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For A Hearing On Infant Mortality
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Chairman Burke. Vice Chair Manning, Ranking Member Cafaro, and distinguished members of the Medicaid Committee, thank you for inviting me to appear before you today to discuss the important issue of infant mortality.

Health, as defined by the World Health Organization*, is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity*. Health is created through the interaction of **individual, social, economic, and environmental factors**, and by the **policies**, systems, and processes encountered in everyday life.

(Source: Infant Mortality Reduction Plan for Minnesota, March 2015)

These systems, policies, and processes influence **access to health care**, the availability of jobs, wages, transportation, the quality of housing and neighborhoods, the food supply, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of support networks.

Infant mortality is defined as the death of any live-born baby prior to his or her first birthday. The infant mortality rate reflects how well a society organizes and allocates the above-mentioned resources to benefit the health of its population and

is considered one of the world's most reliable and sensitive indicators of well-being. Based on this measure, Ohio is not doing well.

Last week, on May 13th, the Ohio House of Representatives unanimously passed Ohio House Concurrent Resolution 12, sponsored by the distinguished State Representatives Sarah LaTourette and Nickie Antonio and co-sponsored by approximately sixty-two (62) other State Representatives. That Concurrent Resolution states *"Ohio is ranked among the worst in the nation in infant mortality at #47"* (from the NCHS, 2011 data) and *"declares Ohio's rate of infant mortality a public health crisis that deserves significant and immediate attention by all stakeholders…".*

The same resolution reminds us that:

- *"Preterm birth is the leading cause of infant mortality in Ohio."*
- *"About half of all pregnancy-related costs are driven by preterm births, (largely because of expensive care of infants in neonatal intensive care units (NICUs)."*
- *"Socioeconomics, education, geography, and other factors contribute to **health access barriers for many Ohio women and a lack of prenatal care increases the risk of preterm birth and infant mortality**."*
- The statewide utilization of cervical length measurement in pregnant women is important to assist efforts to identify expectant mothers at risk of preterm delivery and to enhance our opportunity to favorably influence the outcomes of pregnancies with a short cervix by using Progesterone. To do this, the resolution points out that
- *"Among the top priorities of the Ohio Department of Medicaid is **the more timely identification of high risk expectant mothers** to provide enhanced services, such as ensuring "progesterone without barriers" for pregnant women."*

Despite this declaration, this same General Assembly is simultaneously considering legislation (policy) that would restrict availability of the services that House Concurrent Resolution 12 declares to be essential to improve birth outcomes and decrease infant mortality. Cervical length measurement and (often) the initiation of Progesterone treatment need to occur early in the second trimester of pregnancy. If women do not have insurance in early pregnancy, they cannot access these essential services.

A recent fact sheet provided by the Ohio Chapter of the March of Dimes entitled Medicaid Coverage for Pregnant Women, states that:

> *"Access to regular, quality prenatal care and labor and delivery services is essential to both the health and economic stability of pregnant women and their families. Medicaid provides vital coverage to pregnant women who might otherwise be unable to afford insurance, including coverage purchased through the Exchange.*
>
> *In our state, Medicaid offers coverage to women who become pregnant and earn up to*

205% of the federal poverty level (FPL). Medicaid covers regular prenatal care visits, medications needed to maintain good health during pregnancy, and related services with little or no cost-sharing. It also covers labor and delivery services, and hospital care for both mother and baby.

If this coverage is rolled back to lower eligibility levels, many low-income pregnant women may be left without access to affordable care*. While pregnant women can enroll in Medicaid at any time, Exchange coverage is only available during open enrollment periods. Exchange plans benefits may not be adequate and cost-sharing is shown to be much higher than in Medicaid. As a result, some pregnant women may be forced to forego care. The March of Dimes opposes proposals to roll back Medicaid coverage for pregnant women from current levels."*

Our policies form the foundation for life in Ohio. Our poor infant mortality rate ranking is not because babies born elsewhere are hardier than babies born in Ohio. Our challenge is not because other States have smarter doctors, midwives, and nurses or better hospitals than we do in Ohio. Much of the deficit we experience is as a consequence of policies, systems, and processes supported (or not adopted) in our State that place families at increased risk of compromised outcomes.

