



**Maternal and Infant Health Monthly Surveillance Report**  
**Hamilton County**  
**January 2012**

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# Introduction

The series of Maternal and Infant Health Monthly Surveillance Reports are part of a county-wide initiative to improve maternal and infant health and to reduce infant mortality. In order to take effective actions to improve the health and safety of infants in the community, it is essential to identify, describe, and monitor the problems and the populations at risk. This report characterizes the current status of infant mortality in Hamilton County.

The data sources for this report series have been enhanced to improve the monthly surveillance process. The Ohio Department of Health (ODH) is now providing additional mortality data to Hamilton County Public Health on a monthly basis that will be used to improve the timeliness and accuracy of monthly surveillance. These provisional data are numbers only and do not include any additional information from birth or death certificates (**Appendix A**). The mortality data included in this report were obtained from ODH on January 9, 2012; the birth data were obtained on January 12, 2012.

## Infant Mortality Surveillance

- Number of infant deaths by month
- Current monthly infant mortality rate
- Current monthly neonatal mortality rate
- Current monthly preterm birth rate
- Current two year IMR moving average
- Comparison of “Filed” and “Unfiled” data

## Infant Mortality Surveillance

Public health surveillance is the ongoing systematic collection, analysis, interpretation and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.<sup>1</sup> The Maternal and Infant Health Surveillance System is designed to better understand infant morbidity and mortality in our community, monitor infant deaths and evaluate whether collective actions to prevent infant death are effective. The surveillance charts contained within this report are tools that are used to monitor infant mortality and select risk factors in our community. Please read the General Guidelines for Using Surveillance Charts in **Appendix B**.

<sup>1</sup>Centers for Disease Control and Prevention. *Updated Guidelines for Evaluating Public Health Surveillance Systems: Recommendations from the Guidelines Working Group*, MMWR, July 27, 2001, Vol.50 No. RR—13

