CELEBRATEONE COLUMBUS

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

CelebrateOne
Strategic Plan
2021 - 2026

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Letter from the Mayor

Andrew J. Ginther
Mayor, Columbus Ohio

Dear Fellow Residents of Columbus:

I am proud to support CelebrateOne's continued growth and development in the form of their new strategic plan. Since January 2015, CelebrateOne and our community partners have been fully committed to eliminating preventable sleep-related infant deaths, decreasing preterm births and improving service delivery to reduce infant mortality and racial disparities in birth outcomes. CelebrateOne has made important progress over the last six years, and this journey continues with new recommendations and strategies to reduce infant mortality with a laser focus on eliminating health disparities in our community.

This bold new plan calls for deeper investment into racial equity, expanded effort on the social determinants of health and a strong, connected health and social service system. The work ahead of us will be challenging. It is imperative we continue the great work of CelebrateOne, saving the lives of our most vulnerable and forging pathways to positive outcomes for all mothers and babies in our community. Every child in every Columbus neighborhood deserves the opportunity to thrive.

CelebrateOne's new strategic plan builds on the foundation set by the Greater Columbus Infant Mortality Task Force and the incredible work done by CelebrateOne and its Lead Entity partners. The plan recommends growth in spaces where we have seen great success and innovation in areas where our community has struggled to make progress. The plan will continue to grow and expand as we implement its recommendations and learn how to better serve women and families in our community.
We are especially appreciative of our partners in this work: the entire

CelebrateOne team and Board, the Ohio Better Birth Outcomes Collaborative (OBBO) and many other City and County departments and community organizations.

Six years into this critically important work, we firmly believe that saving babies requires the coordination and collaboration of many partners aiming for the same goal. Each of our committee members and stakeholders have been invaluable in developing strategies that advance equity and move this work upstream for a promising future for the families we serve. I'd especially like to thank the six women with lived experiences who shared their voices in this process. We are proud this plan was built with the partnership of women and families in our community. The future of our City depends on all of us.

We very much appreciate the generous support from a broad coalition of private, public, corporate and personal contributors. We value our partnerships and believe that, collectively, we have the power to make our city work for ALL of our residents, especially our youngest.

Sincerely,

Mayor Andrew J. Ginther

Call to Action

Maureen L. Stapleton
Executive Director, CelebrateOne

Dear friends,

Since our last strategic planning effort in 2014, we have seen significant change across Columbus and the world. As a CelebrateOne community we have developed a deeper understanding of the challenges that face our families as we strive to ensure our mothers are healthy during pregnancy and that children get to first of year of life and beyond. Over the course of the last six years, we have seen infant mortality decrease. We know the work of our lead entities and partners and their commitments to our previous recommendations have been a key to the reduction in infant mortality that we have achieved in Columbus and Franklin County.

We celebrate our success in moving our community forward and recognize that there is even more work we must do. While we have seen decreases in infant mortality for families in the past 6 years, the gap in infant mortality amongst Black babies and White babies has increased. In recognition of this fact, we embarked on this strategic planning process with these core values at the center of our work:

- **Take Collective Action**
- **Accelerate Racial Equity**
- **Target Upstream Factors**
- **Catalyze Innovation**

"This strategic plan is not only a roadmap for CelebrateOne and our community partners, but also a call to action for all its readers."

With these values at the center of our work and reflected in each of our strategies, we can eradicate the disparity plaguing our communities.

Over the course of the last five months, we hosted five meetings with our key stakeholders, held seven community conversations and received input from over 60 community leaders and health professionals to create a plan that reflects our values and focuses on the lofty goal of ensuring that Columbus is the first city in America that eradicated the racial disparities in infant mortality.
The resulting plan includes the following recommendations:

1. Target and address structural and interpersonal racism as fundamental drivers of infant mortality.
2. Address the social determinants of health (SDoH) across the life course to advance maternal and child health (MCH).
3. Advance policies that prevent poor birth outcomes and promote women's health and wellbeing.
4. Improve access, quality and provision of reproductive health care.
5. Design and implement a connected and consistent care experience for mothers and babies.
6. Accelerate innovation, progress, commitment and accountability for health equity.

In each of these recommendations, we specifically identify the role racial equity must play and how structural, institutional or interpersonal racism, if not addressed, will continue to hinder our progress in protecting our community's families.

This strategic plan is not only a roadmap for CelebrateOne, our Lead Entities community partners, but it is a call to action for all of Columbus and Franklin County. We want to be the first major city to get this done and with your help. We will!

Looking Forward,

Maureen L. Stapleton

Executive Summary

As CelebrateOne and our partners look to the future, we are laser focused on closing the racial disparity gap in the Infant Mortality Rate (IMR). Closing the disparity gap is key to ensuring every child born in Franklin County reaches their first birthday.

The Challenge / Need

Tremendous progress has been made to reduce infant mortality in Franklin County and see that every baby sees their first birthday and thrives for a lifetime. The work of CelebrateOne, its Lead Entities, and a host of community partners has resulted in Franklin County achieving its lowest infant mortality rate (IMR) in recent history (6.7 per 1,000 live births). But even at this level, the IMR is unacceptably high.

Infant mortality is a widely used indicator of population health. Nationally, Columbus ranks 43rd of the 50 largest US Cities on infant mortality in the State of Ohio, which ranks 40th out of the 50 states. Internationally, the United States ranks poorly, ranking 33rd out of 36 member countries of the Economic Organization for Cooperation and Development.

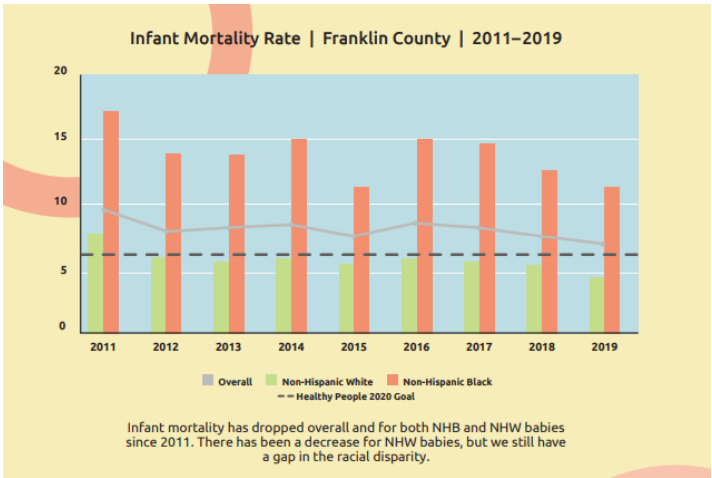
The Numbers / Context

Action steps taken pursuant to CelebrateOne's original 2014 strategic plan – the Greater Columbus Infant Mortality Task Force Final Report – set a strong foundation for the future work of the initiative.

In 2020, more Franklin County babies lived to celebrate their first birthdays than the previous years. The IMR dropped to 6.7 deaths per 1,000 live births, and the data for the CelebrateOne zip codes decreased as well.

CelebrateOne and Columbus Public Health reported 17,495 babies born in Franklin County in 2020; 117 died before reaching the age of one, representing 41 fewer deaths than in 2014.

