



Maternal and Infant Health Monthly Surveillance Report
Hamilton County
March 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 March 13, 2012; the birth data were obtained on March 1, 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.¹ 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**.

¹Centers 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

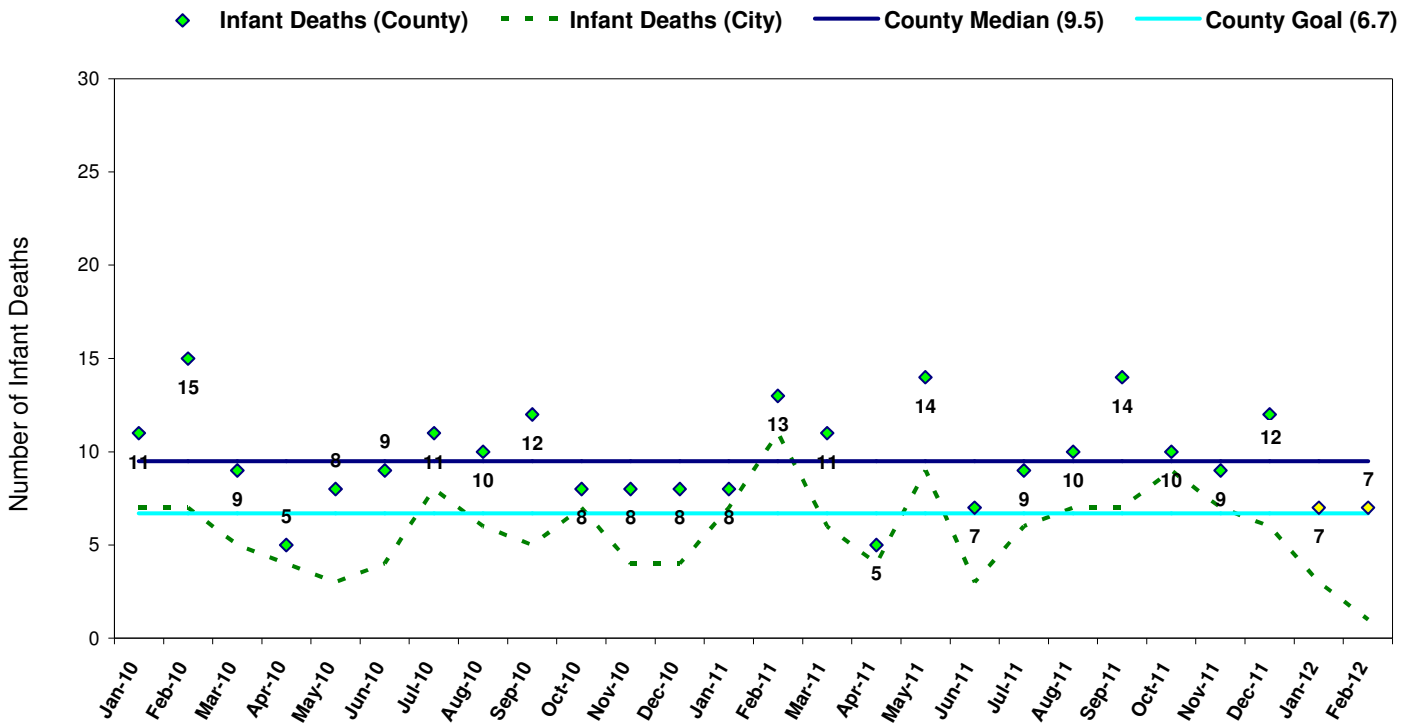
Number of Infant Deaths

Table 1. Number of Infant Deaths and Births, Hamilton County 2011*-2012*

Month	Infant Deaths 2011	Infant Deaths 2012	Infant Births 2011	Infant Births 2012
January	8	7	946	859
February	13	7	845	466
March	11		880	
April	5		880	
May	14		869	
June	7		889	
July	9		1,005	
August	10		977	
September	14		1,012	
October	10		956	
November	9		918	
December	12		882	
Total	122	14	11,059	1,325

One measure of infant mortality is the number of infant deaths per month. Figure 1 below shows the monthly count of infant deaths in Hamilton County and Cincinnati over the past two years. In February 2012, the number of infant deaths (7) within Hamilton County was below the previous 24-month median (Figure 1). Only three infant deaths for January 2012 and one infant death for February 2012 were reported in the City of Cincinnati at the time of data gathering for this report. Table 1 displays the provisional number of infant deaths and births for each month in 2011 and 2012. Provisional data for 2011-2012 indicate that 60.0% of infant deaths have occurred to residents of Cincinnati (Figure 1). Please see **Appendix A** on page 6 to learn more about provisional death data limitations.

