

2026

Maternal Infant Vitality Initiative Annual Report



Lucas County Ohio

Report for July 1st, 2025,
through June 30th, 2026

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Introduction

About

Helping babies and families thrive is our passion. Lucas County is a recipient of the **Maternal and Infant Vitality Initiative (MIVI)** grant through the Department of Children and Youth (DCY). Goal of the grant is to address the biggest drivers of persistent racial disparities in birth outcomes and infant mortality in Ohio.

Lucas County is one of ten counties in Ohio which receives this grant. The other counties are Butler, Cuyahoga, Franklin, Hamilton, Lorain, Mahoning, Montgomery, Stark, and Summit. These counties utilize population data to target areas for outreach and services in the areas at most risk and with the largest disparities such as prematurity and low birth weights.



Fun Fact: Previously, the grant had been under the Ohio Department of Health and had been known as Ohio Equity Initiative/Institute (OEI).

To best tackle infant mortality, it is critical to unite efforts and to tackle issues from as many angles as possible/necessary. Since the factors surrounding infant mortality are numerous, interconnected, and complicated, we can have greater impact when we work together.

MIVI has multiple components to help facilitate change. The Main Components of MIVI are **Navigation Services** (downstream efforts with Navigators working directly with families), **Community Stakeholder Engagement** (upstream efforts through Getting to 1 Coalition), and **Data** (monitoring of local and programmatic data to highlight trends and needs).



Navigation Services
(downstream)



Community/Stakeholder Engagement
(upstream)



Data (monitoring)

MIVI Principles:

1. Make sure all moms and babies can get needed care and support.
2. Strengthen our organization so we can do the work well.
3. Let people most affected lead and guide decisions.
4. Build community power and lift up local voices.
5. Work with partners and communities of color on shared goals, data, and measures.
6. Use local data and community input to create local solutions—both prevention and direct support—to reduce unfair gaps in birth outcomes and infant deaths.
7. Be the local expert on infant mortality and maternal/child health data.
8. Set clear ways to track success and responsibility.
9. Share what we learn with others.

FOR MORE INFORMATION ON MIVI, PLEASE CHECK OUT [DCY WEBSITE](#).

Community Context

Lucas County Snapshot

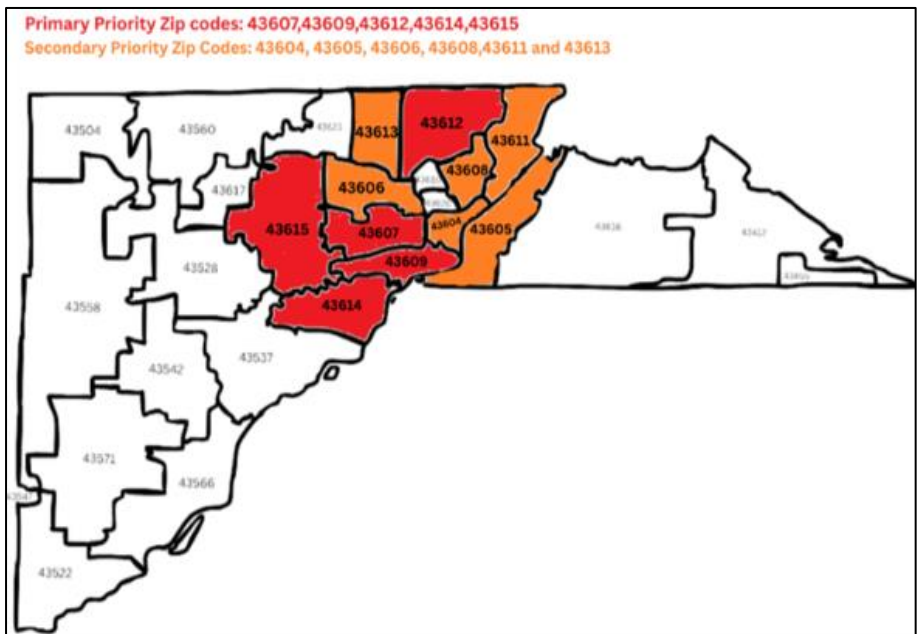
Lucas County is home to 423,347 residents (2025), with a median household income of \$62,224 and a poverty rate of 16.8%. Research increasingly attributes racial disparities in birth outcomes to structural racism like differences in the effects of segregation, neighborhood deprivation, and unequal access to care are estimated to explain some gaps in infant health nationally, even after accounting for individual medical and socioeconomic factors. Chronic stress from lifelong exposure to discrimination is also understood to directly raise the physiological risk of preterm labor and low birth weight, independent of access to care. These conditions concentrate in the priority zip codes as well, and they are the reason MIVI's work in Lucas County is structured around targeted, place-based outreach rather than county-wide services alone.

423,347 Population (2025 est.)	\$62,224 Median household income	16.8% People in poverty	20.8% Black or African American	66.5% White, non-Hispanic
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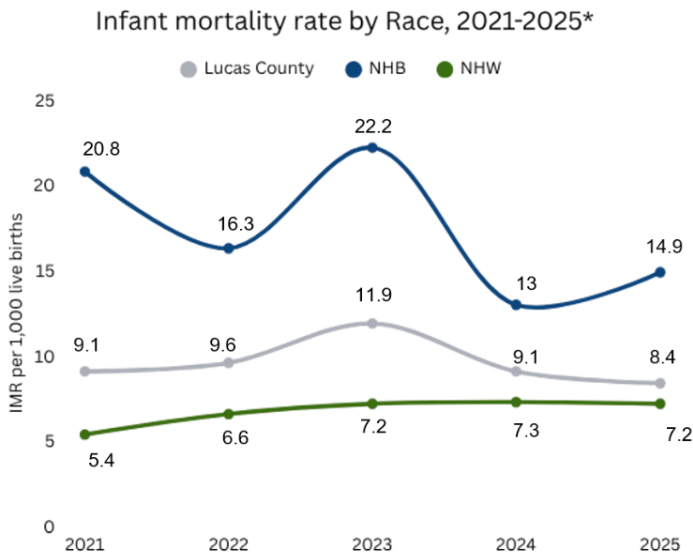
Source: U.S. Census Bureau QuickFacts, Lucas County, Ohio. 2020–2024 ACS 5-year estimates and 2025 population vintage.