This data represents marked progress across key performance indicators:

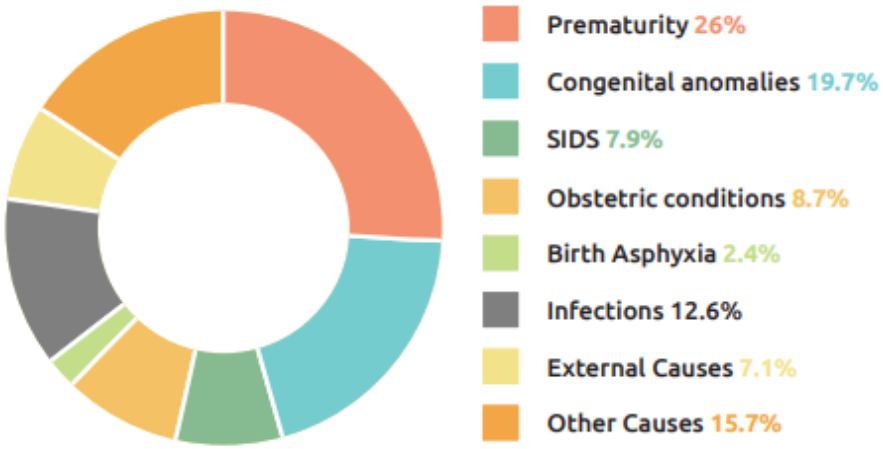


- 20% Decrease in Franklin County Infant mortality rate: from 8.4 infant deaths per 1,000 live births (2014) to 6.7 (2020).
- 20% Decrease in infant mortality rate in CelebrateOne Neighborhoods: from 12.3 infant deaths per 1,000 live births (2014) to 9.9 (2020).
- 18% Decrease in sleep related deaths: from 22 (2014) to 18 (2020).

The data on infant and maternal health outcomes, alongside insights from CelebrateOne's Lead Entities, partners and stakeholders, highlighted three critical opportunities: Accelerating progress on racial equity, expanding upstream interventions and leveraging the collaborative nature of the community ("the Columbus Way") to enhance positive outcomes.

Accelerate: Local and national reductions in White infant mortality have far outpaced the reduction of Black infant mortality. The Franklin County 2020 Black IMR of 11.6 is nearly three times higher than the 2020 White IMR of 4.1. Since the start of this initiative, the White IMR decrease by 28% compared to the Black IMR which represents a 22% reduction since 2014. National and local data trends affirm that at this pace, without focused intervention, it will take 52 years (until 2073) or longer before the Black IMR is as low as the 2020 White rate.

Throughout 2020, Mayor Andrew Ginther, Columbus City Council and the Franklin County Board of Health declared racism a public crisis. The national and local attention on fighting racism and its impact has increased, and community expectations have expanded the opportunity to address racism in infant and maternal health. This can be done through racial equity focused practices and programming. Reducing Black infant deaths by as little as four to seven deaths each month would help narrow the gap and drive our community to equity.



In 2019 more than one-quarter of all infant deaths were caused by prematurity.

Data Tableau report: https://public.tableau.com/views/InfantMortalityReport/IMReport

Upstream: Prematurity is the leading cause of infant death. Despite concerted effort, the county prematurity rate has remained at 10.4%, which is the same rate the county began with at CelebrateOne's inception.

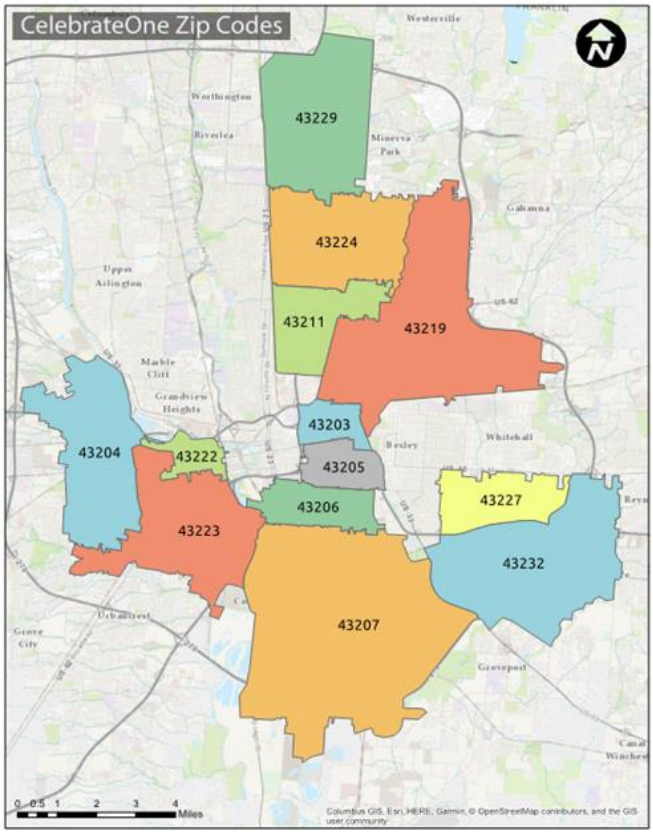
Research, data and lived experiences make it clear that infant mortality and prematurity are heavily influenced by a woman's health and wellbeing before she becomes pregnant and after she has given birth. This highlights the need for focused interventions before conception and between pregnancies.

Together: Collaboration has been embedded into the initiative's DNA and will continue to be a critical aspect of the work. To further CelebrateOne's bold new goals, its level of collaboration and

These three opportunities, now embodied with CelebrateOne's core values, are at the heart of the six new recommendations of the CelebrateOne strategic plan.

The Future

Franklin County's infant mortality rate and persistent disparities are largely affected by racism as well as the unjust distribution of conditions that support health – the social determinants of health.



Factors like access to safe affordable housing, education quality and access, food insecurity, health insurance, employment and transportation can result in poor maternal health outcomes, premature births and infant deaths.

CelebrateOne continues to focus its work in the original eight "CelebrateOne neighborhoods" where the infant mortality rate is three times higher than county, state and national averages. Future work will include CelebrateOne's more recent expansion to three additional neighborhoods. These high priority areas include the Hilltop, Linden, Franklinton, South Side, Near East, Southeast, Northeast, Northland neighborhoods, the far East Side, Whitehall and the far West Side.

New Goals: CelebrateOne has set a bold new goal to bring the Black infant mortality rate down to 5.0 by 2030 with the intermediary goal of bringing the Black rate down to 7.6 and the Franklin County rate to 5.7. This step will be key to the initiative's overall goal to bring the Franklin County IMR to 5.0 by 2030.

Reading this Document

Key Terms & Concepts

How We Got Here

Key Terms & Concepts

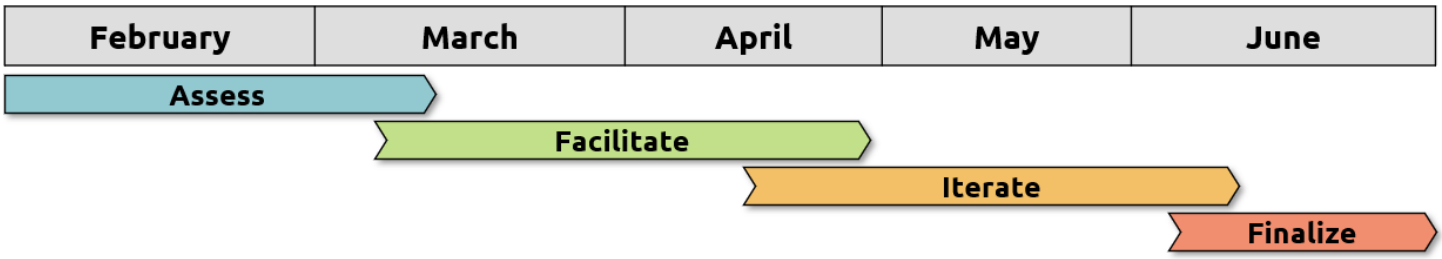
To advance transformational approaches to health equity collaboratively, it is important to develop shared definitions and concepts. CelebrateOne offers the following key terms and concepts as a starting point to support our work with mothers, babies, and families throughout Columbus.

Health Equity	A fair and just opportunity to be as healthy as possible by removing obstacles to health such as poverty, discrimination, and deep power imbalances and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.[1]
Social Determinants of Health	Social determinants of health are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.[2]
Society	Looks at broad societal factors that help create a climate in which positive health is encouraged or inhibited.[3]
Community	Explores the settings such as schools, workplaces, and neighborhoods in which social relationships occur.[3]
Interpersonal	Examines close relationships meaning a person's closest social circle-peers, partners and family members.[3]
Individual	Identifies biological and personal history factors including age, education, income, substance use or history of abuse.[3]

1. This definition of Health Equity is slightly adapted from one developed by Paula Braveman and colleagues in the RWJF commissioned paper, "What Is Health Equity? And What Difference Does a Definition Make?"
2. Source: https://www.ahajournals.org/doi/10.1161/CIR.0000000000000936
3. Source for Society/Community/Interpersonal/Individual https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

How We Got Here:
Strategic Planning Process

Over the course of 2021, the CelebrateOne team engaged in a series of working sessions with our key stakeholder community. We met with more than 60 individuals including healthcare providers, state and local policymakers, business leaders and community leaders, as well as women with lived experiences. We sought to bring together a group of individuals whose diversity of experience, knowledge, and passion for our work would allow us to build on the excellent work that has taken place since 2014 and to help us shape the future of our work over the next five years.



