

Office of Health Transformation **Reduce Infant Mortality**

Governor Kasich's Budget:

- *Provides enhanced maternal services through Medicaid health plans for every woman in neighborhoods most at risk for poor infant health outcomes.*
- *Requires Medicaid health plans to engage leaders from within high-risk neighborhoods to connect women to health care and other services.*
- *Launches new initiatives to prevent maternal smoking.*

Background:

Infant deaths – when a baby who is born alive dies within the first year of life – account for 63 percent of all childhood deaths in Ohio. The three leading causes of infant death are preterm births (47 percent), birth defects (14 percent), and sleep-related deaths (15 percent). Some risk factors, such as smoking, increase the risk of all three leading causes of infant death. There are many non-medical factors that correlate to poor infant health outcomes, including race, poverty, poor nutrition, and education.

Ohio's high infant mortality rate is among the worst in the nation. In 2011, Ohio's infant mortality rate was 7.88 (infant deaths per 1,000 live births) compared to the national rate of 6.07. Infant mortality impacts Ohio families differently, greatly influenced by race and location. In 2011, the black infant mortality rate was 15.45, more than twice the white rate of 6.39. Black babies are more likely to die within the first year of life even when social and economic factors are considered. Metropolitan and Appalachian counties also have higher rates of infant mortality compared to the state as a whole.

First Four Years:

In March 2011, Governor Kasich made reducing low birth weight babies a priority in his State of the State address. The Governor's Office of Health Transformation, working with Ohio Departments of Medicaid, Health, Mental Health and Addiction Services, and other human services agencies initiated an unprecedented package of reforms to improve overall health system performance for pregnant women and infants (*see more detail on each initiative [here](#)*). Although it is too early to see results in infant mortality outcomes, the scope and focus of these efforts is expected to significantly improve birth outcomes over time:

Improve Overall Health System Performance

- Extended Medicaid coverage to previously uninsured parents.
- Simplified the Medicaid eligibility and enrollment process for pregnant women.

- Supported the development of regional systems of perinatal care.
- Provided enhanced maternal care management for high risk pregnancies.
- Used vital statistics data linked to Medicaid claims to identify high-risk women.
- Required better discharge planning for babies in neonatal intensive care units.
- Financially rewarded health plans that improve infant health outcomes.
- Expanded access to Medicaid family planning benefits.

Focus Resources Where the Need is Greatest

- Supported community-specific efforts to reduce infant mortality.
- Increased local capacity to conduct fetal infant mortality reviews.
- Created “pregnancy pathways” connecting women to health care and other services.
- Provided more comprehensive care for opiate-challenged mothers.
- Standardized treatment options for Neonatal Abstinence Syndrome.

Prevent Premature Birth

- Facilitated Progesterone therapies for mothers at risk for preterm birth.
- Reduced scheduled deliveries prior to 39 weeks without medical necessity.
- Improved antenatal corticosteroid use to promote lung development in newborns.
- Increased the use of human milk to reduce infections in premature infants.
- Encouraged breast feeding, which is highly correlated to preventing infant death.
- Provided pregnant mothers access to tobacco cessation programs.

Prevent Birth Defects

- Trained nurses to encourage women to take folic acid supplements.
- Required newborn screening for Critical Congenital Heart Disease.
- Required newborn screening for Severe Combined Immunodeficiency.
- Piloted an obesity control program in the highest-risk counties.

Prevent Sleep-Related Deaths

- Launched a “safe sleep” campaign.
- Implemented a Sudden Unexpected Infant Death training protocol.

Executive Budget Proposal and Impact:

On December 4, 2014, Governor Kasich previewed elements of his Executive Budget with a group of 1,700 local leaders attending the 2014 Ohio Infant Mortality Summit sponsored by the Ohio Department of Health, in conjunction with the Ohio Collaborative to Prevent Infant Mortality. At the event, the Governor said the current infant mortality rate is “clearly unacceptable” and announced that the Ohio Departments of Medicaid and Health would work together to surge resources into the neighborhoods with the highest incidence of preterm birth and low-birth weight babies. Specifically, the Executive Budget will:

Focus Resources Where the Need is Greatest

- **Support enhanced care management for every woman in high-risk neighborhoods.** Ohio Medicaid managed care plans will be required to provide enhanced care management services for both pregnant and non-pregnant women in the most high-risk neighborhoods as a strategy to improve health status and future birth outcomes. The Ohio Department of Health is using vital statistics data to pinpoint specific “hot spot” neighborhoods that have the poorest birth outcomes in the state as measured by preterm birth and low-birth weight babies. Using this data, Ohio Medicaid will be directing its health plans to automatically connect pregnant women and infants in these neighborhoods to enhanced care management services. In addition, women in these neighborhoods who are not pregnant now have access to additional care management services to improve their overall health and ultimately impact the health of future babies. The cost of this initiative is included in the rate currently paid to health plans and has no impact on the budget.
- **Engage leaders in high-risk neighborhoods to connect women to health care.** In addition to automatically requiring enhanced care management for all women of child-bearing age in high-risk neighborhoods, Ohio Medicaid will also direct its managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach and identification of women, especially pregnant women, to make sure they are connected to ideal health care and other community supports. Rather than reach into a community and risk misunderstanding the issues that confront the women who live there, this proposal requires the plans to identify individuals from within the community who understand the issues and can remove barriers for the women living there. The community health worker will be expected to address more than just health care, and also connect women to community services outside the health plan that support healthy living and work. The health plans will be required to coordinate with local health districts in high-risk neighborhoods and, together, develop a communications plan to ensure all health care and community supports are aligned toward decreasing infant mortality and improving the health of families. This provision costs \$13.4 million (\$5.0 million state share) per year in 2016 and 2017.
- **Focus evidence-based strategies to reduce maternal smoking.** Smoking during pregnancy accounts for 20 to 30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and about 10 percent of all infant deaths.¹ The Executive Budget proposes a number of initiatives to reduce tobacco use, including a significant increase in the tobacco tax (see *Reduce Tobacco Use*). In addition, ODH and Ohio Medicaid will use Tobacco Master Settlement Agreement funds to develop two standardized tobacco cessation toolkits, one to *initiate* tobacco cessation (2-3 months duration) and one to *maintain* tobacco cessation (up to 12 months). The toolkits will be used by Medicaid health plans, health care providers, and local health districts to provide individualized

