

Ohio Infant Mortality Summit Roundtable Sessions

Promoting and Providing the Ultimate Embrace...Our Kangaroo Care Journey

Mary Walters MSN, RN, Marianne Marinelli BSN, RNC, CLC and Kimberly Price BSN, RN, IBCLC, CLC; Grant Medical Center, Columbus

Abstract: The journey to providing Kangaroo Care (skin-to-skin) as a routine, standard practice for all mothers and babies delivered at Grant Medical Center began in 2004 with a research project conducted in our birthing suites. Results have been shared via poster/podium presentations at National/International Conferences and published in 2007. Numerous professional publications have referenced our findings. By 2007, one-third of our patients practiced KC during the first hour after delivery. However, after 60-90 minutes, the infant was separated from his/her mother and moved to the Newborn Nursery for further testing/evaluation for the next 2-4 hours. While most Maternity programs now support KC at the time of delivery after vaginal birth, it is still not standard practice for the 30+% of all births delivered by Cesarean. Many mother/baby couplets are moved to the post-partum area after 60-90 minutes. November, 2011 we began a change of practice which affords the dyad up to at LEAST two hours together BEFORE moving them. Assessments are completed with the dyad in KC following the first breastfeeding/feeding. This practice is also provided to all our Cesarean deliveries so that currently 90% of all our patients receive this optimal treatment. Separate benefits to the mother and baby are numerous and the results and challenges to this “Best Practice” will be presented.

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What Mothers Tell Us about Their Experience of Pregnancy Loss

Karen McGee, CNM MSN FIMR Interviewer; Cincinnati Health Department

Abstract: Fetal and Infant Mortality Review (FIMR) in Cincinnati has been privileged to listen and record interviews with 80 mothers. National FIMR protocols were followed and the results were shared with a Case Review Team. Recommendations were generated and offered to the Perinatal Community Action Team who has the responsibility of implementing an action plan to make changes that could improve care. Social and medical interventions were suggested. The purpose of FIMR is to listen to the consumer/mother to affect change. The presentation will be based on actual interviews while protecting the mothers and providers confidentiality.

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K.O.B.A. (Keep Our Babies Alive)

Sherry Smith, K.O.B.A. Program Manager Tasha Catron, Richelle Setordzie, Michelle Watkins; Stark County Health Department K.O.B.A. (OIMRI) Program

Abstract: This roundtable discussion will increase the awareness of the high rate of infant mortality that exists in Stark County and in all of Ohio and to promote the Stark County, K.O.B.A. Ohio Infant

Mortality Reduction Initiative innovative program best practices through round table discussions. Target audience includes: Maternal and Child Health and other public health practitioners, health care providers, state and local officials, advocates, community leaders and concerned citizens. Information presented may be especially beneficial for Community Outreach Workers, Social Service agencies; faith based organizers as well as health providers. K.O.B.A. or Keep Our Babies Alive is a FREE and confidential grant-funded program through the Ohio Department of Health under Ohio's Infant Mortality Reduction Initiative. It is managed and administered through the Stark County Health Department. K.O.B.A. aims to help eliminate racial health disparities among African Americans with a focus on infant mortality and low and very low birth weight infants

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Implementation of a hospital-based “Fetal Infant Mortality Review” (FIMR) Committee: Obstacles and Solutions

Marc Collin, MD; Sharon Groh-Wargo, RD, PhD; MetroHealth Medical Center

Abstract: A review of the PPOR (Perinatal Periods of Risk) data for our Region in Northeast Ohio revealed that nearly 28% of the mortality rate was due to large fetal deaths. The current formulation of the county ‘Child Death Review’ committee did not address this issue. The results from a 10 year retrospective review of our fetal deaths revealed that the cause was undetermined in 29% of cases, or due to placental abruption (23%), lethal anomalies (17%), chorioamnionitis/infection (12%), cord accidents (11%) or placental insufficiency (8%). Virtually all (90/92 =97%) of the fetal deaths were known to the delivery staff prior to induction and delivery. Even after autopsy, the primary cause of death could not be determined in nearly 1/3 of the deaths. Fetal death was 2.8 times more likely to occur in a woman with a pre-pregnancy BMI ≥ 25 than a woman with a normal BMI ($p < 0.0001$). Mean weight of study subjects approximated the 10th percentile for gestational age. We created a hospital-based FIMR committee. An access data base containing a modified version of the ACOG NFIMR forms was developed to house aggregate data. Cases are reviewed quarterly and trends and commonalities noted. Hospital-based FIMR committees can identify trends in the causes of fetal mortality. These committees can increase the awareness among perinatal health care providers about the issues surrounding late pregnancy fetal demise. FIMR can help improve the quality of the information reported on the fetal death certificate.

