cradle cincinnati

Strategic Plan for Infant Mortality Reduction

HAMILTON COUNTY, 2023-2027

Table of Contents

Executive Summary

As recently as 2011, Hamilton County had the second worst infant mortality rate in the entire country. However, thanks to hundreds of partners working together over the last 10 years, we've seen significant progress.

Despite this progress, the problem of infant death continues to plague our community. The loss of even one baby is too many. We want to see every child born in Hamilton County live to celebrate their first birthday, so there is still work to be done. Specifically, we continue to see racial disparities in infant health outcomes, with Black families more likely to experience infant loss than other racial and ethnic groups.

Over a period of seven months, we gathered input from more than 200 birthing people, partners, families, social service providers, health professionals and other key stakeholders across Hamilton County. We asked them what it would take to eliminate disparities and create an ecosystem where every pregnant person felt respected, cared for and supported, and all babies lived to celebrate their first birthdays.

We are introducing universal goals that we want all racial and ethnic groups to meet.

Everyone in our community deserves the same opportunity to live and thrive. For this to happen, we must approach our goals with an equity lens. Setting universal goals and reviewing the outcomes for each individual race and ethnicity allows us to focus our efforts on the groups that are most disproportionately impacted.

Our universal goals for the next five years are:

1) Infant Mortality Rate

6.4/1,000 live births

2) Extreme Preterm Birth Rate

6.4/1,000 live births

3) Sleep-related Death Rate

1.4/1,000 live births

By setting universal goals, we can better identify which families in Hamilton County need to be the focus of our collective efforts. Our data reveals to us that Black infants need our attention so they have the same chance to live their life as infants born the same time as them. As such, our strategies for the next five years will focus squarely on improving outcomes for the Black community.

We aim to achieve these universal goals through the following:

Goal 1

Create a community-based ecosystem of support for Black birthing people.

Goal 2

Support Black birthing people across all stages of pregnancy and parenthood by meeting their basic needs.

Goal 3

Expand the medical system's capacity to center the needs of Black birthing people.

Goal 1
Create a community-based ecosystem of support for Black birthing people.

Objective 1A

Expand Black birthing peoples' formal and informal support systems, resulting in a higher quality, holistic ecosystem of support.

Strategy 1A.1

Create spaces for Black birthing people to support each other by building a knowledgeable community who journeys through pregnancy and parenthood together.

Strategy 1A.2

Increase access to advocates and patient support for Black birthing people when interacting with the medical system.

Strategy 1A.3

Connect Black birthing people to a sustainable village-based mental health support system.

Strategy 1A.4

Provide focused attention on postpartum support, including resources to process grief.

Goal 2

Support Black birthing people across all stages of pregnancy and parenthood by meeting their basic needs.

Objective 2A

Ensure Black birthing people are aware of and can easily access existing programs, services and resources.

Strategy 2A.1

Improve access to existing services by reducing barriers for who qualifies.

Strategy 2A.2

Develop a central hub where Black birthing people, healthcare professionals and social service providers can learn about available programs, services and resources related to central needs such as transportation, housing, financial assistance, etc.

Objective 2B

Increase Black birthing people's sense of independence and family self-sufficiency to improve long-term life outcomes.

Strategy 2B.1

Develop initiatives to aid Black birthing people in gaining life skills so they feel informed and confident entering pregnancy and parenthood.

Strategy 2B.2

Building Black birthing peoples' capacity for financial stability.

Goal 3
Expand the medical system's capacity to center the needs of Black birthing people.

Objective 3A

Increase the medical system's capacity to build connections with Black birthing people.

Strategy 3A.1

Create more spaces where healthcare professionals can directly hear and learn from Black birthing people with the specific goal of improving the prenatal care experience.

Strategy 3A.2

Include Black birthing people in the development of strategies and interventions that health systems are implementing to improve equitable outcomes.

Objective 3B

Create mechanisms to measure and monitor health systems' efforts to improve equitable outcomes for all.

Strategy 3B.1

Establish and expand certifications that can be used to assess hospital systems and other birthing people's health related programs' efforts toward providing more equitable care and service.

Strategy 3B.2

Build a system where Black birthing people can provide honest feedback about their care experience and ensure health systems can be responsive to their concerns to increase accountability and transparency.

Our Model

Cradle Cincinnati is committed to helping every baby reach their first birthday.

Collective Impact Model

To address Hamilton County's infant mortality rate, a broad and diverse collaborative of partners formed Cradle Cincinnati in 2013. The collaboration model we have used and continue to use is called "collective impact." Initially described in 2011 in the Stanford Social Innovation Review, collective impact has as its core premise that no single program or organization can solve complex social problems by itself. With that in mind, we work to create a space where partners throughout Hamilton County can come together under a common goal: helping our babies live to celebrate their first birthday.

We will never eliminate infant mortality until everyone in our community has the same opportunities, regardless of who they are and where they live. As we move into the next five years and continue to engage in a collective impact model, Cradle Cincinnati is committed to centering equity in every aspect of our work. We have adopted the following principles, as outlined in the Winter 2022 issue of the Stanford Social Innovation Review, in order to do so.

We use these principles as a map to guide us on how to truly embrace collective impact with an equity lens.

1) Ground the work in data and context and target solutions: The participants in the collective have shared language and understanding around race, equity and the origins and of existing inequities. Participants use this shared understanding to develop solutions to achieve equity.

2) Focus on systems change, in addition to programs and services: Solutions to the root causes of social problems cannot be achieved solely through programs and services. Achieving equitable outcomes requires changes to systems, structures and policies.

3) Shift power within the collaborative: Those most affected by an issue should have a voice in the setting of priorities, distribution of resources and be able to hold programs and systems accountable. Achieving equitable outcomes requires more equitable decision-making spaces.

4) Listen to and act with the community: Recognize and value the knowledge, skills and experiences that already exist in communities. Build on and support the solutions communities have already created.

5) Build equity leadership and accountability: Have leaders that reflect the population being served and explicitly state the importance of having an unwavering focus on equity in the collective's work.

As we continue to grow our strategies and partnerships, we will continue to rely on the voice of our community to lead our work.

Through our last strategic plan, we largely focused on...

01
Spreading and scaling place-based work, concentrating in neighborhoods with the worst outcomes.

02
Centering Black birthing people's voices through the establishment of Queens Village.

03
Implementing equity initiatives to address implicit bias in healthcare systems through the Cradle Cincinnati Learning Collaborative.

