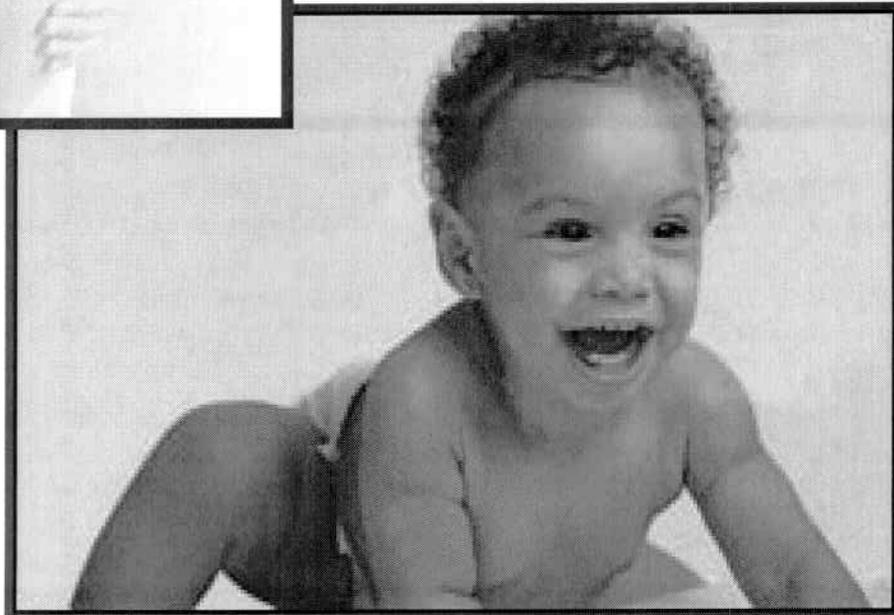
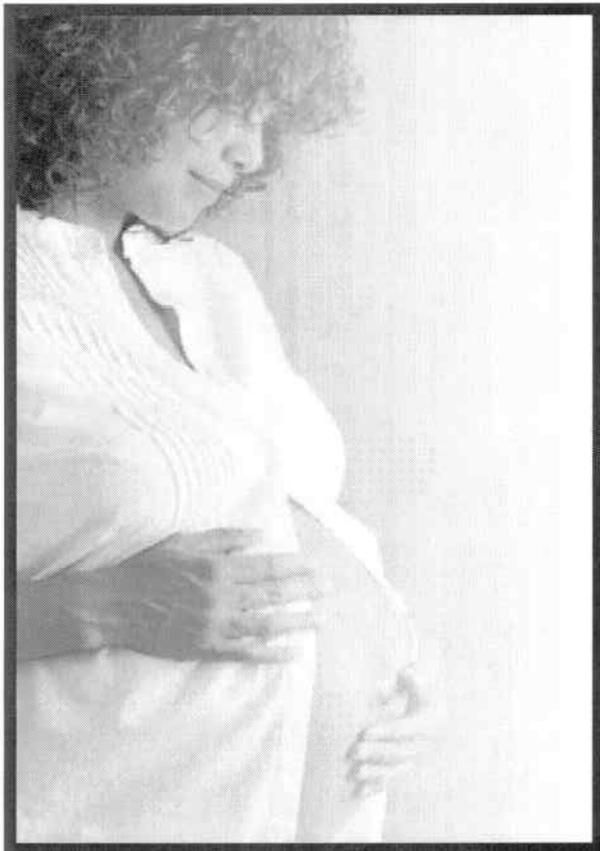


**INFANT MORTALITY TASK FORCE
PRELIMINARY REPORT**

JUNE 2009



INFANT MORTALITY TASK FORCE—PRELIMINARY REPORT—June 30, 2009

Problem Statement: The infant mortality rate is an important measure of public health. This rate is calculated as the number of all live-born infants who die within the first year of life per 1,000 live births for the same time frame. The United States, at a rate of 6.37*, has a higher infant mortality rate than 28 other developed nations *. Ohio's rate, after steadily decreasing for years, has not substantially changed for more than decade. The infant mortality rate in Ohio (7.7**), is the eighth-highest in the country*** and exceeds the goal for Healthy People 2010 (4.5). In addition, there are marked disparities in birth outcomes identified when comparing different racial, demographic and geographic subpopulations.

