



# Infant Mortality Reduction Programs: Examples of Successful Models

MDH African American Infant Mortality Project  
Community Co-learning Sessions

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October 2, 2017

# 4 Examples

1. B'More Baltimore
2. Cradle Cincinnati
3. Genessee County (MI) REACH
4. Pathways HUB Ohio

There are many others (IM Programs or Perinatal Collaboratives)

# Will touch on these:

- Start date
- Population and/or Geographic Foci
- Context, Impetus
- Administration, Partners
- Overall Goal, Objectives
- Approaches/Strategies
- Results to Date

# B'more for Healthy Babies



## B'More for Healthy Babies (Baltimore, MD)

# B'More for Healthy Babies (Baltimore, MD) - 2

- Started 1996
- BHB was launched by leaders from across the city after the city's infant mortality rate hit a record high of 128 in 2009 — when African-American babies were 5x more likely to die before their first birthdays than white babies.
- Policymakers, service providers, community organizers and residents wanted to improve the health and well-being of Baltimore's families.
- Before BHB, Baltimore's primary prevention involved prenatal and early childhood home visiting programs.
  - Successful at the individual level, but at the city level not much was happening.
  - Wanted a more holistic approach that is grounded not only in individual behavior change, but also in policy change, service improvements, and community mobilization

# B'More for Healthy Babies (Baltimore, MD) - 3

- Partners
  - Convened by the Baltimore City Health Department with Family League of Baltimore and HealthCare Access Maryland.
  - Supported by more than 100 partner agencies from the corporate, nonprofit, health, academic, donor, and government sectors.
- BHB works to decrease the 3 leading causes of infant death: premature birth, low birth weight birth, and unsafe sleep.
- Goal: Improve an often-fragmented health care system to reach all of Baltimore's families with quality maternal and infant health services and support.

# B'More for Healthy Babies (Baltimore, MD) - 4

Uses a mix of collective impact strategies that include:

- Addressing structural racism and implicit biases;
- Partnering with youth, men and women to take charge of their health and wellness;
- Eliminating sleep-related infant deaths;
- Preventing the damaging effects of substance use disorder on infants, toddlers, youth, pregnant women, mothers and fathers; and
- Decreasing teen pregnancy by ensuring all women and teens have access to effective contraception.

# B'More for Healthy Babies (Baltimore, MD) - 5

## Successes to date:

- Baltimore's IM rate has declined by 38% and the gap between black and white babies is closing.
- Mayor Stephanie Rawlings-Blake's 2010 proclamation requires standardized safe sleep education for all parents upon discharge from birthing hospitals.
- 3,500 providers from 220 venues have been trained in safe sleep education.
- Community collaboratives have reached more than 30,000 community members with messages, materials and support.
- Neighborhood action teams have been created to provide input on the city's Fetal and Infant Mortality Review (FIMR) process.
- 9 Baby Basics Moms Clubs provide prenatal education and support to pregnant women.
- 250,000 copies of posters, rack cards and other materials have been disseminated citywide for the campaigns of SLEEP SAFE, Just Hold Off (smoke-free environments), Know What U Want U choose (teen pregnancy prevention), and other initiatives.





# Cradle Cincinnati

# Cradle Cincinnati - 2

- Hamilton County ranks among the bottom 10% of counties across the nation for infant mortality.
- From 2012-2016, the county lost 486 infants, a rate that put it well behind national and state averages.
- Infant mortality rate (# deaths per 1,000 live births) in Hamilton County: 2002-2006=10.8, 2007-2011=10.69, 2012=2016=8.96.
- IM rate going down, but disparities persist. From 2012-2016, IM rate for African American = 15.2, White=5.5, Hispanic=5.0
- Causes of infant mortality: Preterm birth (59.7%), Birth defects (18.7%), Sleep-related deaths (13.2%), Other (8.4%)
- Vision: Every child born in Hamilton County lives to see their first birthday.

## Cradle Cincinnati Connections:

- Within Cradle Cincinnati
- Healthy Start Program supported through the Health Resources Services Administration (HRSA)
- Designed to enhance and support existing Maternal and Child Health social support programs
- Helps families thrive by connecting moms-to-be with the services they need, filling system gaps that families in West Side communities fall through all too often.
- Provides families and organizations with health education and screenings, case conferencing, access to supplies
- Wrap-around service model to promote better health outcomes
- Team comprised of: Social Workers, Registered Nurse, Dietitian, Community Health Workers, and Mental Health Specialists.