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The Franklin County Maternal Depression Initiative

Tonya Fulwider, POEM Director and FCMDTF Co-Chair; Karen Gray-Medina; Grace Kolliesuah; POEM and the Franklin County Maternal Depression Task Force

Abstract: The Franklin County Maternal Depression Task Force (FCMDTF) is a Healthy Start Caring for 2 sponsored collaborative of individuals from health and social service fields that address lack of awareness and education regarding depression resources during and after pregnancy. Its formation was prompted by the high risk rates of pregnancy and postpartum depression indicated through screenings by

Caring for 2 nurses. The methodology has been a 3-pronged approach: needs assessment – identify how mental health system works and determine how women at-risk for depression are identified; resource assessment – assess availability and gaps of mental health services, and; strategic action identification – identify strategies to effectively educate on the severity of maternal depression and develop mental health system improvement plan. Over the last 4 years, the FCMDTF has developed a Resource Directory, an evidence-based PowerPoint educational tool for health care providers, and a variety of outreach and awareness materials. With the ongoing collaboration of POEM (Perinatal Outreach and Encouragement for Moms), Ohio's only perinatal mental health support network, the Resource Directory and numerous educational offerings continue. The accomplishments of the FCMDTF have worked to address the following issues: data are compelling and underscore the lack of community resources available for screening and treating depression for high risk mothers; data highlight a critical community need for a mental/behavioral health partnership that can respond quickly and effectively to maternal depression, and; untreated depression complicates our efforts to help moms achieve good birth outcomes.

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Karen Gray-Medina is the Co-Chair of the Franklin County Maternal Depression Task Force.

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Analyzing Sleep Related Deaths: Age & Location of Infant

Richard Stacklin, Lorrie Considine; Cuyahoga County Board of Health

Abstract: Sleep related deaths are the number one cause of death of post-neonatal fatalities in Ohio and in Cuyahoga County. In Cuyahoga County we had 145 sleep related fatalities from 2005 to 2011 Sleep related deaths removes one kindergarten class from our schools each year. We analyzed the data with two main purposes. First we wanted to know what types of sleep related deaths and age of the infant. Cuyahoga County had no Sudden Infant Death Syndrome (SIDS) deaths in the last four years. We have found that all sleep related fatalities occurred with at least one known hazard in the sleep area such as a comforter, pillow, or blanket in every case in the last three years. Three out of five sleep-related deaths occurred for babies one month to three months old. In the last four years, we had eight infant deaths occurring after six months of age. From 2005 to 2007 no sleep related fatalities occurred in the same age group. Second, we analyzed data with a social determinant of health lens. Deaths were mapped to determine if certain locales experienced a higher rate of sleep related fatalities. The map also shows the percentage of people living under the federal poverty level. Then we analyzed known economic, medical, and environmental risk factors to where they lived (Cleveland, First Ring Suburbs, or Outer Ring Suburbs). Studying risk factors and providing guidance to parents and medical professionals can hopefully lead to the prevention of infants lost in Cuyahoga County.

About the Authors: Richard Stacklin focuses on analyzing maternal and child health (MCH) indicator data at the Cuyahoga County Board of Health. Email: rstacklin@ccbh.net

Lorrie Considine is the Cuyahoga County safe sleep expert.

Breastfeeding Peer Helper Program

Tasha Ross, Esther Gillett; Columbus Public Health- WIC

Abstract: The Breastfeeding Peer Helper (BPH) program began in 2004 in 11 Ohio WIC counties and in Franklin County since 2011. BPH are currently or have been a WIC participant, have breastfed exclusively for at least 6 months, are enthusiastic about breastfeeding, and want to help other mothers enjoy a positive experience. They provide basic breastfeeding education and support to WIC mothers. Peers must complete a 20 hours of training and 6 hours of continuing education per year. Peers free up staff time to help mothers explore and address barriers and concerns. They provide realistic and practical guidance as a result of shared personal backgrounds and experiences. They refer to WIC staff if a mother has questions or concerns outside their scope of practice. Peer Helpers have been used successfully to increase breastfeeding rates among low-income women of all ethnicities. Studies have shown increases in breastfeeding rates in teen moms, women unsure about their feeding plans in pregnant and African American mothers. A study of Ohio Peer Programs from 2004-2007 showed that Caucasian infants experienced a significantly greater increase in initiation rates when exposed to peers than African American infants. One possible reason for this difference may be that women are more likely to accept advice from women who are more like themselves. Only 3 of the 11 projects had an African American Peer on staff.

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Esther Gillett is the Breastfeeding Coordinator/Peer Supervisor for the Franklin County WIC Program.

