

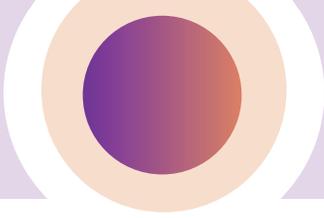


**Ohio Collaborative**  
to Prevent Infant Mortality

## Ohio Infant Mortality Reduction Plan 2015-2020



Turning up the  
**V**olume on  
Infant Mortality  
*Step Up to Catch Up!*



## Preface to the OIMRP:

Dear Ohioans,

In November of 2009 the introductory paragraph of a report prepared by the Ohio Infant Mortality Task Force read as follows:

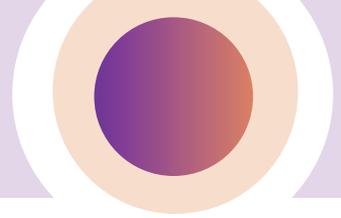
*“Despite continuing statewide and local efforts, Ohio’s infant mortality rate fails to meet the nationally established goal, exceeds the national rate and has not improved in more than a decade. Persistent disparities in birth outcomes and infant health within the first year of life exist between the population as a whole and certain subpopulations. Ohio recognizes that a new, science-based, coordinated approach to reducing infant mortality will create a better quality of life, assure healthier children, strengthen families and contribute to a more efficient and cost-effective use of medical services.”*

Unfortunately, the same paragraph could be written today. The Task Force was commissioned by former Governor Ted Strickland. It made a set of recommendations aimed at improving the rate that Ohio babies survive the first year of life and called for the formation of a statewide organization to assure that those recommendations were fulfilled. The oversight organization became the Ohio Collaborative to Prevent Infant Mortality (OCPIM). Now, six years later OCPIM, along with substantial support from Governor John Kasich, the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Chapter of the March of Dimes, and representation from numerous organizations, businesses, academic institutions, legislators, and individuals have worked together to develop this document, the first Ohio Infant Mortality Reduction Plan (OIMRP).

This same cadre of committed, passionate, and hard working Ohioans have been steadfast in their resolve to make certain that all babies, no matter their ethnic origin, economic status, political affiliation, urban or rural, from the north/south/east/or west, born to a family that is Right-to-Life or Pro-Choice, citizen or immigrant, insured or not, an adolescent or more mature mother who is single or married all deserve better from us. Simply put, OCPIM’s motto is that any baby who takes her or his first breath within the borders of Ohio deserves an optimal opportunity to live to celebrate their first birthday because “EVERY BABY MATTERS.”

Ohio history suggests that this motto has not always been embraced by our state. Nationally Ohio ranks #7 for the number of babies born within a state per year and, simultaneously, we rank amongst the worst in the nation for keeping our babies alive. In the most recent National Vital Statistics Report (NVSR) of 3-year aggregated infant mortality data from 2011-2013 Ohio was amongst the worst 10 states for overall, white, black, and Hispanic infant mortality rates AND Ohio was the only state to appear amongst the worst in all 4 of these groupings. (NVSR, Vol. 64, #9, August 6, 2015, Table #2) While all Ohioans are affected, the poor and African-Americans are disproportionately influenced by these high rates. Black babies in Ohio die at more than two times the rate of white babies and during the 3-year aggregate period of time from 2010-2012 no other state had a higher black infant mortality rate ([ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/DVS/periodlinked/LinkPE12Guide.pdf](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/periodlinked/LinkPE12Guide.pdf))

Since the formation of the 2009 Infant Mortality Task Force, much has occurred and, although Ohio’s infant mortality rates remain much too high, in 2013 Ohio’s overall and black infant mortality rates



achieved record low rates for our state and our white infant mortality rate attained the Healthy People 2020 infant mortality rate goal and tied its previous low rate of 6.0 (initially set in 2008).

These improvements would not have happened without the combined commitment of many individuals. This Ohio Infant Mortality Reduction Plan would never have been written if not for the incredible hard work of OCPIM membership and the Bureau of Maternal Child Health of ODH. While there is a long list of individuals who deserve recognition, special acknowledgment has to be given to the incredible leadership, inspiration, and insight of Ms. Karen Hughes, Mrs. Jo Bouchard, and Ms. Theresa Seagraves who each worked tirelessly to assure that this plan was completed.

All intervention strategies decay over time. This plan is no exception. Therefore, it is our hope that it will guide our infant mortality reduction efforts for the next five years. We anticipate that by 2018 we will need to begin revising our strategies and provide an updated plan by 2020.

It would be nice if all improvements occurred in a straight line and that the slope of that line was always steep, but that almost never happens. Setbacks occur. Improvements always take longer than we would like. Discouragement is an inevitable characteristic of this work. Nevertheless, we pursue these improvements with a sense of urgency because we are fighting for our babies...and this fight is literally about life or death. This harsh reality compels our efforts and constantly renews our commitment. Our responsibility is to help Ohio avoid all preventable infant deaths and disability, especially amongst those who are under-served or who experience health disparities. Please join our fight. Read the report and find a strategy within this plan that you can help individuals within your sphere of influence commit to because in Ohio...EVERY BABY MATTERS!

Sincerely,

Arthur R. James, MD, FACOG  
Co-Chair, OCPIM  
Associate Professor Department of Ob/Gyn and Pediatrics  
Ohio State University Wexner Medical Center  
Nationwide Children's Hospital

Lisa Amlung Holloway, MBA  
Co-Chair, OCPIM  
Director of Program Services & Government Affairs  
March of Dimes Ohio Chapter

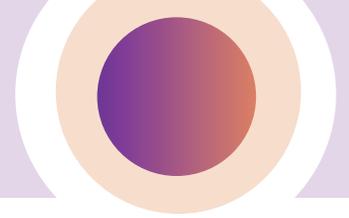




## Infant Mortality Reduction Plan 2015-2020

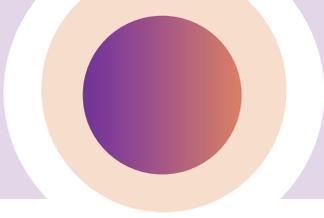
"The Ohio Collaborative to Prevent Infant Mortality would like to thank the numerous individuals and organizations that have assisted with gathering information and the writing of this infant mortality reduction plan. OCPIM's intent is that Ohio will come together in the spirit of collective impact to address this public health crisis."



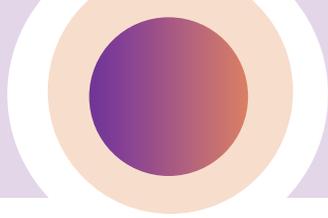


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## Introduction

Infant mortality is defined as the death of a live-born baby before his or her first birthday. The infant mortality rate is the number of babies who died during the first year of life per 1,000 live births. This rate is considered an important indicator of the overall health of a society. Ohio's 2013 infant mortality rate was 7.4 (7.4 infant deaths/1,000 live births). That means for every 1,000 babies born, more than seven died before they turned one year old.

Ohio's infant mortality rate is among the worst in the nation. Of particular concern are the disparities in birth outcomes for certain racial, ethnic groups and certain geographic areas in Ohio, with African-American babies being twice as likely to die in the first year of life as white babies and certain areas of urban and rural Ohio, especially Appalachia, representing locations of higher risk.

**“The core mission of public health is the reduction of the leading causes of preventable death and disability, with a special emphasis on the underserved population and health disparities. This is our perpetual north star.”**

— Public Health Leadership Forum/RESOLVE. The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist. May 2014.

## Causes of Infant Death

The three leading clinical causes of infant death are prematurity due to preterm birth (babies born too early), birth defects, and sleep-related deaths. Some risk factors, such as poverty, living in an under-resourced neighborhood, and smoking increase the risk of all three leading causes of infant death. There are many contributors to and risk factors for infant deaths including a woman's health before, during and after pregnancy as well as social determinants of health. Social determinants of health are non-medical factors that influence health outcomes, such as racism, poverty, poor nutrition, and poor education. This plan seeks to increase awareness and knowledge of the causes of infant deaths in Ohio and to identify and support initiatives to address those causes.

### Birth Outcomes in Ohio (2013)

There were 139,035 births in Ohio.

16,944 babies were born prematurely.

11,862 babies were born with low birth weight.

1,024 babies died before their 1<sup>st</sup> birthday.

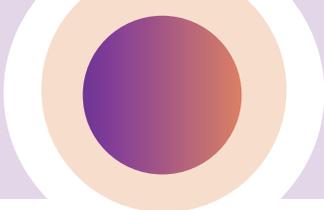
Source: 2013 Bureau of Vital Statistics Birth and Death Records, Ohio Department of Health

### Social Determinants of Health (SDOH)

The non-medical complex, social structures and economic systems that are responsible for most health inequities.

Social determinants are the root cause of health disparities!

Source: <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf>



## Major Risk Factors

### Social Determinants of Health

To be successful, Ohio's infant mortality reduction plan must address not only the clinical but also the socio-economic and racial inequities that drive disparities in infant deaths. Poverty and racism are major contributors to disparities in infant deaths. Efforts should be comprehensive and community-based to increase access, opportunity, and resources in high-risk areas and include addressing access to care, child care, employment, housing, educational success and community revitalization.

### Prematurity/Preterm Birth

The highest rates of infant death are for babies who are born too soon and too small. Babies at highest risk of being born prematurely are those whose mothers are non-Hispanic black, live in metropolitan counties or southeast Ohio Appalachian counties, had a previous preterm birth or poor birth outcome, delivered within 18 to 24 months of a prior pregnancy, or are low income (see Graph 3 in Appendix 2 page 37). Smoking is an important risk factor contributing to babies being born too early and too small. Smoking during pregnancy occurs too often in Ohio (Graph 6, Appendix 2, page 39) is most common among low-income women living in Ohio's Appalachian counties (see Graph 5 in Appendix 2, page 39).

### Birth Defects

Birth defects also contribute to babies being born prematurely and a few birth defects are not compatible with life. Some birth defects can be prevented by ensuring mothers are healthy before and during pregnancy; have adequate nutrition; take folic acid supplementation prior to pregnancy; controlling chronic health issues such as diabetes; maintain a healthy weight; achieve healthy birth spacing; and avoid alcohol, tobacco and certain drugs.

### Sleep-Related Deaths

Sleep-related deaths are the most common cause of death for infants from one month to one year of age. Babies are safest when breastfed and when they sleep alone, on their back, and in a crib without blankets, soft bedding, bumpers, stuffed animals and other items. Also, they need to be free from exposure to tobacco smoke. Educating Ohioans about safe sleep will help eliminate the three sleep-related infant deaths that occur each week in Ohio (Ohio Child Fatality Review 2006-2010).



### What is Health Equity?

Health equity represents the ability of marginalized groups to achieve optimal health.

Health inequity is defined as "a difference or disparity in health outcomes that is systematic, avoidable, and unjust."

### Did You Know?

Certain groups in Ohio face significant barriers to achieving the best health possible, including Ohio's poorest residents, persons with disabilities and racial and ethnic minority groups. Those most impacted by these barriers tend to have less access to resources like:

- Healthy food
- Good housing
- Good education
- Safe neighborhoods
- Freedom from racism and other forms of discrimination

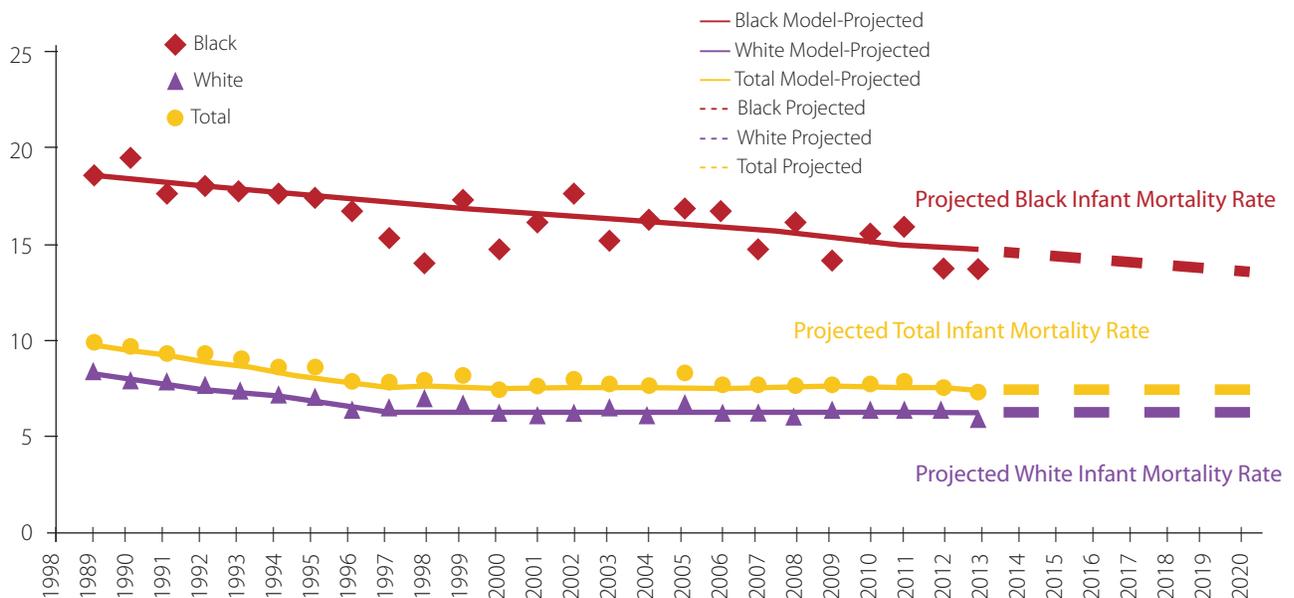
## Ohio's Challenge

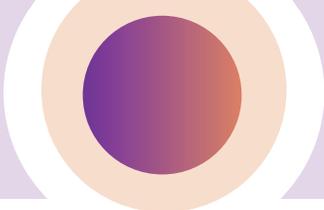
Healthy People 2020 challenges the nation to achieve an infant mortality rate of 6/1,000 by 2020. Ohio's strategies to address infant mortality and preterm birth are supported through statewide partnerships and include strengthening connections between families and community support systems; improving the quality of care provided to women before, during, and after pregnancy and to their infants after delivery; and aligning with statewide efforts to reduce sleep-related infant deaths. Through collaboration and a focus on eliminating disparities, all babies in Ohio can live to see their first birthday and celebrate day 366 of life.