The work of developing our new strategic plan took place over the course of five months and four project phases (Assess, Facilitate, Iterate and Finalize). We engaged with our key stakeholder groups, which we called our Strategic Planning Committee and our Operational Working Group, every step of the way. Finally, we benchmarked these insights against leading and promising practices in Maternal and Child Health (MCH) to ensure our team is bringing the best available approach to the communities that we serve.

Assess

This phase was dedicated to taking stock of the great work already completed, evaluating strengths and areas for growth and connecting with the CelebrateOne community of partners.

Key Activities

- Project **kick-off**
- Evaluate current strategic plan for **strengths and growth areas**
- Identify and establish **Strategic Planning Committee** and **Operational Working Group**
- Develop strategic planning **roadmap**
- Develop Strawman **Health Equity Framework**

Facilitate

During this phase, we worked directly with our partners and members of the community to envision CelebrateOne's future.

Key Activities

- Conduct working sessions with Steering Committee (weekly / bi-weekly, ongoing)
- Working Session 1 with Operational Working Group to assess goals and refine Strawman Health Equity Framework
- Full Session 1 with Strategic Planning Committee to engage all partners for input and set project baseline
- Deploy and analyze results from post-session survey
- Develop the Strategic Plan framework and outline, including a second draft of the Health Equity Framework

Iterate

We further developed and iterated our stakeholders' fantastic insights, taking a national perspective to our locally tailored approach.

Key Activities

- Assess input from the planning process and leading external initiatives
- Assess input in comparison with national leading practices in MCH
- Working Session 2 with Operational Working Group to refine strategies and activities that will comprise Strategic Plan
- Full Session 2 with Strategic Planning Committee to provide midpoint update on strategic planning process
- Refine the Strategic Plan document with input from Steering Committee, Operational Working Group, and other key stakeholders as needed
- Stakeholder Survey with Strategic Planning Committee for additional input

Finalize

Finally, we shared the plan and the vision for implementing the plan to our key stakeholders and began the work of transitioning from thought to action.

Key Activities

- Full Session 3 with Strategic Planning Committee to unveil final Strategic Plan, including implementation roadmap overview
- Stakeholder Survey with Strategic Planning Committee for additional input
- Transition into the implementation phase with our key partners and lead entities
- Public unveiling of Strategic Plan document

About CelebrateOne

Mission

Vision

Goals

Core Values

CelebrateOne Mission & Vision

MISSION

CelebrateOne is a place-based, collective impact initiative founded to reduce infant mortality and improve health equity, so more babies reach their first birthday in Franklin County.

VISION

Every baby deserves to celebrate her or his first birthday, regardless of race, address or family income.

OUTCOMES / GOALS

To lower the Black infant mortality rate to 5.0 by 2030 with the intermediary goal of bringing the Black IMR to 7.6. And to bring the overall Franklin County IMR to 5.0 by 2030 with the intermediary goal of 5.7.

CelebrateOne Core Values

CelebrateOne's Core Values provide a guidepost around which our staff, partners and community can coalesce. These are the values that drive our work every day and underpin the Recommendations, Strategies and Activities that comprise our strategic plan. We keep these Core Values in mind as we enact the plan and as we make any changes to our strategy. Our team seeks to embody these values as we carry out our work in the communities we serve.

Working together to make our systems more equitable.

Take Collective Action: Reducing infant mortality and enhancing infant vitality through collaborative effort.

Lowering the infant mortality rate and increasing equity in Franklin County is a critical and complex undertaking that requires a broad base of knowledge, skills and resources. In order to fully support our community and take a holistic view of health, our approach must be both clinical and community driven. We are grateful for our wonderful community of stakeholders, without whom we could not be successful.

Accelerate Racial Equity: Eliminating racism, discrimination and their impact as fundamental drivers of maternal and child health.

Only through eliminating racism can we achieve true equity with respect to maternal and child health in our community. Racism and discrimination are fundamental drivers of health, and to consider them otherwise is a disservice to the women and families we serve. CelebrateOne is intentionally taking and supporting actions that accelerate equity, both within our organization and amongst the constituencies we serve.

Target Upstream Factors: Intervening to address the social determinants of health across the life course.

The set of factors that impact health beyond individual-level characteristics are often referred to as “upstream factors” or more commonly, social determinants of health. Social determinants of health (SDOH) are sometimes loosely defined as the conditions in the places where people live, learn, work and play that can affect a wide range of health risks and outcomes. We are focused upstream, even as our partners help women and families who are struggling today. Thinking upstream is the way of the future, and we intend to lead the way.

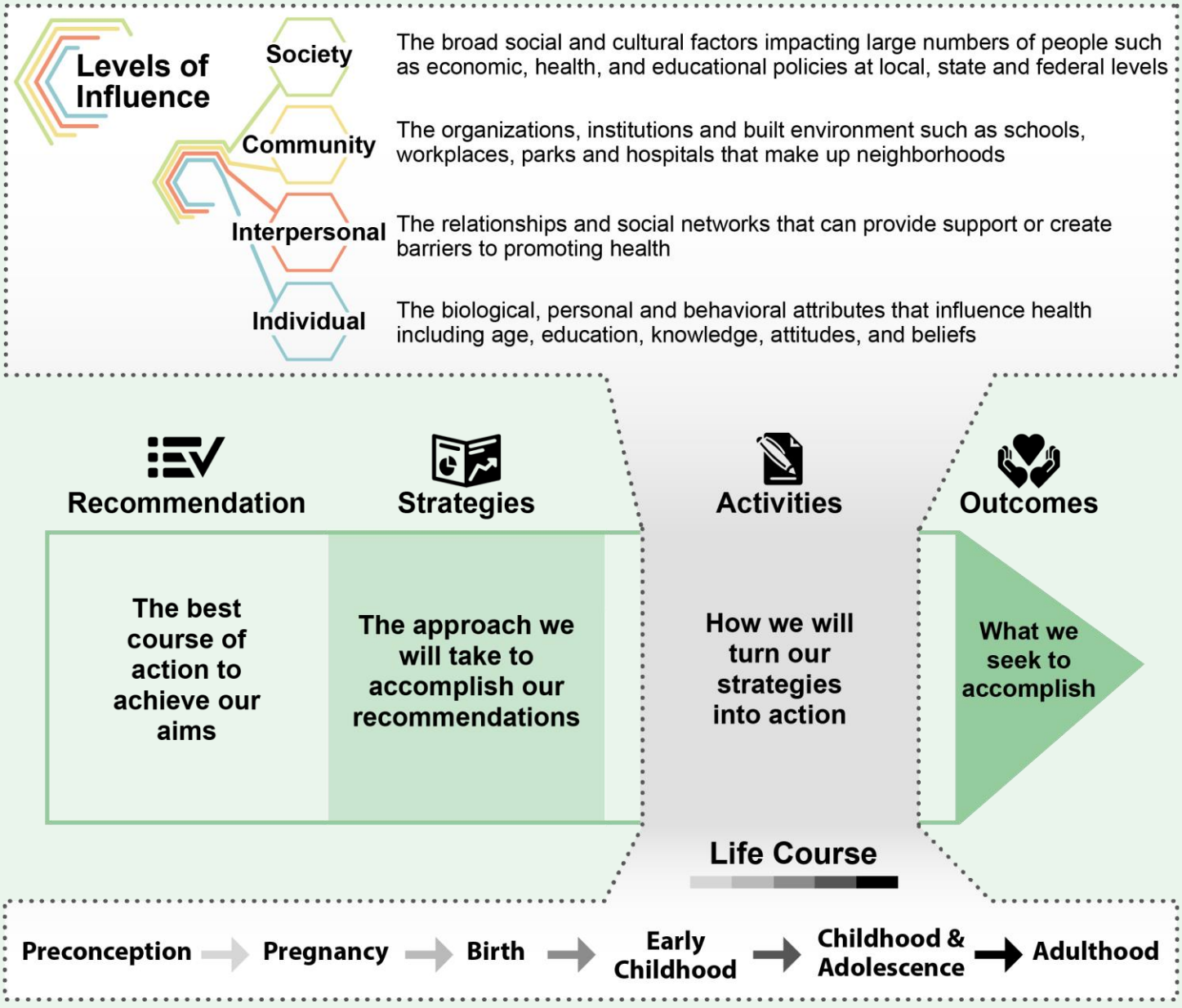
Catalyze Innovation: Harnessing new ideas and approaches to maximize impact and equitable solutions.