04
Developing new partnerships and strategies around safe sleep.

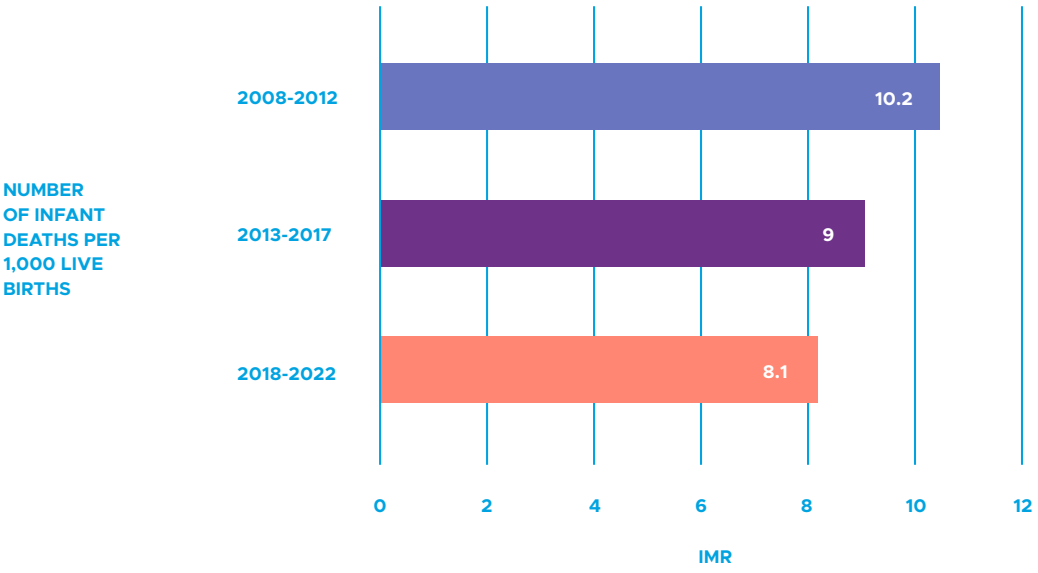
05
Partnering with local health systems and community groups to reduce maternal smoking.

06
Increasing capacity of community health worker programs.

As a result of these strategies and more, our community celebrated reductions in infant mortality, Black infant mortality and extreme preterm birth. We learned that centering the voices of those most impacted by infant death builds trust and leads to more responsive and effective initiatives to address their needs. We also learned the importance of deep partnerships and ongoing collaborations across organizations, inviting everyone to the table who could potentially impact infant health outcomes.

Although we are celebrating this progress, we know that our work is not done yet. We must double down on the strategies that have worked and expand our footprint to reach more birthing people and families. And while we recognize the undeniable impact that direct service can have on addressing an individuals' needs, we also recognize that in order to see sustained improvement we must move upstream and also focus on systems-level change. Systems-level change addresses the root causes of an issue, as opposed to only addressing the symptoms of an issue. Changing systems is not easy. It requires shared vision, ownership and collective action. Thankfully, the partners who have been engaged in this work for the past 10 years are willing and able to come together and change the policies and systems that have lasting impacts on infant mortality in our community.

Infant Mortality Rate in Hamilton County 2008-2022



Since 2013, the number of infant deaths has decreased by 6.3%.

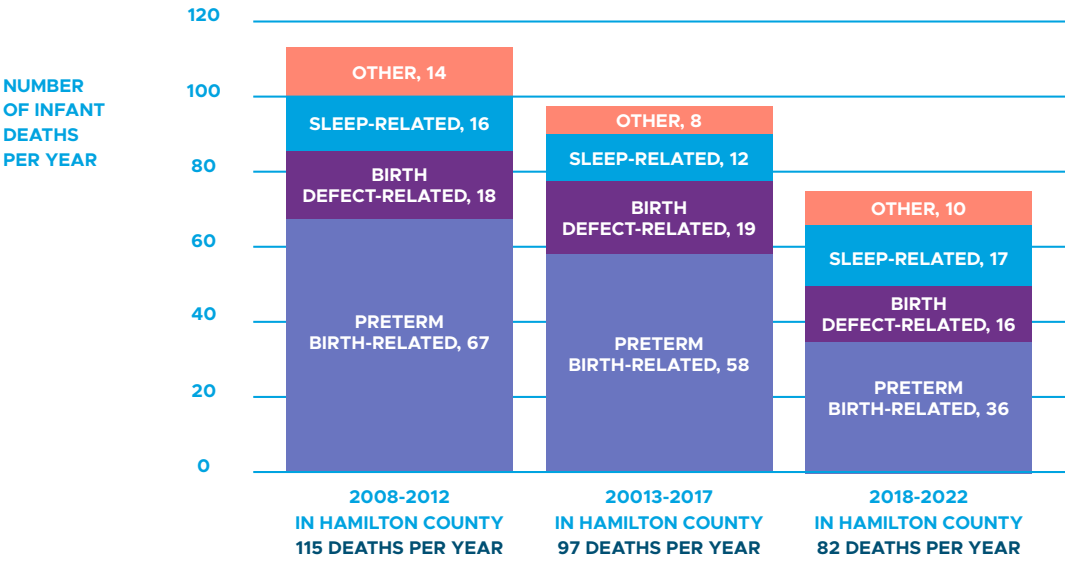
Source: Ohio Department of Health (ODH) - Vital Statistics

Causes of Infant Death in Hamilton County 2018-2022

Preterm birth-related deaths remains the leading cause of infant death in Hamilton County, specifically "extreme preterm birth," those children born before the end of the birthing person's second trimester.

Source: Hamilton County Fetal and Infant Mortality Review (FIMR)

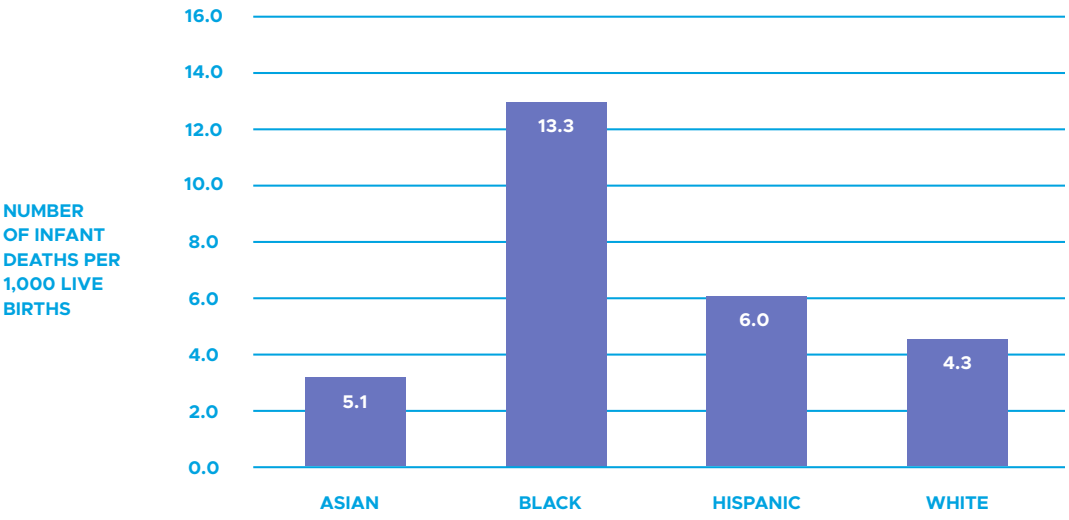
Infant Deaths by Cause Over Time in Hamilton County 2008-2022



Preterm birth-related infant deaths are steadily decreasing. We still have work to do on sleep-related infant deaths.