## Approaches:

- Promote spacing: >12 months in between pregnancies decreases chances of premature birth.
- Prevent smoking: No tobacco during pregnancy. Call 1-800-QUIT-NOW for help.
- Promote Safe Sleep: Babies sleep safest Alone, on their Back, in a Crib. Never share a bed with a baby.

## Results

- 12% decline in short pregnancy spacing
- 19% decline in smoking during pregnancy
- 24% decline in sleep-related deaths
- 92% fewer babies born who are extremely preterm (less than 28 weeks gestation)
- 128 fewer infant deaths


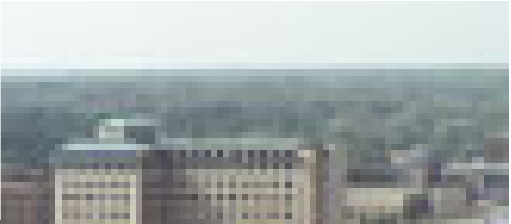

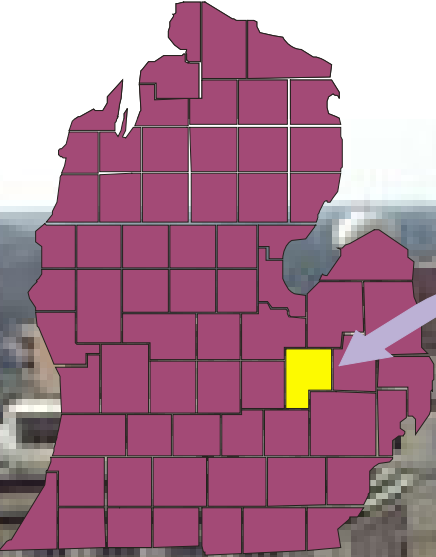


Genesee County  
**REACH**...together to save our  
2010 *precious black babies!*

## Genesee County, Michigan REACH

# Genesee County REACH

## Genesee County, Michigan



- Population – 441,000 (20% African American, 77% White)
- Largest city – Flint (population 117,000 -- 53% African American)
- Decreasing auto industry jobs
- Declining population
- Increasing unemployment, poverty, violence
- Persistent community activism

# Genesee County REACH - 2





# Genesee County REACH - 3

- Started forming partnerships to address IM in early 1990s
- In 1998, the partnership was awarded a Prevention Research Center grant from CDC
- Building in part on earlier work of a community coalition, Programs to Reduce Infant Deaths Effectively (PRIDE), applied for CDC funding Racial and Ethnic Approaches to Community Health (REACH) in 1999
- In 2000, one of 40 entities awarded REACH funding. Additional funding from Mott Foundation.

## Partners

- FACED
- Flint Odyssey House/Health Awareness Center
- Genesee County Community Action Resource Department
- Genesee County Health Department
- U-M SPH/PRC
- Genesys Regional Medical Center
- Greater Flint Health Coalition
- Hurley Medical Center
- Mott Children's Health Center
- PRIDE
- Priority Children
- U-M Flint