Addressing the issue of infant mortality is complex and requires a long-term investment by multiple stakeholders whose contributions are aligned. Ohio's current efforts to improve infant mortality can be traced back to 2009 when State Leadership called for the formation of an Ohio Infant Mortality Task Force. The Task Force consisted of public health officials, policy makers, community members, health care providers and other stakeholders representing much of Ohio. That Task Force made 10 recommendations to State Government. The Ohio Collaborative to Prevent Infant Mortality (OCPIM) is the organization that was formed to implement the recommendations, evaluate their impact, and oversee our infant mortality reduction efforts. Today OCPIM consist of representation from over 100 community and state organizations and we have done our best to be good and faithful stewards of this responsibility.

After more than a decade of worsening infant mortality rates, from 2011 to 2013 (preliminary data) the Ohio overall, white, and black infant mortality rates improved by 7%, 7.3%, and 13.5%, respectively. While it is much too early to suggest that we have "turned the corner" regarding infant mortality, we believe we are headed in the right direction. These improvements occurred as a consequence of informing Ohio citizens of the reality of the number of babies that are dying in their very own communities, helping people understand what needs to be done to improve our results, assisting local communities generate conversations and implement interventions to improve outcomes, and working with various State agencies and organizations (ODH, Medicaid, the Ohio Hospital Association, OPQC, March of Dimes and others) to figure out how we can augment these local efforts and all work together to improve these outcomes.

The Ohio Senate is included in the State agencies involved in this work. Under the leadership of Senators Shannon Jones, Charletta Tavares, and Peggy Lehner of the Senate Health and Human Services Committee, the Ohio General Assembly and Governor Kasich enacted bills that strengthen the foundation for our efforts to decrease the rate from which Ohio babies die from SIDS and sleep related deaths. These causes of infant deaths are the most common reason for babies dying from one month to one year of age. Death during this period is referred to as post-neonatal mortality. As a consequence of everyone working together, the post neonatal mortality rate for Ohio from 2011 to 2013 (preliminary) improved by 14.9%, 19.7%, and 24.5% for overall, white, and black post neonatal rates of death, respectively. Though this is preliminary data, they represent incredible rates of improvement. We should all be exceptionally proud of this accomplishment. More importantly, this improvement demonstrates what we can do **when we all work together and when you create and support policies that facilitate our opportunity to improve outcomes.**

Many other statewide efforts are summarized below:

In 2012:

- OCPIM oversaw the first public release of Ohio infant mortality data (beginning a continuing process of educating the public about why babies die and what we can do about it).
- OCPIM and ODH hosted the State's first Infant Mortality Summit (over 900 Ohioans attended), and encouraged communities to host their own Summits to initiate local conversations about how to improve infant mortality.
  - Subsequently, Summit County conducted its own Summit, and several other communities held infant mortality meetings.
- Cincinnati developed a Best Baby Zone (now one of only three in the nation).
- Ohio adopts the State Plan Amendment (SPA -- available nationally since 1986, but not adopted in our State until January of 2012)…and is currently amongst the policies you are considering eliminating.
  - This policy provides a modified form of Medicaid that covers contraception, pap smears, STD screening and treatment, mammography, etc. It does not cover abortions or assisted reproductive technology. The SPA is considered an important mechanism to assist efforts to decrease the incidence of unintended pregnancies (which are associated with a higher risk of infant mortality).

During 2013:

- ODH revised its breast feeding policy and introduced Ohio's first ever Safe Sleep Policy.
- Hamilton County developed Cradle Cincinnati.
- Governor Kasich increased funding for infant mortality efforts.