Source: Hamilton County Fetal and Infant Mortality Review (FIMR)

Infant Mortality Rate by Race and Ethnicity in Hamilton County 2018-2022



Black infant mortality in Hamilton County continues to be far greater than other racial and ethnic groups.

Notes: Race and ethnicity are defined by mother. Sources: Ohio Department of Health (ODH), Hamilton County Fetal and Infant Mortality Review (FIMR) and Centers for Disease Control and Prevention (CDC)

Identifying Areas of Opportunity

Understanding needs of the community to eliminate infant mortality.

In thinking about the next five years of work as a collective, we knew we needed to engage with the Hamilton County community to understand their needs concerning Black infant mortality and leverage their voice to identify actions to achieve the ultimate goal of eliminating infant mortality.

Cradle Cincinnati partnered with consulting firm DC Design to conduct a series of interviews and focus groups with stakeholders across the pregnancy ecosystem — from birthing people to those caring for them, like spouses, social service providers and health professionals.

Initial Focus Groups and Interviews

Participants

07 Moms who have experienced infant loss

32 Moms who have not experienced infant loss

Those who have experienced motherhood firsthand.

14 Social service providers

10 Fathers/spouses, partners

09 Perinatal support (community health workers, community navigators, doulas)

Those who have witnessed closely.

07 Cradle Cincinnati team members

30 Cradle Cincinnati Advisory Board Committee

Those who are working toward baby's and mother's well-being.

Common Themes

Strengthening Mother's Mental Health
How might we prioritize mother's mental health to alleviate factors that lead to stress before, during and after pregnancy?

Galvanizing Social Support
How might we help mothers build a strong sense of security through identifying and building a social support system that serves her emotional, physical and informational needs?

Improving Life Outcomes for Mothers
How might we best prepare women for pregnancy through life planning, body knowledge, fulfilling basic needs and reducing barriers to support?

Increasing Doctor-Patient Trust
How might we shift relationship dynamics between doctors and patients and fuel more trust and healthy communication?

Birthing people, partners, healthcare workers and social service providers worked together.

Solutions Design Sessions

After identifying the core themes or critical areas of opportunity, we hosted three Solutions Design Sessions where birthing people, partners, healthcare workers and social service providers worked together to identify recommendations that could address the core themes. By bringing a diverse set of stakeholders together and centering on Black birthing people's lived experience, the participants were able to design solutions that can be both effective for birthing people and actionable for partners.

The Plan: Goals, Objectives and Strategies

The goals and strategies are derived directly from the ideas generated by the community members and stakeholders that were engaged in the aforementioned process.

Over the next five years, we will focus on a set of goals, objectives and strategies meant to drive down the leading causes of infant mortality (extreme preterm birth and unsafe sleep) and address racial disparities.

For too long, improvements in maternal and infant health have not been shared across different racial and ethnic groups in our community. Because there is no one-size-fits-all strategy for reducing infant mortality, interventions must be tailored to the unique realities of those most impacted.

We are setting universal goals that we want all racial and ethnic groups in our community to meet.

Equity Lens Approach

Everyone in our community deserves the same opportunity to live and thrive. For this to happen, we must approach our goals with an equity lens. Setting universal goals and reviewing the outcomes by race and ethnicity allows us to focus our efforts on the groups that are most disproportionately impacted. We can then develop tailored interventions to more effectively address their specific needs. This is true equity.

Our universal goals for the next five years are:

1) Infant Mortality Rate

6.4/1,000 live births

2) Extreme Preterm Birth Rate

6.4/1,000 live births

3) Sleep-related Death Rate

1.4/1,000 live births

By setting universal goals, we can better identify which families in Hamilton County need to be the focus of our collective efforts. Our data reveals to us that Black infants need our attention so they have the same chance to live their life as infants born the same time as them. As such, our strategies for the next five years will focus squarely on improving outcomes for the Black community.

We aim to achieve these universal goals through the following strategic goals:

Goal 1

Create a community-based ecosystem of support for Black birthing people.

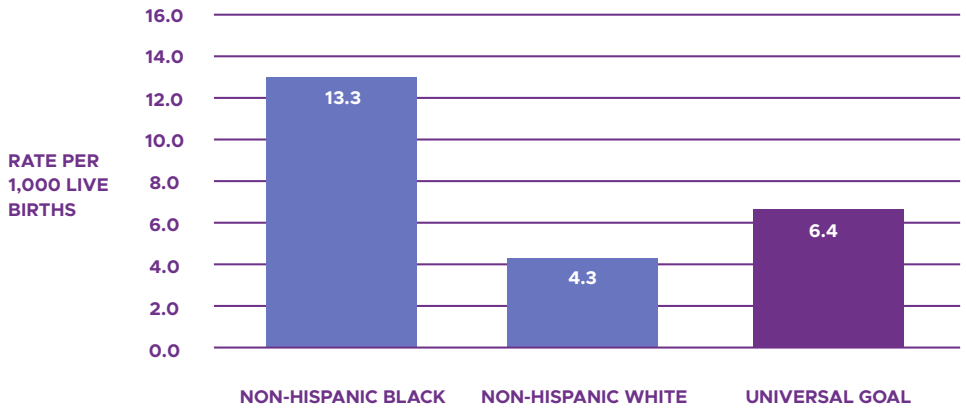
Goal 2

Support Black birthing people across all stages of pregnancy and parenthood by meeting their basic needs.

