optimal health for childbirth and result in delays in vital prenatal care, affecting the health of the baby. Further, pregnancies spaced fewer than 18 months apart put mothers and babies at increased risk of premature birth and infant mortality.

Teen mothers have higher infant mortality rates than their adult counterparts, but also face critical barriers to educational attainment and job opportunities, as they are less likely to finish high school. These challenges are compounded for women who have a second pregnancy while still in their teens.

High-quality, comprehensive and accessible reproductive health services are essential to preventing unintended and teen pregnancies. In particular, access to long-acting reversible contraceptives have proven to be safe and highly effective and make a significant difference in preventing teen and unplanned pregnancies. Reproductive health means that women, men and youth will have the knowledge and access to services they need to make safe and responsible life-planning decisions that are critical to individual and family well-being.

WHAT WE LEARNED

- Nearly half of all pregnancies in Franklin County are unintended.
- Almost 20 percent of Franklin County births are to women who report that they are not doing anything after delivery to keep from getting pregnant.
- Fourteen percent of Franklin County births are not "safely spaced" – that is, they occur fewer than 18 months apart.
- Due to a lack of health care coverage and challenging reimbursement policies, low-income women in our community do not have adequate access to contraception.
- Franklin County youth have limited opportunities for reproductive health education.

As a result of these findings, the Task Force's recommendations are intended to raise awareness of the importance of reproductive health planning and increase access to safe and effective contraception for sexually active women and teens. This will help to prevent unintended pregnancies and ensure that pregnancies are safely spaced.

Strategies	Key Activities	Lead Entity	Year 1
1. Address reproductive health planning as part of prenatal and postpartum care to ensure "safe spacing" between pregnancies.	Develop culturally sensitive materials to educate women, their partners and providers about the importance of safe spacing.	Ohio Better Birth Outcomes Collaborative	YES
	Work with providers to ensure that prenatal and postpartum visits include information about reproductive health planning and safe pregnancy spacing. This should include linkage to safe and effective contraception, especially long-acting, reversible contraception.		
2. Increase use of safe and effective methods of preventing pregnancy.	Pilot the evidence-based CHOICE project (St. Louis) to remove financial barriers to contraception, promote the most effective birth control methods and reduce unintended pregnancy; evaluate and plan for scaling.	Ohio Better Birth Outcomes Collaborative	YES
	Advocate for an Ohio Medicaid policy change to remove existing barriers for hospitals to provide long-acting reproductive contraception at the time of delivery.		
	Incorporate counseling on long-acting reversible contraception as part of prenatal care, postpartum visits and other program interventions for teens.		
	For those who prefer an option other than contraception, incorporate counseling on natural family planning and abstinence.		

Strategies	Key Activities	Lead Entity	Year 1
3. Implement evidence-based teen pregnancy prevention programming in schools and community organizations that serve teens who are at highest risk of becoming pregnant.	Implement "Safer Choices/Making Proud Choices" or other evidence-based teen pregnancy prevention curriculum, targeting: • Middle schools, high schools and community-based programs serving adolescents in hot spot neighborhoods. • Other high-risk adolescents, including those in jails, prisons, homeless shelters and foster care.	Columbus City Schools/Franklin County Department of Job and Family Services	
4. Implement a multimedia campaign that provides user-friendly information to young people and their families and helps them make responsible decisions and avoid unplanned pregnancies.	Involve key partners and contract with a communications consultant to engage youth and develop a communitywide campaign and social media strategy, e.g., website.	Franklin County Department of Job and Family Services	

4

RECOMMENDATION:
Improve Prenatal Care Systems and Supports for Highest Risk Families

Prenatal care is essential to monitor the progress of a woman's pregnancy and identify potential problems that can result in a negative birth outcome. Women who receive late or no prenatal care are at higher risk of having babies that:

- Arrive too soon
- Are born too small
- Have birth defects
- Have developmental issues
- Develop chronic medical conditions

Women who receive inadequate prenatal care also run a higher risk of dying from pregnancy complications.

Planned Impact and Metrics

Key Drivers
Prematurity
Disparities

Year One Metrics

↑ Early entry into prenatal care

WHAT WE LEARNED

- Nearly 30 percent of all pregnant women in Franklin County do not receive prenatal care in their first trimester. That figure rises to more than 40 percent for black women in Franklin County.
- Twenty-three percent of Franklin County women of childbearing age (18-44 years) are uninsured.
- A 2013 study concluded that Franklin County's capacity to provide general prenatal care for low-income women is sufficient, but access to high-risk care is more challenging.
- This same study found that nearly 23 percent of women who make prenatal care appointments at Columbus' safety net clinics do not show up, creating inefficiencies for both patients and providers.
- Ohio Medicaid is a large insurer for prenatal care and deliveries, covering more than 30 percent of total births in Franklin County, more than 55 percent of births to black women, and 60 percent of births to teens.
- Maternal and child home visiting programs can be effective in providing enhanced services to at-risk pregnant mothers. Certain models have been linked to improved birth outcomes and infant health.
- Home visiting resources in the community cannot reach all high-risk women. Currently, there is no mechanism to ensure that these services are directed to the women with the highest need.

Because prenatal care and home visiting services are critical to identifying and mitigating risks for poor birth outcomes, the Task Force's recommendations focus on systems improvements that will address access and quality of services provided to our highest risk pregnant women.

Strategies	Key Activities	Lead Entity	Year 1
1. Increase women's entry into prenatal care during the first trimester.	Increase public and private health-insurance enrollment for low-income women (see Recommendation 2 for key activities).	Ohio Better Birth Outcomes Collaborative	YES
	Develop an effective centralized prenatal care intake and referral service; conduct a competitive bid process to identify and select a vendor; market the service.		
	Identify and deploy strategies to improve early enrollment in managed care organizations' pregnancy care management programs.		
	Develop targeted outreach strategies to identify and engage women with high-risk conditions (e.g., substance abuse, diabetes) or living in high-risk settings (e.g., hot spot neighborhoods, foster care, jail) and link them with resources.		
	Educate women and their partners about the importance of prenatal care for good birth outcomes.		
2. Ensure prenatal care access and capacity across the community, particularly for the highest risk women.	Evaluate access to and capacity of prenatal care services and develop a plan to address gaps that includes consideration of evidence-based prenatal and pregnancy support services (e.g., centering).	Ohio Better Birth Outcomes Collaborative	YES
	Establish mobile prenatal care services at Columbus' new homeless family shelter.		
	Advocate for a supportive state policy to mitigate provider liability for providing prenatal care to teens without parental consent.		
	Partner with Franklin County Alcohol, Drug Addiction and Mental Health Board and others to develop strategies to support prenatal care access and support for women who are addicted to drugs, are in jail or on probation, or who have chronic mental illness.		