Baby Friendly in Ohio...Every Baby Matters

Jennifer Foster, BSN, RN, IBCLC, Sylvia Ellison, Linda Smith; Summa Health System

Abstract: Infant mortality rates in the United States are reduced by 21% in breastfed infants. Research suggests that breastfeeding is a key modifiable risk factor for disease for both mothers and infants. Data suggest that variations in hospital practices account for disparities in breastfeeding duration. Improvements in the quality of antenatal and perinatal support could have a substantial impact on mother and infant health. Racial breastfeeding disparity disappears at Baby Friendly Hospitals. Breastfeeding initiation rates are significantly lower in African-American women. Women who deliver in Baby Friendly Designated Hospitals are more likely to breastfeed. Studies show low-income black women who give birth at a Baby-Friendly hospital have breastfeeding rates similar to the overall population. On the Breastfeeding Report Card 2012 (CDC National Immunization Survey), which was released in August of 2012, only 5 states had lower breastfeeding rates than Ohio. Ohio's breastfeeding rates are significantly lower than the national goals. Our current rates are: 62.3% ever breastfed, 39.5% breastfed at 6 months, 25.6% breastfed at 12 months, 29.1% exclusive breastfed at 3 months, and 11% exclusive breastfed at 6 months. Baby Friendly Hospital Initiative (BFHI) is an initiative from the World Health Organization and UNICEF, which began in 1991. BFHI creates a supportive environment for those mothers and families who have chosen to breastfeed their newborns and has benefits for those who have chosen to formula feed. This designation identifies hospitals that have chosen to protect, promote, and support breastfeeding as optimal for infant health. Less than 9% of Ohio births occur in Baby Friendly designated birth facilities. What can Ohio hospitals do to improve the health of Ohio Infants and reduce infant mortality? Follow the World Health Organization's 10 Steps to Successful Breastfeeding. And, obtain Baby Friendly Hospital Designation.

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Sylvia Ellison, MA, MPH teaches in the Master of Public Health program at Wright State University.
Linda Smith, MPH, FACCE, IBCLC, FILCA, is a lactation consultant, childbirth educator, author, and internationally-known consultant on breastfeeding and birthing issues.

Southeastern Ohio Community HUB and Pathways Program

Jane Hamel-Lambert, PhD, Associate Professor; Dawn Mollica; Ohio University Heritage College of Osteopathic Medicine

Abstract: The Community HUB/Pathways Model was developed by Drs. Mark and Sarah Redding from Community Health Access Project (CHAP) to improve health and preventive care for high risk mothers and children. The services delivered coordinate care for individuals within targeted medical and social service “Pathways.” Each Pathway is designed to address a single health or social issue. Tracking progress along the Pathway ensures that those concerns identified are resolved. Additionally, the HUB offers a single point of registry for individuals receiving care coordination services. This database allows the HUB to increase the accountability of service providers, to reduce the duplication of services in the region, and to improve communication across the multiple stakeholders invested in effective care coordination. The Community HUB/Pathways Model utilizes a pay-for-performance methodology that provides financial incentives to providers that are tied to desired health outcomes. Specific health outcomes include birth weight > 2500 grams, children fully-immunized by 24 months, reduced Emergency Department utilization for non-emergency care through engagement of medical homes, full enrollment in Medicaid for qualified children. The HUB improves the quality of care, the region’s population health and it reduces health care costs.

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Dawn Mollica is the Executive Director for IPAC.

A Community Collaborative Approach for Infant Safe Sleep in the Valley

Melissa LaManna, OIMRI Program Manager; Planned Parenthood of Greater Ohio

Abstract: The round table discussion will examine how two neighboring counties have come together to bring awareness and education on the topic of infant mortality and infant safe sleep environment. Participants will learn about partners involved, how data was collected, examples of methods used to promote awareness and how they became a stronger voice in the community. The presentation will identify some of the challenges encountered when engaging the community. Undoubtedly, funding or lack thereof can be a barrier to programs. Examples of funding used to promote message will be included. An overview will be provided on the first initiative and how the collaboration has evolved over the past few years. Discussion will include why infant safe sleep was brought to the forefront and how one county was able to partner with a neighboring county to broaden the service area. Finally, the presentation will encourage communities to come together to be stronger voices in promoting infant safe sleep and reducing infant mortality.

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Ohio Better Birth Outcomes-Progesterone Promotion Project

Sara Frantz, Nurse Educator Coordinator; Jeff Klinger, Members from OBBO collaborative; Ohio Better Birth Outcomes/Nationwide Children's Hospital

Abstract: In 2011, 13.6% of births in Franklin County occurred before 37 weeks of gestation.

OBJECTIVE: To reduce the number of recurrent preterm births in Franklin County.