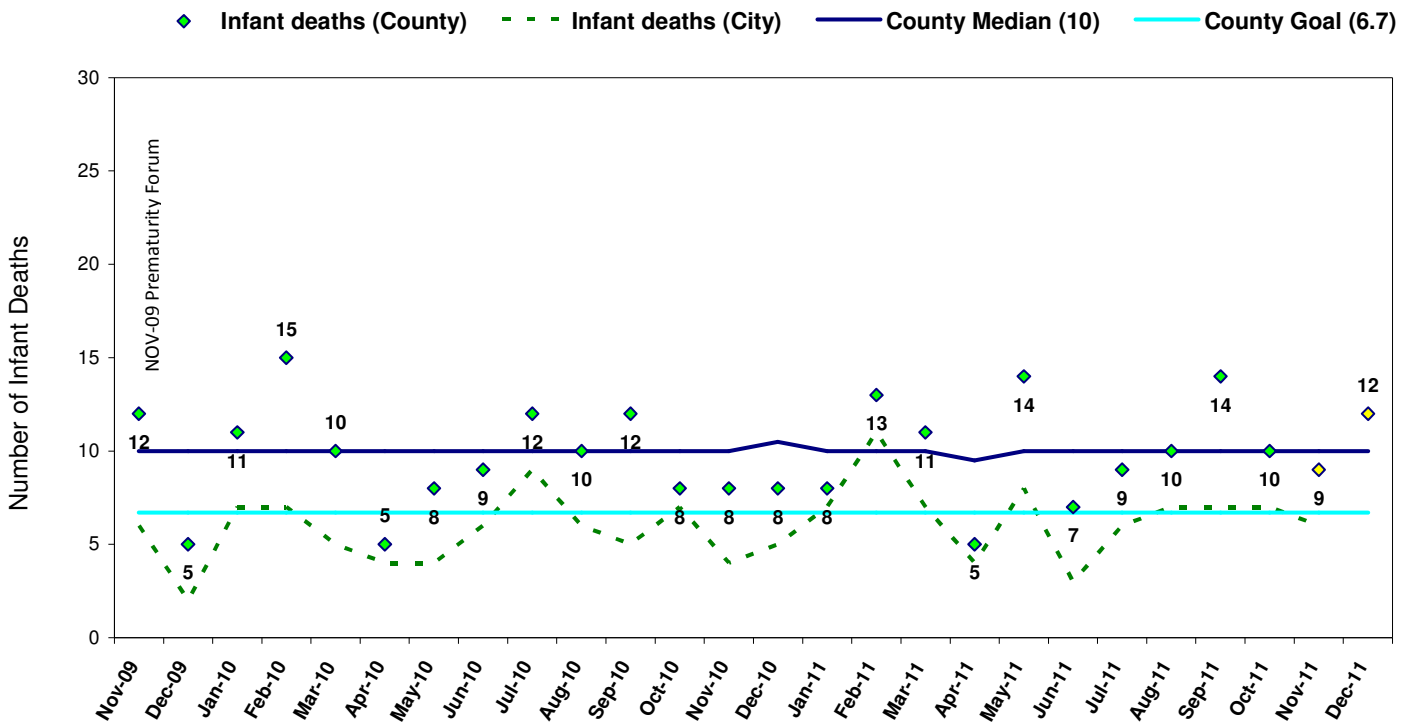
## Number of Infant Deaths

**Table 1. Number of Infant Deaths, Hamilton County 2010\*-2011\***

Month	Infant Deaths 2010	Infant Deaths 2011
January	11	8
February	15	13
March	9	11
April	5	5
May	8	14
June	9	7
July	12	9
August	10	10
September	12	14
October	8	10
November	8	9
December	8	12
<b>Total</b>	<b>115</b>	<b>122</b>

One measure of infant mortality is the number of infant deaths per month. Figure 1 below shows the count of infant deaths in Hamilton County and Cincinnati by month over the past two years. In December 2011, the number of infant deaths (12) within Hamilton County was above the median of infant deaths for the prior 24 months (Figure 1). No infant deaths had been reported for the City of Cincinnati in December 2011 at the time of data gathering for this report. Table 1 displays the provisional number of infant deaths each month in 2010 and 2011. In 2011, the highest infant death count occurred in May and September. Provisional data for 2011 indicate that 60% of infant deaths have occurred to residents of Cincinnati (Figure 1). Please see **Appendix A** on page 6 to learn more about the provisional death data limitations.

**Figure 1. Number of Infant Deaths, Hamilton County Nov 2009 – Dec 2011\***



NOTE: The county median is calculated using data from Nov 2009 – Oct 2011.

\* Data for 2010-2011 are provisional; ODH reconciles (i.e., finalizes) data by fall of the subsequent year. Yellow points are more likely to change in future reports.

\*\* Data for the City of Cincinnati should be interpreted with caution after 2009. Records in 2010-2011 have not been geo-coded and city assignment is based on provisional methods; data are subject to change. December data contained 0 infant deaths for Cincinnati as of 1/9/12.