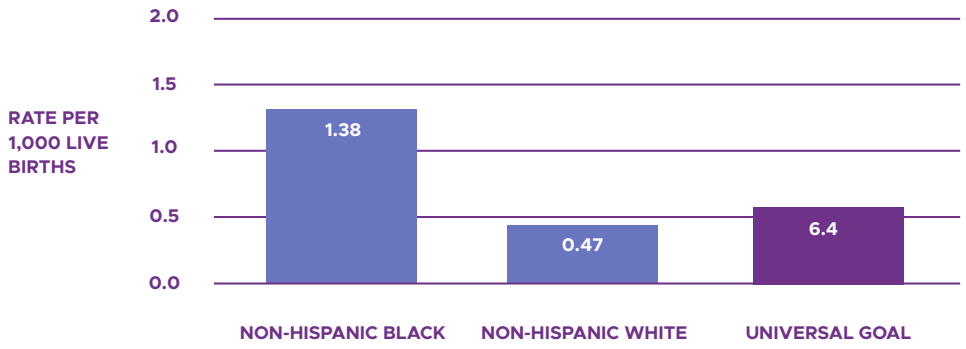
Goal 3

Expand the medical system's capacity to center the needs of Black birthing people.

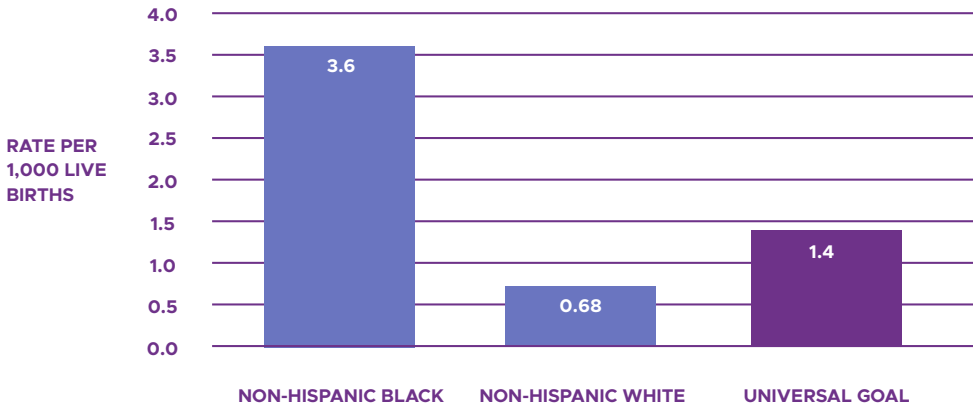
2018-2022 Average Infant Mortality Rate by Race and Ethnicity



2018-2022 Average Preterm Birth Rate by Race and Ethnicity



2018-2022 Average Sleep-Related Infant Death Rate By Race And Ethnicity



Due to small sample sizes in the Hispanic, non-Hispanic Asian and Native American/Alaskan Native groups, we are unable to share rates for these groups for the 2018-2022 time frame. Therefore they are not reflected on the graphs above, however we are regularly monitoring the data for all groups in our community.

Note: The small sample size in the Hispanic, non-Hispanic Asian and Native American/Alaskan Native races/ethnicity produce data that is not reliable for use in statistical analysis and interpretation. Therefore we are unable to share rates for these groups in the charts above. However we monitor this data very closely and should the data shift we will report it and revisit our strategies.

Goal 1

Create a community-based ecosystem of support for Black birthing people.

Objective 1A

Expand Black birthing people's formal and informal support systems, resulting in a higher quality, holistic ecosystem of support.

Birthing people's support systems heavily impact their sense of security, confidence and stress levels during and after pregnancy. When birthing people get pregnant they typically interact with their primary doctors, nurses and other hospital staff. Some birthing people may seek additional support through community health workers, midwives, doulas, or close family and friends. It is essential to surround them with a larger ecosystem of individuals and organizations who are knowledgeable, readily accessible, regularly available, approachable and who allow for more personable and informal interactions. A strong ecosystem of support has the potential to mitigate stress, a key influencer in extreme preterm birth, and support families in practicing safe sleep.

Strategy Summary

Strategy 1A.1

Create spaces for Black birthing people to support each other by building a knowledgeable community that journeys through pregnancy and parenthood together.

Strategy 1A.2

Increase access to advocates and patient support for Black birthing people when interacting with the medical system.

Strategy 1A.3

Connect Black birthing people to a sustainable village-based mental health support system.

Strategy 1A.4

Provide focused attention on postpartum support, including resources to process grief.

Strategy 1A.1

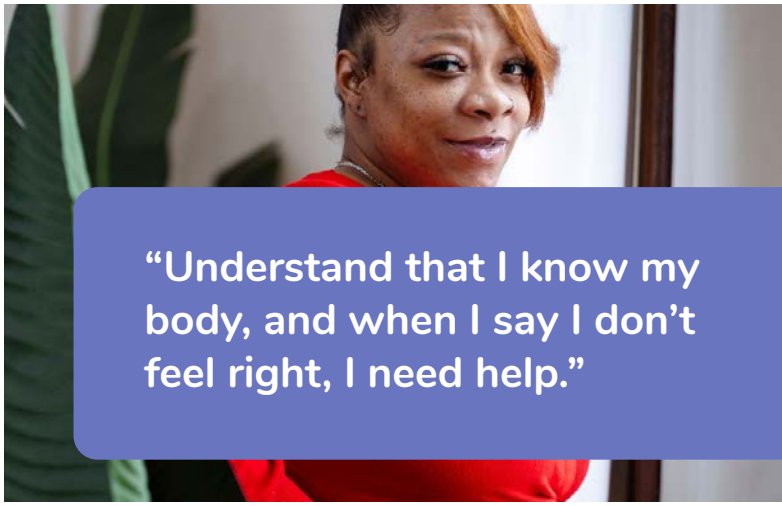
Create spaces for Black birthing people to support each other by building a knowledgeable community who journeys through pregnancy and parenthood together.

Receiving moral and emotional support from people who care is intangible. Birthing people desire to be in community with other parents-to-be and understand the value of sharing experiences and asking for or providing support. Peer-based interaction such as breastfeeding groups, Centering Pregnancy® groups and pregnancy and postpartum support groups are crucial to birthing people who want to build community. Being in community with other birthing people results in parents who feel more informed, engaged and comfortable navigating any concerns during the pregnancy journey. This can lead to increased knowledge, satisfaction, and compliance with care and has proven to be valuable to both the maternal and infant health outcomes.

Strategy 1A.2

Increase access to advocates and patient support for Black birthing people when interacting with the medical system.