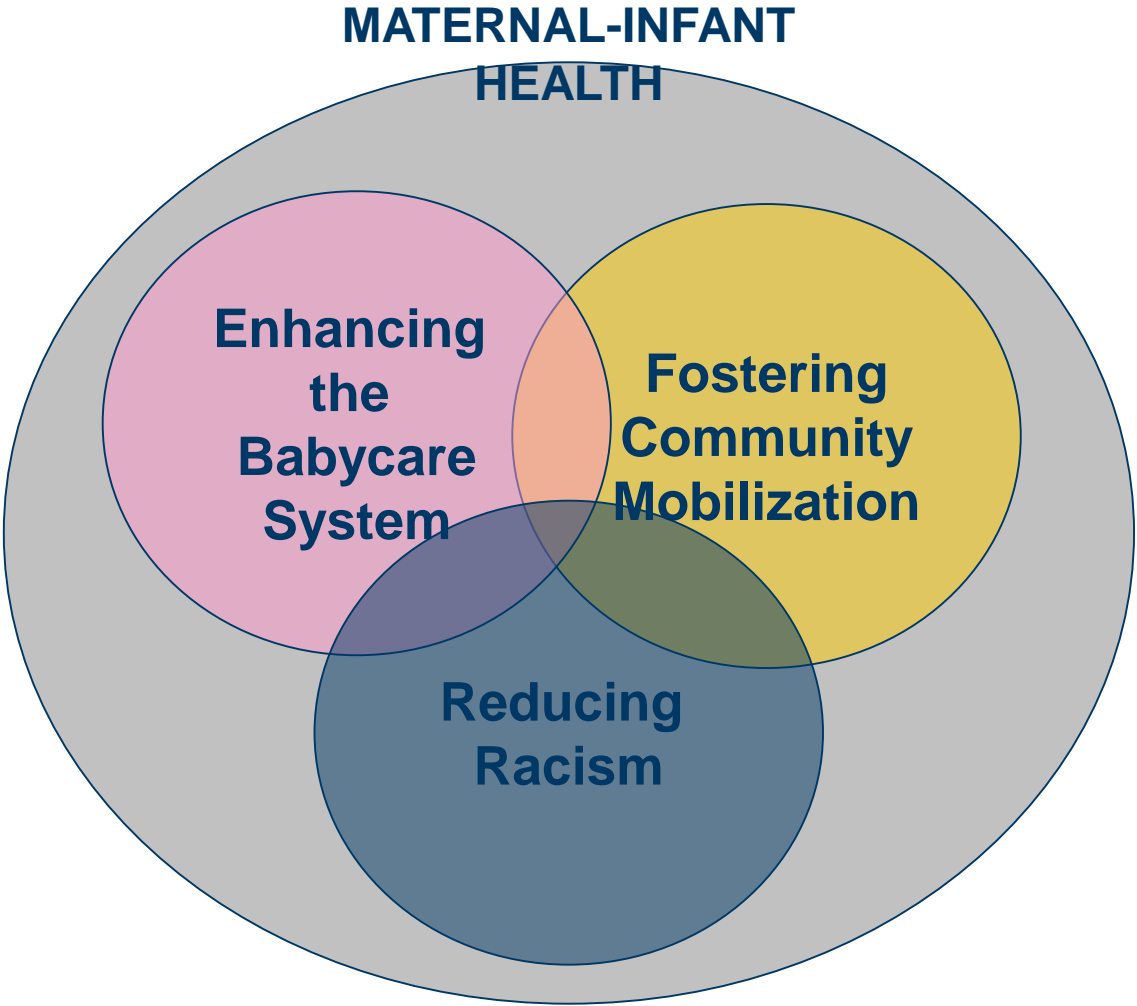
# Genessee County REACH

- Primary objective : Reduce the disparity in infant mortality through multifaceted practice and evidence-based interventions using a 3-theme approach of community mobilization, enhancing the babycare system, and reducing racism.
- Goal:Reduce racial and ethnic health disparities through population-focused and systemic structural interventions that embody community engagement and cultural relevance.

# Genesee County REACH - 5

## MODEL

Bench-and-Trench Approach  
- Developed a plan utilizing  
“bench” science and  
community residents’  
“trench” knowledge



## Community Mobilization

- Priority setting and problem-solving regarding infant mortality – 2 action groups organized
  - Black Men for Social Change
  - Women Taking Charge of Their Health Destiny
- Media campaign – Billboards, Radio spots, TV commercial, Posters, fans, T-shirts

## Enhancing the Babycare System

- PRIDE Medical Services Committee - Provider seminars and community roundtables, Perinatal risk assessment tool, Perinatal morbidity and mortality reviews, Safe sleep campaign
- Maternal and Infant Health Advocates (MIHAs) - Peer support, System navigation, Community “windshield” tours
- University “Cultural Competence in Health Care” Course offered at U of MI-Flint - Specialized training for client advocates, Enhance culturally competent practice, Improve patient-provider communication