Strategies	Key Activities	Lead Entity	Year 1
3. Improve coordination of prenatal care and pregnancy support services.	Develop a risk assessment tool that includes assessment of pregnancy risks, including health, social and economic factors.	Ohio Better Birth Outcomes Collaborative	
	Engage prenatal care providers, Medicaid managed care plans and other partners to implement standardized pregnancy risk assessment.		
	Develop strategies to ensure coordinated case management and information sharing between organizations for high-risk clients.		
	Enroll every pregnant woman in the Text4Baby pregnancy education service.		
	Collaborate with existing community-based providers to co-locate services and coordinate outreach efforts.		
	Target educational and social supports to help pregnant teens finish high school and prevent a second pregnancy.		
4. Target maternal home visiting resources to improve outcomes for the highest risk families.	Assess current home visiting capacity and distribution and develop a plan to direct resources to the highest risk clients and/or to expand capacity.	Franklin County Family and Children First Council/Ohio Department of Health	YES
	Require all home visiting programs to be trauma-informed and provide evidence supporting their effectiveness in improving maternal and infant outcomes, especially prematurity.		
	Develop a coordinated process for screening and triaging clients to appropriate home visiting programs, monitoring data and outcomes.		

5

RECOMMENDATION:
Ensure Highest Standards of Quality for Perinatal Care

Ensuring the highest standards of clinical quality for perinatal care – the period leading up to and immediately following the delivery of a baby – can reduce the rate of preterm births in our community and improve outcomes for the smallest and most vulnerable infants.

Babies that are born too early often have more health problems at birth and later in life than babies born at full term. Women who have had a previous preterm birth are also at increased risk for another when they become pregnant again. This risk can be reduced by providing these women with a synthetic form of progesterone that reduces the risk of a repeat preterm birth by more than a third.

Planned Impact and Metrics

Key Drivers

Prematurity
Disparities

Year One Metrics

↑ Progesterone therapy for eligible women

↓ Early elective deliveries

While sometimes early deliveries are not preventable, too many early deliveries are planned. Experts have found that scheduling an early delivery before 39-weeks gestation that is not medically necessary puts both mothers and babies at increased risk for complications and poor outcomes. Consequently, leading national organizations such as the American Congress of Obstetricians and Gynecologists have identified elective deliveries prior to 39 weeks as a key quality indicator for obstetrical care.

The quality of care provided in neonatal intensive care units (NICUs) is also critical to the survival and long-term outcomes of babies born at a very low birth weight (less than 1,500 grams). To ensure the most vulnerable newborns receive the highest quality of care and the most successful birth outcomes possible, there are two benchmarks considered: whether a facility offers the highest capabilities of a NICU (Level III) and whether the Level III facility treats a higher volume of high-risk, low birth weight babies.

WHAT WE LEARNED

- In 2013, prenatal care providers participating in the Ohio Better Birth Outcomes Collaborative identified and enrolled 171 women in a program to receive progesterone. Each year, there are nearly 2,400 preterm births in Columbus. While not all of these women will benefit from receiving the progesterone supplement, there is a clear opportunity to reach more women.
- Progesterone is covered by all of the Franklin County Medicaid managed care plans. Policies for private insurers are more varied, with some insurers covering one form of progesterone but not others. These variations create delays for starting progesterone therapy while coverage is being determined.
- Since 2008, hospitals in Franklin County have been working to reduce elective deliveries in our community through the Ohio Perinatal Quality Collaborative, a statewide, multistakeholder network dedicated to improving perinatal health in the state.
- Through this work, the rate of early elective deliveries in Franklin County has decreased significantly and is currently hovering around 6 percent. The current national average is about 4.6 percent, and some hospital systems have managed to achieve even better results. There is a clear opportunity for further improvement in our community.

- In Franklin County, 10 out of 11 hospitals have the highest level designation for maternity and neonatal intensive care units (Level III). Evidence suggests this designation is important, but the volume of patients seen is also important. There is currently no systematic effort to monitor individual hospital volume or perinatal quality outcomes for these babies, an important consideration for overall quality outcomes.

The Task Force's recommended strategies are designed to promote the application and expansion of clinical quality standards to improve birth outcomes in our community.

Strategies	Key Activities	Lead Entity	Year 1
1. Increase the percentage of eligible women receiving progesterone.	Ensure culturally competent education for providers and consumers about the importance and availability of progesterone.	Ohio Better Birth Outcomes Collaborative	YES
	Monitor education and outreach activities around this strategy to ensure that efforts are appropriately culturally sensitive.		
	Collaborate with Ohio Medicaid to remove barriers to progesterone access for women and physicians.		
2. Establish a community standard and continue to monitor performance, by hospital, to reduce early elective deliveries.	Establish a quality improvement project to identify additional action steps that delivery hospitals can take to further reduce scheduled early deliveries.	Central Ohio Hospital Council	YES
3. Modify community practices, as necessary, to ensure that very low birth weight newborns are cared for in Level III facilities that also have consistently high volumes of patients.	Determine an appropriate mechanism to ensure very low birth weight babies are delivered at Level III facilities that meet volume threshold.	Central Ohio Hospital Council	YES

6 RECOMMENDATION:
Reduce Maternal and Household Smoking

Smoking is widely known to be a leading cause of preventable infant mortality. Women who smoke during pregnancy are more likely than those who don't to: have a low birth weight baby, deliver prematurely or lose a baby to sleep-related death. Infants exposed to secondhand smoke are also at increased risk for sleep-related deaths.

Research shows that "cutting back" while pregnant is not enough to reduce the impact of smoking. Pregnancy is a time when women may be particularly motivated to quit smoking. Women can successfully quit smoking, if linked with evidence-based clinical interventions, such as counseling. The most successful approaches to reducing the impact of smoking have been through efforts that keep youth from ever starting to smoke, smoke-free environmental supports and tobacco taxes.

Planned Impact and Metrics

Key Drivers

Prematurity
Sleep-related
Disparities

Year One Metrics

↑ Percentage of smokers who quit during pregnancy and postpartum

WHAT WE LEARNED

- Although there is no racial disparity in Franklin County related to smoking, it disproportionately affects populations with lower income and educational attainment.
- Thirty-one percent of Franklin County women report that they had smoked during the two years prior to becoming pregnant. Of those, 59 percent reported smoking during the third trimester of pregnancy, and 72 percent of those women reported smoking two to six months after delivery.
- There are no systematic efforts in our community to ensure that prenatal care providers follow national guidelines for tobacco screening and intervention among pregnant women.