CelebrateOne’s approach to our work relies on both being both data-driven and looking at promising practices. Many leading practices in the Maternal and Child Health space have proven to be successful in White communities but continue to leave Black communities behind. Our mission is to promote equity by making sure every baby in Franklin County reaches their first birthday. This means we cannot shy away from piloting new and promising practices in Maternal and Child Health.

Advance Accountability: Affirming commitment and accountability to our mission, values and community.

For our work to be successful, we need to hold ourselves and each other accountable. A significant part of our work at CelebrateOne is convening the many experts we need to successfully enact our strategies. We are firm believers in the mantra, “what gets measured, gets done,” and we are here to support our community of partners in identifying, tracking and sharing progress on key performance indicators. Sharing data amongst each other and our communities will help to manage this collective accountability effort.

Health Equity Framework



The Strategic Plan at a Glance

Recommendations	Strategies
1. Target and address structural and interpersonal racism as fundamental drivers of infant mortality.	1.1. Center perinatal community resources and supports in accessible locations in each neighborhood with the highest Black infant mortality rates. 1.2. Advocate for state, local, and organizational policies that support Black women's reproductive health and rights. 1.3. Develop standards, assessments, and incentive structures for public and private sector partners to engage in action on racial equity in maternal and infant health. 1.4. Center the voice of Black women and women with lived experience to consistently drive the work. 1.5. Ensure individual-level representation and advocacy in care for Black women and families. 1.6. Inform the public of the effects of race and racism on infant mortality. 1.7. Increase Black enrollment in health insurance.
2. Address the social determinants of health (SDoH) across the life course to advance MCH.	2.1. Expand the availability of safe, environmentally appropriate, affordable housing. 2.2. Increase options and accessibility for medical and nonmedical transportation. 2.3. Bridge the digital divide for pregnant women and parenting families. 2.4. Advance economic mobility for women of conception age, pregnant women, and families with children under the age of one. 2.5. Ensure education access and advancement. 2.6: Ensure the nutritional needs of pregnant women and parenting families are met.
3. Advance policies that prevent poor birth outcomes and promote women's health and wellbeing rights.	3.1. Advance policies to improve infant and maternal health, including policies designed to reduce infant mortality and maternal mortality and eliminate racial and ethnic inequities. 3.2. Pursue public and private funding to prioritize maternal and child health populations, especially Black families. 3.3. Expand access to preconception care and family planning services, including efforts to ensure access to comprehensive health care services and supports and efforts to promote intended pregnancies and healthy births.
4. Improve provision of reproductive health care from preconception through one year of age.	4.1. Improve access to reproductive health care. 4.2. Improve quality of reproductive health care.
5. Design and implement a connected and consistent care experience for mothers and babies.	5.1. Connect families with perinatal support and advocates as a standard of prenatal and perinatal care practice. 5.2. Develop plan to address gaps in prenatal support services including but not limited to centering, doula, Moms2B, etc. 5.3. Empower women to be co-creators of their unique pregnancy journey. 5.4. Develop programs that support families and caretakers as well as mothers and parents.
6. Accelerate innovation, progress, and accountability for health equity.	6.1. Target new investments using data to measure local programmatic and community outcomes by race and other demographic factors. 6.2. Increase investments in programs/interventions with known positive outcomes for Black women and babies. 6.3. Implement maternal health solutions based on the results of maternal health data and maternal mortality review processes. 6.4. Identify opportunities to align City/County/business community strategies to improve social and economic conditions for mothers.

Recommendation 1

Transform the interpersonal and structural factors necessary for racial equity in infant mortality.

	Strategies	Activities	Society	Community	Interpersonal	Individual
1.1	Center community resources in accessible locations in each neighborhood with the highest Black maternal and infant morbidity and mortality rates.	1.1.1. Build and strengthen the partnerships that will help support and	●	●	●	●
		1.1.1.a. Develop public-private partnerships to implement safe, place-based, culturally appropriate resource centers.		●	●	
		1.1.1.b. Develop accelerated upstream interventions based on targeted factors that drive health disparities; Work with public/private sector partners to replicate and expand current Maternal and Child Health (MCH) innovations.	●	●		
		1.1.1.c. Incentivize community models supporting Black women's maternal care (Birthing Centers; local housing prioritization for target populations).		●	●	
		1.1.2. Develop program connections with workforce development and housing and other economic drivers of health.	●	●	●	
		1.1.3. Systematically monitor, track, and evaluate services being provided in each location.	●	●	●	●
1.2	Advocate for state, local, and organizational policies that support Black women's reproductive health and rights.	1.2.1. Pursue public policy options aligned with advancing equity, mitigating immediate challenges, and rebuilding structures.	●	●		
		1.2.2. Review policies that have created inequitable results for Black women, families, and communities and develop recommendations to improve future outcomes.	●			
		1.2.2.a. Promote City/County investment in equitable economic development.	●	●		
		1.2.2.b. Look at the City/County role specifically in addressing historical policy and investment-based sources of systemic racism.	●	●		
		1.2.3. Engage City departments and agencies to increase CelebrateOne's capacity to promote racial equity in health policies within all City systems and structures.	●	●		
1.3	Develop standards, assessments, and incentive structures to engage in action on racial equity in both the public and private sectors.	1.3.1. Develop and implement Racial Equity Impact Assessments for forming policies and programs to address institutionalized racism, especially when evaluating policies and programs that impact the well-being of babies, moms, and families.	●	●		
		1.3.2. Develop and implement Assessment and Response Standards with an emphasis on serving every mom and pregnant woman.	●	●		
		1.3.3. Designate a City-led accrediting body empowered to award a "racial equity designation" for the public and private sectors with an emphasis on maternal and infant health.		●		
1.4	Center the voice of Black women and women with lived experience to consistently drive our work.	1.4.1. Using human centered design, convene Black women of diverse backgrounds, experiences, and local geographies to meet regularly and provide key insights to expand reach and impact for Black communities.			●	●
1.5	Ensure individual-level representation and advocacy in care for Black women and families.	1.5.1. Connect women with perinatal support and birth advocates as the standard of care, with a focus on Black women, by enhancing the community infrastructure, organizational capacity, and community support.	●	●		
		1.5.2. Ensure that the diversity of the MCH workforce reflects the diversity of the community.		●	●	●
		1.5.2.a. Increase the number of Black physicians and other birth professionals interfacing with moms (includes doctors, nurses, doulas, etc.).		●	●	●
		1.5.2.b. Incentivize Black individuals to pursue careers in the healthcare community in Franklin County.		●	●	●
		1.5.3: Increase the number of Black led organizations implementing strategies to enhance representation and advocacy in the CelebrateOne ecosystem, and to enhance the capacity of the existing organizations.		●		
		1.5.4: Work with partners to ensure continuity of responsible clinical prenatal care providers.		●		
1.6	Inform the public of the effects of race and racism on infant mortality.	1.6.1: Build a public and transparent racial equity dashboard for ecosystem accountability, showcasing work on racial equity, and reporting measurable change and action.	●	●		
		1.6.2: Require CelebrateOne funded entities to publicly report racial disparities in program and data reports to raise awareness and accountability for closing the race gap in the infant mortality rate.		●		
		1.6.3: Offer professional training on implicit bias and structural racism to new and existing CelebrateOne partners.		●		
1.7	Increase Black enrollment in health insurance.	1.7.1: Educate families about available insurance options.		●	●	
		1.7.2: Support streamlined public insurance enrollment.	●	●		
		1.7.3: Promote use of the web-based Pregnancy Risk Assessment Form (PRAF 2.0) among prenatal care and emergency department providers to prevent patients from losing Medicaid coverage during pregnancy and to facilitate more efficient linkage to needed services and resources.		●	●	