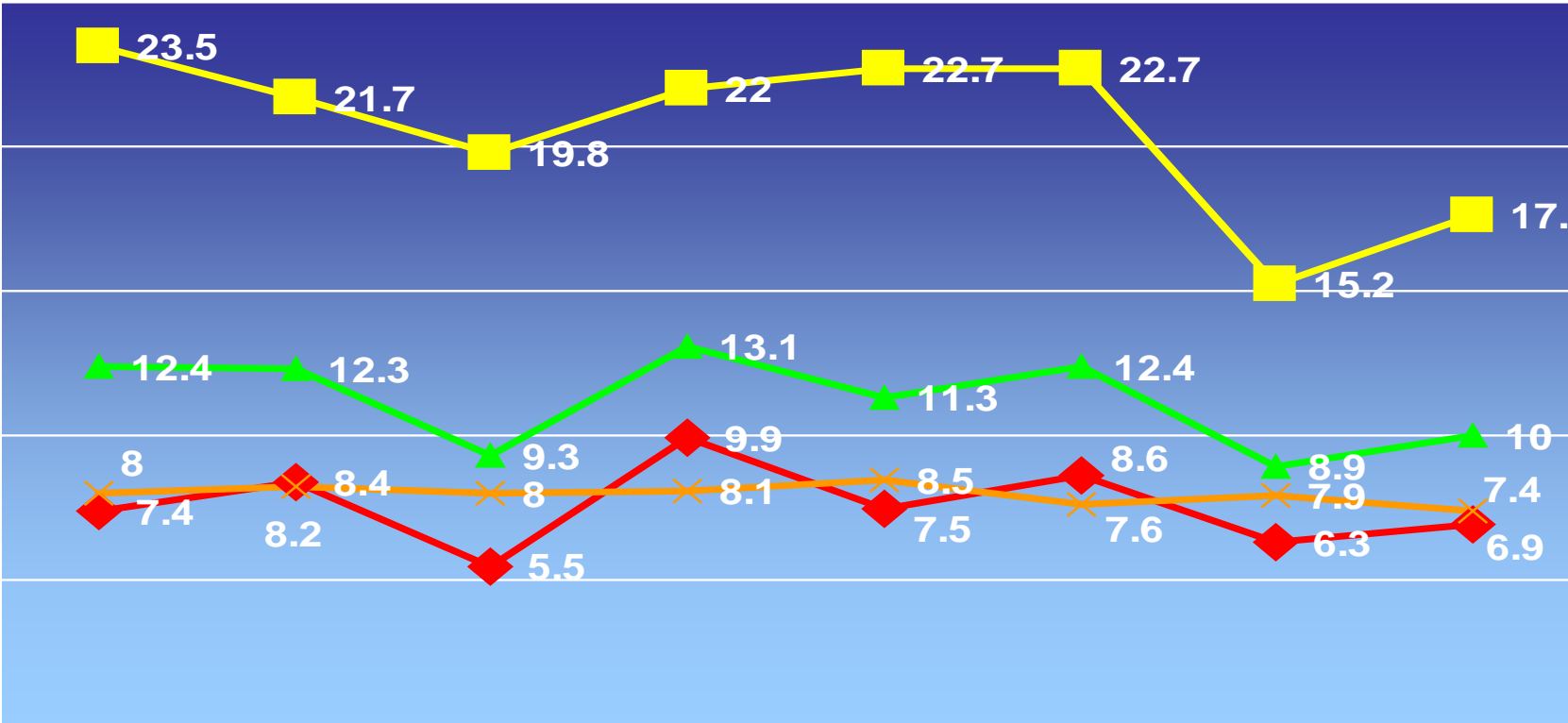
## Reducing Racism

- Undoing Racism workshops - 2 ½ day facilitated event, 24 workshops with over 880 participants
- African Culture Education Development Center - History and culture lectures, Middle Passage Experience, Post-Traumatic Slavery Disorder Curriculum
- Healthy Eating Curriculum – Afrocentric, Peer Trainers, Harambee (“pulling together”) celebrations