The Task Force's recommendations leverage pregnancy as a "window of opportunity" to intervene with smokers, but also include population-focused policies and initiatives to impact the overall rates of smoking in the community.

Strategies	Key Activities	Lead Entity	Year 1
1. Target resources to reduce smoking among pregnant and postpartum women and their families.	Assess capacity and accessibility of evidence-based cessation resources.	Ohio Medicaid/ Medicaid Managed Care Plans	YES
	Work with providers to conduct a standardized assessment of smoking risk and link pregnant, parenting and postpartum women and their families to evidence-based smoking cessation resources, starting with providers who serve a high volume of low-income families, such as safety net prenatal care providers, WIC and home visiting programs.		
	Develop and deploy a provider tool kit that includes assessment tools, educational materials and cessation resources.		
2. Adopt smoke-free policies in multiunit housing facilities and other housing settings for high-risk women and families.	Target activities in shelters and low-income housing in high-risk neighborhoods, and expand to other settings.	Columbus Housing Division/Columbus Metropolitan Housing Authority	YES
3. Standardize screening, risk assessment and preconception counseling for high-risk populations.	Adopt a local policy to restrict the sale of e-cigarettes to anyone under age 18.	Executive Committee/ Project Director	
	Advocate for state policy to raise the age for tobacco purchases from 18 to 21.		
4. Develop an anti-tobacco mass-media campaign created and directed by youth.	Engage communications and a marketing firm to support campaign development and implementation.	Executive Committee/ Project Director	
5. Reduce smoking rates across the community through increased taxes on tobacco products.	Support an Ohio tax on cigarettes and other tobacco products.	Executive Committee/ Project Director	
	Evaluate a potential Columbus City tax on cigarettes and other tobacco products with proceeds to fund efforts to reduce tobacco use and/or infant mortality work.		

7

RECOMMENDATION:
Promote Infant Safe Sleep

Sleep-related infant deaths are those that happen suddenly and unexpectedly in a sleep environment due to a variety of causes, including accidental suffocation, positional asphyxia, overlay, sudden infant death syndrome (SIDS) and undetermined causes. There is strong and consistent scientific evidence that placing babies in a safe sleep environment – ALONE, on their BACKS, and in a CRIB – is important to reducing the risk of sleep-related infant deaths. In addition, babies who are breast-fed throughout their infancy are at reduced risk for sleep-related infant death.

Planned Impact and Metrics

Key Drivers Sleep-related Disparities

Year One Metrics

↑ Percentage of babies placed in safe sleep environments

WHAT WE LEARNED

- In Franklin County, 16 percent of infant deaths were sleep-related, and nearly half of them were among black babies.
- More than half the babies who died were sharing a bed or not sleeping on their backs.
- Twenty-five percent of new mothers across the community say they do not lay their baby down to sleep on his or her back.

The Task Force's recommendations to promote infant safe sleep will leverage existing initiatives to raise public awareness, educate families and caregivers, and change social norms to promote safe sleep.

Strategies	Key Activities	Lead Entity	Year 1
1. Implement a comprehensive public awareness and education campaign to improve safe sleep practices.	Engage an advertising/marketing firm to localize the existing statewide safe sleep campaign and ensure that messages are effective in reaching and improving safe sleep behavior across the community and in the highest risk populations. Specifically tailor culturally competent messages and outreach to reduce racial disparity gap. Develop metrics to analyze the campaign's impact and effectiveness.	Columbus Public Health	YES
	Develop and deploy safe sleep messages, advertisements and collateral materials in places that caregivers frequent, focusing on neighborhoods with the highest number of sleep-related deaths.		
	Share sleep-related death data with each delivery hospital to identify opportunities for improvement.		

Strategies	Key Activities	Lead Entity	Year 1
2. Incorporate safe sleep and breast-feeding as a key component of prenatal care, at the time of delivery, and postpartum.	Ensure that local health systems model safe sleep practices and standardize education of families about safe sleep before they leave the hospital.	Central Ohio Hospital Council	YES
	Educate providers about the importance of breast-feeding and safe sleep in preventing sleep-related deaths.		
	Collaborate with providers to develop user-friendly, culturally appropriate materials to educate patients about the importance of breast-feeding and safe sleep.		
	Ensure adequate lactation support resources are available to women who need them.		
3. Establish infant safe sleep practices as a community social norm.	Conduct education and audits to ensure that hospitals, child care centers and other providers consistently teach safe sleep practices.	Columbus Public Health	YES
	Partner with media and businesses to establish standards to ensure that images depict infants only in safe sleep environments.		
4. Develop a coordinated community process for ensuring high-risk families have a crib before the baby leaves the hospital.	Develop a process to track, obtain and distribute free and low-cost cribs to high-risk families.	Columbus Public Health	YES
	Establish standard eligibility criteria for families to receive free or reduced cost cribs.		
	Identify and educate partners for assessing eligibility, distributing cribs and conducting follow-up to support the effective use of cribs for safe sleep.		

8

RECOMMENDATION:
Create a Collective Impact and Accountability Structure to Support Strategy Implementation and Goal Attainment

The Greater Columbus Infant Mortality Task Force has put forth an ambitious plan to reduce the rate of infant mortality in Franklin County by nearly 40 percent and to cut the racial disparity gap between white and black infants.

There is no single agency or entity in our community that can accomplish these goals alone. Instead, this work will require organizations – many of which have not traditionally worked together – to collaborate to address complex social, economic and health factors that drive infant mortality and disparities in our community. To meet our goals, we must pursue a collective approach by which we set clear goals and a common agenda for achieving those goals. We must establish clear performance metrics and measurement systems, as well as processes to ensure communication and coordination. This work will require new partnerships, realignment of community resources and creation of a community accountability structure to ensure that the Task Force's recommendations are successfully implemented and its goals achieved.