Black birthing people need advocates and trusted navigators to both move through the medical world and reduce stress, mistrust and miscommunication when interacting with health professionals. Birthing people desire a care team who can get to know them and their goals, ask and answer questions and provide solutions to their unique challenges. Birthing people benefit from access to individuals whose sole responsibility is to be available to their needs, such as patient navigators and doulas. Their role is to ensure birthing people feel informed, safe, supported and confident in their pregnancy plan, check in when they experience challenges or struggle to keep appointments, and empower them with resources to achieve self-sufficiency.



Strategy 1A.3

Connect Black birthing people to a sustainable village-based mental health support system.

Given the stress of pregnancy, it is important to prioritize the mental health of Black birthing people. Their mental health is directly related to the amount and quality of support from their immediate community, including partners, family members, other birthing people and local organizations. It is essential to leverage these community members to create a caring village around birthing people who empathize with, encourage and create spaces where birthing people can truly take care of themselves.

Strategy 1A.4

Provide focused attention on postpartum support, including resources to process grief.

The postpartum period is a time of tremendous change, responsibility and healing. Birthing people are stretched thin after delivery, physically and emotionally. The first year after the birth of their child is critical in ensuring birthing people have easy access to professionals and specialists who can support them with their physical health, mental health, caring for their baby and more. Additionally, feedback from community members shows that it is imperative to provide ample resources and a caring, gentle environment for birthing people who have lost their babies. They are experiencing an unparalleled level of grief that is extremely difficult to process alone.

"I wish I could connect to other moms that could help me, and this would help me feel better. I need moral, mental and emotional support."

What this looks like in practice.

01 Postpartum support groups

02 Neighborhood wellness journeys

03 Access to birth and postpartum doula

04 Launching Queens Village spaces within health centers

05 Infant loss support group for Black birthing people

06 Expand Queens Village advisory boards in neighborhoods

Potential Partners

01
Doula groups

02
Black-owned mental health services

03
Birthing hospitals and community health centers

04
Organizations that provide grief support and counseling

05
Community health workers

How we measure success.

01
# of individuals connected to doula services (Source: Cradle Cincinnati Collaborative)

02
# of individuals connected to mental health services (Source: Cradle Cincinnati Collaborative)

03
% of Queens Village participants report feeling a sense of community (Source: Queens Village annual survey)

04
% of Hamilton County Black birthing people who reported having someone to talk to about their problems during their most recent pregnancy (source: OPAS)

05
% of Hamilton County Black birthing people who reported suffering from anxiety during the three months before their most recent pregnancy (Source: OPAS)

06
% of Hamilton County Black birthing people who reported suffering from anxiety during their most recent pregnancy (Source: OPAS)

Goal 2

Support Black birthing people across all stages of pregnancy and parenthood by meeting their basic needs.

Objective 2A

Ensure Black birthing people are aware of the existing programs, services and resources and are able to easily access them.

Our community is full of organizations, partners, initiatives and programs dedicated to improving the health and well-being of birthing people and babies. However, many families — and even service providers — have trouble finding and navigating the resource providers available to them. We have the opportunity to partner with these resources to increase their visibility and make them more accessible for families.

Strategy Summary

Strategy 2A.1

Improve access to existing services by reducing barriers for who qualifies.

Strategy 2A.2

Develop a central hub where Black birthing people, healthcare professionals and social service providers can learn about available programs, services and resources related to central needs such as transportation, housing, financial assistance, etc.

Strategy 2A.1

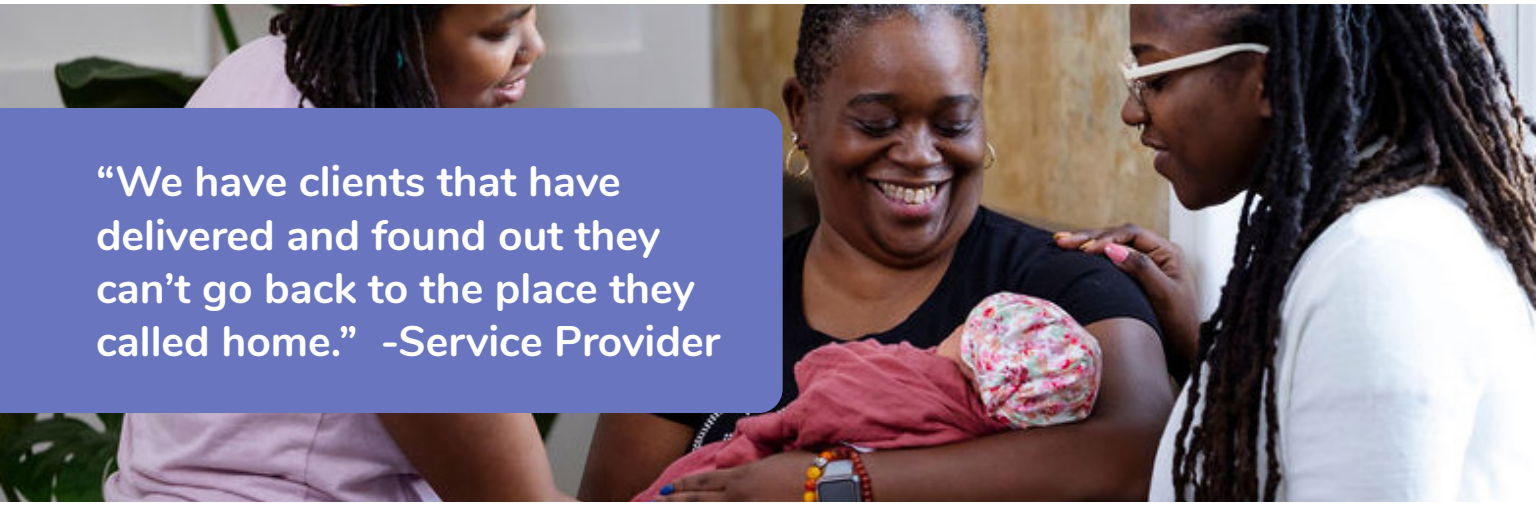
Improve access to existing services by reducing barriers for who qualifies.

Everyone needs their basic needs met in order to achieve their optimal health and well-being. Too many families struggle with basic needs like stable housing, reliable transportation and access to affordable childcare — and face a complex set of barriers that prevent them from accessing resources in our community. As such, we need to broaden eligibility criteria that will allow more Black people to easily connect with available resources. By doing so, birthing people will be better able to prioritize their own health as well as the health of their baby.

Strategy 2A.2

Develop a central hub where Black birthing people and providers can learn about available community resources.

Strategy 2A.1 focuses on broadening the eligibility requirements for existing programs, services and resources. However, families who are aware of and eligible for such programs can feel confused and overwhelmed when trying to navigate the sheer number of programs (many of which fill very specific needs) and their individualized processes. This is not only time-consuming, but can also be difficult for birthing people and their care providers to understand which program or resource is right for them. Instead, birthing people and providers need a centralized location, whether physical or web-based, to learn about all the available resources and help guide them in applying for the programs and resources that will best serve their needs.