Priority Zip Codes

To ensure that we focus on meeting the needs of parents who are most at risk for poor birth outcomes, and that services are delivered effectively, population data is utilized to identify five primary five zip codes, 43609, 43607, 43612, 43615, and 43614, as Priority Service Areas (PSAs). Most of these zip codes are consistent with last year's analysis; however, the list was refined this year by distinguishing between primary and secondary priority areas for greater clarity. In addition to the designated primary PSAs, secondary zip codes 43604, 43605, 43606, 43608, 43611 and 43613 remain on a watchlist due to elevated disparities but smaller or less stable numbers. Ongoing monitoring of these areas is important to ensure that emerging needs are not overlooked. These zip codes were utilized by staff to help inform outreach efforts.



Birth Outcomes



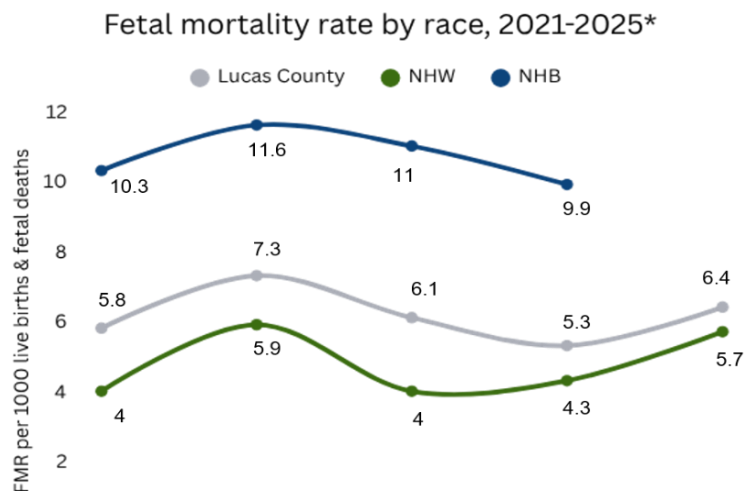
Source: Ohio Department of Health, Bureau of Vital Statistics, resident birth and death files. 2025 data is still preliminary

A stillbirth, or fetal death, is the loss of a baby before or during delivery after 20 weeks of gestation. Fetal Mortality Rate (FMR) is the number of fetal deaths per 1,000 live births plus fetal deaths.

Fetal mortality or stillbirth follows a similar pattern: the fetal mortality rate was **6.4** per 1,000 live births and fetal deaths in 2025 and Black women are approximately **2.5 times** more likely to experience fetal loss than White women. These disparities are the reason MIVI's Neighborhood Navigation work is targeted specifically at Black/African American pregnant women in the highest-risk zip codes in efforts to reduce disparities.

Infant mortality (IM) is the death of an infant before their first birthday, measured per 1,000 live births. It remains a key indicator of community health.

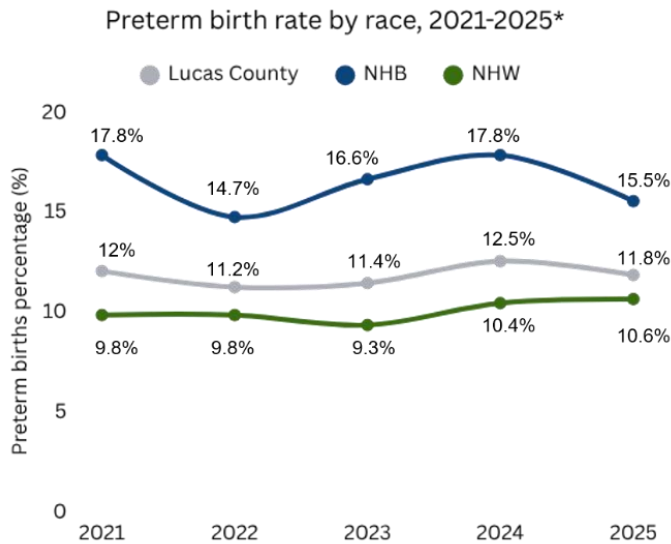
In 2025, 39 infants died before their first birthday in Lucas County, out of 4,627 live births with an overall Infant Mortality Rate (IMR) of **8.4** per 1,000 live births compared to **9.1** per 1000 live births in 2024. Racial disparities can be seen in infant mortality rates as Black infants die at approximately **2.3 times** the rate of White infants. Hispanic-specific rates are not reported here, as the underlying counts are too small for a stable rate.



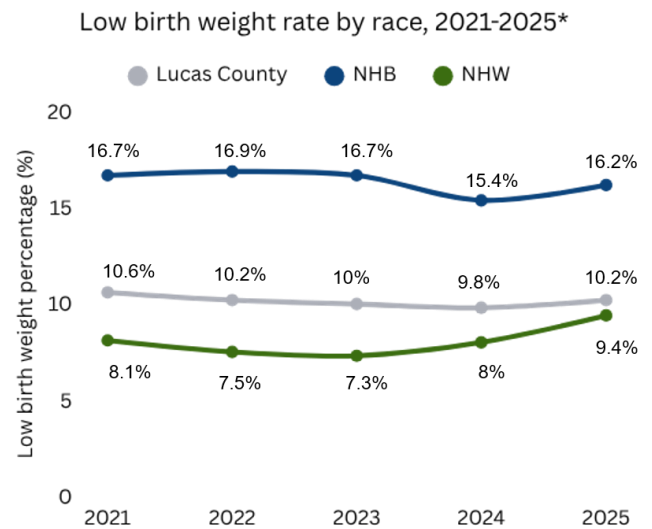
Source: Ohio Department of Health, Bureau of Vital Statistics, resident birth and death files. 2025 data is still preliminary and NHB fetal mortality rate suppressed for 2025 due to fewer than 10 events; does not meet standards of reliability,