¹ HHS, Women and Smoking: A Report of the Surgeon General (2001).

assessments and match individuals to the most effective services available for them. This effort will focus first on neighborhoods identified by ODH as most at risk for poor birth outcomes, and provide an opportunity for multiple community partners to target tobacco cessation messages, health-related activities, and grassroots engagement in ways that account for regional and cultural differences. Over five years, \$13.7 million in Tobacco Master Settlement Agreement funds will support this initiative.

- **Expand access to peer support programs for expecting mothers.** “Centering Pregnancy” is an evidence-based health care delivery model that integrates maternal health care assessment, education, and support. The Ohio Department of Health together with the Ohio Association of Community Health Centers will establish and evaluate the Centering Pregnancy model of care in two urban and two rural settings. The four projects will be located in communities that are at high risk for poor infant health outcomes. Governor Kasich committed \$900,000 over three years from Ohio’s Health Innovation Fund for this project, so there is no impact on the Executive Budget.

Strengthen Ongoing Initiatives

- **Eliminate payments for medically unnecessary scheduled deliveries.** In 2007, ODH and Ohio Medicaid created the Ohio Perinatal Quality Collaborative (OPQC). This group is committed to reducing preterm births and improving outcomes of preterm newborns through evidence-based practices and data-driven strategies. From 2008-2010, OPQC worked with 20 Ohio maternity hospitals to prevent unnecessary scheduled early deliveries between 36 and 39 weeks and, based on the success of that early work, expanded to all maternity hospitals. These efforts coincided with a substantial decrease in early scheduled deliveries, moving 31,600 births from 36-38 weeks to 39 weeks or more between 2008 and 2013. Based on recent Ohio experience and data, this decrease in near term births likely prevented as many as 950 Neonatal Intensive Care Unit (NICU) admissions, with an estimated cost savings of \$19 million. Now Ohio Medicaid will revise its rules to only pay providers if the gestational age of the fetus is at least 39 weeks or maternal and/or fetal conditions indicate medical necessity.
- **Improve the administration of Progesterone for at-risk mothers.** Providing Progesterone to women at risk is an effective way to prevent preterm birth. Progesterone treatment (called 17P) has the potential to reduce the incidence of preterm birth by as much as 30 percent, and specifically to reduce the number of infants born before 32 weeks when rates of infant mortality are highest. Ohio Medicaid estimates that currently less than 20 percent of high-risk women enrolled in Medicaid that are eligible for 17P are receiving it. Ohio Medicaid initiated a Progesterone Quality Improvement project to increase the number of eligible high-risk pregnant women receiving 17P. As one of two states receiving federal permission for Ohio Medicaid to restructure quality improvement and data processes, it allows for a continuous accounting of health plan performance using data from birth certificates identifying birth outcomes and providing this information back to health plans in real time. This

data transparency is in alignment with OPQC and health system processes, and holds promise for accelerating improved preterm birth rates that can be measured at a population level.

- **Strengthen regional systems of perinatal care.** Perinatal regionalization is a system of designating and planning for at-risk mothers and infants to be matched to facilities that can manage their complex care. ODH will work to update rules regarding Maternity Units and Homes to align with the professional standards in the most recent edition of the Guidelines for Perinatal Care, and convene a Maternity and Newborn Advisory Council to engage stakeholders to provide recommendations on rules that reinforce effective regional systems of perinatal care.
- **Partner with hospitals to educate parents about safe sleep for their infant.** The Ohio Hospital Association and ODH have been working together to educate Ohioans about infant safe sleep, and recently launched the Safe Sleep is Good4Baby statewide initiative to draw attention to the importance of safe sleep in the hospital and at home. This initiative focuses on modeling safe sleep practices in the hospital, educating parents and families, and advocating and educating community members. As a result, new moms and dads now receive a safe sleep kit prior to leaving the hospital, including education materials to protect their newborn and a book called *Sleep Baby Safe and Snug*.
- **Invest in research to reduce infant mortality.** To better understand the factors contributing to Ohio's unacceptable infant mortality rate, the Executive Budget provides \$1 million per year in 2016 and 2017 from the Third Frontier Fund to the Board of Regents to advance collaborative research at institutions of higher education.
- **Conduct state infant and child fatality reviews.** Every county maintains a local board to review all infant and child deaths in each of Ohio's 88 counties. These local boards annually submit a report to ODH, including data about each death. The Executive Budget allows ODH to convene a state-level review board composed of experts to examine this data and, if necessary, review particularly difficult or complex cases. This review will assist in not only increasing knowledge about these deaths, but help support the development of future recommendations to decrease infant mortality.
- **Increase the state's capability to analyze and respond to infant mortality data.** ODH holds a tremendous amount of vital statistics data within its data warehouse that can be used to drive Ohio's infant mortality reduction initiatives. As the State continues to increase investments and focus on these initiatives, there is a need for increased analytical capacity and evaluation of both state and local efforts. ODH will work with state and local partners to develop information sharing capabilities and evaluation of existing interventions. The goal is to expand state capability to measure progress in reducing infant mortality, and ensure that decisions are data-driven and investments are outcome based. This provision costs \$1 million per year in 2016 and 2017.