Racial differences in infant mortality are one of the most significant disparities in public health. This racial disparity is found nationwide and is present even after considering known risk factors such as health behaviors, teen pregnancy, marital status, education, poverty and genetics. In Ohio, the infant mortality rate for non-Hispanic blacks has been more than twice the rate of non-Hispanic whites for as long as Ohio has recorded infant deaths by race. Ohio's black infant mortality rate ranks among the worst in the nation. (National Center for Health Statistics provides state-level infant mortality data by race).

The graph below shows the Ohio overall, white, and black infant mortality rates from 1989 to 2013 with actual rates shown by the "marks" and a trend line that shows the slope of the rates. In addition, the dotted lines show the projections of the trends out to 2020. These projection lines suggest what Ohio's infant mortality rates will be in 2020 if our current trends continue. This graph indicates that the black infant mortality rate has decreased at an estimated rate of 16 hundredths per 1,000 black live births per year. At this rate of decline, the black infant mortality rate will be 13.6 per 1,000 live births in 2020. The white infant mortality rate significantly decreased until about 1997 and has since seen no significant change. Using current trends, the white infant mortality rate will be 5.8 per 1,000 live births in 2020. Similar to white infant mortality, total infant mortality decreased until 1997 and then saw no significant change. At this rate the total infant mortality rate would be 7.3 per 1,000 live births in 2020. These data indicate that significant changes are needed to meet Ohio's 2020 infant mortality goals.

**Figure 1: Infant Mortality Rate, By Race and Year, Ohio, 1989-2013**





## Addressing Infant Mortality in Ohio

### The Ohio Collaborative to Prevent Infant Mortality (OCPIM)

The mission of the Ohio Collaborative to Prevent Infant Mortality (OCPIM) is to prevent infant mortality and improve the health of women of childbearing age and infants throughout Ohio by promoting optimal health for all women before and during their childbearing years, employing evidence-based approaches to the reduction of infant mortality, and educating Ohioans about having and raising healthy babies.

The OCPIM purpose is to assist in the development, guidance, recommendations, and implementation of strategies outlined in the 2015 Ohio Infant Mortality Reduction Plan (OIMRP).

In addition, OCPIM monitors and annually assesses the strategies and performance measures outlined in the plan, which incorporates recommendations from the Ohio Infant Mortality Task Force's 2009 report: *Preventing Infant Mortality in Ohio*. OCPIM is also an advocacy organization, promoting improved and optimal maternal and child health. Membership is open to agencies, organizations, groups, and individuals that have a commitment to the prevention of infant mortality and related disparities and/or advocacy related to these issues. The task force report and more information on OCPIM are available at <http://bit.ly/everybabymatters>.

### Economic Impact of Infant Mortality

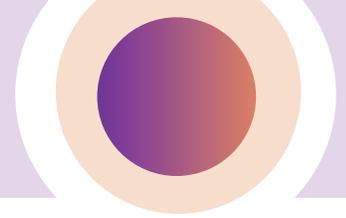
Infant mortality and poor birth outcomes have a significant financial impact on Ohio, although it is not easy to quantify that impact. Most of the information available addresses costs from low birth weight (babies born under 5.5 pounds or 2,500 grams) and preterm birth, a closely associated condition. Prematurity because (babies born before 37 weeks gestation) is the leading clinical risk factor for infant death in Ohio. The medical and social services that are required by premature, low birth weight and very low birth weight infants are significant and the costs are high to society and the American taxpayer.

- In 2013, 70,479 babies were born to mothers enrolled in Ohio's Medicaid program, accounting for 52% of live births in Ohio. Prenatal and delivery services totaled \$596,126,541 according to the Department of Medicaid.
- Low birth weight babies that survive the first year incur medical bills averaging \$93,800. First-year expenses for the smallest survivors average \$273,900 (March of Dimes).



"I knew that whatever I did affected my baby, from everything I ate to everything I felt. My husband passing away really, really stressed me out. I didn't want my child to be underweight or susceptible to illness because of what I was going through at the time. The OIMRI program gave me an outlet to work through my grieving process in the best way possible.

— Family participant at the 2014 Infant Mortality Summit



- Significant savings can accrue from enabling mothers to add a few ounces to a baby's weight before birth. An increase of 250 grams (about 1/2 pound) in birth weight saves an average of \$12,000 to \$16,000 in first-year medical expenses (March of Dimes).
- 16,944 babies (12.2% of live births) were born prematurely in 2013 (ODH Vital Statistics).
- Nationally, the average 2007 cost for premature babies was \$49,033 (March of Dimes).
- Prematurity affects 10% of babies covered by employer health plans (March of Dimes).

**None of these figures include:**

- The many thousands of dollars premature delivery, low birth weight, and infant death cost employers in absenteeism and lost productivity.
- The cost associated with maternity hospitalizations or long-term health problems and disabilities often experienced by babies born too early.
- Re-hospitalization costs, many other medical and social service costs and, when the child enters school, often large special-education expenses. These public expenses can go on for a lifetime (March of Dimes).



**Prevention presents an opportunity for considerable cost savings:**

- Prenatal interventions that result in a normal birth save \$59,700 in medical expenses in the infant's first year (March of Dimes).
- Analysis of vital statistics data of areas with the worst birth outcomes consistently reflect lower educational attainment, higher unemployment and lower median household incomes compared to areas with the best birth outcomes. Each of these is a social determinant of health.

## Life Course Perspective

The life course perspective is a framework used to describe the multidisciplinary approach to understanding the mental, physical, and social health of individuals. It includes events across the life span and life stages that impact an individual's health direction and outcomes. The life course perspective looks at health as an integrated continuum.

- Today's experiences and exposures influence tomorrow's health, socio-emotional development and intellect.
- Health outcomes are especially affected during critical or sensitive periods in our lives.
- Biological, behavioral, psychological, social, and environmental factors contribute to health outcomes.

### The Female Life Course

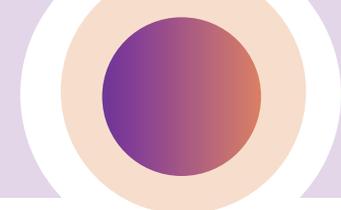


Source: <http://mchb.hrsa.gov/lifecourse>

## Collective Impact

The framework being used in Ohio to address infant mortality and disparities is collective impact, which brings people together in a structured way to achieve change. It starts with a common agenda, people coming together to collectively define the problem and create a shared vision to solve it. It establishes shared measurements, which means agreeing to track progress in the same way, allowing for continuous improvement. Collective impact fosters mutually reinforcing activities which means coordinating efforts to maximize the end result (Fay Hanleybrown, 2012). It encourages continuous communication that builds trust and relations among participants. It also requires the sharing of resources, information and data to overcome the multi-faceted challenges associated with infant mortality.

Finally, collective impact requires a strong backbone organization dedicated to orchestrating the work of the group. The Ohio Collaborative to Prevent Infant Mortality (OCPIM) is the organization dedicated to and leading efforts to address infant mortality in Ohio. The Ohio Department of Health (ODH) serves as the backbone agency for OCPIM.



## Socio-ecological Model

Using collective impact as the framework for addressing infant mortality allows the entire state to focus on the same strategies whether at an individual, community, or state level. The health of an individual is determined by more than their genetic makeup and the lifestyle choices they make. While both play a role in determining health outcomes, there are other structural and social forces individuals may have little control over that impact their health. The socio-ecological model describes the potential impact these structural and social forces have on infant mortality rates and how they contribute to disparities.

The socio-ecological model includes influences at a public policy, community, organizational, interpersonal and individual level. It highlights the different roles required to address a social health problem and can highlight the contributors to the disparities in social problems such as infant mortality.

At the heart of the model is the **individual** mother or infant. At the individual level, the socio-ecological model suggests that factors such as maternal stress, age of the mother and smoking have a direct impact on birth outcomes. Therefore, behavioral changes at an individual level are warranted. The disparities can be found as a result of the high levels of stress that often affect black women at a higher rate due to perceived racism, poverty and discrimination. These higher stress levels can lead to prematurity, low birth weight, and infant death. At an **interpersonal** level, support or lack of support from family, friends, and social networks contributes to positive or negative health and birth outcomes.

The next two levels of the model (**organizational, community**) take into account an individual's interactions with organizations and social institutions that contribute to their life circumstances. These levels might include interactions with health care agencies, educational systems, place of employment and income status. The community level of the model provides insight into health outcomes based on the impact of the relationships between individuals and their living environment. The quality of housing, environmental conditions in their local community (e.g., air quality in communities adjacent to highways, living near toxic waste dumps, homes with lead paint), and access to healthy foods all contribute to health outcomes. In Ohio, blacks are three times more likely to live in extremely poor neighborhoods compared to whites.

### In Reference to the 2014 Infant Mortality Summit:

"The event about infant mortality was an awesome experience. I learned so much about what

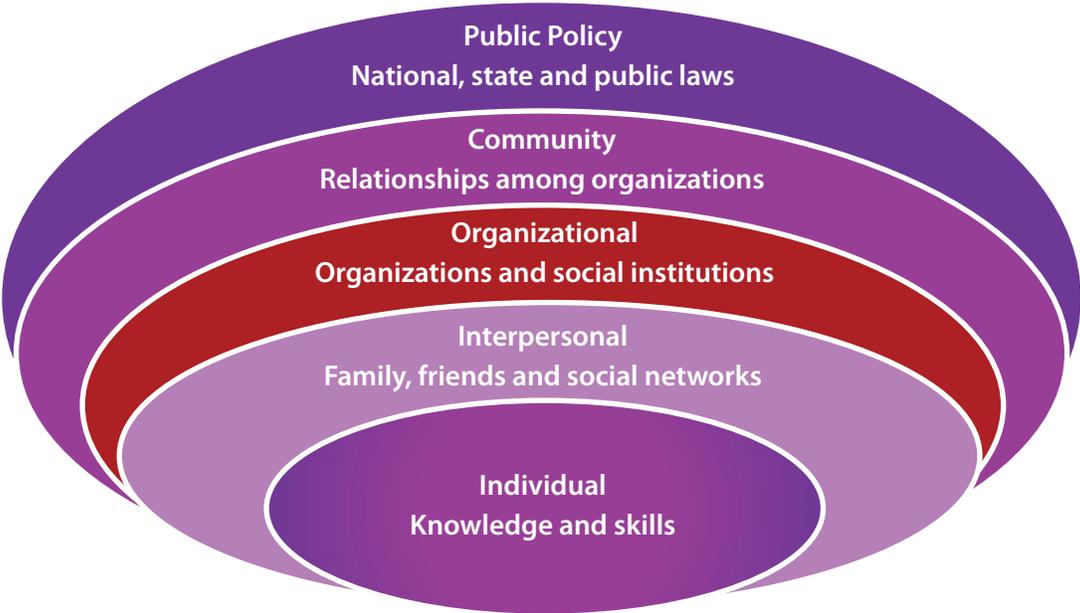


is better for an infant even my preemie when sleeping, nutrition, and health tips the total package to keep infants safe and alive, and the facts about the deaths of infant when not taken care of properly . . . Since the event I have joined a group in my community to help spread the facts to African-American women with infants and also grandparents, and baby sitters. Thank you so much for the experience. I would love to experience this again it has equipped me to help keep infants even my own infant safe and healthy. Thank you again for this empowering event."

*- Family participant at the 2014 Infant Mortality Summit*

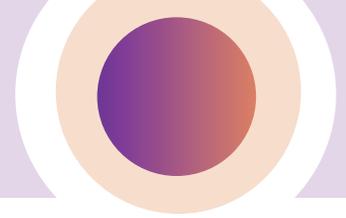
Finally, the **public policy** level of the socio-ecological model demonstrates how policies and initiatives at a national, state and local level can be a major contributor to health outcomes. Public health policies, funding, and models of treatment can have a direct impact on infant mortality in Ohio. The next section of this report will outline a few of the national, state and local policy efforts to address infant mortality.

**Figure 2: The Socio-ecological Model**



*Source: Ohio Statewide Health Disparities Collaborative and Kirwan Institute*





## Infant Mortality Public Policy

### National Level

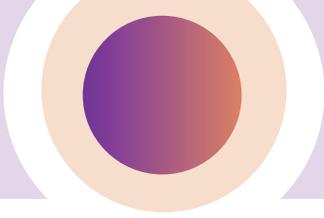
There is a nationwide movement to prevent babies from dying and to eliminate racial disparities in infant mortality. The U.S. Department of Health and Human Services Secretary's Advisory Committee on Infant Mortality (SACIM) was charged with developing recommendations for national strategies. The committee consists of expert members who represent diverse backgrounds and perspectives including public and private, federal, state, and local areas. The committee also collaborates with various national and federal agencies that work to address infant mortality.

SACIM uses the life course perspective (LCP) as a guiding framework for the development of its recommendations. The LCP views life not as disconnected stages but as an integrated continuum, recognizing that the current environment and historical experience of individuals influence their health outcomes. SACIM proposes six strategic directions or "big ideas:"

1. Improve women's health before, during, and after pregnancy.
2. Ensure access to a continuum of safe and high-quality, patient-centered care.
3. Redeploy key evidence-based, highly effective preventive interventions to a new generation of families.
4. Increase health equity and reduce disparities by targeting social determinants of health through both investments in high-risk, under-resourced communities and major initiatives to address poverty.
5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.
6. Maximize the potential of interagency, public-private, and multidisciplinary collaboration.

The use of the nationally recommended strategies has helped provide support for local, statewide, and regional efforts. It has also helped to fine-tune OCPIM's infant mortality reduction initiatives and further benefit the work of like-minded colleagues. The SACIM report and recommendations can be found at [www.hrsa.gov/advisorycommittees/mchbadvisory/Infantmortality/correspondence](http://www.hrsa.gov/advisorycommittees/mchbadvisory/Infantmortality/correspondence).

In addition to the SACIM recommendations, in 2013 the first-ever national strategy to address infant mortality was announced by the U.S. Department of Health and Human Services (HHS). This call to action included a partnership with state officials "to find out what works to reduce infant mortality and scale up the best interventions to the national level." The Infant Mortality Collaborative Improvement and Innovation Network (CollIN) is a major contributor to the national infant mortality improvement effort. The CollIN initiative aims to reduce infant mortality and disparities in birth outcomes by providing states with a mechanism for working together jointly on key strategy areas contributing to infant mortality and to show measurable improvements. Ohio is a partner in this national effort. Based on feedback from states, the six national CollIN Learning Networks are focusing on the strategies on the strategies below.