Recommendation	Strategies
1 **Target and address structural and interpersonal racism as fundamental drivers of infant mortality.**	**1.1** Center perinatal community resources and supports in accessible locations in each neighborhood with the highest Black infant mortality rates. **1.2** Advocate for state, local, and organizational policies that support Black women's reproductive health and rights. **1.3** Develop standards, assessments, and incentive structures for public and private sector partners to engage in action on racial equity in maternal and infant health. **1.4** Center the voice of Black women and women with lived experience to consistently drive the work. **1.5** Ensure individual-level representation and advocacy in care for Black women and families. **1.6** Inform the public of the effects of race and racism on infant mortality. **1.7** Increase Black enrollment in health insurance.

Racial inequity is a fundamental driver of infant mortality and socio-economic differences do not explain the racial inequity. Racial disparity must be addressed head on with focused interventions. Without strong action, it could take 52 years (until 2073) or more before the Black IMR is as low as the 2020 White rate.

Example Activities & Measures:

- Develop and implement Racial Equity Impact Assessments tracked by the creation and utilization of the assessment.
- Build a public and transparent racial equity dashboard for ecosystem accountability.
- Connect women with perinatal support and birth advocates as the standard of care tracked by program enrollment into specified perinatal support programs (ex. Baby Bump & Beyond, Centering Pregnancy, etc.).

Recommendation 2

Address the social determinants of health (SDoH) across the life course to advance MCH.

	Strategies	Activities	Society	Community	Interpersonal	Individual
2.1	Expand the availability of safe, environmentally appropriate, affordable housing.	2.1.1. Prioritize the care of pregnant women who are homeless and prevent women at high risk of homelessness from needing to enter shelters.	●	●		
		2.1.1.a. Ensure that pregnant women who are homeless or housing insecure have wrap-around support to address current needs and support to sustain housing in the future.	●	●		
		2.1.2. Educate landlords on how to support pregnant women and mothers of young children.		●	●	●
		2.1.3. Expand affordable housing opportunities for pregnant and parenting families.	●	●		
		2.1.4. Eliminate environmental hazards (e.g., lead, poor air quality, other toxins, etc.). in neighborhoods with unusually high numbers of infant deaths.	●			
2.2	Increase options and accessibility for medical and nonmedical transportation.	2.2.1. Expand the number of options for and the availability of free and low-cost transportation for pregnant women and parenting families.	●			
		2.2.1.a. Advocate for broader Medicaid funding for (NEMT) transportation to doctor's appointments, clinics, grocery stores, pharmacies, and housing searches.	●			
		2.2.1.b. Leverage programmatic studies to enhance transportation options and availability for pregnant women and parenting families.	●			
2.3	Bridge the digital divide for pregnant women and parenting families.	2.3.1. Increase access for pregnant women and parenting families to broadband, technology, and other tools needed to participate in telehealth and other technology-enabled activities that enhance birth outcomes.	●			●
		2.3.2. Increase access for telehealth tools (hardware, software, and devices) and education that allow for safe care at a distance (e.g., blood pressure cuffs, fundal tape, etc.).	●			●
		2.3.3. Promote telehealth availability allowing hospital partners, prenatal providers, and Federally Qualified Health Centers (FQHCs) to serve virtually and expand practitioners who can provide telehealth.		●		
		2.3.4. Engage community organizations to encourage the use of virtual or web-based options for pregnant and parenting women and their families.		●		
2.4	Advance economic mobility for women of conception age, pregnant women, and families with children under the age of one.	2.4.1. Help women to take advantage of the wide variety of existing resources including mobility mentoring, financial planning, education, workforce development training, and employment.	●		●	●
		2.4.2. Develop a community strategy to support women in jeopardy of encountering their benefits cliff.		●		
		2.4.3. Align City/County/business community strategies to improve social and economic conditions in high-risk neighborhoods.	●	●		
		2.4.4. Identify and work with partners to create, track, and evaluate pregnant and parenting women's economic mobility.	●	●		
		2.4.5. Increase access to high quality early childhood education to support workforce engagement.	●			●
2.5	Ensure education access and advancement.	2.5.1. Link early developmental assessment to children in all maternal and infant programs, including home visiting.	●			●
		2.5.2. Identify development opportunities that minimize stigma on children and families.				●
2.6	Ensure the nutritional needs of pregnant women and parenting families are met.	2.6.1. Develop a set of interventions to link pregnant women and parenting families with healthy foods.	●			●
		2.6.2. Encourage hospitals, emergency departments, prenatal care providers, pediatricians, and community agencies to screen for food insecurity and connect families with resources.	●	●		●
		2.6.3. Explore food delivery options to disrupt food insecurity amongst pregnant women and parenting families.	●			●

Recommendation

Strategies

2

Address the social determinants of health (SDoH) across the life course to advance MCH.

2.1 Expand the availability of safe, environmentally appropriate, affordable housing.

2.2 Increase options and accessibility for medical and nonmedical transportation.

2.3 Bridge the digital divide for pregnant women and parenting families.

2.4 Advance economic mobility for women of conception age, pregnant women, and families with children under the age of one.

2.5 Ensure education access and advancement.

2.6 Ensure the nutritional needs of pregnant women and parenting families are met.

The neighborhoods most affected by housing, education, hunger and food insecurity, poverty and employment issues are also those most affected by infant mortality. By targeting the social determinants of health, we can set the stage for mothers, babies, families and communities to thrive.

Example Activities & Measures:

- Expand affordable housing opportunities for pregnant and parenting families tracked by the number of pregnant women housed and diverted from shelter.
- Increase access for pregnant women and parenting families to broadband, technology and other tools needed to participate in telehealth tracked by increased participation in telehealth.
- Encourage hospitals, emergency departments, prenatal care providers, pediatricians and community agencies to screen for food insecurity and connect families with resources tracked by the number of patients screened.

Recommendation 3

Advance policies that prevent poor birth outcomes and promote women's health and wellbeing rights.

	Strategies	Activities	Society	Community	Interpersonal	Individual
3.1	Advance policies to improve infant and maternal health, including policies designed to reduce infant mortality and maternal mortality and eliminate racial and ethnic inequities.	3.1.1. Support and advocate for legislation to advance policies that improve Black infant and maternal health (Federal).	●	●		
3.2		3.1.2. Advocate for the Supporting Best Practices for Healthy Moms Act (Federal).	●	●		
		3.1.3. Advocate for Medicaid and private insurance to cover perinatal doula care services, focusing first on high-risk groups and populations (State).	●	●		
		3.1.4. Encourage state leaders to extend presumptive Medicaid coverage to a year postpartum (State).	●	●		
		3.1.5. Develop a shared policy agenda with the State Commission on Infant Mortality (State).	●	●		
		3.1.6. Develop a shared policy agenda with the major state and local infant mortality and health collaboratives and other entities (State).	●	●		
		3.1.7. Advance equity, safety, and racial justice for women and girls of color, across justice, education, health and other systems with documented racial disparities (Local).	●	●		
3.3		3.1.7.a. Increase the capacity of the City's network of childcare and early learning providers and increase access to quality, affordable childcare for working families (Local).	●	●		
		3.1.7.b. Work with government and local partners to align strategies for equitable economic development and targeted supportive resources for Black families (Local).	●	●		
		3.1.7.c. Work with the local administrative and legislative partners to ensure American Rescue Plan Act funds are being used to advance CelebrateOne's programming wherever possible (Local).	●	●		
	Pursue public and private funding to prioritize maternal and child health populations, especially Black families.	3.2.1. Leverage local support to pursue national funding and grant opportunities to enhance MCH practices and services (Federal).	●			
		3.2.2. Scale existing evidence-based and pilot MCH and SDoH programs (State).	●			
		3.2.3. Seek state funding to support innovative, place-based, community partnered change models in areas with highest Black maternal and infant morbidity and mortality (State).	●			
		3.2.4. Increase City and County funding for infant mortality initiatives annually through the respective budget processes (Local).	●	●		
	Expand access to preconception care and family planning services, including efforts to ensure access to comprehensive health care services and supports and efforts to promote intended pregnancies and healthy births.	3.3.1. Develop and evaluate new and innovative approaches to prevent teen pregnancy, prevent sexually transmitted infections among adolescents, and promote optimal health (Federal).	●	●	●	
		3.3.2. Support legislation for the State Board of Education to adopt Health Education Standards (State).	●	●		
		3.3.3. Increase accessibility of reproductive health services (Local).	●	●		
		3.3.4. Expand access to sexual health information and education and services (Local).	●	●		
		3.3.5. Develop and evaluate new and innovative local approaches to prevent teen pregnancy and promote optimal health (Local).	●	●		