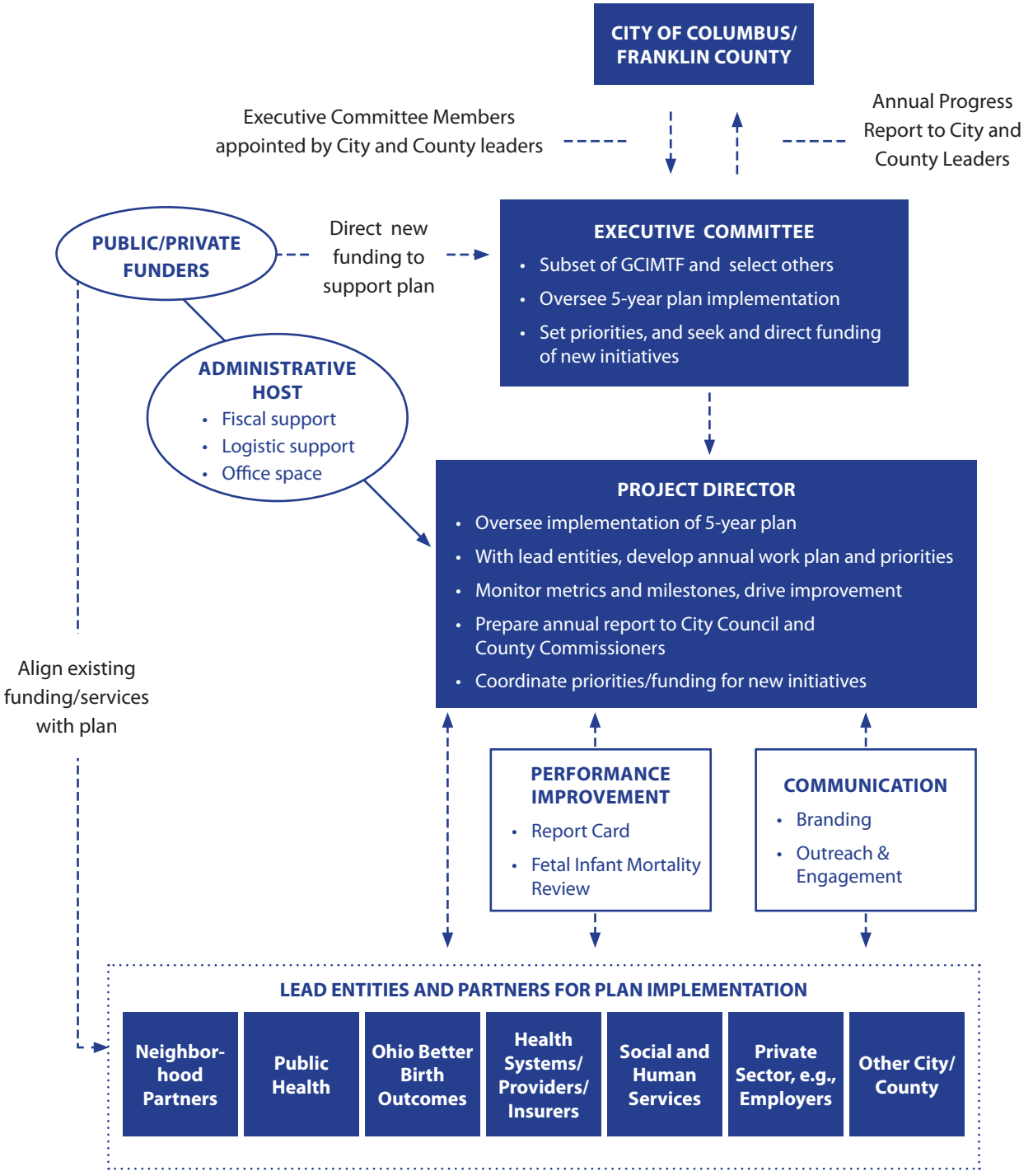
WHAT WE LEARNED

- Infant mortality reduction efforts have largely been concentrated in the health care sector and have not systematically addressed the underlying social and economic factors that are crucial to this work.
- To date, while there are many organizations working to address infant mortality and related issues, our community has not defined any mechanisms for creating and measuring the collective impact in these areas.
- Data must drive decisions and continuous improvement activities. A variety of data sources can be used to develop an Infant Mortality Report Card and metrics to drive successful plan implementation. Currently, much of the data is available at the county level, but due to small sample size it cannot be analyzed by race or neighborhood.
- A review of infant mortality reduction initiatives in cities across the country found considerable variation in how initiatives were organized and results achieved.
- Baltimore's successful approach is most similar to that of Greater Columbus in terms of the comprehensiveness of the plan and the delineation of clear improvement priorities and goals. The key to Baltimore's success has been the establishment of a branded "B'More for Healthy Babies" umbrella for specific initiatives, a clearly defined logic model, metrics and accountabilities to support goal attainment, and the ongoing use of data to drive improvement at the community and neighborhood levels.

The Task Force's recommendations are based on successful collaborative efforts in other communities and are designed to ensure successful plan implementation, clear community oversight and, most importantly, accountability for results. This accountability structure will also ensure that our community is coordinated in its approach to advocacy for supportive state and local policy and pursuit of funding sources to advance infant mortality reduction initiatives.

Strategies	Key Activities	Lead Entity	Year 1
1. Develop an infrastructure to effectively implement recommendations, monitor progress and drive improvement.	Appoint an executive committee of the Task Force to provide ongoing oversight capacity.	City Council/County Commissioners	YES
	Identify an administrative host organization.		
	Engage a consultant to serve as project director and oversee plan implementation.		
2. Develop an Infant Mortality Report Card and implementation plan metrics; use the report card to drive ongoing improvement and prioritize resource needs.	Develop a robust local sample of Pregnancy Risk Assessment Monitoring System data to enable tracking of key plan indicators by race and neighborhood.	Project Director/ Columbus Public Health	YES
	Identify additional data needs and potential sources necessary to support plan metrics at the community and neighborhood level.		
	Establish responsibilities for report card production, targeting publication for each June.		
	Partner with the Ohio Perinatal Quality Collaborative, public health and local hospitals to improve quality of birth certificate data.		
3. Support implementation of a Franklin County Fetal Infant Mortality Review (FIMR) as a key part of performance improvement.	Establish case review team and process.	Columbus Public Health	YES
	Routinely share findings with Project Director and Executive Committee to inform and drive improvement.		
4. Develop communications plan and strategy to support plan implementation.	Contract with a communications consultant to support development and implementation of plan "rollout" and goals for ongoing community engagement.	Executive Committee/ Project Director	YES
	Create a recognizable "brand" for Columbus' infant mortality reduction initiative.		
	Establish a centralized website as a "hub" for information about infant mortality in Columbus, plan initiatives and opportunities for engagement.		
	Routinely communicate with the community about initiatives and progress.		