Figure 1. Number of Infant Deaths, Hamilton County Jan 2010 – Feb 2012*



NOTE: The county median is calculated using data from Jan 2010 – Dec 2011.

* Data for 2011-2012 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. Records in 2011-2012 have not been geo-coded and city assignment is based on provisional methods; data are subject to change.

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 February 2012 is estimated to be 15.0. This provisional rate is within the control limits for the data, but above the Healthy People 2020 goal (6.0).

The IMR for February 2012 is currently estimated to be 15.0 (Figure 2). February was above the average IMR (10.8) as shown in Figure 2. The February IMR was calculated based on only 466 reported births for the month of February 2012. Subsequent reports will provide improved statistical validity of these estimates (**Appendix A**). The February 2012 NIMR remained within the statistical thresholds and is displayed in Figure 3. The February 2012 NIMR (10.7) is above the Healthy People 2020 goal of 4.1 neonatal deaths per 1,000 live births. Neonatal deaths account for 72.8% of the 2011-2012 infant deaths as of data collected on March 13, 2012.

Figure 2. Infant Mortality Rate Surveillance Chart, Hamilton County Jan 2010 - Feb 2012*

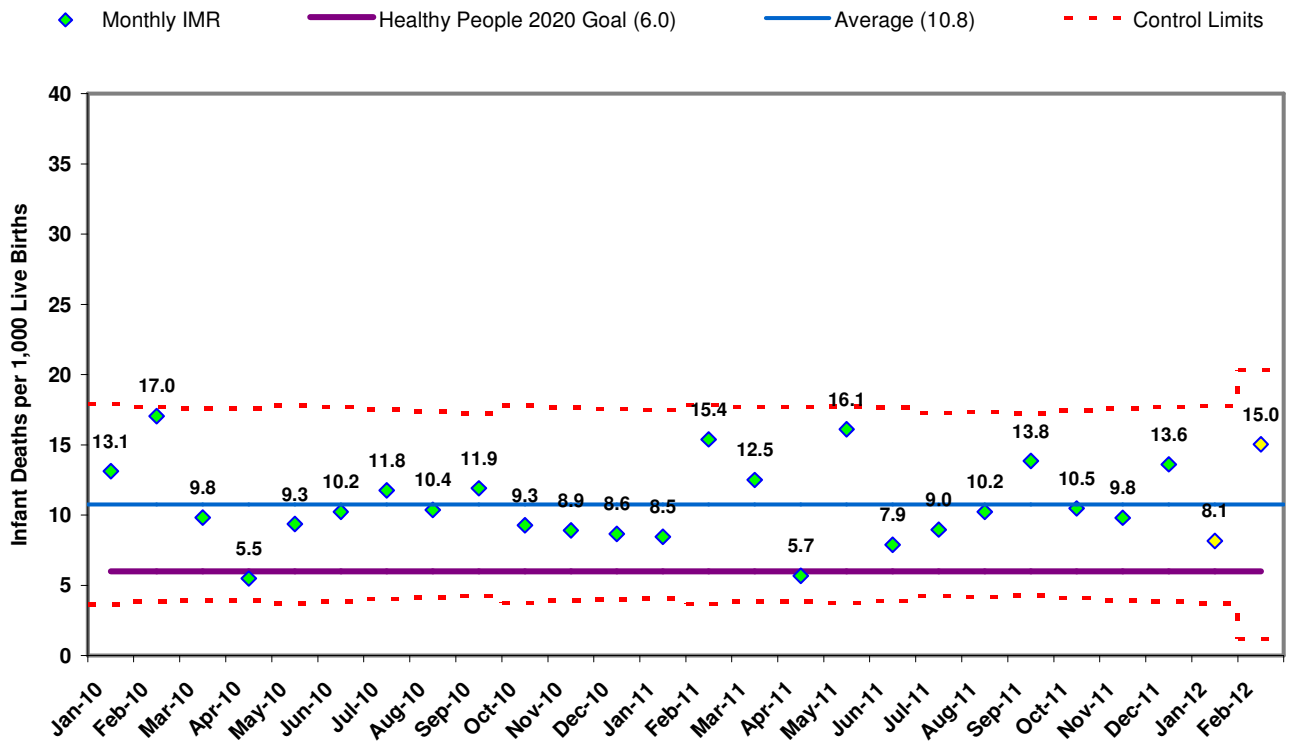
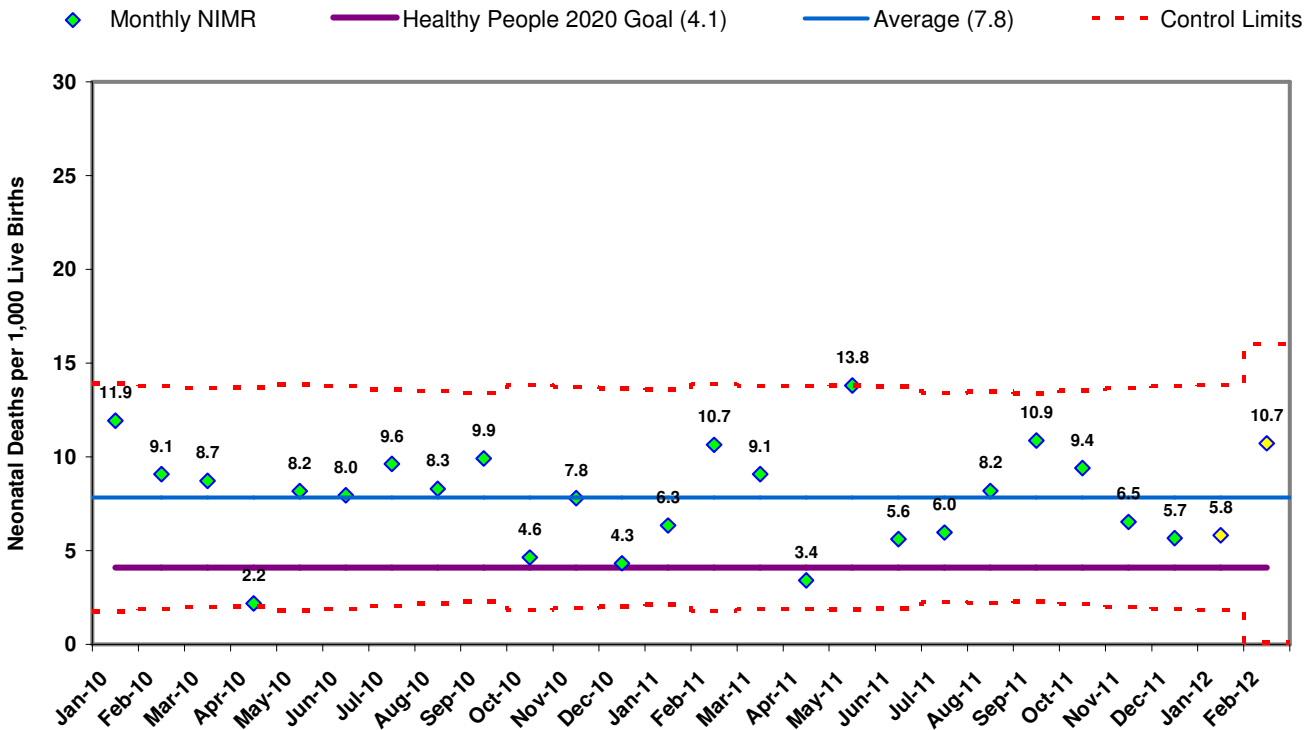


Figure 3. Neonatal Mortality Rate Surveillance Chart, Hamilton County Jan 2010 - Feb 2012*



NOTE: The mean is calculated using two years of data from Jan 2010 – Dec 2011. Yellow points are more likely to change in future reports.
 * Data for 2011-2012 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 Source: Ohio Department of Health Vital Statistics