**Figure 3: CoIIN Strategies**

Social Determinants of Health	Reduce Smoking Before, During and/or after Pregnancy	Improve Safe Sleep Practices
Pre/Interconception Care	Prevent Preterm and Early Term Births	Risk Appropriate Perinatal Care

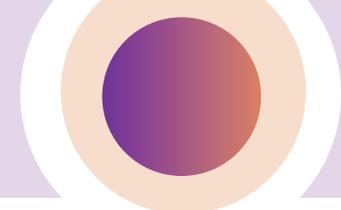
Ohio has elected to participate in three CoIIN strategies, highlighted in purple on the chart above: Social Determinants of Health, Prevent Preterm and Early Term Births, and Pre/Interconception Care. These strategies align with three of the strategic focus areas in this plan: Increasing Health Equity, Addressing the Social Determinants of Health and Eliminate Racism; Preventing Premature/Preterm Births; and Promoting Optimal Women’s Health Before, During and After Pregnancy. Nationally, these are referred to as the 3 Ss and the 3 Ps. Selection of these three strategic focus areas doesn’t mean that Ohio is not working on others, but working on these on a national level will be a way to help Ohio reach our goal.

In 2012, the director of the Ohio Department of Health, along with health directors of most states, signed the Association of State and Territorial Health Officials (ASTHO) President’s Challenge to reduce prematurity. By signing this national challenge, created in conjunction with the March of Dimes, the director agreed to:

- Publicly announce my state health agency’s goal to reduce the rate of premature birth by 8% by 2014 (measured against 2009 data).
- Initiate and support programs and policies that reduce the premature birth rate in my state.
- Build wider awareness of my state’s prematurity rates and other related MCH indicators.

Although Ohio failed to meet this 8% reduction goal, we continue to address prematurity as a major component of the complex infant mortality challenge.





### State Level

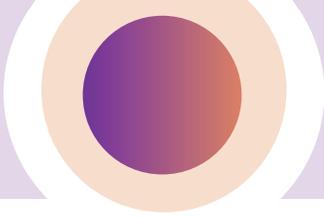
In 2009, former Governor Ted Strickland established a task force on infant mortality to make recommendations for improving infant mortality in Ohio. This task force led to the formation of the Ohio Collaborative to Prevent Infant Mortality to carry out these recommendations. State-level support of this priority remains strong. In March 2011, Governor John Kasich made reducing low birth weight babies a priority in his State of the State address and reinforced that priority again in 2012. The Governor’s Office of Health Transformation, working with Ohio’s Departments of Health, Medicaid, and Mental Health and Addiction Services and other human services agencies, initiated reforms to improve overall health system performance for pregnant women and infants. In combination, these initiatives focus on the areas that account for the majority of infant deaths: infants born prematurely, infants born with birth defects, and infants who die of sleep-related causes.

**On Dec. 4, 2014**, Gov. John R. Kasich previewed elements of his proposed Executive Budget with a group of 1,700 local leaders attending the 2014 Ohio Infant Mortality Summit sponsored by ODH in conjunction with OCPIM. At the event, the governor said the current infant mortality rate is “clearly unacceptable” and announced that the Ohio Departments of Health and Medicaid would work together to commit resources into the neighborhoods with the highest incidence of preterm birth and low birth weight babies. In the new biennial budget, Gov. John Kasich continues to support initiatives to reduce infant mortality. The State Fiscal Year 2016-17 budget contains important public health provisions that will help protect and improve the health of all Ohioans. These provisions include, but are not limited to:

- Focusing resources where the need is greatest to reduce infant mortality and save babies’ lives.
- Increasing the state’s capability to analyze and respond to infant mortality data.
- Investing in hepatitis surveillance.
- Expanding the ODH Lab’s molecular testing capabilities in support of infectious disease and foodborne illness investigations.
- Strengthening tobacco use cessation and prevention efforts.
- Strengthening Ohio’s preparedness for public health emergencies.
- Developing an ODH informatics infrastructure to convert public health data into actionable information.

**On June 30, 2015**, Gov. Kasich signed the state’s two-year budget (HB 64), which includes the Governor’s Dec. 4 proposal and additional reforms that focus resources where the need is greatest. The final version of the budget:

- Supports enhanced care management for women in high-risk neighborhoods and engages leaders in those neighborhoods to connect women to care,
- Creates a process to identify communities with the highest rates of infant mortality in order to prioritize and surge resources into those areas,



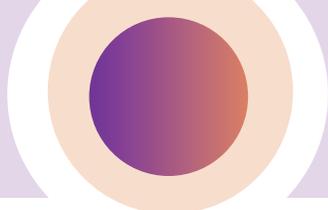
- Maintains current Medicaid eligibility levels for pregnant women,
- Covers additional services in home visitation for pregnant women and newborns, including cognitive behavioral therapy and depression screenings,
- Requires annual reporting on the effectiveness of Medicaid at meeting health care needs of pregnant women, infants, and children,
- Requires the Health Director to identify and report on performance of programs to reduce infant mortality,
- Improves the administration of Progesterone for at-risk mothers,
- Requires additional disease screenings for newborns,
- Provides funds for maternal and child health projects in Appalachia,
- Provides funding for evidence-based tobacco cessation programs for pregnant women in areas with high infant mortality rates and
- Conducts state infant and child fatality reviews.

Details on Gov. Kasich's budget can be found at:

<http://www.healthtransformation.ohio.gov/Budget/Budget20162017.aspx>

ODH-specific public policy initiatives included assembling public health partners and stakeholders as a planning council to complete a State Health Assessment (SHA) and from it developed the State Health Improvement Plan (SHIP) (see <http://www.odh.ohio.gov>). This process was completed in 2011 and generated a document to address the population health needs of the state. The process included input from a diverse array of multi-sectoral stakeholders and community partners and nine priorities emerged. Infant mortality and premature birth were one of the health improvement priorities identified. The strategies to address infant mortality in the SHIP include:

1. Implement or provide access to an evidence-based care coordination model.
2. Implement and spread quality improvement initiatives via the Ohio Perinatal Quality Collaborative (OPQC) to reduce infant mortality and birth outcomes disparities.
3. Partner with Ohio Injury Prevention Partnership (OIPP) and Child Injury Action Group to implement its action plan.
4. Continue to decrease the birth rate among 13 to 19 year olds in Ohio.
5. Address the effects of racism and the impact of racism on infant mortality.
6. Reduce the percentage of women who smoke during pregnancy.



While ODH has implemented many initiatives to address infant mortality, one of its major efforts focuses on the Ohio Institute for Equity in Birth Outcomes, known as OEI (Ohio Equity Institute). OEI is a partnership between ODH, select urban health departments, and CityMatCH (a national membership organization that supports urban maternal and child health efforts at the local level). The focus of OEI is to partner with nine (9) urban Ohio communities to improve overall birth outcomes through the implementation of evidence-based strategies to reduce the racial and ethnic disparities in infant mortality. During a three-year timeframe, these nine Ohio communities receive training as they select, implement, and evaluate equity-focused projects.



**Figure 4: OEI Teams**

- Butler County
- Canton – Stark County
- Cincinnati – Hamilton County
- Columbus
- Cleveland – Cuyahoga County
- Youngstown – Mahoning County
- Dayton – Montgomery County
- Summit County
- Toledo - Lucas County

This effort marks the first time that CityMatCH has worked to reduce disparities in birth outcomes in so many cities in a single state at the same time. The OEI communities focus attention in the urban areas where birth outcomes are the worst, called “hot spots” or “warm spots”(Figure 4). This effort has the potential to become a national template to enhance our country’s collective success in making measurable reductions in birth outcome inequities. OEI is one of the state’s major state and local partnerships to reduce infant mortality.

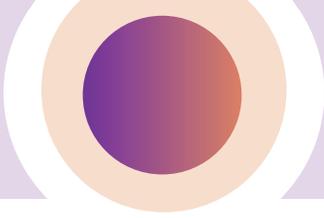
**Ohio Hospital Association**

In early 2014, the Ohio Hospital Association (OHA) established a goal to reduce the rate of infant mortality by five percent per year through 2016 by working with its statewide hospital membership to achieve an overall infant mortality rate of less than six infant deaths per 1,000 live births by 2020. OHA’s plan consists of six tactical focus areas: safe sleep, breastfeeding, access to care, birth spacing, progesterone use, and achieving 39 weeks gestation as the standard for pregnancy length. All these efforts are focused around the need for disparity reduction in Ohio’s African-American population.

**In Reference to the 2014 Infant Mortality Summit:**

“Our participants have verbalized to us that they are interested in participating in more activities and they had a wonderful learning experience . . . I would suggest that we have community sessions that explain some basic information to make the summit more grassroots friendly. It would be wonderful if we had a “canned” presentation that we can take to the communities in preparation for the next summit.”

*- Family participant at the 2014 Infant Mortality Summit*



## Medicaid Managed Care Plans

Ohio's Medicaid managed care plans (MCPs) are charged with leveraging their relationships with members and participating providers to reduce Ohio's rate of infant mortality. For example, all the managed care plans have incentives for patients to receive early and adequate prenatal and well child care. High-risk mothers are identified for care management services that include face-to-face visits and culturally competent outreach that includes developing a plan for any identified medical and behavioral health risks. This care plan is most successful when the managed care plans partner with communities to impact social determinants of health including literacy levels, stable housing, and transportation. Access to health care services and sub-specialists are a necessary but incomplete part of the equation in maintaining overall good health. MCP care managers may be positioned as trusted, nonjudgmental individuals to help members who may be challenged with drug and alcohol problems bridging inpatient and outpatient systems that may be difficult to navigate.

Finally, the MCPs use their historical and current data to identify those members who are most in need of interconception interventions. Helping members understand their intentions of pregnancy leads to better pregnancy spacing and preconception care. Disease management and care management of members with chronic disease and histories of poor birth outcomes also improves health in subsequent pregnancies.

## Perinatal Quality Improvement

Ohio is an award-winning national leader in addressing perinatal quality improvement which has led to improved clinical outcomes for mothers and babies. The Ohio Perinatal Quality Collaborative (OPQC) is a statewide consortium of perinatal clinicians, hospitals, policy makers and governmental entities that aims, through the use of improvement science, to reduce preterm births and improve birth outcomes across Ohio. Success comes from a collaborative approach that builds upon an established network of OPQC-member hospitals with a history of executing successful statewide quality-improvement initiatives. Current and past projects include improving the use of progesterone for women at risk of preterm birth, improving care for infants with neonatal abstinence syndrome (NAS), improving antenatal corticosteroids administration for women in preterm labor, decreasing late onset and bloodstream infections in babies in the NICU, increasing the use of human milk as medicine, and reducing 39 week scheduled deliveries. The state has invested over \$1.6 million in these efforts.

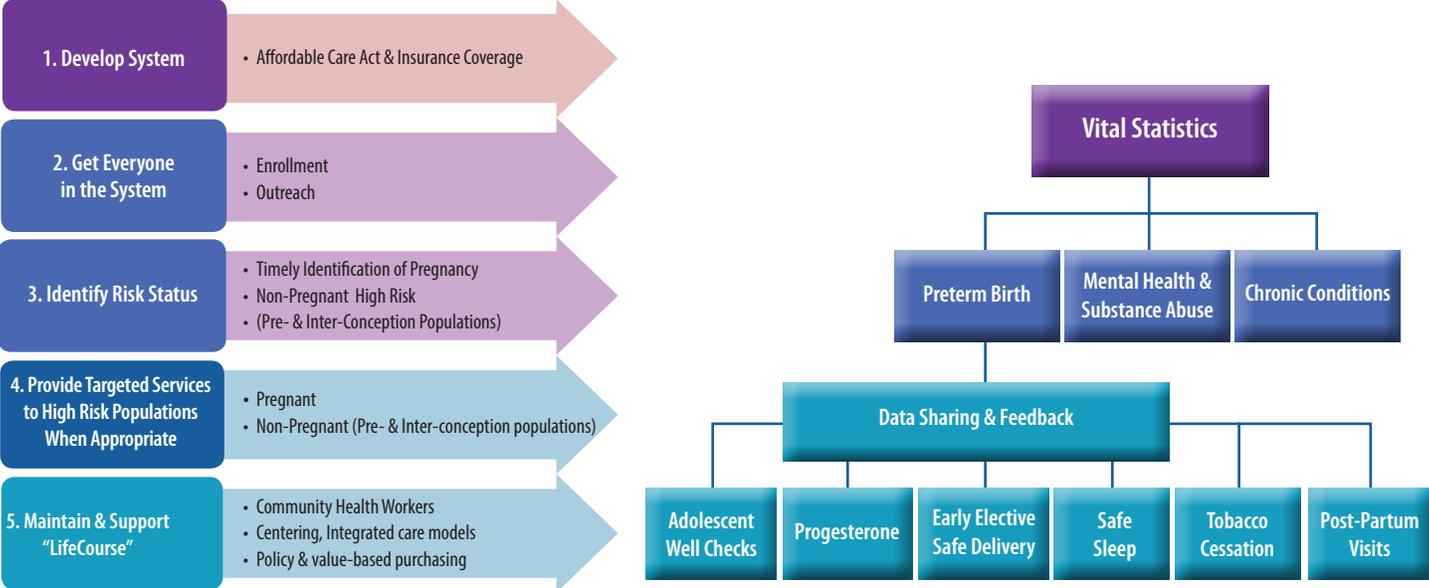
ODH also coordinates the Pregnancy Associated Mortality Review Program (PAMR), a state-wide committee of volunteer professionals from across a variety of different areas of expertise participating in an in-depth review of maternal mortality identifying the cause of death and its relationship to pregnancy, potential preventability, contributing factors, and gaps in care.

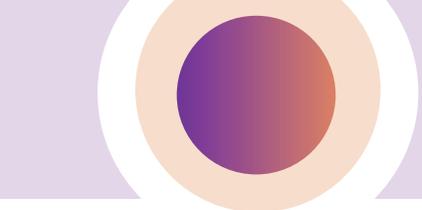
The Department of Medicaid (ODM) is contributing to improved birth outcomes in conjunction with state and community partners by focusing on continued outreach and enrollment in the Medicaid program as the foundation for the timely identification of high risk women and

the delivery of appropriate health care. Medicaid Managed Care Plans (MCPs) are responsible for the provision of enhanced reproductive health services for pregnant and non-pregnant women, particularly in the hot-spot regions, ensuring the integration of both physical and behavioral health care services. Reliably streamlining these processes can be described as delivering the “Best Baby Bundle” which is detailed in the table below. Additionally, Medicaid has partnered with The Ohio Department of Health (ODH) to link data systems to better identify high risk women and neighborhoods, with plans for measuring and reporting key outcomes on a quarterly basis. MCPs will deploy community workers as a strategy to remove barriers to the many challenges that face Ohio’s families, particularly as it relates to inequities in social determinants of health. Finally, Medicaid is leveraging value-based purchasing contract arrangements to bring a focus to this high-risk maternal population.