COLLECTIVE IMPACT AND ACCOUNTABILITY STRUCTURE



GREATER COLUMBUS INFANT MORTALITY REPORT CARD

GREATER COLUMBUS INFANT MORTALITY REPORT CARD

In 2011…

- 18,045 babies were born in Franklin County
- 174 of these babies died before their first birthday, 22 were sleep-related
- 2,462 were born prematurely at less than 37-weeks gestation

Tracking Our Progress . . .

Achieving our 2020 goals means that 65 more babies in our community will celebrate their first birthdays.

Franklin County Indicator			Baseline*	2020 Goal**	Reporting Year
Outcomes and Key Drivers					
Infant Mortality[1] (# infant deaths/ 1,000 live births)		Total	9.6	6	*To be reported annually.* *Will include notation if progress is "on track" or not.*
		White	7.5	5.8	
		Black	17.1	6.6	
		Hispanic	5.3	4.9	
Sleep-related infant deaths[2] (# infant deaths/ 1,000 live births)		Total	1.3	0.94	
		White	1.1		
		Black	2.2		
Prematurity[3]	Preterm Birth (% babies born <37-weeks gestation)	Total	13.6%	9.6%	
		White	11.8%		
		Black	17%		
	Low birthweight (% of babies born <2,500 grams)	Total	9.3%	7.8%	
		White	7.7%		
		Black	12.8%		
Strategy Implementation					
Neighborhood	*2014-15 focus neighborhoods will be identified in first 90-days of implementation. Neighborhood-level scorecards with health, social and economic indicators will be developed.*				
Preconception Health[4]	% women age 18-44 years with health insurance		77%	*2020 Goals and Annual Metrics and milestones to be finalized by lead entities in the first 90-days of plan implementation .*	
	% adolescents with preventive visits		TBD		
Reproductive Health[5, 6]	% births "safely spaced" (≥ 18 months from previous)		86%		
	Birth rate among teens (15-17 years) (# births per 1,000 females)		16.4		
Prenatal care[7]	% Medicaid women with first trimester entry into prenatal care		57%		
Labor and Delivery[3, 8]	% eligible women receiving recommended course of progesterone		TBD		
	% elective deliveries before 39 weeks		6%		
Smoking[9]	% smokers not smoking during pregnancy		41%		
	% smokers not smoking postpartum		28%		
Safe Sleep[10]	% babies placed to sleep on their back		76%		

**Baseline data is most recent as of January 2014. See following page for notes on data sources and indicators.*
***2020 goals are based on national benchmarks from the March of Dimes (prematurity) and Healthy People 2020 (all others).*

NOTES ON DATA AND SOURCES

	Indicator	Source/ Years[a]
1	Infant mortality rate # infant deaths per 1,000 live births	Ohio Department of Health, Vital Statistics, 2011
2	Sleep-related infant mortality rate # infants dying while sleeping per 1,000 live births	Franklin County Child Fatality Review, 2010-2012[b]
3	Preterm birth % of births <37-weeks gestation Low birth weight % of births <2,500 grams	Ohio Department of Health, Vital Statistics, 2011-2013[c]
4	% women age 18-44 without health insurance	U.S .Census, 2008-2012
5	% births "safely spaced" (% births <18-months from previous birth)	Ohio Department of Health, Vital Statistics, 2011-2013
6	Birth rate among teens (15-17 years) (# pregnancies per 1,000 females)	Ohio Department of Health, 2011-2012, Vital Statistics and U.S. Census, 2011-2012
7	% Medicaid women with first trimester entry into prenatal care	Ohio Department of Health, Vital Statistics 2011[d]
8	% of elective deliveries before 39-weeks Resident births, induced at 36-38 weeks gestation with no medical indication	Ohio Department of Health, Vital Statistics, 2013 (preliminary)
9	% of smokers NOT smoking in third trimester of pregnancy	Ohio Department of Health, Pregnancy Risk Assessment and Monitoring System (PRAMS), 2009-2011[e]
	% of smokers NOT smoking postpartum	
10	% of babies placed to sleep on their back	

[a] For all indicators, most recent data available as of January, 2014; data analyzed by Columbus Public Health, Office of Epidemiology

[b] Combined years necessary to calculate a stable rate due to small numbers

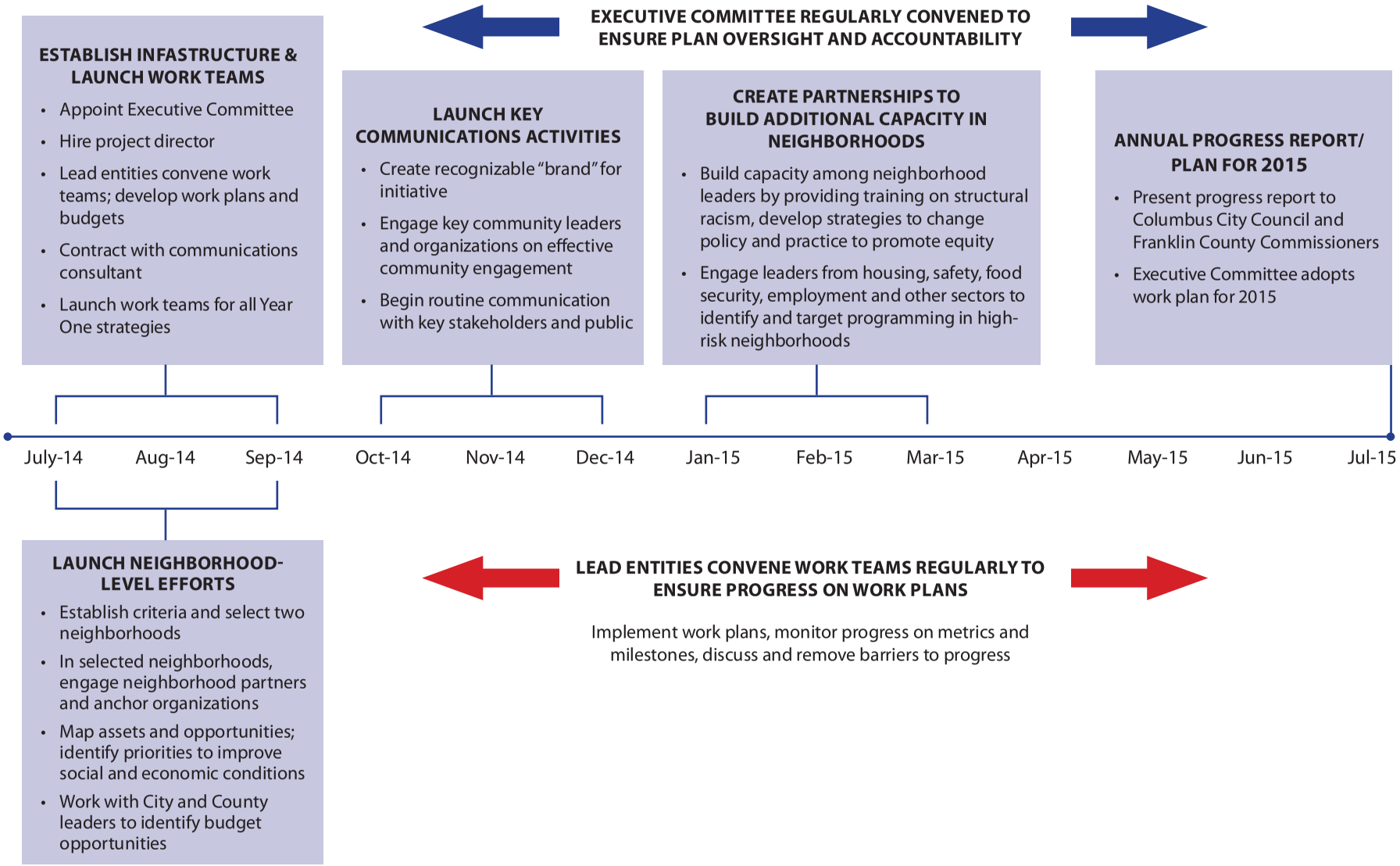
[c] Combined years necessary for analysis by race