"We have clients that have delivered and found out they can't go back to the place they called home." -Service Provider

Objective 2B

Increase Black birthing people's sense of independence and family self-sufficiency to improve long-term life outcomes.

Birthing people need support during pregnancy and parenting, plain and simple. When Black birthing people feel supported and have access to the right tools and resources, they gain confidence, thrive and are able to meet their potential. When birthing people are able to invest in themselves, our whole community is able to grow and thrive too.

Strategy Summary

Strategy 2B.1

Develop initiatives to aid Black birthing people in gaining life skills so they feel informed and confident entering pregnancy and parenthood.

Strategy 2B.2

Building Black birthing people's capacity for financial stability.

Strategy 2B.1

Develop initiatives to aid Black birthing people in gaining life skills so they feel informed and confident entering pregnancy and parenthood.

Pregnancy is a unique experience, and many birthing people have expressed wanting to feel more prepared for this big life change. Preparation includes tools and skills needed to embrace this new experience, such as how to maintain a healthy pregnancy, how to babyproof their home, how to keep their baby safe during sleep time, how to sustain healthy communication with partners and family members and more.

"No one prepared me for anything that I needed when it came to what goes into being a mom. I have seven younger siblings. They didn't tell me WHAT I NEEDED TO KNOW about what mothers go through."

Strategy 2B.2

Building Black birthing people's capacity for financial stability.

Creating a strong financial base gives birthing people more choices when making decisions about their pregnancies. Building their ability to maintain a stable financial state also helps support birthing people's physical and mental health in addition to basic needs. No-cost, community-based programs covering topics such as financial planning, budgeting, skill building, etc., would help birthing people reach their financial goals.

What this looks like in practice.

01
Increase access to community health workers who can connect women with needed community resources

02
Develop a universal application for social service programs

03
Pilot a guaranteed income program that combines financial stability and workforce development

04
Community programming for mothers and families focused on parenting skills and life planning

05
Affordable housing programs that prioritize pregnant people

06
Through the Cradle Cincinnati Policy Committee, champion policies that positively impact pregnant people such as affordable housing programs, doula reimbursement through Medicaid, etc.

Potential Partners

01
Government agencies

02
Health systems

03
Community health worker organizations

04
Organizations focused on economic empowerment and workforce development

How we measure success.

01
# of individuals connected to community health workers (Source: Cradle Cincinnati Collaborative)

02
# of individuals participating in parenting and life-planning classes (Source: Cradle Cincinnati Collaborative)

03
TBD: Measures of increased partnerships with workforce development and economic empowerment organizations

04
TBD: Measure for creation and implementation of universal application for social service programs

05
TBD: Measures related to advocacy efforts once policy committee agenda is set

Goal 3

Expand the medical system's capacity to center the needs of Black birthing people.

Objective 3A
Increase the medical system's capacity to build connections with Black birthing people.

The doctor-patient relationship is important, as it affects a birthing person's health outcomes and stress levels. While health professionals are trained on the function and science of the human body, patients know what they are feeling and experiencing — but, this is oftentimes overlooked.

When patients feel unheard or ignored, this can lead to feelings of mistrust of the medical system and result in non-compliance with medical advice or increased stress for the patient. Hence, it is crucial healthcare professionals, and the medical system as a whole, are able to build connections and trusting relationships with birthing people in such a way that allows them to truly understand their needs.

Strategy Summary

Strategy 3A.1

Create more spaces where healthcare professionals can directly hear and learn from Black birthing people with the specific goal of improving the prenatal care experience.

Strategy 3A.2

Include Black birthing people in the development of strategies and interventions that health systems are implementing to improve equitable outcomes.

Strategy 3A.1

Create more spaces where health professionals and Black birthing people can come together to bridge their differences.

During our listening, Black birthing people consistently expressed a desire to feel heard and understood by their care teams. Likewise, health professionals express interest in getting to know their patients better. Doctors have told us that listening to the patients' stories outside of healthcare settings helped them more deeply understand their patients' challenges from a different perspective. It's clear we need to create more safe spaces outside prenatal visits where health professionals and birthing people can share experiences. This could look like story shares, community gatherings even patient advisory boards. Such actions will create a culture of openness and reflection on difficult subjects like implicit bias or systemic racism.

Strategy 3A.2

Include Black birthing people in the development of strategies and interventions that health systems are implementing to improve equitable outcomes.

The medical system has deployed a variety of trainings and tools focused on addressing implicit bias. Despite having these tools, Black birthing people still express feeling unheard, misunderstood and discriminated against. While health systems have the best interest of their patients, there is a limited understanding of what patients believe would be most effective to address these issues. Centering Black birthing people's voices means including them in the co-creation of strategies or interventions the medical system is implementing aimed at improving outcomes.

To close this gap, it is important to ensure all training materials and program structures are created by and with Black birthing people. When programs are created with the people who have lived the experience of said issues, they are more effective in touching the root problems and achieving desired outcomes.

Objective 3B

Create mechanisms to measure and monitor health systems' efforts to improve equitable outcomes for all.

If we cannot measure the ways in which health systems are working to improve patients' experiences and ultimately equitable outcomes, we can't evaluate whether changes are having the desired impact. Monitoring and evaluation also allows for community accountability.

Strategy Summary

Strategy 3B.1

Establish and expand certifications that can be used to assess hospital systems and other birthing people's health related programs' efforts toward providing more equitable care and service.

Strategy 3B.2

Build a system where Black birthing people can provide honest feedback about their care experience and ensure health systems can be responsive to their concerns to increase accountability and transparency.

Strategy 3B.1

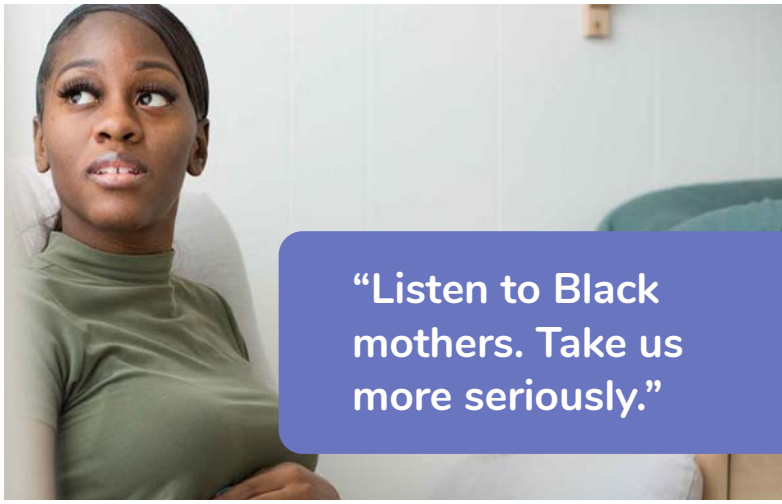
Establish and expand certifications that promote equitable care and services for organizations that serve birthing people.