Recommendation

3

Advance policies that prevent poor birth outcomes and promote women's health and wellbeing rights.

Strategies

3.1 Advance policies to improve infant and maternal health, including policies designed to reduce infant mortality and maternal mortality and eliminate racial and ethnic inequities.

3.2 Pursue public and private funding to prioritize maternal and child health populations, especially Black families.

3.3 Expand access to preconception care and family planning services, including efforts to ensure access to comprehensive health care services and supports and efforts to promote intended pregnancies and healthy births.

Maternal child health is driven by a host of factors that exist outside of healthcare and public health activities. Public policy guides the allocation of public and private resources and can be used to positively impact birth and health outcomes.

Example Activities & Measures:

- Support and advocate for legislation to advance policies that improve Black infant and maternal health tracked by the number of policies developed and adopted.
- Leverage local support to pursue national funding and grant opportunities to enhance MCH practices and services tracked by the amount of new funding acquired.
- Scale existing evidence-based programs tracked by increased program capacity and enrollment
- Pilot new MCH and SDoH programs.

Recommendation 4

Improve provision of reproductive health care from preconception through one year of age.

Strategies	Activities	Society	Community	Interpersonal	Individual
4.1 Improve access to reproductive health care.	4.1.1. Maintain support of organizations that provide coordinated access to prenatal care and perinatal supports (including but not limited to StepOne, Home Visiting, Moms2B).		●		
	4.1.2. Optimize access points (e.g., hospital-based, FQHC, private practice, mobile care units) to ensure reproductive and prenatal care is available in geographies with high prematurity rates.		●		●
	4.1.3. Establish Community Innovation HUBs (may include birthing centers)	●	●		
	4.1.4. Promote early exposure to advocacy skills and education for women of childbearing age and their families.			●	●
	4.1.5. Establish focused plans and initiatives for the most vulnerable populations based on Fetal Infant Mortality Review (FIMR) findings (e.g., housing insecure, experiencing interpersonal violence, food insecure).	●	●	●	●
	4.1.6. Develop 24-hour "hotline" for women or birth advocates to escalate provider concerns and feedback.		●		●
	4.1.7. Improve access to sexual health information/education in schools and community settings.		●	●	●
	4.1.8. Implement primary care and subspecialty (e.g., Family Practice, Internal Medicine, Endocrinology) pre-pregnancy counseling and access to contraception to reduce unintended pregnancy with a focus on high-impact birth outcomes (including but not limited to BH, diabetes, hypertension, Crohn's disease, sickle cell).		●	●	●
	4.1.9. Ensure 13- to 18-year-old women are connected to a medical home and have had a well visit within prior 12 months.			●	●
	4.1.1. Ensure all women are connected to a medical home and have had a well visit within X months postpartum.			●	●
4.2 Improve quality of reproductive health care.	4.2.1. Prioritize quality improvements at sites of care serving Black women.		●		●
	4.2.1.a. Leverage vital statistics data with hospital electronic medical record (EMR) data to drive quality improvement (QI) interventions based on adherence to American College of Obstetricians and Gynecologists (ACOG) clinical guidelines and equitable provision of care between White and Black prenatal patients (e.g., aspirin for hypertension, progesterone).	●	●		
	4.2.1.b. Continue regionalization of delivery for very low birth weight (VLBW) infants.		●		
	4.2.1.c. Continue hospital-driven birth vital statistics documentation improvement.	●	●		
	4.2.1.d. Ensure continuity of provider during pregnancy. (see Rec 1)	●	●		
	4.2.1.e. Improve response to postpartum emergencies (including but not limited to the Alliance for Innovation on Maternal Health [AIM] bundle for hypertension).	●	●		●
	4.2.1.f. Improve ongoing provider (physician, nurse, residents, etc.) continuing education on racial bias, stigma, discrimination, and the history of structural racism.	●	●	●	●
	4.2.1.g. Build providers' cultural competency to meet the needs of Black women by educating them on the impacts of racism on reproductive health.		●		●
	4.2.2. Continue with existing and expand postpartum Long-Acting Reversible Contraception (LARC) efforts immediate and within 90 days postpartum.				●

Recommendation

Strategies

4

Improve provision of reproductive health care from preconception through one year of age.

4.1 Improve access to reproductive health care.

4.2 Improve quality of reproductive health care.

While infant mortality is driven by many non-health factors, the importance of high-quality health care before, during and after pregnancy is undeniable. Our health system and health care providers must have the will, knowledge and resources necessary to significantly improve birth outcomes.

Example Activities & Measures:

- Optimize access points (e.g., hospitals, FQHCs, private practices, mobile care units) to reproductive healthcare measured by the percent of women who deliver without prenatal care.
- Improve access to sexual health information and education measured by the number of teens to receive reproductive health education.
- Prioritize quality improvements at sites of care serving Black women measured by the number of women receiving “adequate” prenatal care.

Recommendation 5

Design and implement a connected and consistent care experience for mothers and babies.

	Strategies	Activities	Society	Community	Interpersonal	Individual
5.1	Connect families with perinatal support and advocates as a standard of prenatal and perinatal care practice.	5.1.1. Establish and develop universal screening elements to assess health and social risk education (e.g., motivational interviewing approaches) to share perinatal support options with families.	●	●		
		5.1.2. Develop strategies for coordination of case management data through electronic referral and tracking process between healthcare providers and perinatal support agencies.	●	●		
		5.1.3. Increase capacity among doulas, home visiting, community health workers, and birthing centers to improve communication between patients and providers, and educate the community on these birthing	●	●		
		5.1.4. Ensure that professional interpretation services, including in-person and phone options, are consistently available during prenatal care visits and at delivery.	●	●		
		5.1.5. Invest and develop in a Shared Health Record (SHR) system (e.g., Epic Software) to facilitate the sharing of clinical information between systems, social and prenatal care providers to ensure the development of care plans for conception age women.	●	●		
		5.1.6. Continue and expand safe sleep and breastfeeding education.	●	●	●	●
		5.1.7. Continue and expand tobacco cessation programs including but not limited to Baby & Me Tobacco Free.	●	●	●	●
		5.1.8. Expand coordinated crib distribution (Cribs4Kids).	●	●		●
		5.1.9. Continue and expand OBBO Medical Legal Partnership.	●	●		
5.2	Develop plan to address gaps in prenatal support services including but not limited to centering, doula, Moms2B, etc.	5.2.1. Expand and develop ongoing provider training to improve outcomes Including but not limited to trauma-informed, Cognitive Behavioral Therapy, race equity awareness, etc.	●	●		
		5.2.2. Monitor and ensure perinatal providers offer continuity of care from pregnancy to postpartum.	●	●		
		5.2.3. Continue to expand the availability of mental health services with partners, in schools and communities for women and girls who have experienced trauma.	●	●		
		5.2.4. Develop and implement a communications strategy with partners to drive engagement to appropriate prenatal and perinatal programs and tools including but not limited to, doula care, home visiting, behavioral and physical health services.	●	●	●	●
5.3	Empower women to be co-creators of their unique pregnancy journey.	5.3.1. Develop and implement patient-centered education regarding engagement in clinical care (e.g., develop a clinical conversation guide).		●	●	●
		5.3.2. Educate pregnant women to question or change providers if they are unsatisfied with the care they are receiving.		●	●	●
		5.3.3. Identify, develop and implement strategies that inform, educate and alleviate the stress that Black women face when interacting with the health community.		●	●	●
		5.3.4. Develop permanent structures to integrate community voice into state, county, and local decision-making processes (e.g., Queens Village).	●	●		
5.4	Develop programs that support families and caretakers as well as mothers and parents.	5.4.1. Develop strategies for family inclusion in the coordination and case management of care for pregnant and parenting family members.	●	●	●	
		5.4.2. Develop health system policies that accept and encourage family advocacy in care.	●	●		
		5.4.3. Invest in a parent-centered group care model, such as Centering Parenting®, to address the needs of families during postpartum and throughout a child's first year of life.	●	●		
		5.4.4. Expand and amplify programs and educational opportunities to help fathers and partners understand that they are a valuable member of the birthing and parenting (e.g., Doula and Dude-La services, male community health workers and Boot Camps for Dad at OhioHealth, Malcolm White, Fatherhood Commission as potential partner, etc.).	●	●	●	●