Participants: The Ohio Better Birth Outcomes (OBBO) initiative brings together central Ohio's four hospital systems, along with the Columbus Neighborhood Family Health Centers, the Columbus Public Health Department and local government and community organizations.

Design: Local providers are using a common protocol to identify pregnant women who have had a previous preterm birth and provide them with progesterone therapy in the clinic or home setting. To date, the strategies of the collaborative have included: establish a community "Progesterone Promotion" collaborative and generate support among local pregnancy clinics; establish an agreed to community-wide protocol; identify pregnant women with previous preterm birth(s) and enroll them in the Progesterone Promotion Project (the progesterone project provides women with weekly prenatal therapy injections of 17 Alpha Hydroxyprogesterone Caproate (17P) or with daily progesterone suppositories); and construct a web-based reporting system for community-wide quality improvement purposes. There is also a Progesterone Community Forum that meets every six weeks to monitor results and share best practices. The progesterone promotion project is now being expanded to include the southeast region of Ohio, and as a result of a partnership with Akron Children's Hospital will expand to Summit County.

Results: Since data collection began in 2011, 319 women have participated in the program. The average gestational age at earliest preterm birth is 29 weeks and 1 day. The average gestational age at delivery is 36 weeks and 1 day.

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Social Marketing Amplified: A 'Sound' Effect for Reducing Infant Mortality

Eric Greene, Social Marketing Consultant; Ohio Department of Health

Abstract: Participants at this interactive roundtable will learn about the core elements of social marketing while discussing how each of these elements would be addressed within a social marketing program focusing on infant mortality. Participants will use their creativity and real pre-prepared data from select sources to quickly work through a participatory social marketing planning process so that they will have a practical tool to begin planning their own programs.

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Community Health Worker: The missing link in improving birth outcomes

Marie Jones, Mdiv., LSW; Michelle Hall, Cheryl White; Northeast Ohio Neighborhood Health Services, Inc.

Abstract: In 1978 at the International Conference on Primary Health Care the World Health Organization issued The Declaration of Alma-Ata. There are numerous statements in the Declaration which are pertinent to the issue of reducing infant mortality. 1) Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity; 2) Health is a fundamental human

right; 3) Health is an important world-wide social goal; 4) The realization of health requires the action of many other social and economic sectors in addition to the health sector; and 5) Health disparity between nations and within nations is politically, socially and economically unacceptable. Infant mortality is a barometer of how a nation is dealing with the issue of health as defined by the Declaration of Alma -Ata. Health care spending and technological advances do not always translate into better health outcomes. In 2004 the United States spent on health care more than twice the average of any of the other 29 Organization for Economic Cooperation and Development countries. Yet our medical outcomes and life expectancy was often not as positive as most of the other nations. Finding ways to collectively take in hand social, economic, medical care, and medical access issues is crucial in improving birth outcomes and tackling the disparity in infant mortality. The profession of community health worker as an integral component of the medical and social service team provides a practical approach in helping to collectively address the multiplicity of factors that impact infant mortality and disparity.

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What's the Role of My Community Based Organization in the Fight Against Infant Mortality?
Robyn Taylor, Ohio Department of Health

Abstract: Ohio's high infant mortality rate has stayed the same from 2006 through 2010 and hasn't changed substantially in over a decade, according to the latest figures released by the Ohio Department of Health's Center for Public Health Statistics and Informatics. The National Center for Health Statistics ranks Ohio as having the eleventh highest rate of infant mortality among the states. Ohio's rate also exceeds the rates of all surrounding states for 2008, the latest year available for comparison with other states. While there are current strategies to fight Infant Mortality, should Ohio begin to think outside the box? Who are untraditional partners that can join the fight against infant mortality and help to save our babies? This roundtable will discuss possible partners and strategies to promote health life options for families. How can social services agencies, housing, education, jobs help in the fight against infant mortality? What systems policies can be in place to promote healthy choices, lifestyles, and increase resources for families?

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Coming to Terms with Getting to Term: Improving Outcomes with Case Management
Marta Wunder, RN MSN; Chris Adamsom, LSW; TriHealth

Abstract: One in eight Caucasians are born preterm versus one in five African Americans in this country. TriHealth's Preterm Labor Prevention Case Management program has been diligently working to reduce the incidence of prematurity in low income, high risk specialized patient populations. Case Management for preterm labor prevention is a collaborative process which incorporates assessment, planning

coordination, evaluation, advocacy and education for patients and their families with the goal of attaining a healthy term birth. Nurse case managers are a part of a multidisciplinary team which includes an MD, Social Worker, Dietician, Parish RN and Chaplain. Many patients at risk for preterm labor start their journey with fear and anxiety and easily become lost in the health care maze when they do begin their prenatal care. Topics in this discussion will include how the Preterm Labor Prevention Program supports, guides, educates and advocates for patients in these vulnerable populations. We will also share the barriers that patients and the program itself have faced in the last three years and how we have adapted to changes in treatment options such as the use of 17OHP and including the provision of access to these treatments for our patients. Coming to terms with getting to term is a group effort aimed at each individual patient because we believe every family matters and every voice deserves to be heard.