Data Source: Ohio Department of Health Vital Statistics

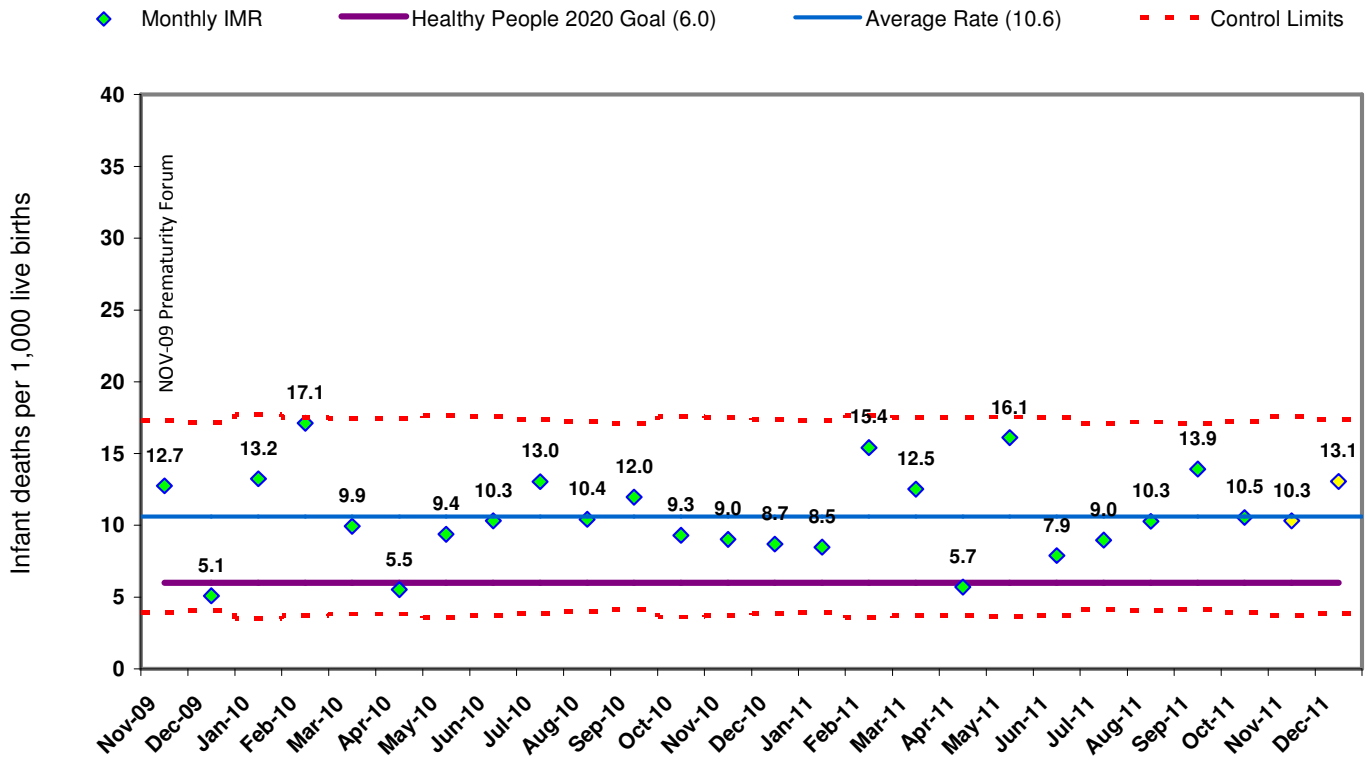
## Infant Mortality Rates

Another method used to monitor infant mortality is examination of the number of infant deaths in relation to the total number of births. An increase in the number of infant deaths may not be surprising if there is also an increase in the overall number of babies born. To evaluate infant deaths with regard to the number of births, the Infant Mortality Rate (IMR) is calculated. The monthly IMR is the number of infants (children less than one year of age) who died divided by the number of live births during the month per 1,000 live births. The Neonatal Infant Mortality Rate (NIMR) is a specific IMR for neonates (infants younger than 28 days) who died per 1,000 live births.