**Figure 5: Medicaid’s Best Baby Bundle**

**Ohio: Delivering the BEST BABY BUNDLE**





## Local Efforts

At the local level many stakeholders and partners are focused on reducing Ohio's infant mortality rate. For example, the health departments are leading the OEI efforts which have already been outlined. OCPIM commends and supports local efforts to address infant mortality and invites communities to OCPIM meetings to share information. Two examples of local community efforts include Cradle Cincinnati and the Greater Columbus Infant Mortality Task Force.

The Ohio Department of Health (ODH) leads Ohio's Fetal Infant Mortality Review (FIMR), a community-based, action-oriented process that continually assesses the causes of fetal and infant death and works to improve infant outcomes and provide resources for women, infants and families. It brings together a team of community members in each of eight urban counties to examine the factors that affect infant mortality. Highlighted below are additional initiatives that have an impact at the local level, with broad implications statewide.

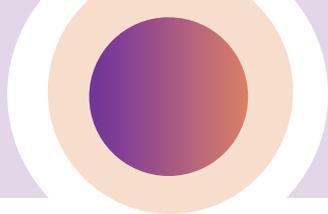
Child Fatality Review (CFR) is a powerful tool in both local and state-level efforts to address infant mortality. Coordinated by ODH, multi-agency boards in each of Ohio's 88 counties thoroughly review the circumstances around child deaths and put knowledge gained into action to prevent future deaths. Infants comprise 67 percent of child deaths reviewed in Ohio (2012 data from the 2014 CFR Report). Although the majority of infant deaths are not preventable, CFR boards recognize the detrimental effects of unhealthy lifestyles and poor prenatal care on the lives of infants. Because of CFR's unique ability to identify cases and the richness of the information, CFR has changed the way of thinking about sleep-related deaths, even on the national level. CFR data and findings have been a major compelling force in local, state and national initiatives to address sleep-related deaths. For more information: <http://www.odh.ohio.gov/odhprograms/cfhs/cfr/cfr1.aspx>.

In addition, as of 2014, Ohio has three new Healthy Start projects, bringing the state total to five: Cleveland (level III), Columbus (level II), Cincinnati, Dayton and Toledo (level I). Nationally, Healthy Start works to prevent infant mortality in 100 communities with infant mortality rates at least 1.5 times the national average and high rates of low birth weight, preterm birth, maternal mortality and maternal morbidity (serious medical conditions resulting from or aggravated by pregnancy and delivery). In these communities, HRSA funds community-based organizations, universities or local health departments to develop Healthy Start programs that improve women's health before, during and after pregnancy and help families care for their infants through their first two years so they are healthy and ready to learn. The Ohio Hospital Association (OHA) and Ohio's Medicaid managed care plans have major infant mortality efforts implemented in communities across Ohio.



"Dear Life Link, I found that Turning up the Volume on Infant Mortality was an enjoyable and educating event. The breakout sessions were quite useful not to just a few people but to the audience. It informed us on how society is affected by many different topics like drug use and infant mortality. Thank you for a wonderful time"

- Family participant at the 2014 Infant Mortality Summit



## Ohio's Call to Action: Too Many Babies Are Dying!

In May 2015, the Ohio House of Representatives adopted House Concurrent Resolution No. 12, declaring Ohio's rate of infant mortality "... a public health crisis that deserves significant and immediate action by all stakeholders ...". The resolution cited Ohio's infant mortality ranking as among the worst in the nation, with preterm birth as the leading cause of infant death. It further noted the high cost of prematurity and supported education and outreach, early prenatal care, and identification and treatment of women at risk of preterm delivery.

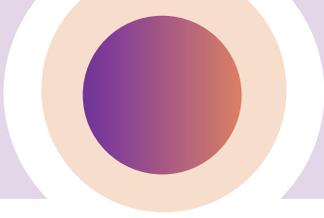


## Keeping Babies Alive is a Number-one Priority in Ohio

The implementation and monitoring of many of Ohio's infant mortality reduction efforts will be guided by OCPIM. OCPIM is calling on Ohio citizens, local communities, state/local, public/private agencies, and state leaders to work collaboratively to address Ohio's infant mortality crisis and reduce health disparities. Achieving health equity is central to every aspect of the work to be done.

The use of the life course perspective, the socio-ecological model and evidence-based or evidence-informed practices is the public-health approach OCPIM supports to have the greatest collective impact on the infant mortality crisis. All efforts will support community involvement to assure diverse perspectives are reflected in service initiatives. Efforts will focus on strengthening relationships with external partners and recognizing the importance of community-wide engagement to keep Ohio babies alive. Lastly, OCPIM will communicate openly and honestly about the work and outcomes, demonstrating the commitment to transparency in all its work.

Considerable efforts are occurring at the local, regional, state and national levels that can collectively benefit Ohio's efforts to reduce infant mortality. However, Ohio has not had a comprehensive statewide plan to help guide and measure its efforts. This plan will serve as the one strategic guide for Ohio. It provides a set of focused strategies that can be coordinated by various organizations while incorporating a response to the root causes of infant mortality. By working collectively, we can address this overwhelming issue and improve birth outcomes in Ohio. The Ohio Infant Mortality Reduction Plan is designed to guide infant mortality reduction efforts in Ohio. It should be used as a reference for those interested in making a positive contribution to the effort to keep babies alive in the state and to reduce the racial disparity in infant mortality.



## Ohio’s Overall Goal for Reducing Infant Mortality

From 2006 to 2013, the infant mortality rate in the United States decreased about 9 percent, from 6.7 deaths per 1,000 live births to 6.0, reaching the Healthy People (HP) 2020 target of 6.0 deaths per 1,000 live births. (Refer to Appendix 2, Graph 1, page 41.)

[https://www.healthypeople.gov/sites/default/files/HP2020\\_LHI\\_Mat\\_Inf\\_Child\\_0.pdf](https://www.healthypeople.gov/sites/default/files/HP2020_LHI_Mat_Inf_Child_0.pdf)

In January of 2013, the US Department of Health and Human Services Secretary’s Advisory Committee on Infant Mortality (SACIM) recommended that the nation reconsider its HP 2020 objective and strive for an overall rate of 5.5 deaths per 1,000 live births by 2015 and 4.5 deaths per 1,000 live births by 2020.

In Ohio, the infant mortality rates (IMR) for 2013 were 7.4, 6.0, and 13.8 for all races, white, and black infant mortality respectively; this results in a relative disparity (or disparity ratio) of 2.3 for black and white infants. OCPIM recommends that Ohio take an aggressive approach in establishing objectives for reducing infant mortality to help us catch up to the rest of the nation so Ohio is no longer among the worst states for infant mortality. While the ideal scenario is the elimination of disparities, given Ohio’s wide gap between white and black infant mortality, decreasing this gap during the next five years (with long-term aspirations to eliminate this disparity) is a more realistic approach.

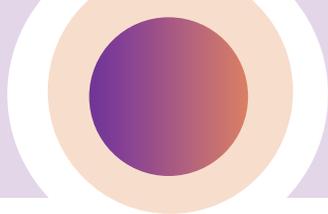
Approximately 140,000 births occur each year in Ohio, 104,000 of which are white. This group has more influence on the overall infant mortality rate than any other segment of the population and as of 2013, has achieved the HP-2020 objective of 6.0. Given these facts, OCPIM suggests that Ohio strives to accomplish the SACIM suggested objective of 4.5 for white deaths per 1,000 live births by 2020.

HP2020 suggests a rate of 6.0 deaths per 1,000 live births and that is what we suggest Ohio strive for by 2020 for Ohio’s black infant mortality rate objective. Ohio’s eventual goal is to eliminate disparities in infant mortality, however moving toward equity in this area by establishing an objective of 6.0 by 2020 seeks to reduce the relative disparity between black and white infant mortality from 2.3 to 1.3.

To set a 2020 objective for overall infant mortality in Ohio, the actual numbers of white and black infants born in 2012 were used to calculate what the overall infant mortality rate would be if the white and black infant mortality objectives were met. In 2012, if white IMR were 4.5 and black IMR were 6.0, the overall IMR (including all races) would have been 4.8 per 1,000 live births.

**Figure 6: Ohio’s Infant Mortality Reduction Objectives**

Ohio’s Infant Mortality Reduction Objectives for 2020	
4.5/1,000	For white infants
6.0/1,000	For black infants
4.8/1,000	Overall



## Strategic Focus Areas

The strategies to address infant death should be multisector, public and private collaborations. They must engage consumers by embracing the life course perspective and social determinants of health while advancing care coordination and service integration. The strategies must also be data-informed and measured.

To accomplish these strategic focus areas, outreach and education are key components of infant mortality prevention. As with any major public-health challenge, those in leadership positions and the public at large need to be made aware of the problem and get behind the movement in order to effect the widespread changes needed to achieve significant progress. Finally, Ohio's women and men of childbearing age, their families and caregivers of their infants must be encouraged and helped to develop a much higher level of knowledge than currently demonstrated about reproductive planning, preconception health, maintaining a healthy pregnancy, and promoting health and safety for infants. Each strategic focus area will include outreach and education to achieve objectives so that activities are prioritized and resources are maximized to move ahead strongly in this effort.

At the state level, Ohio is committed to increasing the state's capability to analyze and respond to infant mortality data by:

- Seeking funding to help increase the state's capability to analyze and respond to infant mortality data.
- Using vital statistics data within its data warehouse to inform Ohio's infant mortality reduction initiatives.
- Increasing analytical capacity and evaluation of infant mortality data, particularly at the local level, by epidemiologists to ensure that infant mortality efforts are data-driven and outcomes-based.
- In addition to outreach, education and increasing Ohio's data capacity, OCPIM has identified the following seven strategic focus areas, specifically geared towards reducing infant mortality in Ohio.





## 1. Improving Health Equity, Addressing the Social Determinants of Health and Eliminating Racism

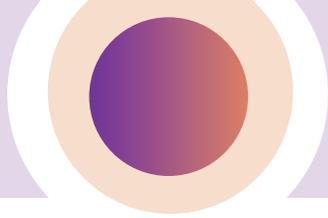
- a. Develop and support strategic partnerships among public, nonprofit, and private entities that address the social determinants of health, especially in the areas of educational attainment, employment, poverty, income, housing, healthcare, racism and safety.
- b. Increase diversity and competency of the healthcare and allied health workforce through recruitment, retention and training of individuals from racial and ethnic minority and culturally diverse communities.
- c. Ensure the availability and use of a wide array of data sources (e.g., healthcare, demographic, economic, market research) to enhance data-driven decision-making for policy and program development to achieve health equity in birth outcomes.
- d. Build capacity at all levels of decision-making to include local community members for community-based solutions to eliminate disparities in infant mortality.
- e. Improve funding and resource allocation to build and sustain partnerships, community-based initiatives, programs and services in local communities that function to achieve health equity.



## 2. Promoting Optimal Women's Health Before, During and After Pregnancy

- a. Increase access to quality health care among female adolescents and women.
- b. Continue support in extending the Medicaid benefit to all below 138 percent of the Federal Poverty Level.
- c. Increase the screening, identification, intervention and treatment of women at risk for mental health issues, addiction and domestic violence.
- d. Increase the proportion of pregnancies that are planned.
- e. Targeted, evidence-based prenatal and postpartum home visiting and care coordination programs for at-risk women that refocus to drive specific outcomes (e.g., post-partum visits, infant well checks and immunizations).
- f. Support policies, procedures and services to increase exclusive breastfeeding for all babies.





### 3. Preventing Premature Births

- a. Increase providers and educators who emphasize preconception care.
- b. Increase providers who conduct comprehensive medical and psychosocial risk assessment throughout pregnancy and modify care as a result of findings.
- c. Increase the number of women, men and youth who develop a reproductive life plan.
- d. Ensure appropriate management of chronic medical disorders before, during and after pregnancy by developing partnerships among private and public insurers, public health care agencies, community health centers and quality-care improvement initiatives.
- e. Increase the screening, identification, and treatment of pregnant women at risk for preterm delivery.
- f. Reduce late entry into prenatal care.



### 4. Preventing Birth Defects

- a. Implement statewide newborn screening for critical congenital heart disease, monitor and reconcile screening data, and track babies with failed screening results.
- b. Develop and release a new Ohio Connections for Children with Special Needs (OCCSN) birth defects information system at ODH with improved capacity to collect timely and accurate data for research/epidemiologic use (e.g., prevalence rates for specific disorders; conditions-specific mortality rates) and to facilitate referrals to local services such as early intervention to improve health outcomes for infants and toddlers with birth defects.
- c. Collaborate with public and private organization partners to develop a pilot project promoting the use of a reproductive life plan tool by women's primary-care providers.
- d. Collaborate with public partners to promote the 5A's of weight control (a brief intervention counseling method) for obese women of childbearing age in targeted geographic areas of the state.
- e. Collaborate with OCPIM partners to promote preconception/interconception health strategies among women of childbearing age.



### 5. Promoting Optimal Infant Health

- a. Support policies, procedures and services to promote infant health, (e.g., safe sleep, breastfeeding, immunizations, special health needs, neonatal abstinence, violence and injury prevention).
- b. Offer trainings and resources to prenatal care providers, pediatric health care providers, hospitals, child care centers and providers and home visiting programs to promote optimal infant health.
- c. Promote community engagement and ownership in promoting optimal infant health at the local level across Ohio.



## 6. Reducing Smoking Before, During and After Pregnancy

- a. Increase access to evidence-based cessation services and resources for families.
- b. Increase access to tobacco-free education activities for adolescents.
- c. Implement policies that support prevention and cessation for adolescent and adults.
- d. Increase the workforce to assist families with evidence-based interventions to reduce smoking.
- e. Increase public sensitivity to and awareness of women not smoking, avoiding, and ceasing all forms of tobacco and nicotine in childbearing years.
- f. Support systems-level infrastructure changes that support prevention and cessation.



## 7. Promoting Fatherhood Involvement in Maternal and Child Health

- a. Increase awareness with individuals and organizations across all sectors of society (business, civic, government, faith) regarding the importance for children to have involved and committed fathers present.
- b. Evaluate existing fatherhood and male involvement programs and curricula, as well as identifying best practices that further validate the significant role of the father in MCH.
- c. Increase efforts to include young men in reproductive health initiatives.
- d. Promote the inclusion of culturally appropriate males as home visitors or community health providers in evidence-based or promising-practice programs for the purpose of engaging the at-risk father.
- e. Create opportunities for men that allow them to discuss lessons learned, give advice, and share wisdom that can be passed onto others.

