As we venture into our second year of the EveryOne Reach One Infant Mortality Task Force, we continue our momentum by expanding the membership and reach throughout Montgomery County.

The latest numbers continue to show a racial disparity in deaths with Black babies dying at a rate 4x higher than White babies. This reality is helping us guide the efforts of the task force to work even harder to improve the social factors of health that can lead to poor health and poor birth outcomes.

Where we live, work, play and learn can be a significant factor in our ability to be and stay healthy. The work of the task force seeks to form partnerships and contribute to improving many of these factors.

All residents should be able to live in affordable and safe neighborhoods that provide the opportunity to live a healthy and stress-free life. We will also seek to increase access to healthy food options for our most vulnerable populations by encouraging new grocery store options in area food deserts and increase the availability of transportation.

In many ways access to adequate healthcare is linked to education and job opportunities, so we will strive to provide increased options for those who lack the proper skills and training to succeed in the job market.

And finally, we know that the role the father plays before, during and after the birth is vital to the health of both mother and child, so we will work in our community to help educate and empower men to play a significant role in the development of their children.

None of this can be accomplished by Montgomery County and Public Health alone. It will take commitment and effort from our entire community and both public and private partnerships to have a meaningful, long lasting impact on the most vulnerable of our citizens.

Sincerely,

Debbie Lieberman
Montgomery County Commissioner

Jeffrey A. Cooper, MS
Montgomery County Health Commissioner
The Ohio Equity Institute (OEI) began in 2013 and is a partnership between the Ohio Department of Health (ODH) and nine Ohio counties including Montgomery County. The nine counties in Ohio were selected because they account for a large percentage of Black infant deaths in the state. This partnership exists to improve birth outcomes and reduce the racial disparities in infant deaths. The initiative is designed to strengthen the scientific focus and evidence base for realizing equity in birth outcomes in nine of Ohio’s major metropolitan areas.

This report provides background information on birth outcomes and infant mortality in Montgomery County, including current interventions and data trends. Infant mortality and birth outcomes are key population health indicators that have lifelong implications for individuals. The EveryOne Reach One (EORO) Infant Mortality Task Force in Montgomery County is the Montgomery County Partnership to reduce infant mortality. EORO was formed in 2017 and is co-led by Montgomery County and Public Health - Dayton & Montgomery County.

Leadership

Terra Williams - Public Health - Dayton & Montgomery County
  John Theobald - Montgomery County
  Geraldine Pegues - Montgomery County
  Pam Albers - Help Me Grow Brighter Futures
  Gina McFarlane-El - Five Rivers Health Centers
  Janet Schreel - Lifestages Centers for Women
  Sarah Hackenbracht - Greater Dayton Area Hospital Association (GDAHA)
  Mary Reid - Catholic Social Services
  Gregg Hopkins - Community Health Centers of Greater Dayton
  Jonathan Thackeray - Dayton Children’s Hospital
  Mia Foster - Community Representative
  Jennifer Heapy - Greater Dayton Premier Management
  Robert Lyons - West Dayton Health Promotion Partnership
  Shaun Hamilton - Premier Health
  Michelle Beebe - Kettering Health Network
  Jewell Good - Job and Family Services
  Andrea Hoff - Montgomery County Alcohol, Drug Addiction & Mental Health Services (ADAMHS)

Lead Agencies

Dayton & Montgomery County Public Health

Montgomery County

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EVERYONE REACH ONE STRUCTURE

Steering Committee
A diverse spectrum of stakeholders,
Supports the overall vision and
engages the community

Backbone Support
Guide vision and strategies
Approve and support aligned activities
Establish shared measurement practices
Build public support
Advance policy
Provide resources

Joint Information Center
Coordinate common messaging
Engage media coverage
Create public awareness
Provide guidance to member agencies

Operations & Planning Section
Direct branch operations to focus on SDOH and health equity
Provide current operational status to Backbone Support

Data Branch
Coordinate collection of birth outcome and intervention initiatives data

Prevention Branch
Reduce unintended pregnancy by providing education and resources on LARC methods and access to prenatal care

Fatherhood Coalition
Engage fathers to support mothers and their children

Case Review Team and Community Action Team
Review and analyze the information collected in interviews and medical data abstractions