[d] Missing data for 30 percent Medicaid births due to incomplete birth certificate

[e] Combined years necessary due to small numbers; data n/a for detailed analysis by race or geography

IMPLEMENTATION PLAN

GREATER COLUMBUS INFANT MORTALITY TASK FORCE RECOMMENDATIONS 2014-2015 IMPLEMENTATION



YEAR ONE IMPLEMENTATION

1: IMPROVE SOCIAL AND ECONOMIC CONDITIONS THAT DRIVE DISPARITIES ACROSS OUR COMMUNITY AND IN HIGHEST RISK NEIGHBORHOODS

Strategies	Key Activities
Engage, mobilize and target interventions in neighborhoods that have the highest identified risk and opportunity for improving infant mortality and reducing disparities. Lead Entity: City of Columbus (Health and Development)	Establish criteria and select two neighborhoods to pilot approach, develop a plan and timeline for sequencing additional neighborhoods.
	In selected neighborhoods, identify and engage neighborhood leaders, residents, partners and anchor organizations.
	With partners, map assets and opportunities, identify priorities, and develop a plan for addressing social, economic and health factors that impact infant mortality.
	Develop a neighborhood-level report card to monitor progress and drive results, include standardized "core" metrics across neighborhoods and initiative-specific metrics within each neighborhood.
Work with City of Columbus, Franklin County, business and community leaders to align strategies and target supportive resources across sectors to improve the social and economic conditions that impact infant mortality. Lead Entity: Executive Committee/ Project Director	Engage leaders from housing, early childhood, transportation, safety, food security, workforce development and other systems to identify opportunities to align strategies and coordinate efforts to improve conditions for high-risk populations and neighborhoods.
	As part of City and County 2015 budget processes, and annually thereafter, identify and target new resources to identified neighborhoods, implementing steps such as vacant lot/property cleanup programs, safety services, housing, transportation, employment, early childhood, education, etc.
	Prioritize pregnant women in homeless shelter allocations, food distribution and other community programs; consider opportunities to identify pregnant women and coordinate referrals through City 211 service.
	Target workforce development, outreach and supportive employment opportunities in high-risk communities, e.g., FastPath, Columbus' investment in career readiness.
Address the effects of race and racism on infant mortality and disparity. Lead Entity: Executive Committee/ Project Director	Publicly report racial disparities on infant mortality report card to raise awareness and accountability for closing the gap.
	Work with community leaders and organizations to provide advice and insight on ways to effectively engage the black community.
	Build capacity among community, neighborhood leaders and service providers by providing training on structural racism designed to give leaders insight into underlying causes and strategies to change policy and practice to promote equity.
	With trained leaders, develop neighborhood- and community-level strategies for addressing the effects of race and racism.

YEAR ONE IMPLEMENTATION

2: IMPROVE WOMEN'S HEALTH BEFORE PREGNANCY

Strategies	Key Activities
Increase enrollment in public and private health insurance coverage for low-income women. Lead Entity: Franklin County Department of Job and Family Services/ Local insurance navigator program	Educate uninsured families about expanded insurance options.
	Support streamlined public insurance enrollment, including presumptive eligibility and continuous coverage.
Increase preventive health care visits for teens. Lead Entity: Partners for Kids	Educate teens about the importance of preventive and primary care.
	Link teens to providers that offer comprehensive, age-appropriate primary health care to teens.

3: IMPROVE REPRODUCTIVE HEALTH PLANNING

Strategies	Key Activities
Address reproductive health planning as part of prenatal and postpartum care to ensure "safe spacing" between pregnancies. Lead Entity: Ohio Better Birth Outcomes Collaborative	Develop culturally sensitive materials to educate women, their partners and providers about the importance of safe spacing.
	Work with providers to ensure that prenatal and postpartum visits include information about reproductive health planning and safe pregnancy spacing. This should include linkage to safe and effective contraception, especially long-acting reversible contraception.
Increase use of safe and effective methods of preventing pregnancy. Lead Entity: Ohio Better Birth Outcomes Collaborative	Pilot the evidence-based CHOICE project (St. Louis) to remove financial barriers to contraception, promote the most effective birth control methods and reduce unintended pregnancy, evaluate and plan for scaling.
	Advocate for an Ohio Medicaid policy change to remove existing barriers for hospitals to provide long-acting reproductive contraception at the time of delivery.
	Incorporate counseling on long-acting reversible contraception as part of prenatal care, postpartum visits and other program interventions for teens.
	For those who prefer an option other than contraception, incorporate counseling on natural family planning and abstinence.