These seven Strategic Focus Areas recommended by OCPIM consist of interventions in the mid and bottom tiers of the CDC Health Impact Pyramid. The CDC suggests that interventions at the top tiers are designed to help individuals rather than entire populations, although they could have a population impact. In practice, however, even the best programs at the pyramid's higher levels achieve limited public health impact, largely because of their dependence on long-term individual behavior change.

The bottom tier of the health impact pyramid represents changes in socioeconomic factors (e.g., poverty reduction, improved education), also known as the social determinants of health, that help form the basic foundation of a society.

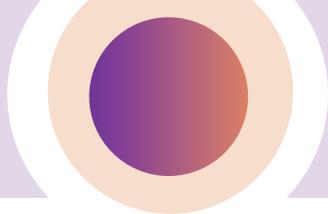
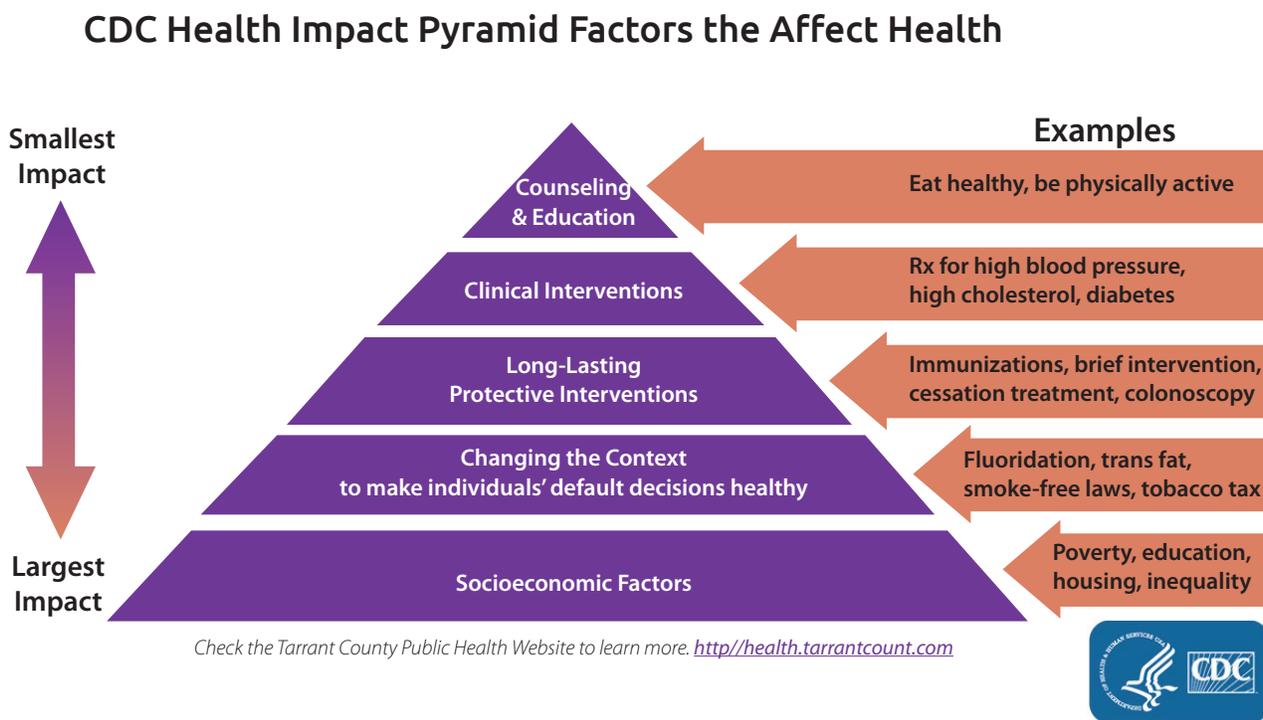


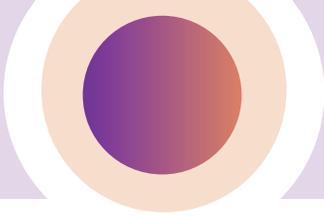
Figure 7: CDC Health Impact Pyramid



The strategies must be data-informed and measured. At the state level, Ohio is committed to increasing the capability to analyze and respond to infant mortality data by:

- Supporting the effort to reduce infant mortality, the Ohio Department of Health will work to improve data collection and epidemiologic capacity. High-quality data collection systems and skilled epidemiologists to analyze and interpret complex data are essential to inform program and policy decisions.





## What You Can Do Now

<http://www.odh.ohio.gov/odhprograms/cfhs/octpim/fs.aspx>

### Together, we can:

- Provide culturally sensitive information to staff and patients on a variety of topics that affect a woman’s health and her baby’s health such as obesity/nutrition, alcohol/tobacco/drug use, physical activity, safe pregnancy spacing, breastfeeding and safe sleep for infants.
- Provide cultural diversity training for staff.
- Develop partnerships with community and government organizations to address the health needs of women of childbearing age in the community.

### Hospitals and Health Systems

- Support and initiate collaborative quality improvement efforts in areas that affect prenatal and infant care in the hospital setting including progesterone.
- Participate in the First Steps Breastfeeding Initiative. <http://bit.ly/ohiofirststeps>
- Implement Centering Pregnancy. <http://bit.ly/centeringpregnancy>
- Implement the 5A’s brief counseling intervention for smoking cessation system-wide.

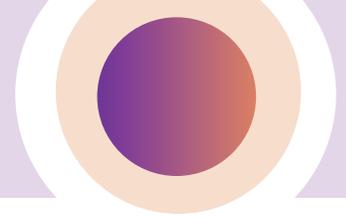
**Figure 8: The 5A’s Smoking Cessation Intervention**

The 5A’s Brief Counseling Intervention	
1.	Ask: ask about tobacco use every time
2.	Advise: advise to quit
3.	Assess: assess willingness to quit
4.	Assist: assist in ways to quit
5.	Arrange: arrange for a follow-up during subsequent visits

<http://bit.ly/IMQuitsmoking>

### Local Health Departments

- <http://bit.ly/ohiolocalhd>
- Provide health screenings/tests and referral information to residents.
- Increase public utilization of resources such as the Ohio Benefit Bank to assist women and children with obtaining health care services.
- Implement Centering Pregnancy.
- Implement the 5A’s brief counseling intervention for smoking cessation.
- Provide safe sleep and breastfeeding support.



## **Community-based Organizations**

- Offer evidence-based services that reduce the risk for infant mortality/pre-term births such as community health workers or home visiting programs.
- Engage fathers and other support people.
- Implement smoke-free policies.

## **Professional Organizations**

- Support and initiate quality improvement efforts in areas that affect prenatal and infant care in the health-care setting including progesterone.
- Develop partnerships with state and local organizations to collaborate on broad issues affecting the health of women of childbearing age and infants.

## **Employers**

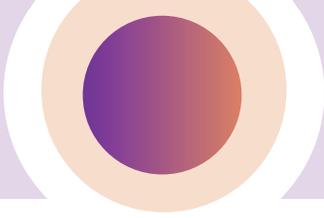
- Provide quality health insurance benefits to employees including preventive health, medical, prescription medications, and dental and mental health services.
- Support employees by providing maternity leave, leave for medical appointments, and an appropriate environment for breastfeeding mothers.
- Support programs that promote the importance of fathers in pregnancy and parenting.

## **Schools and Universities**

- Promote curricula to help young students understand reproductive health and the consequences of their lifestyle choices on their health and the health of their future children.
- Promote curricula on the important role of fathers in pregnancy and parenting.
- Provide opportunities for students to learn about careers in health care fields.
- Adopt smoke-free policies.

## **Faith-based Organizations**

- Offer space for meetings or health fairs.
- Encourage members to volunteer with their local hospital, health department or other community services agencies.
- Support programs that promote the important role of fathers in pregnancy and parenting
- Offer supportive breastfeeding opportunities.
- Adopt smoke-free policies.



## Physicians

- Maximize opportunities to discuss preconception health with patients and their families.
- Educate yourself and your staff about resources and referral agencies available in your community to screen and refer patients for mental health services, smoking cessation, substance abuse treatment, Medicaid, WIC, food pantries, lactation support, child care, etc.
- If you are a women's health provider – encourage women to schedule appointments for preconception counseling and early prenatal care.
- Encourage implementation of the 5A's brief counseling intervention for smoking cessation.
- Encourage men and women to develop a reproductive health plan.

## Ohioans

- Make sure you and your partner are as healthy as possible before becoming pregnant.
- Encourage friends and family members of childbearing age to be as healthy as possible before becoming pregnant.
- Volunteer and support your local hospital, health department, community clinic, faith community, or community services agency in their efforts to promote good pregnancy outcomes and healthy babies.
- Support your friends and family members who have recently had a baby by encouraging safe sleep practices and breastfeeding and by helping them get to follow-up appointments.  
<http://bit.ly/IMsafesleep>
- Develop reproductive life plans that include nutrition, physical fitness and smoke free planning.

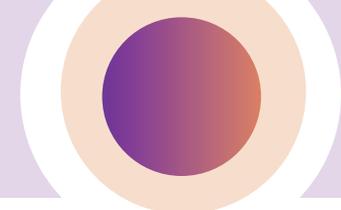
## Communication and Reporting

The Ohio Collaborative to Prevent Infant Mortality (OCPIM), <http://1.usa.gov/1tcHnIW> as the statewide organization with the mission of preventing infant mortality, improving the health of women and infants, and educating Ohioans about having and raising healthy babies, will provide regular communication on matters pertinent to infant mortality reduction/prevention to all members and stakeholders via e-mails, website updates, and sharing at OCPIM meetings. OCPIM members will share pertinent information at OCPIM meetings and by other means as appropriate.

OCPIM will oversee the creation of an annual progress report to be submitted to its members/ member organizations, the Office of Health Transformation (OHT), ODH and other organizations interested in the reduction of infant mortality and disparities.

A scorecard will be created for reporting on progress toward decreased infant mortality and disparities. Adjustments to the Ohio Infant Mortality Reduction Plan may be made based on scorecard results.

Anyone interested in becoming a member of OCPIM may apply to do so by simply filling out a membership form and committing to work on one of the Action Groups. To learn more about OCPIM and to obtain a membership form, you may go to this link: <http://bit.ly/everybabymatters>.



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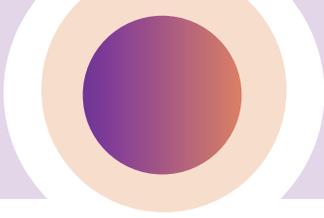
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## Appendix 1: Ohio Infant Mortality Strategic Focus Area Work Plan

### Introduction:

The mission of the Ohio Collaborative to Prevent Infant Mortality (OCPIM) is to prevent infant mortality and improve the health of women of childbearing age and infants throughout Ohio. OCPIM will accomplish its mission by promoting optimal health for all women before and during their childbearing years, employing evidence-based approaches to the reduction of infant mortality, and educating Ohioans about having and raising healthy babies.

The OCPIM purpose is to assist in the development of, and provide guidance and recommendations regarding implementation of, objectives outlined in the Ohio Infant Mortality Reduction Plan (OIMRP). In addition, OCPIM will monitor and annually assess the strategies, measurable outcomes and indicators outlined in the attached work plan.

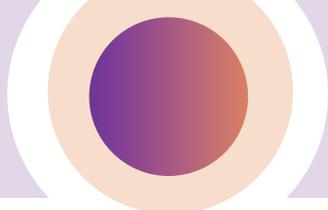
### Using this Work Plan

This work plan identifies the strategies, activities, and measurable outcomes or indicators for each of the seven Strategic Focus Areas in the plan. Each Strategic Focus Area begins with the issue to be addressed, indicates if it aligns with a National Infant Mortality COIIN Strategy, provides a description of the issue, and lists a broad goal statement. OCPIM Action Groups will work with the appropriate state agency to identify activities and measurable outcomes and indicators to address the strategies under each Strategic Focus Area. This plan will be monitored quarterly.

- **Group/Agency Responsible:** Refers to the OCPIM organization or state agency that is the lead for a particular strategy.
- **Status:** A color-coded dot in this area indicates the overall status of the strategy according to the following color-coded key:



- **Activities:** Provides an overview of the interventions being used to address the issues related to the Strategic Focus Area. Specific action plans will be developed for each Strategic Focus Area with further detail regarding timeline and accountability.
- **Measurable Outcomes or Indicators:** Provides specific “critical success factors” associated with a strategy that can be used to assess overall success regarding the implementation of the activities. Measurable outcomes or indicators help determine the progress made in achieving the goal of the Strategic Focus Area.



## Strategic Focus Area 1: Improving Health Equity, Social Determinants of Health and Eliminating Racism.

**Aligns with National COIIN Strategy—Social Determinants of Health.**

**OCPIM Action Group Co-Chairs: Celeste Smith, MS, PC and Teleangé Thomas, BS**

**OCPIM Action Group State Lead: Vivian Jackson Anderson and Robyn Taylor**

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work and age that can contribute to or detract from the health of individuals and communities. Social determinants such as poverty, low socioeconomic status, unfair housing, unequal treatment, lack of access to care and to quality care, institutionalized racism, minority status stressors, etc., that exist because of race can adversely impact birth outcomes.

**Goal:** By 2020, reduce disparities in poor birth outcomes by addressing the social determinants of health.

Strategy
<b>1.1.</b> Develop and support strategic partnerships among public, nonprofit and private entities that address the social determinants of health, especially in the areas of educational attainment, employment, poverty, income, housing, healthcare, racism and safety.
<b>1.2.</b> Increase diversity and competency of the healthcare and allied health workforce through recruitment, retention and training of individuals from racial and ethnic minority and culturally diverse communities.
<b>1.3.</b> Ensure the availability and use of a wide array of data sources (e.g., healthcare, demographic economic, market research) to enhance data-driven decision-making for policy and program development to achieve health equity in birth outcomes.
<b>1.4.</b> Build capacity at all levels of decision-making to include local community members for community-based solutions to eliminate disparities in infant mortality.
<b>1.5.</b> Improve funding and resource allocation to build and sustain partnerships, community-based initiatives, programs and services in local communities that function to achieve health equity.





## Strategic Focus Area 2: Promoting Optimal Women’s Health Before, During and After Pregnancy

**Aligns with National COIIN Strategy—Preconception and Interconception Care.**

**OCPIM Action Group Co-Chairs: Pat Gabbe, MD and Brad Lucas, MD, MBA, FACOG**

**OCPIM Action Group State Lead: Michelle Clark and Molly Kelly**

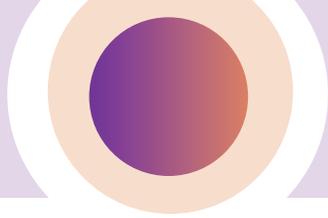
Few things are more critical to the health of the next generation than to improve the health of women of reproductive age prior to conception. Ohio is on the right track with Medicaid Expansion, emphasis on clinical preventive services, innovations to better serve those covered by Medicaid, and community and preventive services investments. Women need clinical services, community services, and social supports to empower them to achieve optimal health and fulfill their reproductive health goals. Effective implementation of such efforts will result in improved birth outcomes, optimal health for infants, and reduced infant morbidity and mortality.