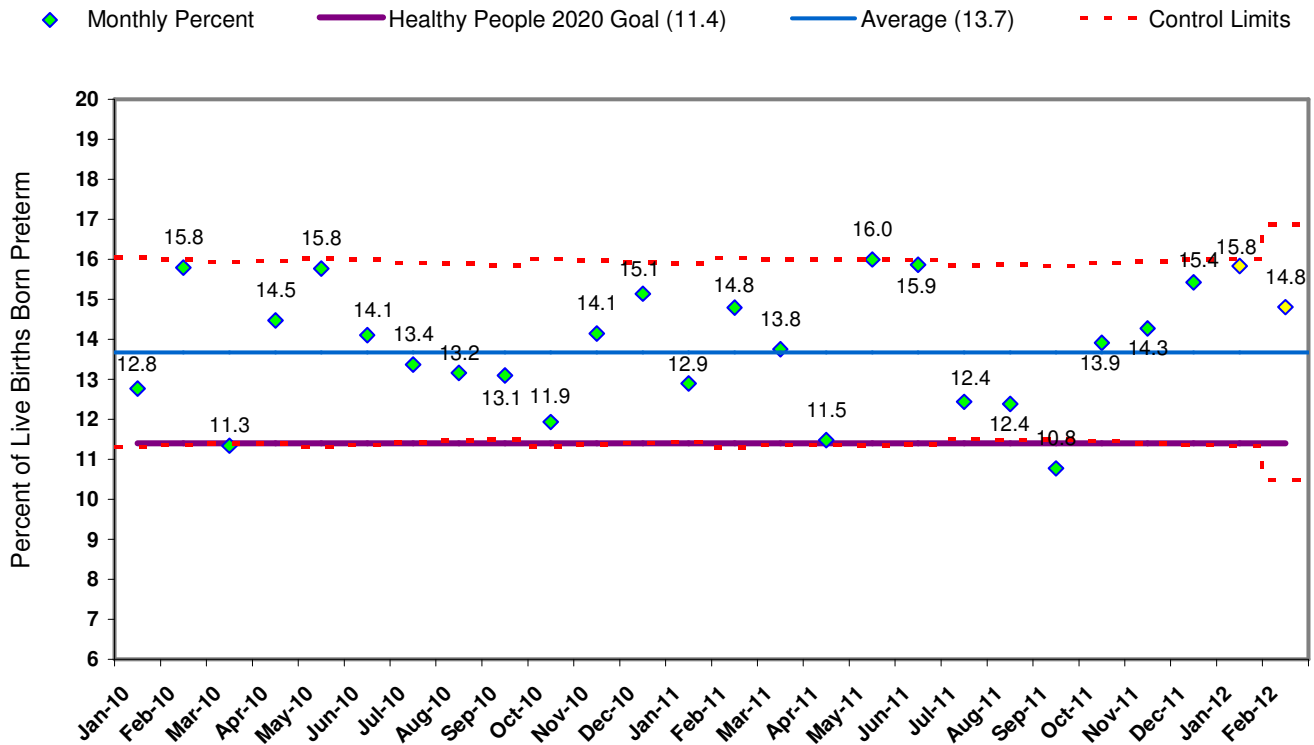
Preterm Birth Rates

The preterm birth rate is the percentage of infants born before 37 weeks gestation. Preterm birth is a significant risk factor of infant mortality and many other adverse health outcomes. The average preterm birth rate in Hamilton County (13.7%) is above the Healthy People 2020 goal of 11.4%. The provisional preterm birth percentage for February is 14.8%; this rate is above the Healthy People 2020 goal of 11.4% for all live births.

The preterm birth rates for both January 2012 (15.8%) and February 2012 (14.8%) were above the average (13.7%) and Healthy People 2020 goal for pre-term births (11.4%). These data are provisional and may change in future reports.

This goal was increased from the Healthy People 2010 goal for preterm births—7.6% of all live births.