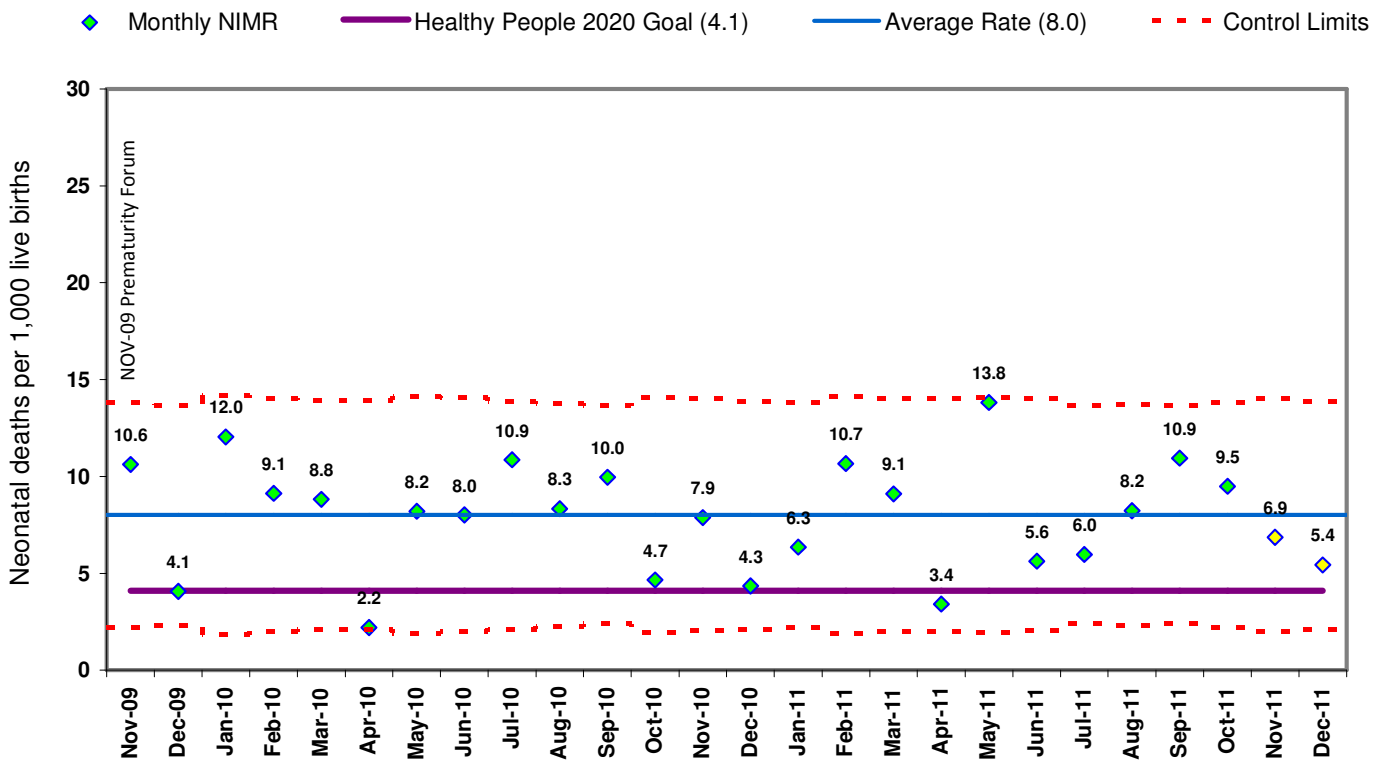
The IMR for December is estimated to be 13.1. This provisional rate is within the control limits for the data, but above the Healthy People 2020 goal (6.0).

The IMR for December is currently estimated to be 13.1 (Figure 2). December was above the average IMR (10.6) as shown in Figure 2. The IMR was calculated based on an estimated 919 births for the month of December. Subsequent reports will provide improved statistical validity of these estimates (**Appendix A**). The December NIMR remained within the statistical thresholds and is displayed in Figure 3. The December (5.4) NIMR is above the Healthy People 2020 goal of 4.1 neonatal deaths per 1,000 live births. Neonatal deaths account for 72.1% of the 2011 infant deaths as of data collected on January 9, 2012.

**Figure 2. Infant Mortality Rate Surveillance Chart, Hamilton County Nov 2009-Dec 2011\***



**Figure 3. Neonatal Mortality Rate Surveillance Chart, Hamilton County Nov 2009-Dec 2011\***



NOTE: The mean is calculated using two years of data from Nov 2009 – Oct 2011. Yellow points are more likely to change in future reports. The current month's mortality rates are calculated with an estimated denominator. The denominator is an average of the number of births from the preceding 24 months.