**Goal:** By 2020 increase the number of women enrolled in health insurance and that receive preconception and inter conception care.

### Strategy

- 2.1. Increase access to quality health care among female adolescents and women.
- 2.2. Continue support in extending the Medicaid benefit to all below 138% of the Federal Poverty Level.
- 2.3. Increase the screening, identification, intervention and treatment of women at risk for mental health issues, addiction and domestic violence.
- 2.4. Increase the proportion of pregnancies that are planned.
- 2.5. Implement targeted, evidence-based prenatal and postpartum home visiting and care coordination programs for at-risk women that refocus to drive specific outcomes (e.g., post-partum visits, infant well checks and immunizations).
- 2.6. Support policies, procedures and services to increase exclusive breastfeeding for all babies.





### Strategic Focus Area 3: Preventing Premature/Preterm Births

**Aligns with National COIIN Strategy—Prevent Preterm and Early Term Births**

**OCPIIM Action Group Co-Chairs: Sarah Redding, MD, MPH and Jay Iams, MD**

**OCPIIM Action Group State Lead: Lori Deacon and Julie Roemke**

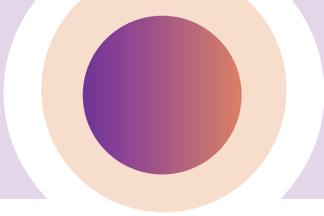
Racial/ethnic disparities in infant mortality have persisted during the last several decades and are a major reason infant mortality remains a focal public health issue. Of special concern are the very high rates of infant death among non-Hispanic black women. In particular, the risk of infant death for babies born to non-Hispanic black women has consistently been more than two times greater than the risk of infant death for non-Hispanic white women for decades. Studies of the racial/ethnic disparities in fetal, infant and maternal mortality suggest that not all race/ethnic groups have benefited equally from social and medical advances.

Preterm birth (prior to 37 weeks gestation) is a factor driving disparities in infant mortality. Higher infant mortality rates for non-Hispanic black women and Puerto Rican women in the United States compared to non-Hispanic white women are largely due to higher rates of preterm birth and preterm related causes of death in these populations.

Importantly, although we emphasize preterm birth, other major causes of death in the first year of life include congenital malformations, Sudden Infant Death Syndrome (SIDS, now expanded to include Sudden Unexpected Infant Death - SUID), maternal complications, and unintentional injuries. More than half of infant deaths are attributable to these five leading causes.

**Goal:** By 2020, increase the number of those at risk for a poor birth outcome or infant death who have a targeted intervention.

Strategy
<b>3.1.</b> Increase providers and educators who emphasize preconception care.
<b>3.2.</b> Increase providers who conduct comprehensive medical and psychosocial risk assessment throughout pregnancy.
<b>3.3.</b> Increase number of women and men who develop a reproductive life plan, including school health classes.
<b>3.4.</b> Ensure appropriate management of chronic medical disorders before, during and after pregnancy by developing partnerships among private and public insurers, public health care agencies, community health centers and quality care improvement initiatives.
<b>3.5.</b> Increase the screening, identification, and treatment of pregnant women at risk for preterm birth.
<b>3.6</b> Reduce late entry into prenatal care.
<b>3.7</b> Decrease the rate of preterm births by 10% before 37 through the use of progesterone, while also enhancing the detection of women who have qualifying conditions for progesterone by improving training for technicians to use trans-vaginal ultrasonography (TVU).



### Strategic Focus Area 4: Preventing Birth Defects

**OCPIM Action Group Co-Chairs: Connie Motter, MS, LGC, Larisa Rippel, MS, LGC, and Katie Ziegler, MS, CGC**

**OCPIM Action Group State Lead: Anna Starr and Norma Ryan**

Birth defects are one of the leading causes of infant mortality and contribute significantly to prematurity, as well as long-term disability. While not all birth defects can be prevented, there are strategies that our state can promote and deploy to educate women of childbearing age on how to maximize their chance of having a healthy baby. These strategies will ensure that state-mandated newborn screening programs work toward early identification and treatment for disorders that can cause permanent disability and death in some cases, and that Ohio has accurate and timely data to describe the burden of birth defects in our state and to provide data to drive targeted messages to at-risk populations.

**Goal:** By 2020, reduce the number of babies born with birth defects amenable to prevention strategies, through data-driven, targeted activities and messages.

Strategy
4.1. Implement statewide newborn screening for critical congenital heart disease; monitor and reconcile screening data; track babies with failed screening results.
4.2. Develop and release a new OCCSN birth defects information system at ODH with improved capacity to collect timely and accurate data for research/epidemiologic use (e.g., prevalence rates for specific disorders, condition-specific mortality rates) and to facilitate referrals to local services such as early intervention to improve health outcomes for infants and toddlers with birth defects.
4.3. Collaborate with public and private organization partners to develop a pilot project promoting the use of a reproductive life plan tool by women’s primary care providers.
4.4. Collaborate with public partners to promote the 5A’s of weight control (a brief intervention counseling method) for obese women of childbearing age in targeted geographic areas of the state.
4.5. Collaborate with OCPIM partners to promote preconception/interconception health strategies among women of childbearing age.





## Strategic Focus Area 5: Promoting Optimal Infant Health

**OCPIM Action Group Co-Chairs: Mark Redding, MD, FAAP and Melissa Wervey Arnold, BSJ**

**OCPIM Action Group State Lead: Dyane Gogan Turner and Theresa Seagraves**

Infant mortality is a complex issue that includes the periods before a woman becomes pregnant, during her pregnancy and the entire first year of life. Evidence-based and promising practices to address the infancy period are critical and include increasing access to health care; increasing immunizations, breastfeeding and safe sleep environments; and decreasing exposure to injury and narcotics. Neonatal mortality is related to gestational age, low birth weight and congenital malformations and other problems originating from the perinatal period. Post-neonatal mortality is related to SUID/SIDS including sleep-related death, injuries and congenital malformations. Most of the deaths during the post-neonatal period are preventable. Every week three Ohio infants die from a sleep-related cause; most of these deaths could be prevented if AAP guidelines were followed—infants sleep alone, on their backs and in their cribs in a smoke-free environment. Contributors to sleep-related deaths and SUID include infants sharing sleep surfaces, exposure to tobacco smoke and lack of breastfeeding. Breastfed infants have a 20 percent lower risk of dying between 28 days and one year old than infants not breastfeeding (Kirwan). Inadequately insured children are less likely to receive adequate or timely care including screening, referrals and education. Vaccination is a cost-effective intervention and one of the greatest public health achievements which results in reduced mortality and morbidity. Domestic-violence screening and counseling must be a routine benefit of preventative health services. Neonatal Abstinence Syndrome (NAS) produces jitteriness, fever, diarrhea, poor feeding and even death if left untreated. Narcotic prescriptions are on the rise during the past several decades. Evidence-based therapies such as antenatal corticosteroids and human milk are administered to infants born too early and too small (OPQC). No infant should die a preventable death. Families are not aware of the risks and benefits or how to access services; interventions must be widespread and effectively communicated.

**Goal:** By 2020, increase breastfeeding rates, immunization rates and infants receiving appropriate neonatal abstinence syndrome therapy and decrease sleep related death and other injuries resulting in infant deaths.

### Strategy

- 5.1.** Support policies, procedures and services to promote infant health (e.g., safe sleep, breastfeeding, immunizations, special health needs, neonatal abstinence and injury prevention).
- 5.2.** Offer trainings and resources to prenatal care providers, pediatric health care providers, hospitals, child care centers and providers and home visiting programs to promote optimal infant health.
- 5.3.** Promote community engagement and ownership in promoting optimal infant health at the local level across Ohio.



## Strategic Focus Area 6: Reduce Smoking Before, During and After Pregnancy

**OCPIM Action Group Co-Chairs: Reina Sims, MSA and Cristie Carlson, MPH, TTS**

**OCPIM Action Group State Lead: Beth Conrey and Rhonda Huckaby**

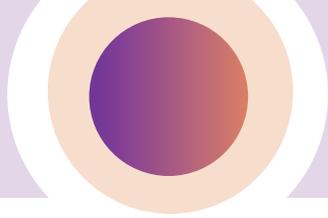
Smoking during pregnancy remains one of the most common preventable causes of infant morbidity and mortality.<sup>1</sup> Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications including placenta previa, placental abruption, premature rupture of the membrane, preterm delivery, restricted fetal growth, and sudden infant death syndrome [SIDS].<sup>1</sup> In the United States, 5 to 8 percent of preterm deliveries, 13 to 19 percent of term low-birth-weight deliveries, 23 to 34 percent of SIDS, and 5 to 7 percent of preterm-related deaths are attributable to prenatal smoking.<sup>3</sup> In 2011, 18 percent of women smoked during pregnancy in Ohio, double that of those who smoked during pregnancy in the United States, at 9 percent.

**Goal:** By 2020, Increase the percent of women who abstain from smoking during the 3<sup>rd</sup> trimester by 5 percent.

### Strategy

- |   |
|---|
| <b>6.1.</b> Increase access to evidence-based cessation services and resources for families.  |
| <b>6.2.</b> Increase access to tobacco-free education activities for adolescents.   |
| <b>6.3.</b> Implement policies that support prevention and cessation for adolescents and adults.  |
| <b>6.4.</b> Increase the workforce to assist families with evidence-based interventions to reduce smoking and substance abuse.                                |
| <b>6.5.</b> Increase public sensitivity to and awareness of women not smoking, avoiding, and ceasing all forms of tobacco and nicotine in childbearing years. |
| <b>6.6.</b> Support systems-level infrastructure changes that support prevention and cessation.   |





## Strategic Focus Area 7: Promoting Fatherhood Involvement in Maternal and Child Health

**OCPIM Action Group Co-Chairs: Kimberly Dent, MPA and Steve Killpack, MS**

**OCPIM Action Group State Lead: Chip Allen and Jye Breckenridge**

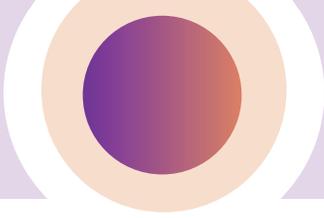
Research has shown that early and consistent involvement of fathers in the lives of children has long-term social, emotional, health and economic benefits. Far too often programs designed to protect the health of mothers and children fail to incorporate the involvement of fathers in a meaningful way or, at best, include fathers as an afterthought. Programs to prevent infant mortality and improve birth outcomes will not reach their full potential without the meaningful involvement of fathers. The strategies below are designed to incorporate the meaningful involvement of fathers in existing programs and systematically assure the inclusion of fathers in all new infant mortality interventions.

**Goal:** By 2020, demonstrate an increase in efforts to engage fathers in the participation in their children’s lives, by encouraging them to actively support their partners in both preconception and interconception health.

### Strategy

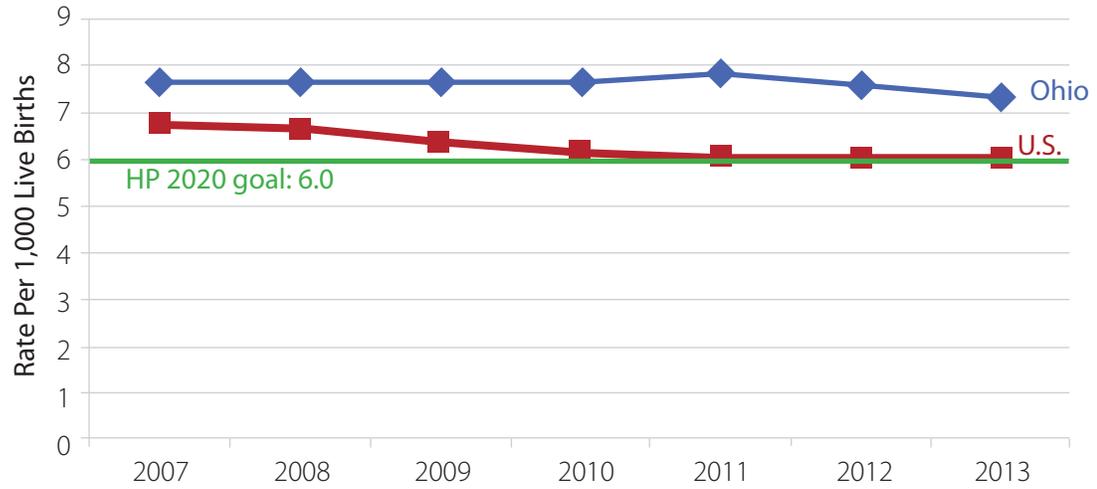
- 7.1.** Increase awareness with individuals and organizations across all sectors of society (business, civic, government, faith) regarding the importance for children to have involved and committed fathers present.
- 7.2.** Evaluate existing fatherhood and male involvement programs and curricula, as well as identifying best practices that further validate the significant role of the father in MCH.
- 7.3.** Increase efforts to include young men in reproductive-health initiatives.
- 7.4** Support policies, procedures and services to increase exclusive breastfeeding for all babies.