Recommendation

Strategies

5

Design and implement a connected and consistent care experience for mothers and babies.

5.1 Connect families with perinatal support and advocates as a standard of prenatal and perinatal care practice.

5.2 Develop plan to address gaps in prenatal support services including but not limited to centering, doula, Moms2B, etc.

5.3 Empower women to be co-creators of their unique pregnancy journey.

5.4 Develop programs that support families and caretakers as well as mothers and parents.

One key in the maternal child health picture is the patient/client experience. Our current system is largely represented by relatively infrequent, disconnected, high-friction, episodic interactions between pregnant women and families, health care providers and social services. We can dramatically enhance birth and health equity outcomes by creating a continuous and consistent care experience within and across the health and social services.

Example Activities & Measures:

- Establish and develop universal screening elements to assess health and social risk education tracked by the percent of patients screened.
- Develop strategies for coordination of case management data through electronic referrals and tracking process between healthcare providers and perinatal support agencies.
- Invest in and develop a Shared Health Record (SHR) system.

Recommendation 6

Accelerate innovation, progress, and accountability for health equity.

	Strategies	Activities	Society	Community	Interpersonal	Individual
6.1	Target new investments using data to measure local programmatic and community outcomes by race and other demographic factors.	6.1.1. Make use of new and emerging data, research, analytic approaches, etc. to reduce bias and enhance program outcomes.	●	●		
		6.1.2. Develop and implement a mutually agreed upon set of standards and evaluation metrics by which program's and organization's outcomes on health equity can be measured.	●	●		
		6.1.3. Develop processes and outcome accountability metrics to better understand and enhance CelebrateOne's and Lead Entity organizations' impact.	●	●		
6.2	Increase investments in programs/ interventions with known positive outcomes for Black women and babies.	6.2.1. Increase capacity among doulas, home visiting, community health workers, birthing centers and other promising practices to increase outcomes for Black women and families.	●	●	●	
		6.2.2. Develop plan to address gaps in prenatal support services including but not limited to centering, doulas, etc.	●	●	●	
		6.2.3. Invest and develop in a Shared Health Record (SHR) system (e.g., Epic Software) to facilitate the sharing of clinical information between systems, social and prenatal care providers to ensure the development of care plans for conception age women.	●	●		
		6.2.4. Support pilots for innovative and high potential promising practices and programs through new and established partnerships with innovation collaboratives.	●	●		
6.3	Implement maternal health solutions based on the results of maternal health data and maternal mortality review processes.	6.3.1. Formalize use of FIMR recommendations on an annual or semi-annual basis.		●		
		6.3.2. Collaborate with state agencies (i.e. ODH/ ODM) to collect, monitor, analyze, and share data.	●	●		
		6.3.3. Enhance professional and racial diversity of representation in program review panels and processes.	●	●	●	●
		6.3.4. Institute monthly or quarterly reviews of available data to share strategic planning progress.		●	●	
		6.3.5. Develop annual goal and outcome review with Lead Entities and partners based on mortality review processes.		●	●	
6.4	Identify opportunities to align City/County/business community strategies to improve social and economic conditions for mothers.	6.4.1. Ensure alignment of SDoH measures with City/County/business strategies and outcome measures on social and economic conditions.	●	●	●	●
		6.4.2. Leverage community assets such as colleges, universities and nonprofits (e.g., Center for Health Innovation, Health Policy Institute of Ohio for design, evaluation and evidence mapping for new and established program initiatives.	●	●		
		6.4.3. Evaluate and increase capacity to align programs, measures and outcomes related to key drivers of MCH (e.g., violence, mental health and domestic/intimate partner violence).	●	●		●

Recommendation

Strategies

6

Accelerate innovation, progress, and accountability for health equity.

6.1 Target new investments using data to measure local programmatic and community outcomes by race and other demographic factors.

6.2 Increase investments in programs/interventions with known positive outcomes for Black women and babies.

6.3 Implement maternal health solutions based on the results of maternal health data and maternal mortality review processes.

6.4 Identify opportunities to align City/County/business community strategies to improve social and economic conditions for mothers.

While CelebrateOne will make use of best practices, we recognize in many instances we will need to innovate to advance health equity using combinations of best and promising practices. In some instances, we will develop new interventions based on research and data. CelebrateOne commits to being data driven and accountable as it develops innovations and moves through iterations of new initiatives to success.

Example Activities & Measures:

- Develop and implement a mutually agreed upon set of standards and evaluation metrics by which program's and organization's outcomes on health equity can be measured.
- Support pilots for innovative and high potential promising practices and programs.
- Institute monthly or quarterly reviews of available data to share strategic planning progress.

Planning for Success

The CelebrateOne Strategic Plan was co-created with a dedicated and diverse group of stakeholders, from government and health organizations to business and non-profit leaders and community members. Their commitment and energy around creating transformative change for families in Franklin County has been steadfast through every step of the process. As CelebrateOne moves into our next Strategic Plan implementation phase, the key to realizing positive change is clearly defining and regularly assessing our roles, goals, data, resources and most impactful ways to track, measure, report and celebrate progress.

PARTNER ENGAGEMENT

To be successful in carrying out our recommendations and strategies, we must continuously engage with our partners to talk about the plan, break down barriers and measure progress. It is equally important to continuously receive feedback from the families we serve in order to pivot when necessary.

For each recommendation, CelebrateOne has a variety of partner relationships to lead and carry out the strategies. They are entities, funders, service providers, advocates, community leaders and community members with lived experience. The role of CelebrateOne and each partner will be determined at the recommendation, strategy and activity levels. Engaging early and often with our partners, allows us to clearly articulate our role in order to best support and provide resources to our partners.

ACCOUNTABILITY & PROGRESS TRACKING

CelebrateOne recognizes the impact and value in accelerating progress in our work for our families and community. To see the plan come to fruition, we must align with our partners and be accountable to each other. CelebrateOne staff, partners and stakeholders collectively affirm our commitment to our mission, values and community. Key drivers need to be in place to support our accountability efforts:

1. **Scheduling** a regular check-in cadence with the lead entities, partners and contributors.
2. **Developing, tracking, iterating** and **housing** our Key Performance Indicators (KPIs) in a way that is easily accessible and usable.

3. **Extracting** compelling data stories and **sharing** our progress with stakeholders and the community.
4. **Asking** for help when needed.
5. **Focusing** on the future state.
6. **Celebrating** our progress, from quick wins to milestones to transformative change.