YEAR ONE IMPLEMENTATION

4: IMPROVE PRENATAL CARE SYSTEMS AND SUPPORTS FOR HIGHEST RISK FAMILIES

Strategies	Key Activities
Increase women's entry into prenatal care during the first trimester. Lead Entity: Ohio Better Birth Outcomes Collaborative	Increase public and private health insurance enrollment for low-income women (see Improve Women's Health Before Pregnancy Recommendation for key activities).
	Develop an effective centralized prenatal care intake and referral service; conduct a competitive bid process to identify and select a vendor; market the service.
	Identify and deploy strategies to improve early enrollment in managed care organizations' pregnancy care management programs.
	Develop targeted outreach strategies to identify and engage women with high-risk conditions (e.g., substance abuse, diabetes) or living in high-risk settings (e.g., hot spot neighborhoods, foster care, jail) and link them with resources.
	Educate women and their partners about the importance of prenatal care for good birth outcomes.
Ensure prenatal care access and capacity across the community, particularly for highest risk women. Lead Entity: Ohio Better Birth Outcomes Collaborative	Evaluate access and capacity of prenatal care services and develop a plan to address gaps that includes consideration of evidence-based prenatal and pregnancy support services (e.g., centering).
	Establish mobile prenatal care services at Columbus' new homeless family shelter.
	Advocate for a supportive state policy to mitigate provider liability for providing prenatal care to teens without parental consent.
	Partnering with Franklin County Alcohol, Drug and Mental Health Board, develop strategies to support prenatal care access and support for women who are addicted to drugs, are in jail or on probation, or who have chronic mental illnesses.
Target maternal home visiting resources to improve outcomes for the highest risk families. Lead Entity: Franklin County Family and Children First Council/Ohio Department of Health	Assess current home visiting capacity and distribution and develop a plan to direct resources to the highest risk clients and/or to expand capacity.
	Require all home visiting programs to be trauma-informed and provide evidence supporting their effectiveness in improving maternal and infant outcomes, especially prematurity.
	Develop a coordinated process for screening and triaging clients to appropriate home visiting programs, monitoring data and outcomes.

YEAR ONE IMPLEMENTATION

5: ENSURE HIGHEST STANDARDS OF QUALITY FOR PERINATAL CARE

Strategies	Key Activities
Increase the percentage of eligible women receiving progesterone. Lead Entity: Ohio Better Birth Outcomes Collaborative	Ensure culturally competent education for providers and consumers about the importance and availability of progesterone.
	Monitor education and outreach activities around this strategy to ensure that efforts are appropriately culturally sensitive.
	Collaborate with Ohio Medicaid to remove barriers to progesterone access for women and physicians.
Establish a community standard and continue to monitor performance, by hospital, to reduce early elective deliveries. Lead Entity: Central Ohio Hospital Council	Establish a quality improvement project to identify additional actions steps delivery hospitals can take to further reduce scheduled early deliveries.
Modify community practices, as necessary, to ensure that very low birth weight newborns are cared for in Level III facilities that also have consistently high volumes of patients. Lead Entity: Central Ohio Hospital Council	Determine an appropriate mechanism to ensure very low birth weight babies are delivered at Level III facilities that meet volume threshold.

6: REDUCE MATERNAL AND HOUSEHOLD SMOKING

Strategies	Key Activities
Target resources to reduce smoking among pregnant and postpartum women and their families. Lead Entity: Ohio Medicaid/ Medicaid Managed Care Plans	Assess capacity and accessibility of evidence-based cessation resources.
	Work with providers to conduct standardized assessment of smoking risk and link pregnant, parenting and postpartum women and their families to evidence-based smoking cessation resources, starting with providers who serve a high volume of low-income families.
	Develop and deploy a provider tool kit that includes assessment tools, educational materials and cessation resources.
Adopt smoke-free policies in multiunit housing facilities and other housing settings for high-risk women and families. Lead Entity: Columbus Housing Division/ Columbus Metropolitan Housing Authority	Target activities in shelters and low-income housing in high-risk neighborhoods and expand to other settings.

YEAR ONE IMPLEMENTATION

7: PROMOTE INFANT SAFE SLEEP

Strategies	Key Activities
Implement a comprehensive public awareness and education campaign to improve safe sleep practices. Lead Entity: Columbus Public Health	Engage an advertising/marketing firm to localize the existing statewide safe sleep campaign and ensure that messages are effective in reaching and improving safe sleep behavior across the community and in the highest risk populations. Specifically tailor culturally-competent messages and outreach to reduce racial disparity gap. Develop metrics to analyze the campaign's impact and effectiveness.
	Develop and deploy safe sleep messages, advertisements and collateral materials in places that caregivers frequent, focusing on neighborhoods with the highest number of sleep-related deaths.
	Share sleep-related death data with each delivery hospital to identify opportunities for improvement.
Incorporate safe sleep and breast-feeding as a key component of prenatal care, at the time of delivery, and postpartum. Lead Entity: Central Ohio Hospital Council	Ensure that local health systems model safe sleep practices and standardize education of families about safe sleep before they leave the hospital.
	Educate providers about the importance of breast-feeding and safe sleep in preventing sleep-related deaths.
	Collaborate with providers to develop user-friendly, culturally appropriate materials to educate patients about the importance of breast-feeding and safe sleep.
	Ensure adequate lactation support resources are available to women who need them.
Establish infant safe sleep practices as a community social norm. Lead Entity: Columbus Public Health	Conduct education and audits to ensure that hospitals, child care centers and other providers consistently teach safe sleep practices.
	Partner with media and businesses to establish standards to ensure that images depict infants only in safe sleep environments.
Develop a coordinated community process for ensuring high-risk families have a crib before the baby leaves the hospital. Lead Entity: Columbus Public Health	Develop a process to track, obtain and distribute free and low-cost cribs to high-risk families.
	Establish standard eligibility criteria for families to receive free or reduced cost cribs.
	Identify and educate partners for assessing eligibility, distributing cribs and conducting follow-up to support effective use of cribs for safe sleep.