Education Branch
Foster educational success of all Montgomery County children from birth

Substance Misuse
Reduce number of mothers who smoke and increase screening for alcohol use in pregnant women

Community Engagement
Collaborate with community members affiliated by geographic area to implement the best place-based initiatives

Preterm and Low Birth Weight
Decrease the percentage of preterm and low birth weight babies

Ohio Equity Institute (OEI)
Statewide initiative to improve birth outcomes and reduce racial disparities in infant mortality

Finance Section
Work collaboratively to secure funding for interventions

Social Determinants of Health Racial and Ethnic Disparities
Address conditions in which people are born, grow, work and live to improve health outcomes

Influences All Actions

Influences All Actions
INFANT MORTALITY
BY THE NUMBERS 2016 - 2017

In 2017, fifty-three Montgomery County babies died before their first birthday; an increase from 45 in 2016. As a result, the county’s infant mortality rate (IMR) rose from 6.8 deaths per 1,000 live births in 2016 to 7.8 deaths per 1,000 live births in 2017. Montgomery County’s IMR was higher than the state (7.2) and the Healthy People 2020 goal of 6.0 deaths per 1,000 live births or fewer.

Infant mortality – or the death of a baby before his or her first birthday – is a critical indicator of a community’s overall health and well-being. The infant mortality rate (IMR) is the number of infant deaths per 1,000 live births. An IMR not only measures the risk of infant death, but it can also be used more broadly as an indicator of social determinants of health. Infant deaths are influenced by maternal health, which can be impacted by factors such as race/ethnicity, age, marital status, education, income, neighborhood quality, and health care access.

DISPARITIES IN OUTCOMES*
An infant mortality racial disparity persists in Montgomery County. In 2017, only 28% of all county births were to Black babies, but Black babies accounted for 60% of all infant deaths.

**2017 Infant deaths per 1,000 live births:**
- Black: 16.9
- White: 4.2
- All Races: 7.8

Black babies died at a rate four times higher than White babies.

WHY ARE BABIES DYING??*
Most Montgomery County babies die because they are born too early and too small.

28% of babies died due to prematurity-related conditions.

68%
of babies died before reaching 28 days of age (neonatal)

32%
of babies died between 28 days and 1 year (post-neonatal)

The most common causes of neonatal death are premature birth, low birth weight, and birth defects.

43%
Of the 53 deaths, 23 babies (or 43%) survived less than 24 hours.

*Ohio Birth & Death Certificates, Ohio Department of Health
**2015-2017
In 2017, there were 6,754 Montgomery County resident births, an increase from 6,646 births in 2016. The percentage of preterm births (gestation less than 37 weeks) rose to 11.6% from 11.4% in 2016, which is higher than the Montgomery County Community Health Improvement Plan (CHIP) goal of 10.4% or less.

The percentage of low birth weight births (less than 2,500g or 5.8lbs.) rose to 9.8% from 9.5%, which is higher than the Healthy People 2020 goal of 7.8% or less.

**DISPARITIES IN OUTCOMES***

Poor birth outcomes affect Montgomery County residents differently. Black women are more likely to have a preterm birth or a low birth weight baby compared to White women. Only 28% of all births were to Black babies, but Black babies accounted for 35% of all preterm births and 44% of all low birth weight births.

<table>
<thead>
<tr>
<th></th>
<th>2017 Preterm Birth</th>
<th>2017 Low Birth Weight Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>14.7%</td>
<td>15.2%</td>
</tr>
<tr>
<td>White</td>
<td>10.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>All Races</td>
<td>11.6%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

**RISK FACTORS FOR POOR BIRTH OUTCOMES***

A woman’s health prior to and during pregnancy can impact the health of her baby. In Montgomery County, the top three risk factors for preterm birth and low birth weight birth are:

- **Chronic high blood pressure** (before or during pregnancy)
- **Smoking cigarettes** during pregnancy
- **Receiving late or no prenatal care**

The percentage of women with chronic high blood pressure before or during pregnancy reduced by 8% in 2017.

The percentage of women who smoked during their third trimester of pregnancy reduced by 4% in 2017.

The percentage of women beginning prenatal care in their third trimester or not receiving care at all increased by 15% in 2017.