HARNESSING INNOVATION

CelebrateOne 2.0 is dedicated to radically doing things differently by looking for thoughtful, innovative ways to provide services to Franklin County families. One of our Core Values is to “catalyze innovation by harnessing new ideas and approaches to maximize impact and equitable solutions.” We are continuously in pursuit of successful, innovative practices grown locally and around the country. We are cognizant that these practices must be designed around the unique circumstances of the people of Franklin County.

We are committed to:

- ***Listening*** to the families and individuals who need the services and continue asking deeper questions.
- ***Convening*** diverse people and ideas to the table.
- ***Piloting*** new and promising practices in Maternal and Child Health.

ROADMAP

As we look ahead, we are developing best practices around implementing our strategic plan. This is accomplished through a cycle of continuous improvement:

Together, we know that we can help ALL babies living in Franklin County thrive to their first birthday and beyond. We look forward to working together to building a better future for Franklin County families tomorrow and for years to come.

If you have any questions about CelebrateOne's Strategic Plan, or if you and your organization would like to get involved, please reach out to:

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CELEBRATEONE COLUMBUS

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

Appendix

Stakeholder & Key Partner Acknowledgments

Accountability Plan (KPIs and Lead Partners)

Glossary

References

Acknowledgments & Partnerships

This strategic plan is the result of strong partnership with the Ohio Better Birth Outcome Collaborative and contributions from CelebrateOne's Board Members, Lead Entities, health centers, state and local government leaders, trusted community research and service providers, and most importantly, women in our community with lived experience.

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Glossary

- **Adverse childhood experiences:** Potentially traumatic events that occur in childhood (0–17 y), such as violence, abuse or neglect that can undermine a child's sense of safety, stability, and bonding. Adverse childhood experiences are linked to chronic health problems, mental illness, and substance misuse in adulthood.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Allyship:** The practice whereby a person or group in a privileged position or position of power seeks to operate in solidarity with a marginalized person or group.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Anti-Black Racism:** The system of beliefs and practices that attack, erode and limit the humanity of Black people.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Co-Creators:** All participants that are responsible for the development of a solution. For the purposes of this strategic plan and human-centered design, a solution for a user and developed alongside that user and others with diverse backgrounds and perspectives.

- **Community:** Explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur.
  Source: Centers for Disease Control and Prevention, The Social-Ecological Model: A Framework for Prevention

- **Cultural Racism:** A form of racism that relies on cultural differences rather than on biological markers of racial superiority or inferiority. The cultural differences can be real, imagined or constructed.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Discrimination**: Inappropriate treatment of people because of their actual or perceived group membership and may include both overt and covert behaviors, including microaggressions, or indirect or subtle behaviors that reflect negative attitudes or beliefs about a non-majority group.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Doula:** Trained professionals that provide physical, emotional, and informational support to women during labor, birth and in the immediate postpartum period.
  Source: The Journal of Perinatal Education

- **Economic Mobility:** The ability for children from the bottom 20% of the income bracket to reach the top 20%.
  Source: U.S. Department of Housing and Urban Development

- **Health disparities**: A particular type of health difference that is closely linked with social, economic, and environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group or other characteristics historically linked to discrimination or exclusion.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Health Inequities:** Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs to both individuals and societies.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Human Centered Design (HCD):** An approach rooted in empathy and collaboration, and allows us to listen to the voices of consumers, reframe problems, and collaboratively develop solutions. This approach is used to combat assumptions about patients' needs and then design health care improvement strategies based on those assumptions.
  Source: Center for Health Care Strategies, Co-Developing Solutions with the Community: The Power of Human-Centered Design

- **Infant Mortality Rate:** The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving us key information about maternal and infant health, the infant mortality rate is an important marker of the overall health of a society.
  Source: Centers for Disease Control and Prevention, Infant Mortality

- **Institutionalized Racism:** Differential access to the goods, services, and opportunities of society by race.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Internalized Racism:** Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Interpersonal racism**: Prejudice and discrimination that can be intentional, and unintentional, as well, and includes acts of commission and acts of omission.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Key Process Indicators (KPIs):** Quantifiable measures that reflect the critical success factors of an organization.
  Source: The Canadian Journal of Hospital Pharmacy

- **Levels of Influence:** The interaction between, and interdependence of, factors within and across all levels of a health problem. It highlights people's interactions with their physical and sociocultural environments.
  Source: Rural Health Information Hub, Ecological Models

- **Life Course:** The interdisciplinary theory that seeks to understand the multiple factors that shape people's lives from birth to death, placing individual and family development in cultural and historical context.
  Source: MCH, Life Course and Social Determinants

- **Lived Experience:** The immediacy of experiencing provides the raw material to be shaped through interpretation, reinterpretation, and communication into its lasting form.
  Source: International Journal of Qualitative Methods, Capturing Lived Experience

- **Perinatal:** The period between 28 weeks of gestation and 7 days after birth.

- **Personally Mediated Racism:** Prejudice and discrimination that can be intentional or unintentional; includes acts of commission and acts of omission. Also known as interpersonal racism, this is the form of racism most people are familiar with.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Preconception Care:** A set of interventions that aim to identify and modify biomedical, behavioral and social risks to the woman's health or pregnancy outcome through prevention and management.
  Source: New York State Department of Health, Preconception Care: A Guide for Optimizing Outcomes

- **Prejudice:** Irrational or unjustifiable negative emotions or evaluations toward persons from other social groups. A primary determinant of discriminatory behavior.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Prenatal:** The period occurring or existing before birth

- **Race**: A social construct primarily based on phenotype, ethnicity and other indicators of social differentiation that results in varying access to power and social and economic resources. [7,8].
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Racial Disparity Gap:** A noted data difference between races. Specifically if it exists when the proportion of a racial/ethnic group within a subset of the population is different from the proportion of such groups in the general population. While the presence of a disparity alone is not evidence of racism, discrimination or disparate treatment, it presents a concern that requires more in-depth analysis. Our plan focuses on the racial disparity between the infant and maternal mortality rate between Black and White families. The gap is the difference between the incidences in the subsets of the population.
  Source: The Inspector General Department of the Air Force: Report of Inquiry, Independent Racial Disparity Review

- **Racial Equity:** Racial equity is achieved when racial identity no longer predicts how a person fares. This includes elimination of policies, practices, attitudes and cultural messages that reinforce different outcomes predicted by race. Racial inequity is when two or more racial groups are not standing on approximately equal footing. For example, in the U.S., Black, Hispanic, Indigenous and other people of color are more likely to live in poverty, be imprisoned, drop out of high school, be unemployed and experience health problems such as heart disease and diabetes.
  Source: American Heart Association, Structural Racism and Health Equity Language Guide

- **Racial trauma**: The events of danger related to real or perceived experience of racial discrimination, including threats of harm and injury, humiliating, and shaming events and witnessing harm to other people of color. [9]
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Social Determinants of Health:** Social determinants of health are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Social-Ecological Model**: A four-level social-ecological model used to better understand health outcomes and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community and societal factors. It allows us to understand the range of factors that put people at risk for poor health and protect them from poor outcomes.
  Source: Centers for Disease Control and Prevention, The Social-Ecological Model: A Framework for Prevention

- **Socioeconomic Position:** An aggregate concept that includes both material and social resources (such as income, wealth and educational credentials) and one's rank in a social hierarchy (conceptualized as access and consumption of goods, services and knowledge) linked to both childhood and adult social class position.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Structural racism**: The normalization and legitimization of an array of dynamics (historical, cultural, institutional and interpersonal) that routinely advantage White people while producing cumulative and chronic adverse outcomes for people of color.
  Source: American Heart Association, Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

- **Telehealth:** The use of electronic information and telecommunication technology to get the clinical and nonclinical health care. Often only requires a phone or device with the internet.
  Source: Centers for Disease Control and Prevention, What is Telemedicine?

- **Upstream Factors:** Aspects of care and policy approaches that have the potential to affect large populations through regulation, increasing access or economic incentives
  Source: CDC, Measuring the Impact of Public Health Policy

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