\*Data for 2010-2011 are provisional

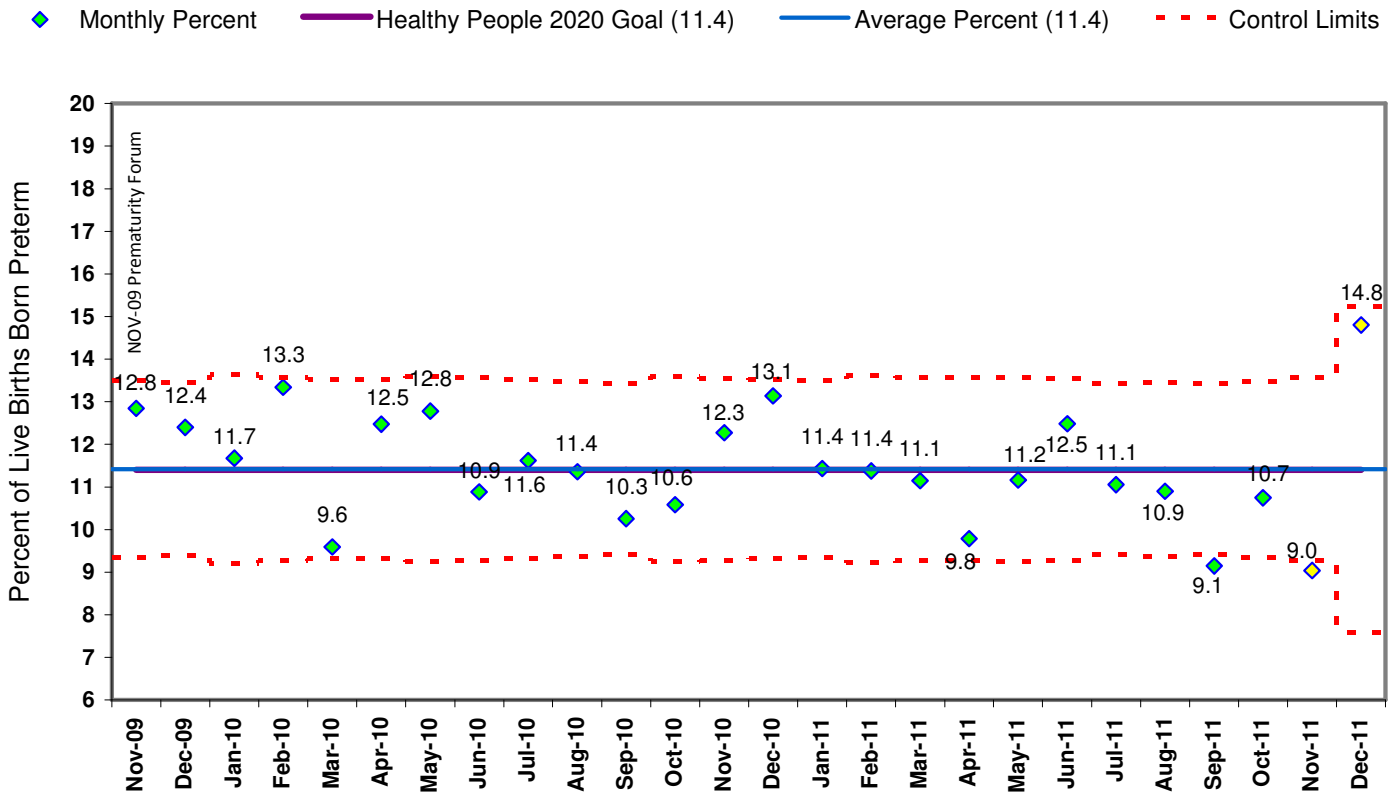
Data Source: Ohio Department of Health Vital Statistics

# Preterm Birth Rates

The preterm birth rate is the percentage of infants born before 37 weeks gestation. Pre-term birth is a significant risk factor of infant mortality and many other adverse health outcomes. The preterm birth rate has been below the current two-year average of 11.4% every month this year except for June and December. The provisional preterm birth percentage for December is 14.8%; this rate is above the Healthy People 2020 goal of 11.4% for all live births. This goal was increased from the Health People 2010 goal for pre-term births—7.6% of all live births.

The preterm birth rate for December (14.8%) was above the average (11.4%) and Healthy People 2020 goal for pre-term births (11.4%). These data are provisional and may change in future reports.