*Ohio Birth Certificates, Ohio Department of Health*
The Ohio Department of Medicaid provided funding for six community initiatives in Montgomery County aimed at reducing infant mortality. These collaborative efforts aim to improve birth outcomes and reduce the racial and ethnic disparities in infant mortality. The initiatives will fund innovative projects that will connect mothers, fathers and infants to quality health care and care management.

Through the EveryOne Reach One Infant Mortality Task Force, the Ohio Department of Medicaid has awarded a $3,177,387 grant to help reduce the number of babies who die before their first birthday. These additional resources will help us in our fight to reduce the infant mortality rate in our community. This new funding will go a long way to help support our collaborative efforts in Montgomery County.

Through EveryOne Reach One, Ohio Medicaid awarded funding to support the following projects in 2018:

- **Help Me Grow Brighter Futures’** home visiting services will be increased for pregnant women in targeted communities. Total Funding Amount: $2,173,940

- **Five Rivers Health Centers** and **Lifestages Centers for Women** will enhance patient-centered prenatal care with the expansion of their CenteringPregnancy® programs. Total Funding Amount: $457,260 with Five Rivers receiving $112,260 and Lifestages Centers for Women receiving $345,000

- **Catholic Social Services of the Miami Valley** in partnership with **The West Dayton Health Promotion Partnership** will implement the Family Wellness Community Health Worker Program. The program will increase the peer-to-peer support tailored to meet the unique needs of their communities. Total Funding: $176,637

- **Miami Valley Organizing Collaborative** in partnership with faith-based organizations will create the Community Hope Project. The Community Hope Project will train ministry leaders in the Peer Health Leadership program to become Health Ambassadors. Another component of the project is the First Ladies Health Initiative of Montgomery County. The First Ladies Health Initiative is a national program sponsored by Walgreens. The project will launch a historic, city-wide health day to provide information and screenings. Total Funding: $156,250

- **Montgomery County Department of Job and Family Services Fatherhood** initiative will work with Public Health - Dayton & Montgomery County, Five Rivers Health Centers and The West Dayton Health Promotion Partnership to create the Every Parent Matters Program. Every Parent Matters is a partnership of fatherhood programs in Montgomery County to connect fathers with each other and to services available in the community. Total Funding: $213,300
On September 28, 2018, the EveryOne Reach One Infant Mortality Task Force held its second conference at Sinclair Community College. The conference theme was “Kasserian Ingera?” which means “How are the children?” There were 267 people in attendance to listen, learn, and advocate for reducing infant mortality in Dayton and Montgomery County. The conference was supported with $21,000 in donations from various community organizations.

Attendees could choose from five concurrent session topics: sustainable fatherhood engagement, reducing preterm births, addressing disparities in breastfeeding, fetal infant mortality review, and state and local data as an opportunity to improve birth outcomes. Angela Dawson, Executive Director, Ohio Commission on Minority Health, spoke about how at the state and local levels more work needs to be done. Dr. Jason Reece, Director of Research at The Kirwan Institute, spoke on ‘Place Matters’ and driving equity within the community. There was also a “Health in All Policies” panel discussion with experts sharing their work experiences related to policy decision making. The conference featured keynote speaker, Tonya Lewis Lee, who was the spokesperson for the U.S. Department of Health and Human Services, Office of Minority Health’s campaign “A Healthy Baby Begins with You.”
COMMUNITY EVENTS

**Faith-Based Forum**
Wednesday, July 25, 2018 - Tabernacle Baptist Church

**A Healthy Community Begins with You Block Party**
Saturday, September 29, 2018 - Boys & Girls Club of Dayton

**Adolescent Health Forum**
Monday, October 1, 2018 - Montgomery County Job Center

**Presentation at City of Dayton’s Neighborhood President’s Forum**
Monday, October 29, 2018 - Sinclair Community College

**Inequity in Birth Outcomes - Let’s Talk About It**
Saturday, November 17, 2018 - Calvary Baptist Church

**Community of Hope - Save Our Babies Luncheon**
Saturday, November 10, 2018 - Corinthian Baptist Church

**Hip Hop Dance Class**
Saturday, November 10, 2018 - Northwest Recreation Center
Five Rivers Health Centers (FRHC) is the tenth largest Federally Qualified Health Center in Ohio. In 2018, the center provided prenatal care to over 1,300 women.