About the Authors: Marta Wunder RN, BS, MSN is currently the Preterm Labor Prevention nurse case manager at Good Samaritan and Bethesda North Hospitals in Cincinnati. Email:

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Quality Improvement for the Largest Delivering Hospital in the State of Ohio

Kathy McClish CNM, Quality Improvement Officer at TriHealth; Michele Jacob RN, Quality Improvement Nurse in Hamilton County.

Abstract: We will discuss quality improvement initiatives related to maternity services and our participation in external quality related projects such as Ohio Perinatal Quality Collaborative and Premier Health Care Alliance. We have a multidisciplinary approach involving leaders, providers, nurses and ancillary departments. In the roundtable session we will share that we are building teams and PDSA cycles around measures tracked such as neonatal birth injuries, uterine rupture, bundles of care, antenatal steroid administration, scheduled births less than 39 weeks and pregnancy dating documentation. We are also performing in-situ simulations with required nursing, resident and house officer attendance. In 2013 we are planning to implement a preterm labor project. All of these projects are interrelated with respect to neonatal morbidity and mortality.

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Ohio Community Health Workers Association

Becky Hartman President, OCHWA

Abstract: The purpose of this group is to establish and support Community Health Workers as professionals who are an integral part of the health and human services system. CHW's are public health outreach professionals who apply his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out at least one of the following roles: 1) Bridging/culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity. 2) Providing culturally appropriate health

education and information; role modeling outreach home visits and referral services. 3) Assuring that people get the services they need that may provide direct services, including informal counseling and social support; and advocating for individual and community needs

About the Author: Becky Hartman is a Certified Community Health Worker and President of the Ohio Community Health Workers Association (OCHWA). Email: ochwa1@gmail.com

The Lucas County Initiative to Improve Birth Outcomes (Pathways): A Care Coordination Approach

Jan Ruma, MEd, CFRE, Vice President Hospital Council of Northwest Ohio Executive Director, Toledo, Ohio; Hospital Council of Northwest Ohio, Toledo, Ohio; Judy Didion PhD, RN, Dean, College of Nursing, Lourdes University, Sylvania, Ohio; Toledo-Lucas County Health Department

Abstract: The Lucas County Initiative to Improve Birth Outcomes began as a result of the high prevalence of low birth weight babies born in central city Toledo, Ohio. In 2006, these percentages were nearly twice that of the national low birth weight percentage (15.4% compared to 8.2%). This program represents a broad partnership of organizations designed to identify those pregnant women most at risk to poor birth outcomes and connecting them to the health and social services they need to improve the health of their unborn children. The Initiative's goals are to find those at risk (outreach), connect them to prenatal care and social services (care coordination), and measure the results. Five community organizations dedicate care coordinators to improve birth outcomes by advocating for low income, high risk pregnant women and empowering them with education. The Initiative funds the care coordinating organization when they reach the goals of finding women at risk, connecting them to care and social services and delivering healthy birth weight babies. Since 2007, 917 pregnancies of 880 women have been served by care coordinators. Low birth weights of this program population have decreased from 13% in 2008 to 5.3% in 2011. Since 2010, the initiative has contracted with two Medicaid managed organizations to expand services. Care coordination services promote early identification and connection to prenatal care. It is a strategy to reduce barriers and address the significant social determinants of health. Care coordination can be a means to advance the future of equity.

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Dr. Judy Didion is the Dean of the College of Nursing at Lourdes University and has mentored the Care Coordinators in this project.

Centering Pregnancy: Reducing Preterm Birth

Sharon Schindler Rising, CEO, Centering Healthcare Institute

Abstract: Centering Pregnancy is a care redesign that brings women out of exam room into a group setting where they receive basic prenatal checkups, build community with other women, and gain knowledge and skills in pregnancy, childbirth and parenting. A healthcare provider and nurse or medical assistant facilitate groups of 8-12 women of similar gestational ages for ten two hour sessions from 14 weeks to early postpartum. That is, 20 hours of prenatal care across pregnancy, compared to about 2 hours – at no additional cost. Centering Parenting continues the groups for well-woman/well-baby care for the first postpartum year and beyond focusing on maternal weight goals, depression screening, and family planning practices along with providing standard well-baby care. Centering Pregnancy care is provided in more than 300 sites in the U.S and serves women of varied socio-economic backgrounds. This prenatal care model transcends barriers to bring women together to share common concerns of pregnancy and

parenting. This experience helps them to gain an increased sense of empowerment and to build community with other women. A Yale randomized controlled trial of 1047 women in public clinics documented a 33% reduction in preterm birth and a 41% reduction for the 80% of the sample who were African American. Other findings included increased breastfeeding, better attendance, and increased satisfaction and decreased incidence of sexually transmitted infections. The return on investment is estimated to be approximately \$2000 per woman in Centering. As one physician said, “This is the one thing in my week that brings me joy”.