Black infants are **2.3X** more likely to die before their first birthday than White infants
 Black women are **2.5X** more likely to experience fetal loss than White women

Poor Birth Outcomes



Source: Ohio Department of Health, Bureau of Vital Statistics, resident birth and death files. 2025 data is still preliminary



Source: Ohio Department of Health, Bureau of Vital Statistics, resident birth and death files. 2025 data is still preliminary

In 2025, there were 4,627 Lucas County resident births, approximately a **2.25% increase** from 4,525 in 2024. Poor birth outcomes occur when babies are born prematurely (born less than 37 weeks gestation) or with a low birth weight (born less than 2,500 grams or 5.5 lbs.). **Prematurity and low birth weights are the greatest risk factors for infant mortality.** Prematurity remains a leading cause of infant death among all infants nationally and in Lucas County. Other risk factors for infant mortality included pre-pregnancy hypertension and previous premature births. In 2025, Black infants in Lucas County had a preterm birth rate of 15.5% versus 10.6% for White infants which is roughly **1.5 times** higher and a low-birth-weight rate of 16.2% versus 9.4% for White infants, roughly **1.7 times** higher.

For more information on data on infant mortality, at the state and county level, check out [Ohio Infant Mortality Scorecards](#).

Neighborhood Navigation

Avenues of Outreach

Identifying Avenues of Outreach

After identifying priority zip codes in our area, staff prioritized identifying unique and non-traditional outreach efforts to engage with community members. These new opportunities are found in several ways including direct invites from relevant agencies and programs, seeking out new spaces as the staff identify a need for them, or connecting with local agencies after engaging in other outreach spaces. Staff have grown to rely on engaging with local services to refer our clients to for resources and this has given us many new opportunities to participate in outreach in spaces we have not worked before.

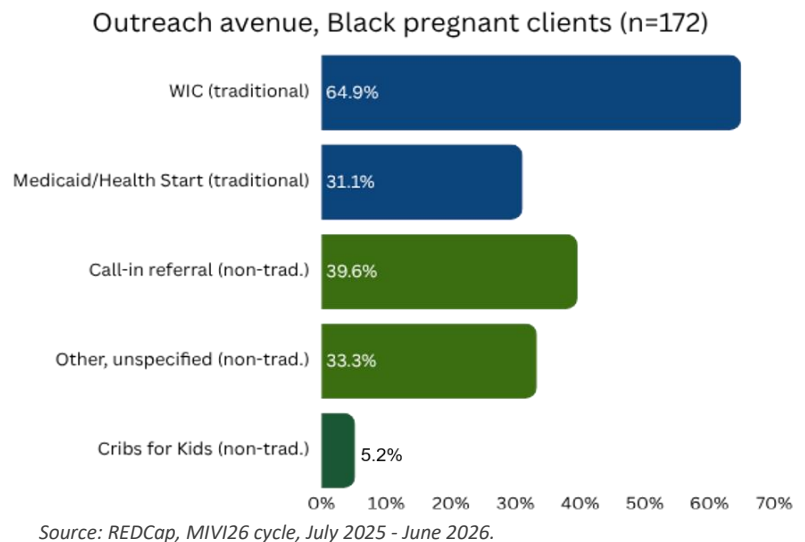
This past grant cycle, our site has made a strong effort to seek out new spaces that outreach was not previously done in and engage with more local partners. In addition to this, we began tracking more metrics around our outreach efforts to ensure they met the grant needs, agency identified goals, community needs, and overall made sense for our team to be there. Spaces that we participated in non-traditional outreach this year included food pantries, cultural events, hospital-based parenting classes, laundromats, day care centers, churches, county agencies, school systems, community baby showers, health fairs, a human trafficking drop-in center, and general tabling at spaces our staff were requested/invited to attend.

Communities of Priority

Our outreach efforts prioritize Black communities and residents in several ways. One specifically being we identify events that prioritize the Black/African American population in agency event advertising. We had staff attend the *Black Family Wellness Expo* in March where health screenings for illnesses that predominantly impact Black/AA individuals took place. We also had staff partner with and attend *Bloom & Thrive*, an event hosted by Queens Village which prioritized in their advertisement new and expecting Black families. The event centered around a book published by Tara Pringle, called *Bloom How You Must: A Black Woman's Guide to Self-Care and Generational Healing*. This event directly prioritized this community and offered a collaborative space. In addition to prioritizing specific events, we focus on attending events in our high risk/ priority zip codes. Our staff attended at least 16 events in the past grant cycle that took place in our identified zip codes. Our goal was to be more intentional with these efforts at the start of 2025 and will carry them into the next grant year. Lastly, we choose to work with and support agencies that also prioritize the Black/ AA population in their work. We have worked extensively with Queens Village, a local chapter of a national organization that prioritizes support, rest, and empowering Black women while offering a supportive community and reducing barriers. We also work closely with Brothers and Sisters United, a program that directly supports pregnant/ parenting family units while reducing barriers and increasing access to all support systems possible to help the family thrive. This program also strongly focuses on the support of Black/AA families.

Successful Avenues of Outreach

Among Black/African American pregnant clients specifically (n=172), 56.5% were identified through non-traditional outreach avenues and 43.5% through traditional avenues. Within traditional settings, WIC was the dominant entry point (64.9%), followed by Medicaid/Ohio Healthy Start (31.1%). Within non-traditional settings, call-in referrals were the single most common avenue (39.6% of non-traditional identifications), followed by an unspecified "other" category (33.3%) which largely include online and walk in contacts and Cribs for Kids referrals (5.2%).