Across all sites, 83% of all women received their initial prenatal care in their first trimester, which exceeds the Healthy People 2020 goal of 77.9%.

There were three major programs that FRHC provided in 2018 that helped to improve outcomes for their patients: Five Rivers Healthy Start, Centering Pregnancy®, and Expanded Healthy Start.

Below are the outcomes that were achieved:

- **Healthy Start Pregnant Women**: 256
- **Expanded Healthy Start Pregnant Women**: 950
- **Centering Participants**: 196

- 82% of women had a documented Reproductive Life Plan (RLP)
- 79% of pregnant participants began in the first trimester
- 76% of women receive a postpartum visit (up to 12 weeks)
- 91% of the participants that followed safe sleep behaviors
- 75% of women reported they were ever breastfed, even for a short period of time
- 87% of prenatal patients abstained from smoking in their third trimester
- 92% of prenatal patients abstained from smoking after delivery
- 92% of prenatal patients met the Kotelchuck model for prenatal visits
- 86% of preterm patients completed progesterone therapy
- 94% of pregnant patients completed progesterone therapy
Help Me Grow Brighter Futures offers several free family support programs for pregnant women, children, new parents and families. Each participating mother is assigned to a nurse or social worker and receives intensive home visits during pregnancy and for 24-36 months after her child’s birth. Our Home Visitors promote a healthy pregnancy, including attention to nutrition, healthy birth outcomes, breastfeeding, and education on parenting strategies to maximize their child’s health and development.

Help Me Grow Brighter Futures employs over 80 well trained Nurses (Nurse Family Partnership Program), social workers and teachers (Healthy Families America, Early Head Start Programs, and Early Intervention) providing services to over 2000 families in Montgomery County. Due to the quality and success of our programs,00 we were able to expand in 2018 and reach an additional 350 new families. Our Home Visitors use a non-judgmental and compassionate approach that empowers parents with skills, tools and confidence to nurture the healthy growth of their children. Help Me Grow believes all parents and young children deserve the same opportunities to realize their full potential in life, regardless of economic, geographic, and demographic considerations. The parenting education and child development strategies allows families to maximize this critical period of development in their child’s life, providing a foundation for lasting success. When a parent schedules a home visit with Help Me Grow Brighter Futures, they will have the opportunity to share their thoughts about parenting, ask questions, and receive reliable information based on their individual family needs.

Help Me Grow Early Intervention is a statewide system providing family-centered coordinated services to parents for infants and toddlers to age 3 with a medical diagnosis or parental concerns about their child’s development. Areas of development can include language and communication, how they think or process information, how they move, and how they interact with others. If a parent or family member has concerns or questions about how their child is growing, then Early Intervention is available.
MOMS & BABIES FIRST

Moms & Babies First (M&BF) is a voluntary home visiting program that aims to reduce the number of low birth weight babies, infant deaths, and sickness among minority communities in Montgomery County.

Certified Community Health Workers (CHWs) conduct regularly scheduled home visits, educating parents on prenatal and postpartum care, along with providing information and education on toddler health and care through age one. The goal of M&BF is to reach women early in their pregnancies (preferably first trimester) who may have risk factors contributing to poor pregnancy outcomes.

In grant cycle three (October 2017 through September 2018), M&BF expanded their team of CHWs which increased the programs ability to reach broader populations through outreach efforts. M&BF saw a 16% increase in referrals compared to the previous year, as a result of canvassing neighborhoods and businesses, and attending community events to interact directly with citizens. M&BF saw an increase in positive birth outcomes and reduced the number of preterm and low birth weight babies.

Enrollment increased by 25% and 13% in the first and second trimester with nearly 80% of enrolled women residing in the Community Health Improvement Plan target zip codes.

M&BF enrolled a total of 77 women in the program, with an increase in enrollment among women 25 to 34 years of age. M&BF also saw an increase in program completion in grant cycle three. Forty-six women graduated from the program once their child reached their first birthday.

16% Increase in program referrals

36% Decrease in low birth weight

11% Decrease in preterm births
The Family Wellness Community Navigator Program of Catholic Social Services of the Miami Valley (CSSMV) strives to reduce infant mortality rates in high risk communities through both community education and early identification and intervention for pregnant women and families parenting infants.