# Genesee County REACH - 9

## Annual Infant Mortality Rates by Race

Genesee County, MI 1999-2006

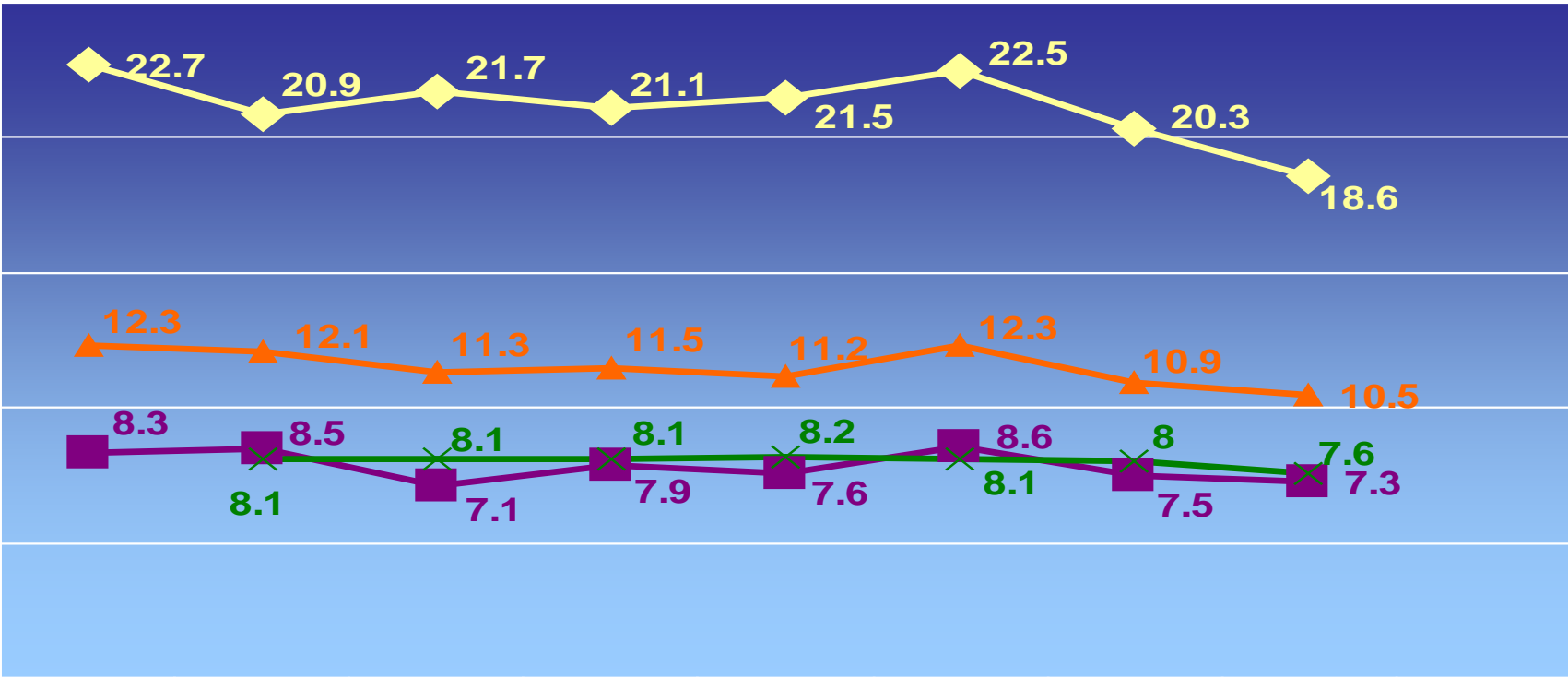


White African American All Michigan (All)