To further understand disparities in Ohio's infant mortality rate, a new method of examining infant mortality, perinatal periods of risk (PPOR), was used to provide a more in-depth analysis. PPOR was developed at the Centers for Disease Control and Prevention and includes five major steps: 1) engaging community partners, 2) mapping feto-infant mortality (fetal and infant deaths, more than 24 weeks and more than 500 grams), 3) focusing on reduction of the overall feto-infant mortality rate, 4) examining potential opportunity for improvement between populations of interest and 5) targeting further investigation of and prevention efforts toward identified gaps. (For detailed information on PPOR methodology, please visit http://www.citymatch.org/ppor_index.php). The following is a summary of the analysis:

- Most deaths had causes related to preconception health. Risk factors include smoking, late/inadequate prenatal care, high parity and multiple gestations.
- The second-largest number of deaths was caused by sudden infant death syndrome. Risk factors include smoking and lack of a safe sleeping environment for all infants.
- The third-largest number of deaths had causes related to inadequate prenatal care and the need for specialized management of high-risk pregnancies due to medical and/or obstetrical complications.
- In the area of newborn care, mortality rates were closest to the ideal rate; prevention activities need to focus on maintaining the progress already seen.

Purpose: The Infant Mortality Task Force was established in early 2009 by the Ohio Department of Health (ODH) at the request of Gov. Ted Strickland to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) make both preliminary and long-term recommendations to reduce infant mortality and disparities.

Process: A core group of about 30 task force members, co-chaired by Thomas Breitenbach, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, M.D., added about 40 stakeholders to provide even broader representation and expertise. The task force formed into maternal health/prematurity, maternal care, newborn care and infant care committees that met separately to work on their areas of concentration and came together for monthly task force meetings. In addition to establishing a Web site and a SharePoint site, ODH staff members supported the task force by developing and conducting surveys of infant mortality-related research efforts and programs throughout Ohio to provide information for the final report. ODH staff also received technical

assistance funding from the federal Maternal and Child Health Block Grant to engage an expert facilitator to coordinate task force meetings.

The task force was launched on March 6, 2009, and held its fourth meeting on June 12, 2009. Each committee looked at best practices from the public health literature, evidence-based interventions from the medical literature, related indicators for infant mortality and risk factors as they developed preliminary recommendations and strategies. After the preliminary recommendations are reviewed by the governor's office, ODH will solicit input from a wide range of stakeholders across Ohio to incorporate into the final report. A key recommendation will be to establish an ongoing consortium to assure effective implementation of task force recommendations and to evaluate progress in continued efforts to address infant mortality and disparities. Recommendations are listed on the following pages.

*2004, National Center for Health Statistics

** 2007, ODH Vital Statistics

*** 2005, U.S. Census Bureau

Recommendation 1: Implement primary and secondary prevention measures including health promotion, education and evidence-based intervention to reduce the incidence of preterm birth.

Rationale: Preterm birth is the No. 1 cause of infant mortality. Women who are at the highest risk for poor birth outcomes need to understand their vulnerability and that there are strategies that can improve outcomes.

Strategies:

- Increase the number of providers who conduct comprehensive medical and psychosocial risk assessment at the initial visit and throughout pregnancy.
- Increase the number of providers who provide comprehensive education and counseling about preterm birth prevention, breastfeeding, tobacco cessation and birth spacing.
- Increase the number of men and women who develop a reproductive health plan.
- Assure appropriate management of chronic medical disorders before and during pregnancy to optimize birth outcomes by developing partnerships among insurers, Medicaid, public health care agencies and quality care improvement initiatives.
- Distribute information and materials to educate women who have experienced prior preterm delivery on risk reduction.
- Educate providers about the use of 17-OH Progesterone injections starting at 17 weeks gestation in patients with history of preterm delivery.
- Plan, pilot and evaluate hospital-based interventions for women with babies in the neonatal intensive care unit on preventing future preterm delivery.

Recommendation 2: Provide equal access to continuous comprehensive care and service coordination, primary prevention and reproductive services for all women and children, especially uninsured/underinsured, before, during and after pregnancy.

Rationale: Some populations have significant barriers to health care and many of the causes of infant mortality are best addressed prior to pregnancy. Community-based interventions have been successful in improving health outcomes for at-risk populations. Without a significant investment in primary prevention, these populations will continue to have poor birth outcomes.

Strategies:

- Study and eliminate the gaps in access and payment for recommended health services that prevent women from obtaining health care services before, during and after pregnancy. This should include studying the alignment between Medicaid Managed Care and state/federal public health funding as well as mechanisms to facilitate early Medicaid coverage and entry into prenatal care.
- Increase public utilization of resources such as the Ohio Benefit Bank to assist women and children with obtaining health care services.
- Obtain a Medicaid Family Planning Waiver from the Centers for Medicare and Medicaid Services by 2010 to provide coverage for contraceptive care between pregnancies for women who do not meet traditional Medicaid guidelines.