About the Author: Sharon Schindler Rising is a certified nurse-midwife and the President and CEO of the Centering Healthcare Institute and on the clinical nursing faculty at the Yale School of Nursing. Email: srising@centeringhealthcare.org

A Public Health Approach to Infant Vitality and Maternal Health Improvement

Noble Maseru, Ph.D. MPH, Health Commissioner (Cincinnati); Elizabeth Kelly, M.D.; Cincinnati Health Department

Abstract: The Cincinnati Health Department (CHD) in concert with the University Hospital Women’s Health Center, through the establishment of an Infant Vitality Surveillance Network (IVSN), has begun the process of documenting the public health burden of infant mortality in Cincinnati. Our focus is on the risks to infant death for specific populations. Our approach is targeted interventions that address the risks; reduces the risks; promote healthier life – takes into account relationships and their affects upon maternal and infant health.

The Problem: The infant mortality rate (IMR) in Cincinnati (2006-2010) was 13.6 deaths/1000 live births; 15 zip codes in Cincinnati have IMR 12.0 – 30.4 (2007-2009). The 15 zip codes are low income and large numbers of vulnerable populations. Those 15 double digit IMR zip codes are the focus of the IVSN.

Goal: To achieve health equity in infant vitality (infant mortality reduction), pre conceptual health and improve perinatal outcomes. The IVSN, with care coordination and public health intervention will achieve single digit IMR in all Cincinnati zip codes by 2015.

Objectives: 1) Expand the CHD UH IVSN; 2) Develop a shared protocol for: a) tracking perinatal and maternal health indicators; b) coordination of care of prenatal and postpartum mothers 3) Address the root causes of disparities in infant vitality by assisting to empower, mobilize and enfranchise communities to affect policy.

Outcomes: By 2015, reduce IMR for targeted zip codes from 16.5 (average IMR) to less than 10. A secondary outcome is by 2015, establish an IVSN that is institutionalized city wide.

About the Author: Noble A-W Maseru, Ph.D., M.P.H., is the Health Commissioner for the City of Cincinnati Health Department. Email: noble.maseru@cincinnati-oh.gov

Linking Women to Services for Maternal Depression

Courtney Hudson, Program Coordinator; Beth Kuckuck; Summit County Public Health

Abstract: Summit County Executive Russ Pry convened a group to create an early care and education system enhancement plan for Summit County. This group determined that maternal depression is an

important issue that needed to be addressed. The following strategies were identified: 1). Increase maternal depression screening and treatment options for new moms. 2). Establish and require the use of standardized tools when screening women for maternal depression. To better address these strategies, the Summit County Maternal Depression Network (SCMDN) was formed. SCMDN is comprised of the three hospital systems, Help Me Grow (HMG), Ohio Infant Mortality Reduction Initiative (OIMRI), public housing, mental health and substance abuse treatment providers, managed care agencies, public health, prenatal care providers and County of Summit Alcohol and Drug Addiction and Mental Health Services Board. The SCMDN has surveyed over 50 agencies, clinics, and health care providers about maternal depression screening and treatment services, identified best practice screening tools, created a fax referral system, trained community members to utilize screening tool, and developed a toolkit for agencies and physicians. Five mental health agencies have agreed to be part of the fax referral system. These agencies have agreed to identify a contact person to manage SCMDN referrals, inform referent of ability or inability to triage client within a week of receiving the faxed referral and contact client within two business days after receiving referral form to schedule first appointment. SCMDN works closely with other perinatal/maternal depression coalitions throughout Northeast Ohio.

About the Author: Courtney Hudson has served as the First Things First Coordinator since January 2011 at Summit County Public Health. Email: chudson@schd.org
Beth Kuckuck, LISW-S is the Children's Program Coordinator for the County of Summit Alcohol, Drug Addiction and Mental Health Services Board.