New and Renewed Community Partnerships

New partnerships were established this past year. Our site began working with and encouraging a referral system with the Academy for Urban Scholars. This is a credit recovery program that is open to students aged 14-21 years old and offers diplomas at the end of schooling. Our staff were able to engage with young pregnant women, and this has been an ongoing partnership since connecting at an outreach event. Our department also established a new connection with Urban Holistic, which is a community-based, grass roots initiative that offers greenspace and local produce while providing engagement through education. (See picture on report cover page). We also attended and worked with the Delroy Chance Angel Wings Foundation to offer athletic equipment to youth and engage with their families during this past year. Lastly, we also connected with Susie's Coats, a local program that offers free coats and winter apparel to those in need. There were a handful of other meaningful partnerships that were identified that include Clean Duds, The Flourishing Wellspring Center, Links Incorporated, Holy Trinity Food Pantry, and a multitude of local daycares.

Navigation Successes

Additional success our team has experienced in Neighborhood Navigation during MIVI26 included more intentional outreach. We did this through additional data collection and review of metrics that staff completed via a survey after attending an event. The survey our staff will continue to use tracks zip code, staff attending, hosting organization, type of event (including training, recruit clients, provide education-clients, provide education-professionals). We also gauge the number of materials given out, referrals collected, number of attendees, population in attendance, and we ask staff if it was meaningful to attend, did any interaction stand out, or should we skip in the future. Collecting this information has allowed us to have a stronger presence in the community and to be where we are needed.

Navigation Challenges

Challenges our team experienced regarding Neighborhood Navigation during MIVI26 included being selective of events our staff should attend and collecting meaningful data. We have a strong community presence and a lot of great local partners, however some of the outreach event opportunities presented to us don't always make sense. This may be due to the zip code it is located in or the primary population attending the event. We continue to maintain these partnerships but work to ensure we send staff to meaningful spaces. In addition to this, we have not always tracked number of community members reached by our navigators, or number of flyers distributed outlining MIVI services, so we chose to be more intentional this year by establishing an outreach survey for staff to complete after attending events.

Navigation Service Outcomes

This grant year, the program served **319 pregnant** clients with an additional **52 non-pregnant** clients who were served nearly all postpartum (96.2%) reflecting continued Navigation support beyond the pregnancy period itself. The target population for Navigation is Black/African American women, this is based on infant mortality rates and birth outcome disparities (e.g., low birth weights, preterm delivery rates).

319 pregnant clients served	53.9% Black or African American	27.6 average age	85.7% on Medicaid
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Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

Responses from intake, shown in the panel above, indicate 53.9% of clients were Black or African American, 44.2% White, and 13.7% Hispanic or Latino/a. The mean age was 27.6 years, with 1.9% under 18. Most clients had a high school diploma GED or less (73.4%), the large majority (85.7%) reported Medicaid as their form of insurance and over half of clients (51.6%) did not enter services until their third trimester, a shift from last year's second-trimester majority. Most pregnant clients served resided in one of the priority service area zip codes, with **43615 (11.1%)** having the highest participation, followed by **43604 (10.1%)** and **43605 (9.2%)**.

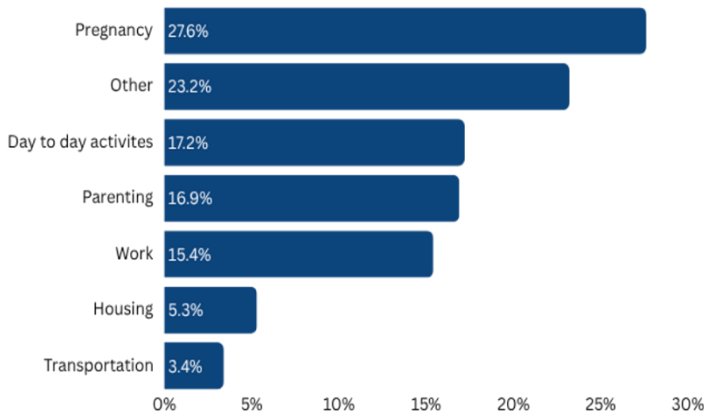
Zip code (Primary)	%	Zip code (Secondary)	%
43615	11.1%	43604	10.1%
43612	8.9%	43605	9.2%
43614	7.3%	43611	7.0%
43609	7.0%	43608	6.3%
43607	5.7%	43606	5.7%
		43613	3.5%

Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

Risk Factors and Stressors for pregnant women served

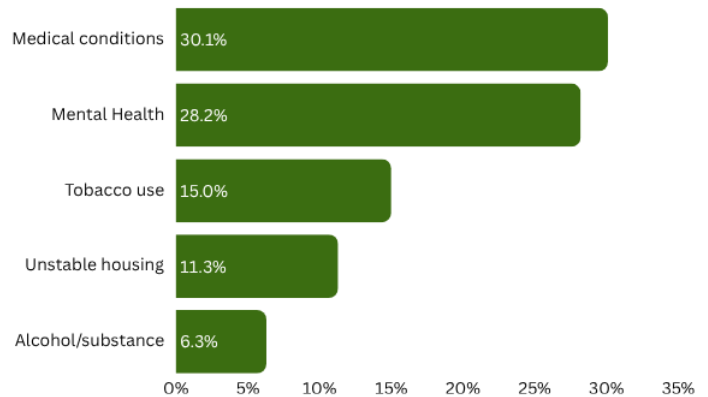
The barriers, stressors, and risk factors shown above remain central to how Neighborhood Navigators identify individual client needs. Among clients reporting barriers to prenatal care (7.1%), 68.2% cited transportation as the main barrier. **Despite these barriers, 99.4% received prenatal care.**

Reported stressors among pregnant clients served (n=319)



Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

Risk factors among pregnant clients served (n=319)



Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

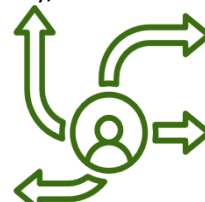
Reported stressors centered on pregnancy itself (27.6%), followed by other category (23.2%), day-to-day activities (17.2%), and parenting (16.9%). Beyond the categories above, clients selecting "other" as their primary stressor most often described either having no significant stress or financial strain including bills, lost income during unpaid maternity leave, and the cost of preparing for a new baby. Other common themes include lacking a support system, mental health concerns such as grief or postpartum anxiety, caring for other children (including a child with special needs), and major life disruptions like a recent move, hospitalization, or a high-risk pregnancy. On average, mothers presented risk factors such as medical conditions (30.1%), mental health (28.2%), tobacco use (15.0%), unstable housing (11.3%), and alcohol/substance use (6.3%).