Black families in our community are eager to know the steps healthcare systems are taking to improve maternal and infant health outcomes. They see the data and the news headlines and want to feel safe when going to receive care. While healthcare systems are actively working on initiatives to improve the quality of care, these efforts can sometimes be invisible to patients. This strategy is focused on establishing a certification program for birthing hospitals and exploring and expansion of this certification to other programs that serve prenatal and postpartum birthing people and their families. Similar certification programs have been successful in identifying people and institutions doing impactful work as well as creating a universal standard that is adopted by participants. A maternal equity certification program would assess, acknowledge and publicize the efforts of organizations providing care for pregnant people and their families with the goal of leading to lasting systems-level change.

Strategy 3B.2

Build a system where Black birthing people can provide honest feedback about their care experience and that hospitals will be responsive to.

As healthcare systems work toward maternal and infant health equity, it is important these efforts are responsive to the needs of those most impacted by disparate outcomes: Black birthing people and their families. The best way to know whether the changes are having the intended impact is to build a system that allows patients to provide honest feedback about their care experience. The system should include a feedback loop that ensures the healthcare facility is responsive to the feedback and open about actions being taken in response. Creating a healthy feedback and evaluation system will not only help hospitals achieve the outcomes they desire but will also build trust and confidence among patients seeking care.



What this looks like in practice.

01

Create opportunities for hospital systems to engage with existing Queens Village advisory boards or establish their own Queens Village patient advisory boards, using these boards to co-create interventions and quality improvement projects

02

Increase transparency of local hospitals' maternal and infant equity-related initiatives through Mama Certified certification to empower Black Mamas to make informed decisions about their birth experiences

03

Co-create and implement a patient and hospital feedback loop with Black birthing people

04

Collaborative events between Queens Village and the Cradle Cincinnati Learning Collaborative

Potential Partners

01
Local hospital systems

02
Managed care plans

03
Community-based health centers

How we measure success.

01
# of Queens Village patient advisory boards (source: Queens Village)

02
# of Cradle Cincinnati Learning Collaborative members engaging in Queens Village events (source: Cradle Cincinnati Learning Collaborative)

03
Mama Certified will have a robust evaluation plan to assess the effectiveness of all aspects of the program. List of measures is TBD

Reaching Our Goals Together

How we get there, together

Centering Black Birthing People and Amplifying Their Voices

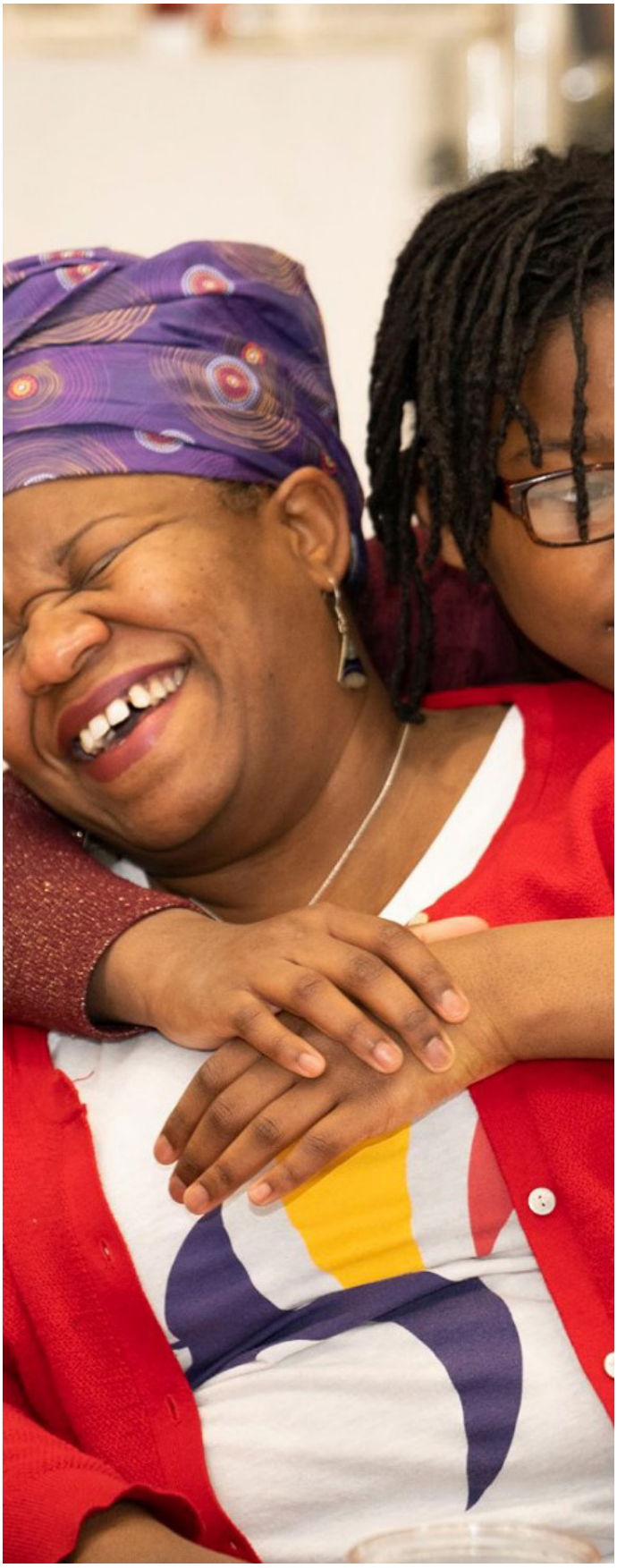
This plan will only be a success if we can find ways to deeply involve and follow the lead of Black birthing people in our community. Black birthing people have a more nuanced understanding of the pregnancy journey and tensions within our health systems that impact birth outcomes. Importantly, they are also best positioned to identify and co-create solutions that will lead to more first birthdays.

Partnering Together Through a Collective Impact Approach

No single program or organization can solve a complex social problem like infant mortality by itself. Our only hope is through extensive partnership. Through the power of collective impact, our community has seen a steady decrease in infant mortality over the past 10 years. By continuing to work together under the model of collective impact, we will continue to pave the way for systems-level change for maternal and infant health equity.