- Expand successful programs to fund health care providers, outreach workers including home visitors and public health agencies to identify and refer women at greatest risk for infant mortality for primary prevention, reproductive services and care coordination.
- Assign a single care coordinator to identified at-risk women.
- Assure access to a community-based, culturally competent, family-centered medical home for all women and children. The desired outcome is coordination of health care and referrals to specialists for optimal health outcomes.
- Assure access to medical specialists via telemedicine, including high-speed Internet access, for every provider in Ohio to improve the quality of care given to pregnant women and newborns.
- Institute a state-supported, early universal prenatal visit including: 1) a dating ultrasound; 2) prenatal battery of laboratory tests; 3) identification of a single care coordinator; 4) access to transportation; and 5) risk assessment.
- Assure that all women of childbearing age including their newborns and families have access to appropriate mental health services and substance abuse programs.

Recommendation 3: Use individual and systemic strategies in a broad-based approach to eliminate disparities and promote health equities to reduce infant mortality.

Rationale: Disparities (differences between individuals or population groups) in infant mortality are longstanding in Ohio; these disparities can be geographic, economic, racial, cultural and gender based.

Strategies:

- Implement and evaluate a social marketing campaign to increase public awareness of the prevalence of infant mortality and the disparities that exist in Ohio.
- Develop partnerships to address the broader issue of health disparities throughout the life span.
- Expand strategies from a strict biomedical model to include strategies from public health and community health models.
- Decrease food insecurity and its effects on infant mortality.
- Support the implementation of the recommendations of the Ohio Anti-Poverty Task Force, especially those with a public health focus such as safe housing and neighborhoods.

Recommendation 4: Invest in culturally competent social marketing and education strategies to increase public awareness of the effect of preconception health choices and preconception care services on birth outcomes.

Rationale: Many causes of poor birth outcomes may be successfully addressed prior to pregnancy, leading to improved outcomes.

Strategies:

- Develop and implement a comprehensive educational curriculum to help girls and boys understand reproductive health and the consequences of choices/behaviors to their own health and to the health of future children.
- Develop and implement social marketing strategies to help women and men of reproductive age make the link between lifestyle choices and healthy pregnancies (e.g. taking folic acid daily, stopping smoking, achieving a healthy weight before pregnancy).
- Establish a social networking/educational tool on the Web or via telephone so women and men are able to obtain health coaching information and services.
- Explore conventional and unconventional communication tools to reach unique populations (i.e. migrant workers, the Amish and others).
- Improve public and professional awareness of benefits/risks/effectiveness of newly developed contraceptive technologies.

Recommendation 5: Promote learning and understanding through supportive activities and services that address the effects of racism and the stress of racism on infant mortality.

Rationale: Marked racial disparities in infant mortality have existed for decades; the cause(s) are incompletely understood. There is a growing evidence base that points to the role of racism as a contributor to infant mortality. Racial disparities in poor birth outcomes are well-recognized; however, it is less well understood that the effects of race are independent of other known risks. For example, in Ohio, a baby born to a black woman with five or more years of college education is more likely to die (10.2/1,000) than a baby born to a white woman with a high school education or less (7.5/1,000).

Strategies:

- Identify and implement evidence-based methods to address the social determinants of birth outcomes/infant mortality impacted by individual and institutional racism.
- Support the implementation of the recommendations of the Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative.
- Recommend that the Ohio General Assembly require all health care and other related licensing boards implement a statewide diversity training program to include the effects of racism on health care and infant mortality. This will be required for any credentialing/licensing/employment for all service and health care providers in Ohio. These competencies will be measured at license renewal.
- Implement (via Ohio Department of Education) a standardized diversity program for all grade levels to include the effects of racism on infant mortality and health care that is required by the state for all school and home-schooled programs.
- Develop/compile instructional materials based on successful models such as CityMatCH and require public health partners to begin dialogue for reducing institutional racism, and incorporating ongoing cultural competence training within their facilities.

Recommendation 6: Improve data collection and analysis to inform program and policy decisions, identify needs and strategies, evaluate strategies and monitor progress in reducing infant mortality.

Rationale: Data must be used to develop interventions and monitor program effectiveness. To completely understand infant mortality, we need to collect and analyze data about the spectrum of risks and indicators in subgroups as well as the overall population.