WIC
80.9%



Community Health Worker
4.7%



Pathways Hub
2.5%

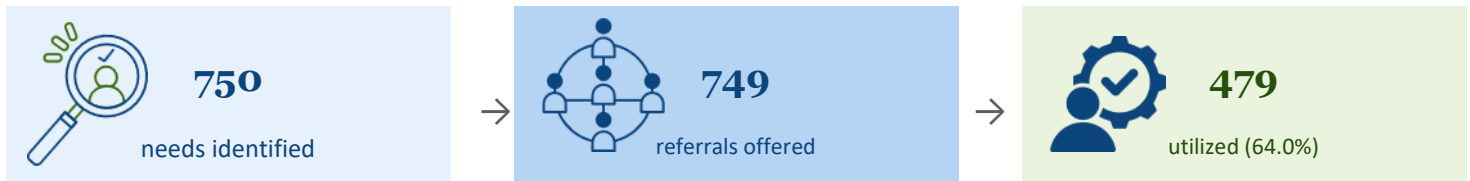


Home Visiting
1.9%

Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

Current services utilized by clients prior to enrollment with Navigation show high participation in WIC (80.9%), followed by Community Health Worker engagement (4.7%), Pathways Community Hub (2.5%) and Home Visiting (1.9%). Many clients not already connected would connect with these services after working with Navigator.

Needs and risks identified



Pregnant clients identified with **750 needs** this cycle (avg. 2.4 per client), with **749 referrals** offered (avg. 2.4 per client) and **479 referrals** utilized (avg. 1.5 per client). Nearly every need identified was met with a referral (100.1%), and 64.0% of those referrals were ultimately utilized by clients. Utilization varied by need type: safe sleep referrals saw strong follow-through (88.3%), baby items referrals were moderate (64.3%), while housing (24.0%), food (20.0%), and transportation (20.0%) referrals lagged well behind despite being identified nearly as often.

Most common community resources and organizations referred to

Need type	Most common organization(s)
Safe sleep	Cribs for Kids
Baby items	Healthy Start, KISS program, local diaper banks, Heartbeat of Toledo
Housing	Lucas Metropolitan Housing Authority, Salvation Army, Catholic Charities
Utilities	HEAP/PIPP program
Food	Southside Life Station, Mom's Mobile Mission
Clothing	Project Dignity, Goodwill Industries, Toledo Free Thrift Store
Prenatal/parenting support	Brother's United/Sister's United, ProMedica Preparation for Parenting

Source: REDCap, MIVI26 cycle, July 2025 - June 2026.

93.7% of pregnant clients were identified as needing safe sleep support which was the single most common need across the program.

Beyond pregnant clients, MIVI served 52 non-pregnant individuals, nearly all postpartum (96.2%; 0–12 months postpartum), with a small number of parenting caregivers (3.8%). This group was slightly more likely to identify as Black or African American (51.9%) and was notably older on average (30.2 years) than pregnant clients (27.6 years). Non-pregnant clients also presented with fewer average number of risk factors (0.77 vs. 0.91) and fewer identified needs (2.0 vs. 2.4) than pregnant clients, with the most common risk factors being mental health and medical condition concerns, tied at 26.9% each. However, referral follow-through was weaker in this group (57.7% vs. 64.0% utilized). As with the pregnant clients, safe sleep was by far the dominant identified need (92.3%) among non-pregnant clients too.

Highlighting Stories from the Community

Throughout this grant year our staff had multiple successes in engaging with their clients and leaving a lifelong impact on their lives. Specifically, in quarter 1, a preteen girl was referred to our MIVI program for resource navigation after becoming pregnant under complex and unsafe circumstances. The program quickly connected her to home visitation services, where a community health worker provided trauma-informed support, helped secure safer housing, and ensured the family had essential items like beds and a crib for the newborn. The staff member also facilitated mental-health counseling through a trusted, home-based provider, helping the young mother begin to process her experience and rebuild trust. Due to the thorough screening process through MIVI's resource navigation system, she was connected with the appropriate resources to meet her needs, allowing her to regain stability, re-engage with school, and begin healing in a safer, more nurturing environment.

Another strong example of how impactful these services are includes an encounter from quarter 2 where a 25-year-old pregnant mother, expecting her fourth child, was identified through the MIVI program during a health fair in a low-income area of Lucas County. Through the MIVI screening and survey process, her needs and interests were assessed, including her desire to participate in parenting workshops that promote healthy pregnancy and parenting behaviors. A MIVI Navigator connected her to Brothers and Sisters United (BSU), recognizing her strong motivation to strengthen her relationships as a mother and partner while intentionally working to break generational cycles and build a healthier future for her children.

Through her engagement with BSU—made possible by the MIVI referral and connection—she and her co-parent participated in a co-parenting program focused on communication, teamwork, and prioritizing children's well-being. Prior to enrollment, she faced challenges related to financial stress, homeschooling responsibilities, and navigating co-parenting dynamics. Through the program, she gained practical tools for effective communication, learned how reducing conflict positively impacts children, and embraced values of resilience, adaptability, and mutual understanding. She reported feeling empowered to create a more nurturing and stable family environment, reinforcing the impact of MIVI's role in identifying needs and linking families to meaningful community resources.





**ARE YOU PREGNANT?
HAVE A BABY OR TODDLER?
LIVE IN LUCAS COUNTY?
NEED HELP WITH RESOURCES?**

The Maternal and Child Health (MCH) Team at the Toledo-Lucas County Health Department is here to serve families who are pregnant or have children under 12 or 18 months. Contact us today!

Healthy Start, **MIVI/Getting to 1 Navigation**, and **Cribs for Kids** programs provide one-on-one support, connection to variety of resources and baby items, parenting education, and much more.