Encouraging Healthy Beginnings through Breastfeeding Promotion

Jeff Klingler, President and CEO- Central Ohio Hospital Council; Kris Reber- Nationwide Children's Hospital

Abstract: Franklin County's four hospital systems are working collaboratively to improve the rate of women who are breastfeeding when they are discharged following delivery. According to the American Academy of Pediatrics, mothers who breastfeed their newborns for a minimum of six months see benefits, including: •Babies are protected from infections and illnesses that include diarrhea, ear infections, pneumonia, and inflammatory bowel syndrome. •Babies are less likely to develop asthma or be readmitted to the hospital for other illnesses. •Children who are breastfed for six months are less likely to become obese, and have a reduced chance of developing type-2 diabetes. •Breastfeeding reduces the risk of sudden infant death syndrome (SIDS). •Mothers who breastfeed have a decreased risk of breast and ovarian cancers. In an effort to encourage breastfeeding among new mothers, local hospitals are working collaboratively to improve the number of women who are committed to breastfeeding at discharge. Hospitals have teamed with local community health centers and Columbus Public Health to understand the barriers pregnant women perceive to breastfeeding their babies through a local survey. Hospital OB directors are using the findings to better educate women on the benefits to breastfeeding and ways to overcome barriers, especially among ethnic populations. The directors are developing community-wide guidelines regarding hospitals' inpatient practices in support of breastfeeding. Local hospitals are also developing an "employer pledge," which is designed to encourage hospitals – and other area employers – to put in place practices that support breastfeeding among employees.

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Innovative programming and effective strategies to reduce infant mortality within the Hispanic Community

Mary Kay Martin Heldman, LISW-S, MSW- TriHealth; Silvia Richard, RN

Abstract: Over the past five years Cincinnati, Ohio has seen a dramatic increase in Spanish speaking families. Since 2007, Trihealth has reached out to the Spanish speaking prenatal families with innovative and effective Case Management. A bilingual RN and Social Worker coordinate comprehensive care to our Spanish speaking perinatal families to bridge the gap for health care and reduce infant mortality. Innovative community outreach targeted to Spanish families has encouraged and enhanced trusting relationships to access perinatal health care. During the roundtable discussions, we will share with the audience strategies that have worked to enhance trust, discuss barriers to care for our Hispanic families, and provide solutions to help prevent infant mortality with Hispanic families. Since 2007, the Hispanic Case Managers have provided services to over 1,200 babies born at Trihealth. Less than 1% of the babies born at Spanish speaking patients at TriHealth had babies that were in the NICU (14 babies), demise (20 babies), preterm (16 babies). We also case managed 98 Gestational Diabetic Mothers. Due to our innovative programming and management of grant funds, we provided needed diabetic supplies to our uninsured families helping prevent infant mortality. Since 2007, through Think Fist, we have provided safety classes to over 300 Spanish families and Cribs for Kids. Our Hispanic Case Management model works because we have partnered with our community, have trusting relationships, excellent medical care and provide solutions to the barriers to care. Es verdad, cada bebe cuenta...it is true every baby counts!

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Perinatal Periods of Risk Analysis: Ohio, 2006-2009

Sarah R Miller, MPH; Tricia Matz, MPH; Richard Thomas, MPH; Melissa VonderBrink, MPH; Connie Geidenberger, PhD; Elizabeth Conrey, PhD -Ohio Department of Health

Abstract: A population's infant mortality rate is considered an indicator of its health and welfare. Perinatal Periods of Risk Analysis (PPOR) applies an analytic framework to feto-infant death to create distinct risk periods based on age at death and birth weight. This model was applied to Vital Statistics data from the state of Ohio, 2006-2009 to determine the distribution of feto-infant deaths within the risk periods in each at-risk population. The overall feto-infant mortality rate was 6.4/1,000 live births and fetal deaths. Feto-infant mortality rates varied by race/ethnicity, age of mother (teen versus adult), and perinatal region of residence with non-Hispanic black births having the highest rate (10.1/1,000). Factors related to maternal health/prematurity contributed a larger share of the excess mortality among non-Hispanic blacks than in other groups. Non-Hispanic white adults with a high school education or less experienced excess feto-infant deaths within the Infant Health risk period associated with post-neonatal injury. Non-Hispanic black births also had excess mortality within this period due to SIDS. A possible explanation is that improper sleep position was found to be more common in this group. Non-Hispanic white teen mothers experienced excess mortality within the Newborn Care Risk period potentially associated with access to care issues. The results of this analysis contribute to the analytic phase of PPOR with the goal of informing subsequent stages so that they may be implemented by public health programs and assessed for effectiveness in reducing infant mortality in Ohio.