Since September of 2018, the CSSMV Community Navigators have provided education on health disparities and infant mortality risk factors. CSSMV provides information regarding community services available to reduce barriers to 45 community groups including health and information fairs, churches and faith groups, and neighborhood organizations.

In total, 680 individuals were touched by these outreach efforts. In addition to educating individual community members, navigators engaged over 40 businesses and organizations by providing infant mortality education. Signed partnership agreements were obtained from 21 of these organizations which committed to distributing outreach materials to make people aware of the community health navigator programs.

The navigators presence in the community has led to more high risk families receiving services. Since the start of outreach activities, CSSMV health navigators have had over 250 encounters with 136 unduplicated individuals identified as pregnant or parenting an infant under the age of one. Outreach efforts have been focused on high risk zip codes with a goal of filling resource gaps for under-served families. Of the individuals engaged, 106 identified as Black, 24 as White, and six as Other. Through these encounters, risk factors impacting the social determinants of health such as lack of healthcare access, unstable housing, and financial and resource challenges were identified. Community health navigators made 191 referrals to evidence-based prenatal and home visiting programs, social services, housing and utility resources, and education and training programs to address underlying barriers.

**FAMILY WELLNESS COMMUNITY NAVIGATOR PROGRAM**

680 Individuals

250 Encounters

191 Referrals
LIFESTAGES CENTERS FOR WOMEN

Lifestages Centers for Women provides high quality prenatal and postnatal care to patients through Mothers Empowered (ME) CenteringPregnancy®. During these extended appointments, physicians, certified nurse midwives, as well as a registered nurse, provide medical care along with valuable education and support to patients on several topics including pregnancy, healthy lifestyle choices, family planning and spacing, childbirth, postpartum depression and postpartum care, newborn care and safe sleep.

Lifestages is one of the few certified CenteringPregnancy® sites in the Dayton area. They currently offer the Mothers Empowered appointments at Miami Valley Hospital North and Dr. Charles R. Drew Health Center in Dayton. They also collaborate with Catholic Social Services of the Miami Valley (CSSMV) to offer patients home visiting options with a family life coach.

Many patients indicated transportation as a significant barrier to attending regular prenatal care appointments. In response, Lifestages provided transportation assistance for ME patients to and from prenatal and postnatal care appointments 65 times during 2018.

### In 2018, 77 women participated in Mothers Empowered CenteringPregnancy®

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>75%</td>
<td>number of ME patients that were African American</td>
</tr>
<tr>
<td>64%</td>
<td>percentage that lived in the target zip codes areas (eg. 45402, 45405, 45406, 45414, 45415, 45416, 45417, 45426)</td>
</tr>
<tr>
<td>74%</td>
<td>were exclusively breastfeeding at discharge from the hospital</td>
</tr>
<tr>
<td>70%</td>
<td>utilized home visiting services through CSSMV</td>
</tr>
<tr>
<td>83%</td>
<td>attended at least one postpartum visit (up to 12 weeks PP)</td>
</tr>
<tr>
<td>100%</td>
<td>family planning method was identified during postpartum visit</td>
</tr>
<tr>
<td>8%</td>
<td>were low birth weight (babies born weighing less than 5 pounds 8 ounces)</td>
</tr>
<tr>
<td>10%</td>
<td>had a preterm delivery (babies born before 37 completed weeks gestation)</td>
</tr>
<tr>
<td>86%</td>
<td>received prenatal care in their first trimester</td>
</tr>
<tr>
<td>65%</td>
<td>attended at least six of the 10 sessions</td>
</tr>
<tr>
<td>100%</td>
<td>were highly satisfied with the care and support they received during ME appointments</td>
</tr>
</tbody>
</table>
The presence of a father is vital to a child’s successful development. Every Parent Matters is a partnership of fatherhood programs in Montgomery County that empower dads to be the best parents, spouses, and partners they can be. The program works to connect fathers with each other and to available services in the community.

Paternal support promotes healthy prenatal behavior and may help to decrease the emotional stress of the pregnant mother, which has been linked to poor pregnancy outcomes.