Programs are free, serve all of Lucas County Ohio, and have no income or insurance requirements

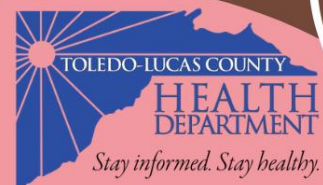
Receive gift cards for completing programs (as available)



CONNECT WITH US TODAY:

419-213-8434 (call) | 419-277-1601 (text)

MCH@co.lucas.oh.us | scan QR code



Stakeholder Engagement and Service Implementation

Summary

Community Partners

Our local Stakeholder Engagement group, Getting to 1 Coalition, is made up of community members and representatives from many sectors and agencies in the Lucas County community. All of these individuals at some point have helped shape and identify our service activity indicated in deliverable 9. Some of the stakeholders that have attended our meetings include Medicaid Managed Care Plans, local health care organizations/providers, doulas, Community Health Workers, local universities, and other community focused agencies. Specifically, some agencies/communities represented include but are not limited to [Queens Village Toledo](#), Mercy Health, ProMedica, Buckeye Health Plan, CareSource Health Plan, AmeriHealth Caritas Plan, [Health Council of Northwest Ohio](#), Compassion Health Toledo, WIC, University of Toledo, Central State University Extension, [Pathway Inc](#), [Pregnancy Center of Greater Toledo](#), [Tiny Hearts Remembered Inc.](#), and more! We are so thankful and grateful for all the hardworking and passionate individuals who have come together to unite work on saving babies and eliminating racial disparities!

Service Implementation

The specific need addressed in MIVI26 is increasing access to blood pressure cuffs and hypertension/preeclampsia education for Black/African American families in Lucas County. In Lucas County, maternal hypertension and complications from hypertension, especially among Black/African American pregnant individuals, remain one of the most significant contributors to adverse perinatal outcomes. This challenge is both clinically urgent and deeply rooted in systemic disparities.

Pre-term birth is still a leading cause of infant mortality. Leading causes/contributing factors of pre-term birth and maternal complications are hypertension and pre-eclampsia. Monitoring blood pressure is important to detect changes and timely intervention to prevent/reduce poor outcomes. Monitoring blood pressure at home is a safe and easy way for birthing people to be proactive about their health. However, there are a variety of barriers to accessing blood pressure cuffs, including knowledge/awareness, cost, insurance hoops, and logistical access.

This need was identified in response to critical findings from Fetal and Infant Mortality Review (FIMR) and Perinatal Periods of Risk (PPOR) analysis, both of which identified hypertension and preeclampsia as major, modifiable contributors to poor maternal and infant outcomes. Additionally, hypertension and preeclampsia are repeatedly brought up as concerns by Navigators/CHWs working with pregnant clients, members of Getting to 1 Coalition, and community members. In 2024 alone, nearly 1 in 4 infant deaths and 1 in 3 fetal deaths reviewed through FIMR involved hypertension as a contributing factor—underscoring the urgency of increased intervention.

Our service implementation requires many roles to be successful and relies heavily on our subcommittee to execute different tasks. Those roles include:

- *Taylor Lewis*: Barrier in Healthcare Subcommittee co-chair. Responsibilities: Identifying partnerships, supporting collaboration, seeking out Hypertension resources and literature, support training efforts by seeking out speakers, location, and training structure. Host meetings and provide committee updates.
- *Ellen Gaietto*: Barrier in Healthcare Subcommittee co-chair. Responsibilities: Identifying partnerships, supporting collaboration, seeking out Hypertension resources and literature, support training efforts, HVAC co-chair and liaison.
- *Barriers in Healthcare Subcommittee members*: Consists of Subject Matter Experts, Trainers, Educators on Hypertension, support persons for efforts in collaboration, seeking out additional literature, and identifying gaps.
- *CHWs*: Working with Community Health Workers through multiple programs, including Healthy Start, Pathway HUB, and Help Me Grow. These are front line staff presenting materials and education directly to families in efforts to reduce hypertension
- *Mercy Community Health Nurses*: Disseminate a compilation of Blood Pressure Resource Packets and report on trends/ findings in the community as well as track information pertaining to our target population (pregnant and post-partum).

Addressing Root Causes

The intervention method we found to be the most beneficial is to increase awareness and education on hypertension and preeclampsia as well as convey the importance of monitoring and knowing personal baseline blood pressure. In addition to this, we want to focus on preventative/protective behaviors, signs/symptoms, and the unique concerns during pregnancy and postpartum. Our goal is to increase access to blood pressure resources, increase training opportunities for CHWs/Navigators, and other staff who work with families. We will coordinate with other programs to prevent duplication and support increased participation and access to resources.

Data

Nationally, hypertension affects 58% of non-Hispanic Black adults, the highest prevalence across all racial/ethnic groups. Black women are also 60% more likely than White women to experience preeclampsia or eclampsia, which significantly increases the risk of very low birth weight (VLBW), preterm birth, and infant death. *Sheehy, Shanshan et al. "Hypertensive Disorders of Pregnancy and Risk of Stroke in U.S. Black Women." NEJM evidence vol. 2,10 (2023): EVIDoA2300058. doi:10.1056/EVIDoA2300058*

Locally, Lucas County data confirms these disparities. A 2023 Perinatal Periods of Risk (PPOR) analysis identified hypertension as the leading modifiable risk factor in adverse outcomes among Black/African American families. The two periods with the greatest excess mortality were: Maternal Health/Prematurity (1.43 excess deaths) and Infant Health (2.11 excess deaths). Under the Maternal Health category: Pre-

pregnancy hypertension increased risk for VLBW [OR 2.17 (1.46, 3.24)], and Gestational hypertension also raised this risk [OR 1.68 (1.15, 2.44)].