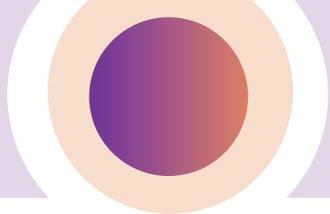
## Appendix 2: Infant Mortality Data

Graph 1 – Infant Mortality in the United States & Ohio by Year, 2007-2013

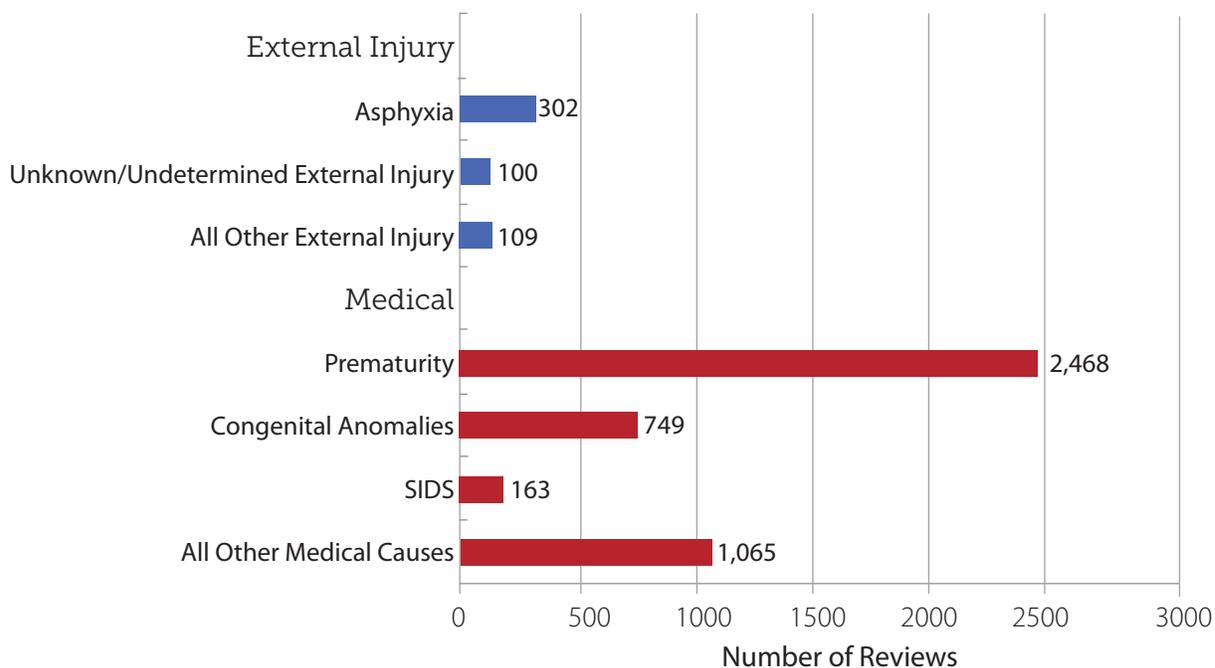


Source: Bureau of Vital Statistics, Ohio Department of Health



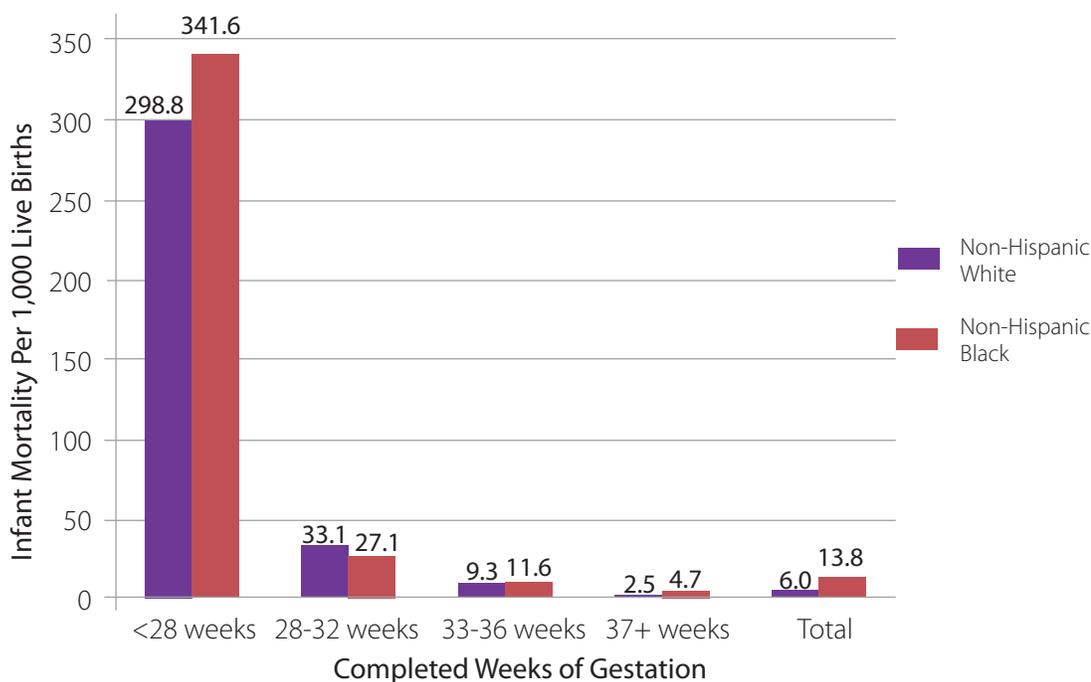


**Graph 2 – Reviews of Infant Deaths by Leading Causes of Death, Ohio, 2008-2012**

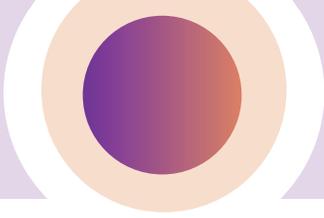


Source: Child Fatality Review 14<sup>th</sup> Annual Report, Ohio Department of Health

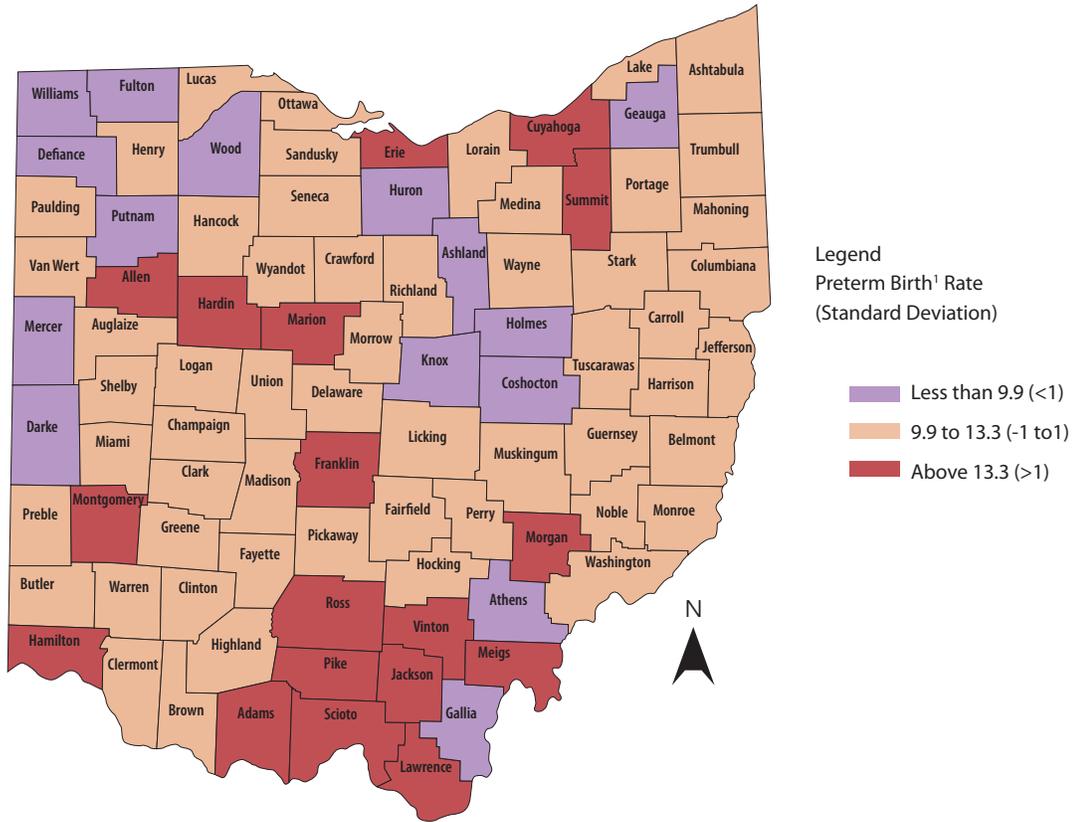
**Graph 3 – Infant Mortality by Gestational Age and Race, Ohio, 2010-2011**



Source: Bureau of Vital Statistics, Linked Birth/Infant Death File, Ohio Department of Health

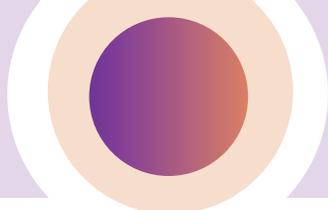


Graph 4 – Percent of Preterm Births by County, 2010-2012

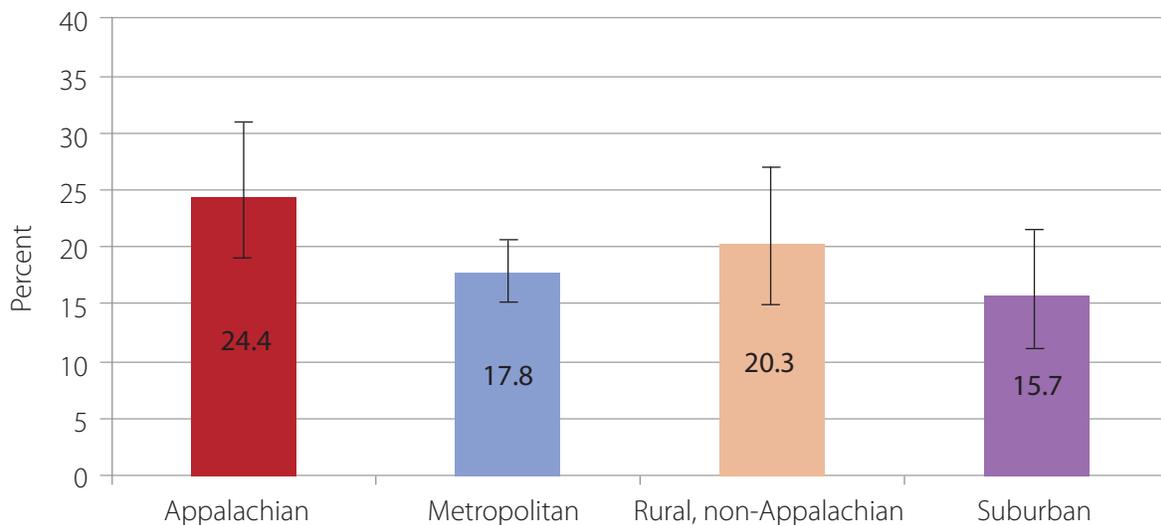


Source: Bureau of Vital Statistics, Ohio Department of Health



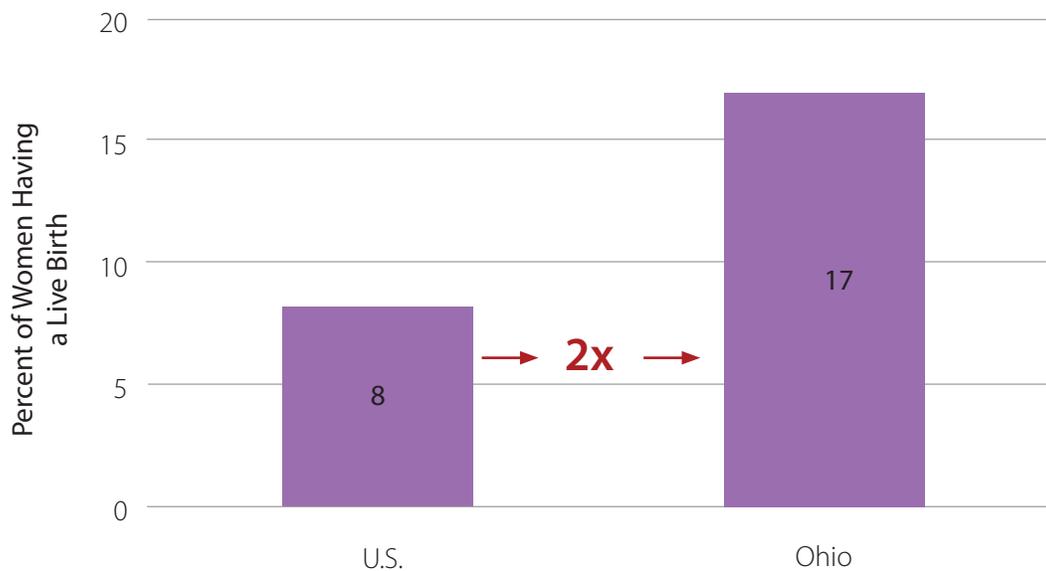


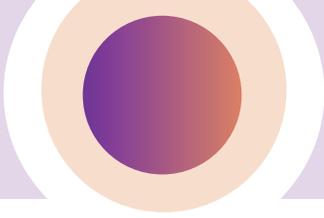
Graph 5 – Mothers Who Smoked During Pregnancy by County Type, Ohio, 2009-2010



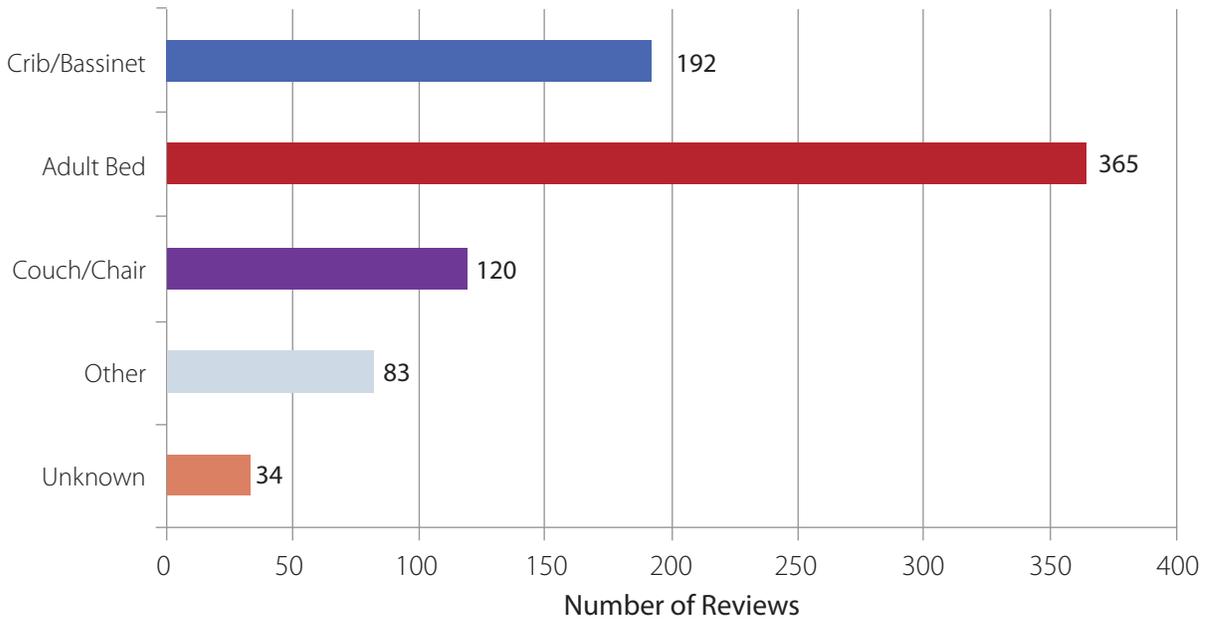
Source: Pregnancy Risk Assessment Monitoring System, Ohio Department of Health