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A Team Approach to Managing Women with Diabetes and Pregnancy

Corinn Taylor, MSN, RN- TriHealth

Abstract: The diabetes and pregnancy program (DAPP) is an innovative program that provides a multi-disciplinary team approach to managing high risk pregnant women with pre-existing diabetes and gestational diabetes in a clinic setting. The DAPP team consists of a Nurse Case Manager (NCM), Social Worker (SW) and Dietician. The NCM and dietician provide education and make referrals to the SW. The NCM coordinate and facilitate care for patients' and emphasizes prevention, patient education, and self-management behaviors. The DAPP team meets weekly with patients' at their Obstetrician appointment to provide follow up education, support, encouragement and assistance with removing barriers interfering with effectively participating in care. The DAPP team assists the patients with transportation set up, obtaining medical insurance if uninsured, medications and diabetic supplies, telephone follow-up, parish nursing, healing touch, stress management and wellness classes, monthly breastfeeding classes and assistance with obtaining a safe link phone if patient does not have a phone. Patients' can receive an infant car seat and other home "safety items" through successful program attendance at "Think First for your Baby" which provides information on safe parenting and "Cribs for Kids" which provides a "pack-n-play" crib after being educated on safe sleep and sudden infant death syndrome. By offering education, support, referrals and services to this high risk vulnerable population, the goal of the DAPP is to improve perinatal health for women and to minimize the increased risk for maternal and neonatal complications associated with diabetic pregnancies.

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Cleveland Perinatal Depression Project - Blueprint for a Community Response

Avril S Albaugh, Project Director- Cleveland Regional Perinatal Network

Abstract: In 2005, the Cleveland Regional Perinatal Network (CRPN) received funding from Cuyahoga County Child and Family Health Services and the City of Cleveland, MomsFirst Project to improve the identification and referral of pregnant women at risk for depression in Cuyahoga County and establish the CRPN Perinatal Depression Project. Core components include: raise public awareness; train providers to identify women at risk; assist providers with developing and incorporating a care path into clinical practice, and; improve linkages between providers. The Project Coordinator developed a provider training model on perinatal depression and has provided free on-site agency training in Cuyahoga County and across Ohio. Training tools include the Edinburgh Postnatal Depression Scale, Carepath for screening and referral and the Maternal Behavioral Health Referral Form. In 2007, the Cuyahoga County Perinatal Depression Task force was convened by the project to address the need for improving linkages between providers involved with identifying, referring and treating perinatal depression. The Task force meets quarterly and representation involves a diverse group of community stakeholders which include health care, mental health and social service agencies. Project outcomes include: over 3000 providers trained locally, regionally and state-wide; a network of perinatal mental health providers following established referral guidelines; Carepaths developed at 10 agencies; quarterly referral data collected; project duplication in other counties; identified as "a promising model for the rest of the country" 2011 by Urban Institute in their research study "Home Visiting and Maternal Depression"; participation in the National Healthy Start "Intimate Partner Violence and Perinatal Depression" workgroup convened by HRSA/MCHB in 2011 and Project's Carepath and materials selected for workgroup's toolkit.

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Opiate Addiction in Pregnancy... Where Do We Go From Here?

Tosha Hill LSW Perinatal Social Worker; Priscilla Conley RN, BSN, MSN Nurse Case Manager-
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Abstract: Women from all walks of life struggle with opiate drug use, and special issues may come up during pregnancy. Women who are using are afraid that they will be treated differently, or made to feel guilty. Often, they avoid care during pregnancy. This can lead to problems for them during pregnancy and for the baby as well. Getting treatment with pregnancy care can improve birth outcomes for pregnant women who admit to opiate use and are willing to make a lifestyle change. Women, who begin the recovery process, do have better outcomes for their baby and their family. Our services were developed in October 2007 to provide quality health care for pregnant women who abuse opiate pain pills and/or heroin. Services include: Nurse case management, social work support, referrals to available community support services, nutrition counseling and financial counseling. The goal of our service is to be sensitive to patient's needs. Care is based on individual plans that may focus on entering into a treatment program and/or counseling. At each health care visit patients meet with the team to discuss current issues and or concerns. The team will include a nurse case manager, physician or nurse midwife, perinatal social worker, dietitian, and financial counselor. The goal of this program is to have better birth outcomes and reduce preterm labor.

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The Project to Reduce Infant Mortality Mobile Unit: Why it makes a difference

Sonia Booker, RN, MSN, Manager- OhioHealth

Abstract: The Project to Reduce Infant Morality was implemented in 1993 by Grant Medical Center and now supported by the health care system, OhioHealth. Over the years, this innovative program has reached over 4000 pregnant women, and delivered over 2600 babies. A mobile unit travels to 5 high schools sites per week, providing care to teens and women from the surrounding community. The staff consists of board certified OB/GYN physicians, register nurses, social worker, driver and registration staff. Several partner agencies provide unique services on board, Nationwide Children's Hospital Dental Clinic and the Columbus Metropolitan Library to name a few. The outcome of the program provides evidence of a best practice program that has embarked on unique approaches in delivering care and has been recognized locally and nationally. Data and outcomes from the program will be saved during the presentation.

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