Involving the Community

Black and/or AA community members as well as specific programs and agencies make up our subcommittee that is working to implement our identified activity from deliverable 9. Some specific programs that are working directly with us include Queens Village, which is a local chapter of a national organization that prioritizes support, rest, and empowering Black women while offering a supportive community and reducing barriers. They have been integral in all steps of identifying a local problem, provided valuable perspective of a vulnerable population, and have suggested strong steps and activities. Additionally, BUSU Pathways Brothers and Sisters United, is a program that directly supports pregnant/parenting family units while reducing barriers and increasing access to all support systems possible to help the family thrive. They have a strong focus on the support of Black/AA families and prioritize this population in their services. Lastly, we have in the past collected race and ethnicity of attendees for our meetings, and many individuals represented the Black/AA population within our meetings, directly supporting and taking part in the adoption of our indicated service.

Coalition Involvement

This intervention was identified through multiple data sources and coalition member suggestions. Additionally, findings from Fetal and Infant Mortality Review (FIMR) and Perinatal Periods of Risk (PPOR) analyses highlighted hypertension and preeclampsia as major, modifiable contributors to poor maternal and infant outcomes. In 2024, nearly one in four infant deaths and one in three fetal deaths reviewed locally involved hypertension. Additional input from CHWs, Navigators, coalition members, and community voices consistently reinforced hypertension as a critical concern. Supporting national data further underscores disparities, showing higher rates of hypertension and pregnancy-related complications among Black women. WE also have relied on the coalition for feedback, training suggestions, dissemination suggestions, educational material compilation, and what type of data metrics to collect. The coalition has been integral in the identification and implementation of our service activity.

Sustaining Efforts

Our planned efforts to sustain the lasting impact of our service/activity based on implementation is a multipronged approach. We are working hard to ensure communication is consistent and clear to the group, to ensure everyone remains on the same page. We also hope this helps support continued engagement and encourage accountability to stay on track for assigned topics or actions. We also are trying to document assigned tasks so there is a track record of what is discussed, what level of progress is achieved, and this allows other people to step in where needed if transitions take place or members availability becomes limited. We have created a flexible timeline that allows for pivoting and general adjustments that will not set

off or negatively impact other identified tasks as we move forward and accomplish goals. Lastly, we foresee our identified action to take some time to see a general impact on the data we identified to support this effort. While we are working to educate and provide general resources to the community regarding their blood pressure, we anticipate it taking quite a long time before this intervention would not be needed, therefore our identified task will remain relevant and persistent in our community.

Stakeholder Engagement Success Story

A success story that we would like to share involves a newly established partnership with a local program. Mercy Health, whom we have had an ongoing working relationship for an extended period of time, has a community health nurse program with staff we have not previously met. The goal of this community-based program is to provide screenings for blood pressure and blood glucose levels to Lucas County community members, directly in the community. Through tabling events that take place at different library branches, community centers, and outreach opportunities. The staff coordinating this program met with us and offered to support our initiative by sharing the compiled blood pressure resource packet we are working on, as well as offering to collect some additional metrics around pregnancy and post-partum to further support our work. This also gave us the opportunity to share and encourage our clients to go and get readings should this be the most accessible option for them.

Another success we noted for this year was involvement of members with the selection and formation of this project. The General Getting to 1 Coalition has always openly discussed their interests for the group to discuss further and different topics to work on addressing. For quite some time now, the general group has shown interest in addressing perinatal hypertension and ways to reduce it based off data in our county and what a lot of agencies are seeing directly impact the clients they serve. Choosing hypertension was a pretty unanimous decision, the group clearly saw it as a concern in the community in a multitude of ways, and this was a topic folks wanted to learn more about. Though there are lots of resources on hypertension, clearly there is still more work to do. Barriers in Healthcare subcommittee had several lively discussions during meetings, sharing resources, suggestions, and building out plans. Blood Pressure Concerns during pregnancy and postpartum was topic of the April 20th Getting to 1 General meeting. Meeting agenda included 1) data presentation by Epi, 2) educational presentation by a Certified Nurse Practitioner and highlights on work ProMedica is doing in this area, 3) CareSource spoke about their initiatives and benefits around hypertension, 4) two local initiatives were highlighted including Mercy Community Health Nurses who provide screenings and education in the community, and the MCH Grant Blood Pressure Mail-In pilot program. Total of 50 participants attended this virtual meeting. Participants were very engaged to learn more about hypertensive disorders and resources.

Other Epi Work:

Data Projects

This year, the epidemiologist disseminated 11 data products to local stakeholders and partner organizations, including presentations, scorecards, and press materials on key maternal and infant health topics:

- Early cesarean sections and inductions, and associated risk factors
- Infant deaths related to unsafe sleep in Lucas County
- Safe Sleep Awareness Month (October) press conference data on observed safe sleep trends
- Ohio AAP Safe Sleep Webinar <https://ohioaap.org/safesleep>
- Hypertension as a risk factor for stillbirth and infant mortality

The objective across these products was to spotlight poor birth outcomes, available resources, and the specific factors contributing to fetal and infant mortality in the county drawing a direct line between modifiable risk factors and outcomes so partners could act on them. This dissemination facilitated outreach efforts and heightened awareness of infant and fetal mortality trends countywide, fostering increased collaboration among partners to address the needs identified.

Priority Zip codes Analysis

Priority Service Areas were identified to determine where most resources or services should be directed for the Neighborhood Navigators. A concentrated analysis was conducted to highlight areas of infant morbidity and mortality among Blacks/African Americans within Lucas County. Although some consistency in service areas was seen from previous years, additional areas of opportunity were identified in zip codes where poor health outcomes were higher than the overall county average. As shown in the analysis, five ZIP codes (43609, 43607, 43612, 43615, and 43614) were identified as Priority Service Areas based on the number of Black infant deaths, the percentage of births to Black mothers, and the proportion of infant deaths that were Non-Hispanic Black/African American. These ZIP codes represent areas with both a high burden of infant mortality and clear evidence of poor birth outcomes, making them central targets for intervention. Most of these ZIP codes are consistent with last year's analysis; however, the list was refined this year by distinguishing between primary and secondary priority areas for greater clarity. In addition, ZIP code 43611 was added to the secondary areas.