Figure 4. Preterm Birth Rate Surveillance Chart, Hamilton County Jan 2010 - Feb 2012*



NOTE: The mean is calculated using two years of data from Jan 2010 – Dec 2011. Yellow points are more likely to change in future reports.
 * Data for 2011-2012 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 Source: Ohio Department of Health Vital Statistics

Maternal Factors Related to Preterm Birth

In an effort to understand factors that may be driving preterm birth, a comparison is presented between mothers who delivered full-term babies to mothers who delivered preterm babies. Live births that occurred at 37 weeks gestation or later were considered full-term. Live births between 32 and 36 weeks gestation were considered moderately preterm, while any birth that took place before 32 weeks gestation was considered very preterm. Table 2 below shows the percentage of each risk factor group attributed to mothers who had full-term, moderately preterm, or very preterm babies in 2010 and 2011.

Notably higher percentages of chlamydia infection, smoking before or during pregnancy, hypertension, and pre-pregnancy diabetes were found within mothers who gave birth moderately preterm or very preterm when compared to full-term pregnancies; the percentages are shown in Table 2. When compared to full-term mothers, mothers who gave birth either moderately or very preterm had a higher percentage of having less than a high school education. Mothers who gave birth to very preterm babies were more likely to be teen mothers than mothers who delivered full-term or moderately preterm. Significant differences were observed between the moderately preterm and very preterm births when looking at chlamydia infections and smoking.

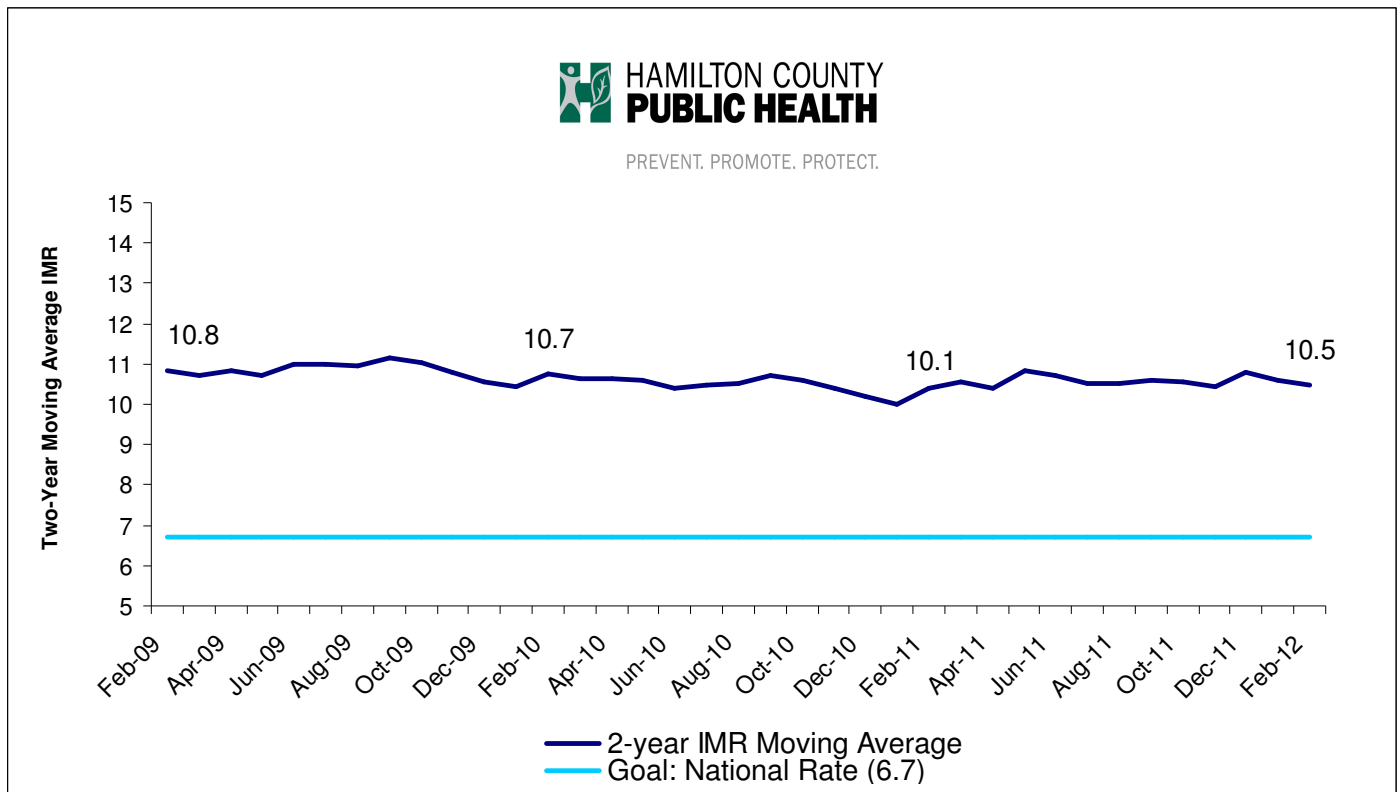
Table 2. Maternal Health, Hamilton County, 2010-2011