Strategies:

- Expand the current Child Fatality Review infrastructure at the Ohio Department of Health to operate a statewide Fetal Infant Mortality Review program.
- Adopt the 2003 National Center for Health Statistics Fetal Death Certificate and computerize state fetal death records to allow analysis of causes of fetal death.
- Support Ohio Vital Statistics in improving data quality from birth and death certificates.
- Adequately fund the Ohio Connections for Children with Special Needs (birth defects surveillance system) so it can effectively identify and mitigate risk in special populations and connect infants with services.
- Increase investment in state capacity to investigate Ohio trends and factors underlying infant mortality and disparity.
- Require any agency or group that receives public funding for maternal and child health programs to identify measurable outcomes and publicly report their findings/outcomes.
- Increase African-American response rates to the Ohio Pregnancy Risk Assessment Monitoring System, in order to conduct analysis specific to the African-American population.
- Develop data collection and analysis processes to identify and monitor progress reducing infant mortality in special population groups such as migrant workers, the Amish and immigrant populations.

Recommendation 7: Using evidence and data analysis, align all preventive health care (primary, secondary and tertiary), health promotion and education interventions that improve maternal care and infant health. Prioritize program investments based on proven effectiveness and disinvest in programs not improving outcomes.

Rationale: Widespread use of evidence-based practices (e.g. breastfeeding education and support, safe sleep practices, medical home, regular GYN visits, accurate/thorough prenatal health histories, smoking cessation, nutrition education, birth spacing, immunization, parenting and child development education) should lead to a reduction in infant mortality. Women receiving consistent messages are more likely to adopt healthy behaviors. Programs aimed at reducing infant mortality constitute a significant investment in resources.

Strategies:

- Integrate the existing programs within the state agencies that are involved in maternal child health to improve infant mortality and reduce state expenditures.

- Support programs and policies that promote the important role of fathers in pregnancy and parenting by removing barriers to paternity identification and promoting fathers signing their children's birth certificates.
- Disseminate and increase the adoption of innovative, evidence-based prenatal care models (e.g. nurse home visiting, community health workers, group care and Centering Pregnancy®).
- Launch a statewide safe sleep campaign to include efforts to standardize diagnosis of sudden, unexpected infant deaths; improve data collection; and to increase education and awareness for health care professionals, child care providers and retailers, in addition to parents and caregivers.
- Support breastfeeding for all Ohio mothers by: 1) assuring availability of hospital-grade breast pumps; 2) implementing culturally sensitive breastfeeding education to families and providers; 3) providing lactation consultant and peer support in hospitals and after discharge; and 4) implementing safety guidelines for standardizing the regulation, inspection and review of breastfeeding equipment, facilities and breast milk, formula or breast milk-formula combination recipes, preparation and storage.
- The State of Ohio should set an example for all employers in supporting parents by providing lactation support; offering paid maternity leave; and sponsoring smoking cessation programs. Engage other partners to promote adoption of these policies among employers.
- Cabinet-level agencies and appropriate state agency staff shall work together in partnership with other relevant organizations to educate and raise awareness of Ohioans through effective and culturally sensitive methods on issues affecting the health of infants.

Recommendation 8: Expand quality improvement initiatives to improve maternal and child health outcomes in Ohio.

Rationale: Widespread use of evidence-based practices will lead to improved birth outcomes over time.

Strategies:

- Support the development and implementation of collaborative quality improvement efforts in women's health, obstetrics, newborn health and infant health (e.g. Ohio Perinatal Quality Collaborative).
- Focus on one neonatal and one obstetric topic annually (via the Ohio Perinatal Collaborative) to facilitate the standardization of evidence-based care.
- Implement quality improvement activities to decrease late-preterm and early-term deliveries (avoid inappropriate elective deliveries prior to 39 weeks gestation).
- Assure Ohio's regionalized care system includes a quality assurance measurement requirement for yearly evaluation. This quality assessment performed by each perinatal region should include, but not be limited to, looking at appropriateness of deliveries and level of care for newborns based on maternity licensure levels of care.

Recommendation 9: Develop, recruit, train, monitor and support a diverse provider network.

Rationale: Adequate access to care starts with the availability of competent providers.

Strategies:

- Develop and implement a standardized education curriculum on prematurity and infant mortality required for prenatal and newborn health care providers (established by Board of Regents).
- Establish standardized competencies for all healthcare providers caring for the ill neonate in special care and neonatal intensive care units. Integrate with existing physician maintenance of certification requirements.
- Assure all Ohio child care providers demonstrate the competencies in the Health, Safety and Nutrition Module in the Ohio's Early Childhood Core Knowledge & Competencies document (e.g. safe sleep, child safety, nutrition and support for breast milk feeding).