**Figure 4. Preterm Birth Rate Surveillance Chart, Hamilton County Nov 2009-Dec 2011\***

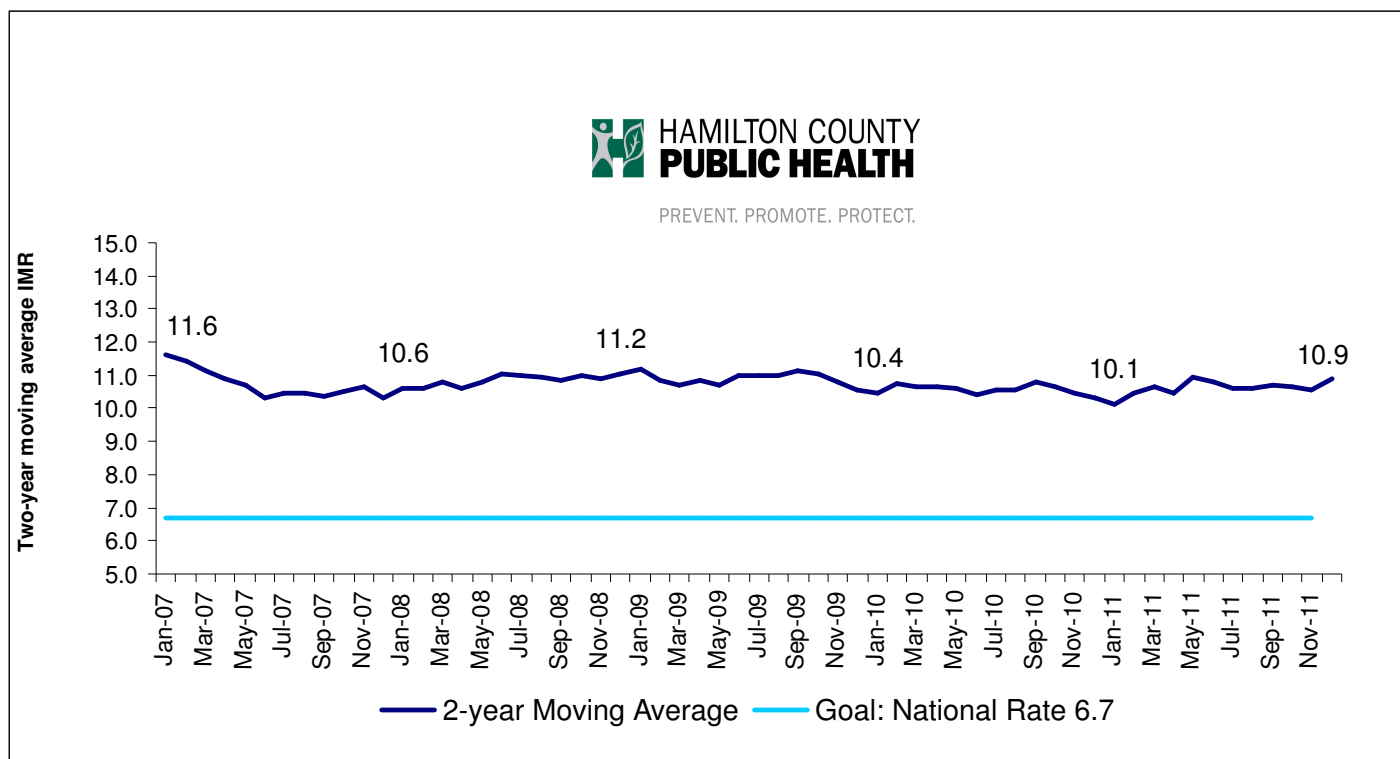


NOTE: The mean is calculated using two years of data from Nov 2009 – Oct 2011. Yellow points are more likely to change in future reports.  
 \*Data for 2010-2011 are provisional  
 Data Source: Ohio Department of Health Vital Statistics

## Two Year Moving Average

Reviewing monthly rates is one approach used to determine whether there has been a change over time in infant mortality. However, monthly rates have a tendency to fluctuate and may disguise emerging trends. An alternative measure is the un-weighted, monthly moving average, which can provide a more stable picture of evolving patterns. In Figure 5, the infant mortality rate for each month is the 24 month average of months immediately prior to and including the current month. The two-year moving average decreased from January 2007 (11.6) to December 2011 (10.9) as shown in Figure 5. Please note that the moving average is subject to change based on new data, which may ultimately affect current trends. Multiple approaches are required to measure the impact of program efforts on infant mortality.