Maternal Health						
	2010			2011		
	Full Term	Moderately PTB	Very PTB	Full Term	Moderately PTB	Very PTB
BMI						
Underweight	6.4%	9.3%	7.6%	6.7%	9.3%	9.4%
Normal	45.8%	43.4%	46.8%	46.6%	45.2%	42.6%
Overweight	24.3%	21.8%	20.5%	23.2%	23.4%	24.4%
Obese	23.5%	25.5%	25.1%	23.5%	22.2%	23.5%
Hypertension						
Pre-pregnancy	2.4%	5.0%	5.2%	2.7%	6.4%	8.5%
Gestational	5.6%	10.0%	9.2%	6.0%	12.6%	15.3%
Eclampsia	1.0%	4.5%	4.3%	1.0%	5.6%	5.9%
Diabetes						
Pre-pregnancy	0.7%	1.7%	2.4%	0.8%	1.8%	1.8%
Gestational	7.0%	8.4%	7.3%	7.1%	9.2%	9.7%
Smoking						
3 Months Before Pregnancy	21.7%	24.4%	34.9%	21.1%	26.0%	30.9%
During Pregnancy	16.1%	19.3%	29.4%	15.9%	21.0%	25.0%
Infections						
Chlamydia	5.4%	6.0%	11.0%	5.5%	5.8%	7.4%
Gonorrhea	1.4%	1.8%	4.0%	1.6%	1.6%	2.4%
Syphilis	0.3%	0.6%	0.3%	0.4%	0.5%	0.9%
HSV	4.1%	3.8%	4.3%	5.0%	5.1%	4.1%
Age						
<15 Years	0.1%	0.3%	0.0%	0.1%	0.3%	0.6%
15-19 Years	9.0%	9.9%	13.8%	8.2%	10.1%	13.2%
20-24 Years	23.8%	24.6%	28.1%	24.1%	25.9%	27.6%
25-29 Years	29.6%	28.9%	23.2%	29.6%	29.5%	25.9%
30-34 Years	24.9%	23.4%	20.5%	25.5%	20.8%	21.5%
35-39 Years	10.3%	10.6%	12.2%	10.3%	10.4%	8.2%
40-44 Years	2.2%	2.0%	2.1%	2.0%	2.8%	2.4%
45+ Years	0.1%	0.3%	0.0%	0.2%	0.3%	0.6%
Education						
Less than H. S. Diploma	16.8%	24.7%	29.1%	16.3%	22.2%	22.6%
Diploma/GED	18.8%	19.4%	20.2%	19.3%	22.9%	19.7%
Some College or Greater	63.2%	54.7%	47.4%	63.2%	51.8%	52.4%
Unknown	1.3%	1.1%	3.4%	1.2%	3.1%	5.3%

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 February 2009 (10.8) to February 2012 (10.5) as shown in Figure 5. Please note that the two year 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 Feb 2009 - Feb 2012*



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

* Data for 2011-2012 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 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). 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 3 displays the discrepancy between the two infant mortality data sources available from ODH. There were two infant deaths in 2011 and nine infant deaths in 2012 that were not yet filed at the time of this report, amounting in an 8.1% difference between the two data sources (Table 3). Please note that delayed certificates directly impact data quality and therefore, the integrity of findings shared in this report.

Table 3. Infant Mortality Data Source Assessment, Hamilton County 2011 - 2012		
Data Source	2011	2012
	No. Infants < 1 yr.	No. Infants < 1 yr.
PDS-A	120	5
PDS-B	122	14
Discrepancy	2	9

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.



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