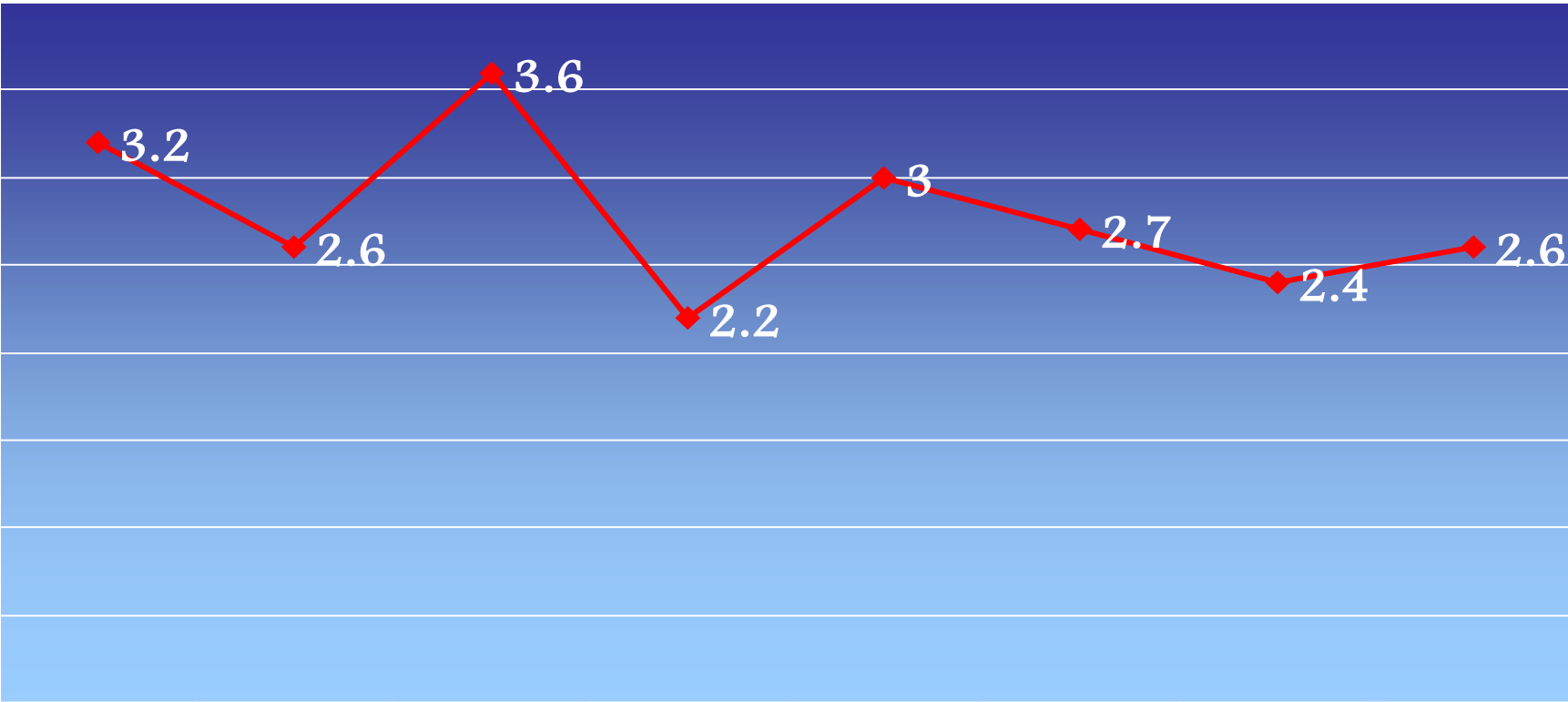
# Genesee County REACH - 10

## 3-Year Moving Average Infant Death Rates Genesee County and Michigan 1997-2006



—◆— African American —■— White —▲— All —×— Michigan (All)

## Infant Mortality Disparity Ratio\* Genesee County, Michigan 1999-2006



# Community Health Access Project (CHAP) in Mansfield, OH

- CHAP serves as the Nationally Certified Pathways Community HUB for the Mansfield community and multicounty region of Ohio.
- 1 of 10 certified HUBs by the Pathways Community HUB Certification Program, a program of the Rockville Institute). Started in 2013.
- HUB certification process is a way of standardizing and formalizing the implementation of the Pathways Community HUB Model of care coordination.

## The Pathways Community HUB

- National model of outcome-focused, pay-for-performance, home visiting-style care coordination.
- Focus is to reach those at greatest risk, identify and address all health, social and behavioral health risk factors.
- The Community HUB serves as the center of a community wide network of care coordination agencies that employ CHWs who provide the care coordination service.
- Individuals are connected to primary care and prevention services, behavioral health, housing, food, clothing, adult education and employment.
- CHAP as the local HUB serves as the central networking center for a team of community care coordination agencies.

## What is this Model of Community Care Coordination?

- Local agencies deploy culturally-connected Community Care Coordinators which include community health workers (CHWs), nurses and social workers. They reach out to engage individuals who are most at risk.
- Using specific checklists, they identify the specific health social and behavioral health risk factors, then work with nurses, social workers and physicians to make sure that the identified risk factors are addressed with specific Pathways.
- CHWs provide necessary services to clients who are otherwise isolated due to cultural, geographic and economic barriers.
- Care coordination services do not duplicate, but facilitate and strengthen existing community resources.
- Through home visits, the Community Care Coordinator serves as an ongoing resource to neighborhood families, identifying individual needs and providing connections to appropriate services.

- Positive results:
  - LBW improvement
  - Cost savings

# Thank you!

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