Graph 6 – Prenatal Smoking – U.S. & Ohio, 2013



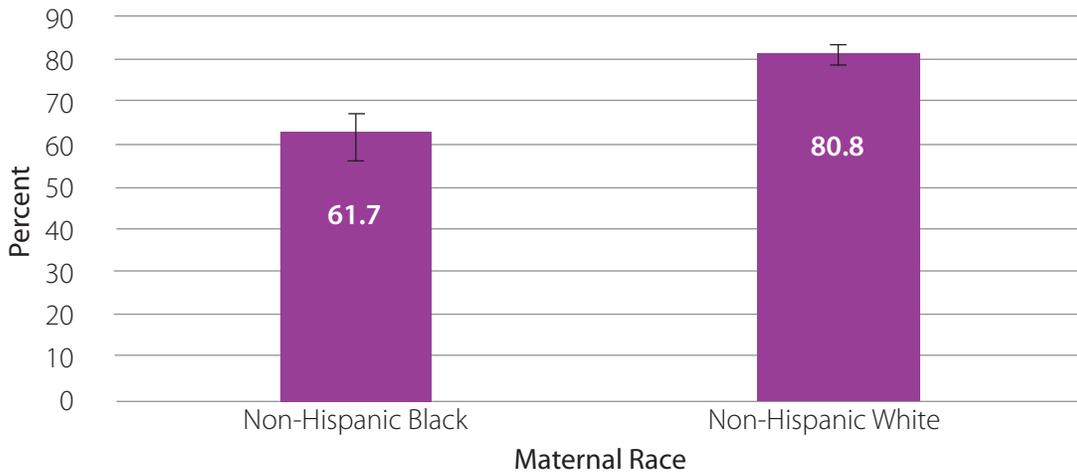


**Graph 7 – Sleep-Related Infant Deaths by Location when Found, Ohio, 2008-2012**

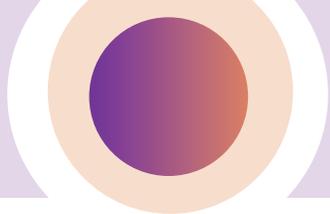


Source: Ohio Child Fatality Review 14<sup>th</sup> Annual Report, Ohio Department of Health

**Graph 8 – Mothers Who Placed Their Infant to Sleep on His/Her Back, by Race, Ohio, 2011-2012**

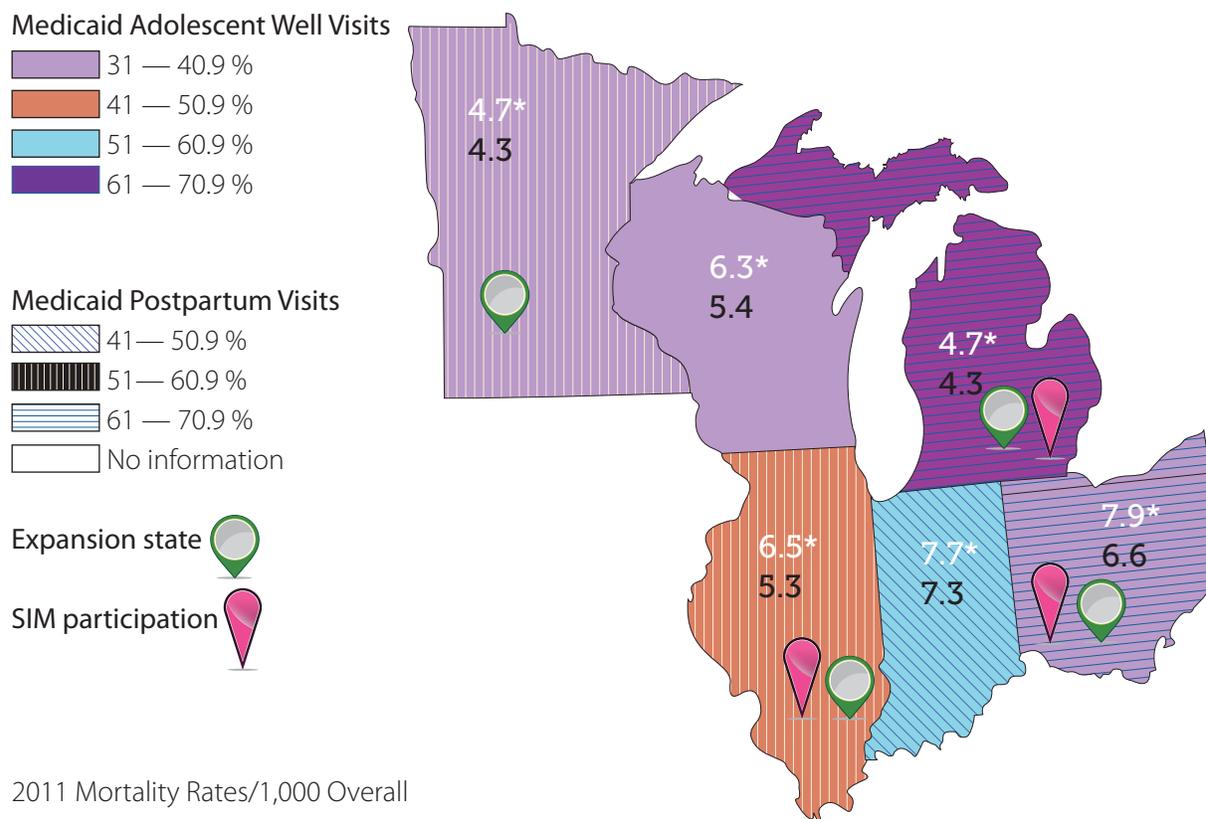


Source: Pregnancy Risk Assessment Monitoring System, Ohio Department of Health



Graph 8 – Midwest Region (Region V) CoIIN

Region V COIIN: Pre- & Inter-Conception Care State Comparisons



2011 Mortality Rates/1,000 Overall  
 2011 Mortality Rates/1000 by Race— White  
 2011 Mortality Rates/1000 by Race— Black

**2011 Medicaid Adolescent Well Visits**

State	IL	IN	MI	MN	OH	WI
	41.0%	57.3%	61.7%	37.6%	37.4%	40.5%

**2011 Medicaid Post-Partum Visits**

State	IL	IN	MI	MN	OH	WI
	57.3%	41.0%	65.0%	55.4%	62.3%	Unknown

**2012 State Based Data for Infant Mortality**

State	Ohio	MI	WI
Overall	7.6	6.9	5.7
Race - White	6.3	5.5	4.7
Race - Black	13.9	13.5	13.2



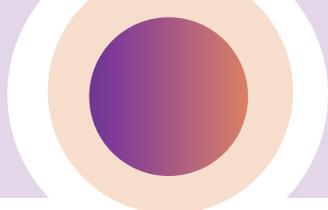
## Appendix 3: Ohio Collaborative to Prevent Infant Mortality Membership

### OPCIM Executive Steering Committee

- **Arthur James**, MD, FACOG, Associate Professor, Department of Obstetrics and Gynecology, The Ohio State University College of Medicine, Nationwide Children's Hospital\*†
- **Lisa Holloway**, MBA, Director of Program Services and Government Affairs, Ohio Chapter, Ohio March Of Dimes\*†
- **Mary Applegate**, MD, Medical Director, Department of Medicaid
- **Melissa Wervey Arnold**, BSJ, CEO Ohio Chapter, American Academy of Pediatrics
- **Cristie Carlson**, MPH, TTS, Health Educator, Hamilton County Public Health
- **Kimberly Dent**, MPA, Executive Director, Ohio Commission on Fatherhood
- **Robert Falcone**, MD, VP of Clinical Policy and Population Health, OHA
- **Pat Gabbe**, MD, Principal Investigator, Center for Perinatal Research, Nationwide Children's Hospital
- **Jay Iams**, MD, Emeritus Professor of OB/GYN OSU Wexner Medical Center
- **Alex Jones**, RN, MS, Director of Nursing, ODH
- **Steve Killpack**, MS, Executive Director, Healthy Fathering Collaborative
- **Brad Lucas**, MD, MBA, FACOG, Chief Medical Officer at Buckeye Health Plan
- **Connie Motter**, MS, CGC, Genetic Counselor, Akron Children's Hospital
- **Mark Redding**, MD, FAAP, Co-Chair, Community Health Access Project
- **Sarah Redding**, MD, MPH, CEO, Care Coordination Systems
- **Larisa Rippel**, MS, Genetic Counselor, Rainbow Babies & Children's Hospital
- **Theresa Seagraves**, MPA, Title V Director and Block Grant Manager, ODH\*
- **Reina Sims**, MSA, Program Manager, Ohio Commission on Minority Health
- **Celeste Smith**, MA, PC, Minority Health Coordinator, Toledo-Lucas County Health Department Office on Minority Health
- **Teleangé Thomas**, BS, Program Director, Sisters of Charity Foundation of Cleveland
- **Katie Ziegler**, MS, CGC, LGC, Genetic Counselor, OSU Wexner Medical Center Division of Maternal Fetal Medicine

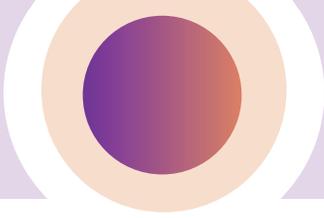
### OCPIM Coordinating Committee\*

- **Chip Allen**, MPH, Director of Health Equity, ODH
- **Vivian Jackson Anderson**, MA, LSLP, Bureau of Maternal and Child Health, ODH
- **Elizabeth Conrey**, PhD, RD, State Maternal and Child Health Epidemiologist, ODH
- **Lori Deacon**, Bureau of Maternal and Child Health, ODH
- **Dyane GoganTurner**, MPH, RD/LD, IBCLC, Bureau of Maternal and Child Health, ODH



**Ohio Collaborative To Prevent Infant Mortality Member Organizations  
Last Updated August 3, 2015**

- Advocates for Basic Legal Equality, Inc.
- AEP Energy, Inc.
- Akron Children’s Hospital
- Allen County Public Health
- Aultman Hospital, Canton
- AVANZA Business Solutions
- Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN)
- Born Community Midwives
- Bright Future Lactation Resource Center
- Buckeye Health Plan
- Canton City Health Department
- Care Coordination Systems
- Caring for 2 Columbus
- CareSource
- Celebrate One
- Center for Community Solutions
- Center for Healthy Families, Inc.
- Central Ohio Club of the National Association of Negro Women, Incorporated
- Child Development Council of Franklin County
- Children’s Medical Center of Dayton
- Cincinnati Children’s Hospital Medical Center
- Cincinnati Department of Health
- Cincinnati Collaboration for Infant Mortality Reduction
- City of Refuge Point of Impact
- Cleveland Department of Public Health
- Collaboration for Infant Mortality Reduction
- Columbus Neighborhood Health Center
- Columbus Public Health
- Community Development for All People
- Community Health Access Project
- Community Health Partners Hospital, Lorain
- CompDrug
- Council on Healthy Mothers and Babies
- Cradle Cincinnati
- Cuyahoga County Board of Health
- Cuyahoga County Invest in Children
- Cuyahoga County Office of Health and Human Services
- Dayton Children’s Hospital
- Euro OB/GYN, Inc., Canton
- Every Child Succeeds
- Franklin County Help Me Grow
- Genetic Counseling Toolkit LLC
- Hamilton County Public Health
- Health Care Access Now
- Health Policy Institute of Ohio
- Highland County Community Action Organization, Inc.
- Hospital Council of Northwest Ohio
- IPAC and Southeast Ohio HUB
- Kroger Pharmacy
- Mahoning County District Board of Health
- March of Dimes Ohio Chapter
- McDonald Hopkins
- Medicine Shoppe Pharmacy
- Mercy St. Vincent Family Care Center, Toledo
- Mercy St. Vincent Hospital, Toledo
- Miami County Public Health
- Miami Valley Hospital, Dayton
- Michigan State University
- Middle East Studies Center, OSU
- Molina Healthcare of Ohio
- Moms2B
- Mt. Carmel Hospital, Columbus
- Mt. Sinai Health Care Foundation
- Nationwide Children’s Hospital, Columbus
- Northwest Ohio Pathways HUB
- Nurse-Family Partnership
- Ohio Association of Health Plans
- Ohio Association of Community Health Centers
- Ohio Better Birth Outcomes

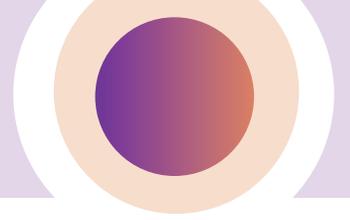


Ohio Chapter, American Academy of Pediatrics  
Ohio Colleges of Medicine Government  
Resource Center  
Ohio Commission on Fatherhood  
Ohio Commission on Minority Health  
Ohio Department of Education  
Ohio Department of Health  
Ohio Department of Job and Family Services  
Ohio Department of Medicaid  
Ohio Department of Mental Health and  
Addiction Services  
OhioHealth  
Ohio Hospital Association  
Ohio Northern University  
Ohio Perinatal Quality Collaborative  
Ohio Public Health Association  
Ohio Section, American Congress of  
Obstetricians and Gynecologists  
Ohio Senate- Office of Senator Jones  
OSU Colleges of Medicine and Nursing  
OSU Wexner Medical Center  
  
Pappas and Associates  
Paramount Health Care  
Price Legal Services  
Providence House, Inc.  
Public Health- Dayton & Montgomery County

Rainbow Babies and Children's Hospital, Cleveland  
SID Network of Ohio  
Sisters of Charity Foundation of Cleveland  
Summa Health Systems  
Summit County Public Health  
  
The Healthcare Connection, Hamilton County  
Toledo Hospital  
Toledo Lucas County Commission on Minority  
Health  
TriHealth  
Trinity Health  
  
United Healthcare Community Plan of Ohio  
University of Cincinnati Hospital  
University Hospitals, Cleveland  
University of Toledo  
  
Voices for Ohio's Children  
  
Winton Hills Medical and Health Center, Inc.  
Wright State University  
  
Youngstown Office on Minority Health

**Note:** OCPIM adds new members frequently.  
For the most up-to-date list, visit [this link](#) or go  
to <http://bit.ly/everybabymatters>.  
†denotes OCPIM Co-chairs





Notes:



**Ohio Collaborative**  
to Prevent Infant Mortality