- Ohio joined a national infant mortality reduction effort called CoIIN (Collaborative Improvement and Innovation Network, an infant mortality improvement program began by HRSA and other national maternal child health organizations).
- Ohio formed the Ohio Institute for Equity in Birth Outcomes (becoming the first and only State in the nation to have such an institute),
    - Partnership between ODH, Local Health Departments and CityMatCH (a national Maternal Child Health organization)
    - Located in 9 Ohio counties (Butler (Hamilton/Middletown), Cuyahoga (Cleveland), Franklin (Columbus), Hamilton (Cincinnati), Lucas (Toledo), Mahoning (Youngstown), Montgomery (Dayton), Stark (Canton), and Summit (Akron)
    - These 9 counties account for 45% of white births and 49% of white infant deaths in Ohio and 90% of black births and 95% of Ohio's black infant deaths. So, if we can implement effective intervention strategies in these communities (and we implement them equitably) we offer Ohio an opportunity to simultaneously decrease its overall infant mortality rate and improve the black:white racial disparity in birth outcomes.
- The March of Dimes (MoD) expanded its semi-annual Prematurity conference from one conference to three regional conferences.
- The MoD started the Prematurity Research Ohio Collaborative.
- The Director of Health made infant mortality one of four priority health issues for our State and toured the State educating Ohio citizens about the issue.
- Subsequently, Senator Shannon Jones and Senator Charletta Tavares also toured much of the State to both learn about infant mortality efforts and educate Ohio citizens about this problem.
    - After the tour the Senators sponsored legislation assisting our efforts to decrease the incidence of sleep related deaths.

During 2014:

- OPQC began a statewide effort to increase utilization of Progesterone to decrease the impact of premature births on infant mortality.
- OPQC launched "Every week Matters" campaign.
- The Greater Columbus Infant Mortality Task Force was formed.
- Medicaid Expansion
- Ohio adopted Presumptive Eligibility (available nationally since 1986 but not adopted statewide for pregnant women in Ohio until mid-2014).
- Expansion of Ohio Healthy Start sites from two (Cleveland and Columbus) to five with the additions of Cincinnati, Dayton, and Toledo.
- Columbus Fire Department began screening all homes they visit for Safe Sleep conditions.
- The Ohio SID Network conducted Safe Sleep Community Forums (Akron, Cleveland, Dayton, Elyria, Loraine, and Youngstown/Mahoning,)

- The Ohio Hospital Association adopted reduction of infant mortality as one of its key projects.
- Ohio Right-to-Life conducted its first ever Infant Mortality Summit.
- The Ohio Chapter of the American Academy of Pediatrics launched a "Say No to Bumpers" Campaign.
- The Ohio Department of Medicaid worked on payment reform and encouraged Ohio Managed Care Organizations to be a bigger part of Ohio's infant mortality reduction efforts.
- OCPIM and ODH host Ohio's second Infant Mortality Summit.
    - Governor Kasich spoke, supports infant mortality reduction in Ohio
    - Over 1700 people attended
- The Ohio Association of Community Health Centers adopted infant mortality reduction as a key project.
- At the Federal level, Senator Sherrod Brown's bill on Sudden Unexpected Infant Deaths and Childhood Deaths passed the House and Senate and is now national law.

During 2015:

- After almost one year of work, just one week ago (May 12, 2015), the Executive Committee of OCPIM approved Ohio's first statewide Infant Mortality Reduction Plan. Although this plan still has to be approved by OCPIM membership, it emphasizes "Collective Impact," "life course", and "equity" as essential pillars and advocates utilizing nationally accepted infant mortality improvement modalities. The seven strategic focus areas are:
    1. Improving Health Equity, Addressing the Social Determinants of Health and Eliminating Racism
    2. Promoting Optimal Women's Health Before, During, and After Pregnancy
    3. Preventing Premature Births
    4. Preventing Birth Defects
    5. Promoting Optimal Infant Health
    6. Reducing Smoking Before, During, and After Pregnancy, and
    7. Promoting Fatherhood Involvement in Maternal Child Health

To date, these efforts have been very "intentional". OCPIM has worked hard to broaden its membership and its impact. Currently, you are considering legislation that will increase the number of uninsured Ohioans. If adopted, this policy increases the number of uninsured expectant mothers who will not receive timely prenatal care and thereby place more of our citizens at increased risk of compromised outcome, including infant mortality. If adopted, you will enact legislation that risks reversing much of the recent accomplishments we have made. While there are many wonderful proposals to improve infant mortality amongst the legislation you are considering, collectively those other proposals will not compensate for the deficit created by no longer providing Medicaid coverage up to 205% of the FPL.

On behalf of OCPIM, I would like to thank the Senate Committee on Medicaid for the opportunity to participate in today's important hearing. I would also like to take this opportunity to thank this Committee, the Ohio General Assembly, the Ohio Department of Health and the Governor's Administration for your efforts to keep Ohio babies alive.

Sincerely,

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