Moving Toward Systems-level Change

Individual behavior change can be powerful. However, to see larger change in our community's health, we must also improve the many stretched systems that prevent people from being as healthy as they can be. This includes continuing key partnerships to improve prenatal care and social service support during pregnancy as well as other partnerships that can mitigate the root causes of infant mortality and lead to more equitable outcomes for all.



How we get there, together

Addressing Immediate Needs

Systems-level change is needed in order to make sustainable change for families in Cincinnati. But it's also a slow-moving process, and many families need support in the here and now. Meeting immediate needs through community health workers and other neighborhood-based services continues to be one of our top priorities.

Using Data for All Decision-making

When addressing an issue as vast and complex as infant mortality, we look to data to help guide us. This includes data sourced from health departments, showing us big picture county-level trends, and data sourced from individual experiences, showing us the nuances of each person's parenthood journey. Taken together, we can get a richer understanding of where our efforts are most needed.

The Numbers

Supporting Data

INFANT HEALTH

	Hamilton County 2017-2021	Hamilton County 2022	Hamilton County, Asian 2022	Hamilton County, Black 2022	Hamilton County, Hispanic 2022	Hamilton County, White 2022
Breastfeeding Rates (upon hospital discharge)	75.0	77.7	85.5	70.8	77.1	81.5
Multiple Births (twins, triplets, etc.) (among women who had live births)	3.9	3.5	1.1	4.3	2.1	3.6
Birth Defect/Congenital Anomaly Rates	0.9	0.7	0.0	0.7	0.5	0.8
Birth Defect/Congenital Anomaly Deaths (deaths per 1,000 live births)	1.6 (2017-2021)	1.6	--	1.6	1.6	--
Unsafe Sleep Deaths (deaths per 1,000 live births)	1.6 (2017-2021)	1.7	--	3.6	--	0.6
Reported consistently placing infant on his or her back for sleep (among women who had live births)	89.0 (2020)	87.9 (2021)	--	76.9 (2021)	91.0 (2021)	92.8 (2021)
Reported always placing a baby in crib for sleep (among women who had live births)	93.0 (2020)	94.2 (2021)	--	91.5 (2021)	98.4 (2021)	94.9 (2021)
Reported receiving paid leave from employer after baby was born (among women who had live births)	42.4 (2020)	46.4 (2021)	--	29.6 (2021)	--	53.7 (2021)

WOMEN'S HEALTH

Pre-Pregnancy Body Mass Index (among women who had live births)						
Underweight (BMI < 18.5)	3.1	2.6	5.4	3.1	1.8	2.4
Obese (BMI ≥ 30)	27.6	29.6	12.7	40.2	25.4	24.9
Sexually Transmitted Infection (among women who had live births)						
Syphillis	0.6	0.5	0.8	1.2	0.0	0.1
Gonorrhea	1.4	1.2	0	2.8	0.5	0.3
Chlamydia	4.5	4.5	3.2	9.1	6.4	1.5
Unintentional Pregnancy (among women who had live births)	23.6 (2020)	47.7 (2021)	--	27.9 (2021)	40.7 (2021)	35.9 (2021)
Inadequately Spaced Pregnancy (among non-first time moms who had live births)						
<6 month Interpregnancy Interval	6.1	5.1	4.5	6.8	4.8	3.9
<12 month Interpregnancy Interval	18.7	17.9	11.4	19	16.9	17.4
<18 month Interpregnancy Interval	33.9	33.3	23.9	30.3	28.1	36.7
Postpartum Depression (among women who had live births)	6.4 (2020)	7.8 (2021)	--	9.1 (2021)	9.5 (2021)	7.2 (2021)

PREGNANCY HEALTH

	Hamilton County 2017-2021	Hamilton County 2022	Hamilton County, Asian 2022	Hamilton County, Black 2022	Hamilton County, Hispanic 2022	Hamilton County, White 2022
Preterm Birth Rate						
<37 Weeks (total preterm births)	10.9	11.1	6.2	15.2	10.5	9.1
<28 Weeks (extreme preterm births)	0.9	0.9	0.3	1.6	0.9	0.4
<23 Weeks (periviable births)	0.2	0.2	0.3	0.5	0.2	0.1
Prenatal Care (among women who had live births)						
Accessed Care in the 1st Trimester	68.0	67.0	64.0	63.7	45.1	74.0
Accessed Care in the 3rd Trimester	3.8	4.3	5.1	4.8	12.7	2.0
No Prenatal Care	2.5	2.4	2.2	3.4	2.5	1.7
Maternal Cigarette Smoking (during 2nd or 3rd trimester)	7.4	4.7	0.3	5.1	0.8	5.5
Drug Exposure During Pregnancy (Among regional women who had live births)						
Drug Exposure During Pregnancy	9.0	6.3	--	--	--	--
Opioid Exposure During Pregnancy	2.6	1.4	--	--	--	--
Previous Preterm Birth (among women with previous births)	7.8	7.6	3.8	11.7	7.4	5.2
Chronic Illness During Pregnancy (among women who had live births)						
Gestational Diabetes	10.3	11.1	17.4	10.4	12.9	10.5
Hypertension	16.9	19	7.8	27.6	9.2	16.6
Stillbirth rate (per 1,000 births)	7.3	7.1	--	--	--	--
Stress (among women who had live births)						
Reported having someone to talk to about problems during pregnancy	82.7 (2020)	82.5 (2021)	--	75.5 (2021)	65.0 (2021)	89.1 (2021)
Maternal Mortality Pregnancy-related mortality (per 1,000 births)	--	.24 (Ohio 2018)	--	--	--	--
Severe Maternal Morbidity (per 1,000 births)	--	.72 (Ohio 2019)	--	--	--	--

COMMUNITY HEALTH

Housing						
Renters	41.7 (2017-2021)	40.5 (2021)	--	--	--	--
Vacancy Rate	8.7 (2017-2021)	7.0 (2021)	--	--	--	--
Reported difficulty paying rent before pregnancy (among women who had live births)	14.8 (2020)	14.9 (2021)	--	24.3 (2021)	16.7 (2021)	9.5 (2021)
Neighborhood Conditions						
Reported always or often feeling unsafe in their neighborhood (among women who had live births)	4.6 (2020)	4.3 (2021)	--	7.4 (2021)	7.5 (2021)-	2.5 (2021)
Transportation (among all adults)						
Reported no vehicle availability in household	10.5 (2017-2021)	7.0 (2021)	--	--	--	--