**Figure 5. Two Year Moving Average Infant Mortality Rate by Month, Hamilton County Jan 2007- Dec 2011\***



NOTE: The infant mortality rate for each month is the average of twenty-four months immediately prior to and including that month.

\*Data for 2010-2011 are provisional

Data Source: Ohio Department of Health Vital Statistics

## Appendix A- Data Limitations

There are multiple datasets that can be used to support surveillance activities associated with infant mortality. Two primary data sources are used to supply the data for monthly Maternal and Infant Health Surveillance Reports ([http://www.hamiltoncountyhealth.org/en/resource\\_library/reports.html](http://www.hamiltoncountyhealth.org/en/resource_library/reports.html)). Both of these data sources are considered provisional until the Ohio Department of Health (ODH) completes data reconciliation processes each year. Provisional Data Source A (PDS-A) contains records that correspond to filed certificates and are linkable (i.e., birth to death records), whereas Provisional Data Source B (PDS-B) contains records that correspond to both filed and unfiled/pending certificates and are not linkable. The former (PDS-A) is used for more in-depth analysis of risk factors, but suffers from incompleteness due to missing unfiled/pending certificates. The latter (PDS-B) is used to collect death data more expeditiously, but provides only count data, precluding more in-depth analysis of prenatal and perinatal risk factors. Data from both PDS-A and PDS-B become more accurate as the length of time increases from event to report. Annually, ODH releases a reconciled dataset that contains final cause of death information and geographic information.

PDS-B is used in this report to provide the count statistics in each section except infant deaths within the city of Cincinnati (Figure 1) and preterm births (Figure 4). Table 2 displays the discrepancy between the two infant mortality data sources available from ODH. There were sixteen (13.1%) infant deaths in 2011 that were not yet filed at the time of this report (Table 2). Please note that delayed certificates directly impact data quality and therefore, the integrity of findings shared in this report.

<b>Data Source</b>	<b>2010</b>	<b>2011</b>
	<b>No. Infants &lt; 1 yr.</b>	<b>No. Infants &lt; 1 yr.</b>
<b>PDS-A</b>	<b>115</b>	<b>106</b>
<b>PDS-B</b>	<b>115</b>	<b>122</b>
<b>Discrepancy</b>	<b>0</b>	<b>16</b>

## Appendix B

### General Guidelines for Using Surveillance Charts

The Hamilton County Infant Mortality Surveillance System, part of the Office of Maternal and Infant Health and Infant Mortality Reduction, uses **surveillance charts** to monitor infant mortality rates and preterm birth rates. These charts provide a method for monitoring the status of infant health over time and provide timely feedback on the effectiveness of local efforts to reduce infant deaths and preterm births.

Several tools are included in the surveillance charts that help facilitate interpretation: (1) a baseline - the center line which is the average number of deaths or births per month over the preceding two years, (2) a goal line which shows the goal that has been established by the community and (3) upper and lower control limits [dashed] that allow users to detect unusual events. Annotations indicate when certain interventions began or special changes occurred.

Here are some types of unexpected events that could be detected within surveillance charts:

- \* A single point outside of the control limit
- \* A run of eight or more consecutive points below or above the center line
- \* Six consecutive decreasing or increasing points
- \* Two out of three consecutive points near a control limit

**This report was prepared for the Office of Maternal and Infant Health and Infant Mortality Reduction, now known as the Women and Infant Vitality Network.**



*Thank you to John Paulson and Inez Williams, Ohio Department of Health Center for Public Health Statistics and Informatics, and Merrily Wholf, Ohio Bureau of Child and Family Health Services, for providing data for this report. We also appreciate the contributions of the Child Policy Research Center at Cincinnati Children's Hospital Medical Center for ongoing quality improvement support and the HCIMSS Data Work Group for input and guidance.*