Every Parent Matters’ Community Health Workers engage expectant fathers, as well as those who already have children. They provide links to services and are willing to meet fathers in settings most comfortable to them, including their homes.

“A significant proportion of infant deaths could be prevented if fathers were to become more involved.”
- Amina Alio, PhD
Baby & Me - Tobacco Free (BMTF) is an evidence-based smoking cessation program created to reduce the burden of tobacco on pregnant and postpartum women. Program facilitators provide counseling support and community resources to encourage pregnant women to quit smoking.

The BMTF program is open to women who are pregnant and are current smokers or who quit smoking within three months of becoming pregnant. Women enrolled in the program must attend four counseling sessions prenatally and must complete a carbon monoxide test at each session. Postpartum visits occur once a month for up to twelve months. Mothers are tested to make sure they are still smoke-free.

Upon successful testing results, participants receive a monthly $25 voucher for diapers. If there is another smoker living in the home with the mother, they are also eligible for an additional $25 per month diaper voucher if they successfully participate in the program.

During the program’s second grant cycle (July 2017 to June 2018), a total of 92 women were served and 230 counseling sessions (167 prenatal and 63 postpartum) were completed. There were 11 reported live births, all of which were born full-term (gestation ≥37 weeks) and of normal birth weight (≥2,500g). Sixty-seven percent (67%) of mothers were non-smokers after completing of all four BMTF prenatal care sessions.
COMMUNITY RESOURCES

Baby & Me - Tobacco Free - (937) 496-3376
A smoking cessation program for women before and after their pregnancy.

Catholic Social Services - (937) 223-7217
Pregnancy counseling, home-based parenting education, family stabilization and support, and food pantry.

Community Health Centers of Greater Dayton - (937) 586-9733
High-quality, affordable primary health care.

Five Rivers Center for Women’s Health - (937) 208-2007
Prenatal care, CenteringPregnancy®, free pregnancy tests and Healthy Start Program.

Help Me Grow Brighter Futures - (937) 208-4769
Home visiting programs to improve birth outcomes, enhance child development, and increase self-sufficiency. Early Intervention services support young children 0-3.

Holy Family Prenatal Care - (937) 228-4492
Prenatal care and free pregnancy tests.

Lifestages Centers for Women - (937) 277-8988
Prenatal care and CenteringPregnancy® that brings women together with similar due dates, out of the exam room and into a group setting.

Moms & Babies First - (937) 224-3696
Home visiting program to educate mothers about infant care.
Glossary of Terms

**Birth Defect**
A structural abnormality present at birth, irrespective of whether the defect is caused by a genetic factor or by prenatal events that are not genetic.

**Birth Spacing**
The time interval from one child’s birth until the next child’s birth. It is generally recommended that at least a two-year interval between births is important for maternal and child health and survival.

**Fetal Alcohol Syndrome (FAS)**
FAS is one of the leading causes of physical and mental disorders in the U.S. in children whose mothers consume alcohol during pregnancy.

**Federally Qualified Health Center Services (FQHC)**
FQHC services are primary and other ambulatory care services provided by community health centers and migrant health centers receiving grants under section 330 of the Public Health Service Act.

**Fetal and Infant Mortality Review (FIMR)**
Fetal Infant Mortality Review is a community-based program that reviews the contributing factors of fetal and infant deaths within a local health jurisdiction. These FIMR community groups identify the necessary actions to prevent these deaths, thus improving health services for families.

**Health Inequity**
Unjust and avoidable differences in health status or in the distribution of health determinants among different population groups.

**Home Visiting Program**
Home Visiting is a frequently used strategy for providing services to improve the health of children and families. The program is popular because it is flexible and allows the family to interact with a health worker (e.g., nurse, Community Health Worker) in a setting that is often most comfortable for them.

**Infant Mortality Rate**
The death of a live-born infant before its first birthday. The infant mortality rate is widely considered to be a measure of the health and well-being of a community and is expressed by the number of infant deaths per 1,000 live births.

**Low Birth Weight**
A birth weight less than 5.8 lbs. Low birth weight may be result of preterm birth (birth before 37 weeks gestation) or intrauterine growth restriction (also known as small-for-gestational age).

**Prematurity**
Infants born before 37 completed weeks of gestation.