Recommendation 10: Establish the Ohio Healthy Women, Mothers and Infants Consortium (OHWMIC) as successor to the current Infant Mortality Task Force (IMTF) to implement and monitor recommendations of the OHWMIC.

Rationale: Addressing the issue of infant mortality requires effective oversight. The OHWMIC will help ensure the effective implementation of the recommendations set forth by the IMTF. The consortium shall report to the governor. The consortium should be a broad-based, diverse group including parents/consumers and patients, as well as representatives from all health care fields.

Strategies:

- Oversee development and implementation of current and future recommendations.
- Prepare a biennial report for the governor, including a capacity study on supply and distribution of services to pregnant women, especially in areas of high infant mortality and an assessment of the financial factors that affect the implementation of the recommendations.
- Develop and maintain an accessible inventory of best/promising practices for reducing infant mortality in the state.
- Conduct ongoing needs assessment in infant mortality as part of the Maternal Child Health Block Grant activities (Title V).

NEXT STEPS

- Hold meeting to brief governor and staff on preliminary recommendations
- Make revisions based on the governor's comments
- Add/refine/prioritize strategies; identify agencies and budgets
- Post recommendations for stakeholder input
- Compile final results of surveys (research activities and infant mortality programs/initiatives) for final report
- Make final revisions
- Publish recommendations/strategies in final report due to the governor's office by Sept. 30, 2009

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Glossary of Terms

Baby Friendly Hospital Initiative - a worldwide program of UNICEF and the World Health Organization that promotes, protects, and supports breastfeeding, a component of which is the **Ten Steps to Successful Breastfeeding**

Centering Pregnancy® - a program of prenatal care that includes the establishment of a group of women/couples who participated in regular, facilitated meetings throughout their pregnancies to share learning and self-care activities, have group discussions and provide mutual support

CMS/Centers for Medicare and Medicaid Services - the federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program

CFR/Child Fatality Review - a collaborative process in which multidisciplinary, multiagency boards review child deaths to consider comprehensive information to determine the circumstances leading to the death and how best to respond as a community

City MatCH - a freestanding national membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States, with the mission to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities

Fetal Infant Mortality Review - a process in which multidisciplinary boards review fetal and infant deaths to identify the factors associated with these deaths, determine if they represent system problems that require change, develop recommendations for change and assist in the implementation of change

Inequity/Inequality - inequity refers to differences that are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all *inequities* are the product of unjust inequalities

Infant Mortality - the death of a child before its 1st birthday, measured by the number of deaths per 1,000 infants

Maternal and Child Health Block Grant Title V – the mission of the Maternal and Child Health (MCH) Block Grant Program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children, and their families. The Ohio Department of Health receives funding from the federal Maternal and Child Health Bureau to administer a Maternal and Child Health Block Grant

Medicaid Family Planning Waiver - a program designed to reduce unintended pregnancies and improve the well-being of children and families by extending eligibility for family planning services to women and sometimes men in specified age groups who meet the eligibility requirements for participation

Neonatal Intensive Care Unit (NICU) - a unit of a hospital specializing in the care of ill or premature newborn infants

Ohio Benefit Bank - a Web-based computer program to connect low- and moderate-income Ohioans with access to work supports such as tax credits, public benefits, health care coverage, home energy assistance, child care subsidies and Food Stamps

Ohio Connections for Children with Special Needs - the Ohio Department of Health's statewide program of reporting birth defects by all Ohio hospitals and informing parents of children with birth defects about resources that may improve their children's outcomes

Ohio Perinatal Quality Collaborative - a collaborative effort by Ohio care providers and hospitals to identify and apply effective methods to reduce preterm birth and morbidity and mortality for preterm infants in Ohio

Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (PEDIM ALC) - a multidisciplinary state/local team working to increase capacity of community, state and local entities to address the impact of racism on birth outcomes and infant health

PRAMS/Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments to collect state-specific, population-based data on maternal attitudes and experiences before, during and shortly after pregnancy

Telemedicine - a rapidly developing application of clinical medicine in which medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations

Prevention - in medicine, any activity that reduces the burden of death or sickness from disease; this takes place at primary, secondary and tertiary levels: **Primary prevention** avoids the development of a disease. Most population-based health promotion activities are primary preventive measures. **Secondary prevention** activities are aimed at early disease detection, thereby increasing opportunities for interventions to prevent progression of the disease and emergence of symptoms. **Tertiary prevention** reduces the negative impact of an already established disease by restoring function and reducing disease-related complications