YEAR ONE IMPLEMENTATION

8: CREATE A COLLECTIVE IMPACT AND ACCOUNTABILITY STRUCTURE TO SUPPORT STRATEGY IMPLEMENTATION AND GOAL ATTAINMENT

Strategies	Key Activities
Develop an infrastructure to effectively implement recommendations, monitor progress and drive improvement. Lead Entity: City Council/County Commissioners	Appoint an executive committee of the Task Force to provide ongoing oversight capacity.
	Identify an administrative host organization.
	Engage a consultant to serve as project director and oversee plan implementation.
Develop an Infant Mortality Report Card and implementation plan metrics; use the report card to drive ongoing improvement and prioritize resource needs. Lead Entity: Project Director/Columbus Public Health	Develop a robust local sample of Pregnancy Risk Assessment Monitoring System data to enable tracking of key plan indicators by race and neighborhood.
	Identify additional data needs and potential sources necessary to support plan metrics at the community and neighborhood level.
	Establish responsibilities for report card production, targeting publication for each June.
	Partner with the Public Health Collaborative, public health and local hospitals to improve quality of birth certificate data.
Support implementation of a Franklin County Fetal Infant Mortality Review (FIMR) as a key part of performance improvement.	Establish case review team and process.
	Routinely share findings with Project Director and Executive Committee to inform and drive improvement.
Develop communications plan and strategy to support plan implementation. Lead Entity: Executive Committee/ Project Director	Contract with a communications consultant to support development and implementation of plan "rollout" and goals for ongoing community engagement.
	Create a recognizable "brand" for Columbus' infant mortality reduction initiative.
	Establish a centralized website as a "hub" for information about infant mortality in Columbus, plan initiatives and opportunities for engagement.
	Routinely communicate with the community about initiatives and progress.

IMPROVE SOCIAL AND ECONOMIC CONDITIONS THAT DRIVE DISPARITIES ACROSS OUR COMMUNITY AND IN HIGHEST RISK NEIGHBORHOODS

- Engage and mobilize neighborhood-level initiatives.
- Align strategies and resources to improve social and economic conditions, particularly in high-risk neighborhoods.
- Address the effects of race and racism on infant mortality.

IMPROVE WOMEN'S HEALTH BEFORE PREGNANCY

- Increase low-income families enrollment in private and public health insurance.
- Expand access and use of patient-centered medical homes, starting with adolescents.

IMPROVE REPRODUCTIVE HEALTH PLANNING

- Emphasize reproductive health planning in prenatal/postpartum care.
- Increase access to safe and effective methods for preventing prengancy.

IMPROVE PRENATAL CARE SYSTEMS AND SUPPORTS FOR HIGHEST RISK FAMILIES

- Increase women's early entry into prenatal care.
- Ensure prenatal care access and capacity, especially for highest risk families.
- Improve coordination of prenatal care and pregnancy support services.

ENSURE HIGHEST STANDARDS OF QUALITY FOR PERINATAL CARE

- Increase progesterone enrollment for eligible women.
- Continue to reduce early elective deliveries.
- Ensure very low birth weight babies are cared for in settings with consistently high volume.

REDUCE MATERNAL AND HOUSEHOLD SMOKING

- Help women quit smoking while pregnant and postpartum.
- Adopt smoke-free policies in multiunit housing facilities.

PROMOTE INFANT SAFE SLEEP

- Launch safe sleep public awareness campaign.
- Emphasize safe sleep and breast-feeding in prenatal care.
- Establish safe sleep practices as community norm.
- Ensure that low-income families have a crib.

CALL TO ACTION

CALL TO ACTION

The Greater Columbus Infant Mortality Task Force has set forth ambitious goals for our community to reduce infant mortality and racial disparities. To be successful in this endeavor and to advance our strategies, we need broad engagement and support from our community.

There are many ways that community partners and organizations can begin to support this work right away – even if they are not formally engaged in implementation efforts. Key opportunities for employers, physicians and other clinicians, faith communities and schools are listed below.

EMPLOYERS

- With key partners, target workforce development to promote and sustain employment in Columbus' infant mortality "hot spot" neighborhoods.
- Provide employee health insurance benefits that cover and support employees' use of preventive health, long-acting reversible and other contraception, smoking cessation resources and mental health services.
- Support employees by providing maternity leave, leave for prenatal care appointments and a supportive environment for breast-feeding.
- As part of employee wellness initiatives, incorporate culturally sensitive messages and provide supportive resources on key issues related to maternal and infant health, including preconception women's health, risks of maternal and household smoking, importance of breast-feeding and infant safe sleep.
- Provide cultural diversity training for staff to support an inclusive environment.

PHYSICIANS AND OTHER CLINICIANS

- Assess risks and provide culturally sensitive patient education to encourage and support good health – before, during and after pregnancies. Issues to address include smoking, obesity, nutrition, breast-feeding and safe sleep.
- Encourage and support patients – both female and male – to be proactive in reproductive health planning before and between pregnancies.
- Educate staff about resources and referral agencies in the community so that they can effectively refer patients to mental health services, smoking cessation, substance abuse treatment, Medicaid, WIC, food pantries, lactation support, child care, etc.

FAITH COMMUNITIES

- Foster social support networks for members who have recently had a baby.
- Incorporate culturally sensitive messages on a variety of topics that affect maternal and infant health into education and outreach initiatives, e.g., obesity, nutrition, risks of smoking and substance abuse, exercise, breast-feeding and safe sleep.
- Educate and engage young men and women to help them understand reproductive health and the health consequences of their lifestyle choices.
- Develop programs to engage young men and promote paternal involvement in pregnancy and parenting.
- Help congregation members get to prenatal care appointments and follow-up appointments after delivery.
- Celebrate success by organizing a community first birthday celebration.
- Offer space for community meetings or health fairs.

SCHOOLS

- Provide age-appropriate education and target resources to support healthy nutrition, physical activity and avoiding risks like tobacco and other drugs.
- Connect young women who do become pregnant to supportive resources to ensure they stay in school.
- Educate staff about resources and referral agencies in the community so they can effectively refer patients to mental health services, smoking cessation, substance abuse treatment, Medicaid, WIC, food pantries, lactation support, child care, etc.
- Offer space for community meetings, health fairs or other "off-hours" programming to support overall neighborhood health.

For more detailed information about the topics covered in this report, go to ***gcinfantmortality.org***.

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Franklinton Area Commission

Near East Area Commission

YWCA

United Way of Central Ohio

South Linden Area Commission

Columbus Southside Area Commission

Columbus Chamber of Commerce

The Women's Fund of Central Ohio

Columbus Urban League

Triedstone Baptist Church

Mid-Ohio Foodbank

LifeCare Alliance

Community Shelter Board

Catholic Social Services

Columbus Metropolitan Club

Godman Guild

March of Dimes Ohio

Council on Healthy Mothers and Babies

Human Services Chamber of Franklin County

Columbus Urban League

Columbus Public Health – Minority Health Committee, South/East/North/West Side Health Committees

Greater Hilltop Area Commission

Molina Healthcare of Ohio

Franklin County Safe Sleep Task Force

Hilltop Shalom Zone

GREATER COLUMBUS INFANT MORTALITY TASK FORCE

gcinfantmortality.org

THE CITY OF
COLUMBUS
CITY COUNCIL