Neighborhood Navigation efforts within the MIVI county should continue to prioritize outreach, resource connection, and support for Non-Hispanic Black/African American women and families living in these PSAs. Maintaining a strong presence in these ZIP codes will help address the social and structural factors that contribute to poor birth outcomes, such as limited access to prenatal care, economic instability, and systemic barriers to health equity.

In addition to the designated PSAs, secondary ZIP codes remain on a watchlist due to elevated disparities but smaller or less stable numbers. Ongoing monitoring of these areas is important to ensure that emerging needs are not overlooked. Together, this approach allows MIVI to focus resources on the neighborhoods with the greatest impact while keeping sight of broader countywide inequities.

Table 1: Priority Service Areas: Non-Hispanic Black Infant Outcomes and Disparities by ZIP Code, Lucas County (2020-2024*)

Lucas County Zipcodes	NHB births	NHB Infant deaths	NHB IMR	NHB % preterm birth	NHB % low birth weight	IMR disparity ratio	PTB disparity ratio	LBW disparity Ratio
43607	744	12	16.1	17.1%	16.7%	5.2	1.7	1.8
43609	617	15	24.3	19.0%	17.5%	1.5	1.5	1.4
43612	686	11	16.0	14.0%	13.3%	2.5	1.3	1.4
43614	480	11	22.9	14.4%	14.4%	3.5	1.4	1.8
43615	911	12	13.2	12.1%	13.0%	1.6	1.3	1.7

Table 2: Secondary Priority Service Areas: Non-Hispanic Black Infant Outcomes and Disparities by ZIP Code, Lucas County (2020-2024*)

Lucas County Zipcodes	NHB births	NHB Infant deaths	NHB IMR	NHB % preterm birth	NHB % low birth weight	IMR disparity ratio	PTB disparity ratio	LBW disparity Ratio
43604	514	7	13.6	20.4%	19.8%	2.9	1.1	1.1
43605	467	7	15.0	18.0%	16.3%	1.1	1.3	1.4
43606	439	7	15.9	15.9%	15.3%	2.8	1.3	1.7
43608	498	6	12.0	20.3%	18.9%	3.2	1.2	1.1
43611	219	8	36.5	17.4%	15.5%	6.0	1.4	1.6
43613	429	5	11.7	14.9%	12.1%	2.3	1.7	1.8



Looking Ahead

Navigation

In MIVI26 our Navigators touched a local record number of families. We are excited to continue serving so many families in MIVI27. We continue to work together as a team, constantly making new resource connections, refining processes, and tweaking services to best meet the needs of the families we serve.

Stakeholder Engagement

We look forward to launching the Blood Pressure educational packets and education trainings we have been working on this cycle. We look forward to strengthening partnerships and new opportunities. We also are excited about potentially bringing back Lunch n Learns. Historically Lunch n Learns have been an enjoyed format to network and receive continued education. As there is not currently a local series of Lunch n Learns going on, we are looking into doing so!

Epidemiology and Data Analysis

Looking to the 2026–2027 cycle, MIVI27 will deepen its epidemiological reporting on infant and fetal mortality, prematurity, and low birth weight including causal factors not historically tracked. This includes expanding measures around hypertension and interpregnancy interval tracking, along with exploring additional ways to utilize metrics to identify gaps in service delivery and target improvement efforts more precisely. This data will be routinely shared with internal and external partners to drive continued improvement.

Conclusion

MIVI26 was a year of growth and collaboration. We are so grateful for our team, our agency Toledo-Lucas County Health Department, our funder Department of Children and Youth, and our many community partners! Thank you for working with us to help our community and helping more babies make it to their first birthday and beyond!

For more information, please visit gettingto1.org

For programmatic questions, contact Program Coordinator at gaiettoe@co.lucas.oh.us

For data questions, contact Epidemiologist at YBhoge@co.lucas.oh.us or use [form](#).

To join Getting to 1 Coalition, reach out to gettingto1lucascounty@gmail.com or complete [this form](#).

Coalition Flyers



EARLY C-SECTIONS AND INDUCTIONS: WHAT IS THE DEAL?

Getting to 1 Coalition is excited to host an informative panel discussion on early C-Sections, Inductions, surrounding factors, and their impacts on birth.

Monday, July 28, 2025
10:30am - 12pm (doors open 10am)
ProMedica Ebeid Center, 2nd floor
1806 Madison Ave, Toledo

**ALL ARE WELCOME TO ATTEND
SNACKS WILL BE SERVED**

www.gettingto1.org | 419-213-4263 | gettingto1lucascounty@gmail.com



REALISTIC SAFE SLEEP

This Getting to 1 Coalition meeting will focus on Safe Sleep, emphasizing that it involves everyone who cares for a baby, addressing realistic (not just ideal) scenarios, and busting myths.

The format will be a short data presentation, a panel discussion, and resource sharing.

Monday, October 27, 2025
10:30am - 12pm
Virtual on Zoom
Everyone is welcome



www.gettingto1.org | 419-213-4263 | gettingto1lucascounty@gmail.com

Getting to 1 Coalition Topics and Flyers during the MIVI26 grant cycle.

All topics were informed by community voices and data.



EARLY C-SECTIONS AND INDUCTIONS: PART 2, DIVING DEEPER INTO WHAT IS THE DEAL?

Join us for discussion going deeper into the factors and data around rates and reasons for early c-sections and inductions. Learn how this impacts maternal and infant health in our community.

Monday, January 26th, 2026
10:00am - 12:00pm
Online on Zoom
(Click or scan to register)



EVERYONE IS WELCOME

www.gettingto1.org | 419-213-4263 | gettingto1lucascounty@gmail.com



BLOOD PRESSURE: PREGNANCY AND POSTPARTUM

Join meeting to learn more about blood pressure concerns during pregnancy (like hypertension and pre-eclampsia), impacts on maternal and infant health in our community, and resources.

Monday, April 20th, 2026
10:00am - 12:00pm
Online on Zoom
(Click or scan to register)



EVERYONE IS WELCOME

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