The Fetal and Infant Mortality Review (FIMR) Process:

A DECADE OF LESSONS LEARNED
This document builds on and expands the conceptual framework and content contained in:


Photographs by Nita Winter appear on pages i, 4, 10, 16, 24, 46.

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since it was first introduced in the late 1980s, Fetal and Infant Mortality Review (FIMR) has been a dynamic, community process. FIMR has enjoyed continued growth and refinement as more communities have used it. Today, there are over two hundred FIMR programs.

While the basic methodology is the same in most programs, the specific recipe for actual operation is local. Funding sources vary from community to community. Different types of agencies sponsor the FIMR program including city and county health departments, local hospitals, regional perinatal centers and community based maternal and child health coalitions. FIMR programs thrive in cities, as well as rural communities. Over time, programs from very different backgrounds have grown and prospered. The lessons they have learned will be useful to new and continuing programs.

In order to understand some of the common elements that contribute to long term FIMR operation, we interviewed a sample of nine programs from different parts of the country that have been in operation for 7 years or more. We also chose programs with different start – up funding sources and a variety of lead agency
sponsors. The FIMR programs reviewed in this report include the following:

1. Chatham County Department of Health, Savannah, Georgia
2. Growing into Life Coalition, Aiken, South Carolina
3. Healthy Mothers/Healthy Babies, Inc., Broward County, Florida
4. Humboldt County Health Department, Eureka, California
5. Milwaukee Department of Health, Wisconsin
7. Saginaw County Department of Health, Michigan
8. San Diego Department of Health, California
9. Southern New Jersey Perinatal Consortium, Camden, New Jersey

This last decade has been a time of tremendous change in health care delivery systems and funding. That these nine programs maintained their efforts during these years is a tribute to their energy, commitment and dedication. We found that a great deal can be learned from these programs – especially about how they continue year in and year out to develop actions to improve service systems and resources for women, infants and families and what keeps team members engaged over the long run. They provide important insights into the FIMR methodology as it has been refined over time, as well.

In addition to capturing lessons learned from these programs, this document also identifies some key concepts about continuous quality improvement, group process, community asset development and coalition building theory. Combining these concepts with the FIMR experience of taking recommendations to action, we believe, will help communities implement FIMR.

It is hoped that this document will provide insights that will help current FIMR programs across the country in their efforts to improve service systems and resources for women, infants and families and sustain their programs over time. We also envision that this information will encourage more communities across the nation to move forward to adopt the action-oriented FIMR process. While
FIMR involves time and effort, communities that take on this action-oriented process are generating better service systems and resources; member pride and satisfaction; and community-wide confidence in a better future.

**Characteristics of Selected FIMR Programs**

<table>
<thead>
<tr>
<th>Site</th>
<th>Original Funding Source</th>
<th>Rural/Urban</th>
<th>Lead Agency Sponsor</th>
<th>Years in Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aiken</td>
<td>State Title V</td>
<td>Rural</td>
<td>County DOH</td>
<td>12</td>
</tr>
<tr>
<td>Broward County</td>
<td>Robert Wood Johnson Foundation</td>
<td>Urban</td>
<td>State Funded HM/HB Coalition</td>
<td>8</td>
</tr>
<tr>
<td>Chatham County</td>
<td>Federal Healthy Star t</td>
<td>Rural/Urban</td>
<td>County DOH</td>
<td>7</td>
</tr>
<tr>
<td>Humboldt County</td>
<td>State Title V</td>
<td>Rural</td>
<td>County DOH</td>
<td>10</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>Robert Wood Johnson Foundation</td>
<td>Urban</td>
<td>City DOH</td>
<td>7</td>
</tr>
<tr>
<td>North County</td>
<td>State Title V</td>
<td>Rural</td>
<td>Local Perinatal Council</td>
<td>7</td>
</tr>
<tr>
<td>Saginaw</td>
<td>March of Dimes and MCHB</td>
<td>Urban</td>
<td>Local Hospital</td>
<td>10</td>
</tr>
<tr>
<td>San Diego</td>
<td>County sur charge on Birth Certificates</td>
<td>Urban</td>
<td>County DOH</td>
<td>7</td>
</tr>
<tr>
<td>So. New Jersey Perinatal Consortium</td>
<td>Robert Wood Johnson Foundation</td>
<td>Urban</td>
<td>State Perinatal Region</td>
<td>7</td>
</tr>
</tbody>
</table>
Fetal and Infant Mortality Review (FIMR)?

Action is the hallmark of the FIMR process. Most FIMR programs have a two-tiered system that leads from review of cases to action and two teams, the case review team and the community action team. As such, FIMR serves as a type of ongoing continuous quality improvement (CQI). CQI developed as a means for industrial companies to achieve a better product by identifying best production practices and implementing them. FIMR, also, develops creative and innovative local actions that improve services and resources for women, infants and families.

Like CQI, FIMR goes far beyond a limited analysis of a few traditional factors to focus on the identification of the social, economic and system issues unique to each community that have an impact on infant morbidity and mortality. Key steps in the FIMR action-oriented process include data gathering, case review, community action, and changes in local community systems.

Data gathering

Many sources identify deaths and provide information for FIMR reviews. These may include records from physicians, hospital, home visits, WIC and, perhaps, additional social service records. Other
information is obtained in an interview with the family, usually the mother. A de-identified summary of the case is prepared and presented to the case review team (CRT).

**Case Review**

Members of the CRT represent a broad range of professional organizations and public and private agencies (health, welfare, education, social services and advocacy), consumers and MCH advocates. The CRT reviews the case summaries to identify barriers to care, gaps in services and trends in service delivery.

**Community Action**

Typically, the CRT presents its recommendations to a team of individuals known as the community action team (CAT). The CAT is diverse and is composed of two types of members: those with the political will and fiscal resources to create both large and small system change and those who can define a community perspective on how best to create the desired change. The CAT translates the case review team recommendations into an action plan. They participate in implementing community action.

**Community Change**

As local problems are resolved and the health care, physical and social environment for families gets better, outcomes also improve.
As depicted below, the relationship among the CRT, the CAT and the community is meant to be dynamic, action-oriented and results in new and creative solutions to community issues or problems.

The FIMR Process is Action-Oriented*

The Process

CASE REVIEW TEAM
Reviews cases, identifies gaps in service systems and resources and reports to

COMMUNITY ACTION TEAM
Assesses broader issues, translates issues into interventions and reports to the

COMMUNITY

Creating Solutions
Where None Exist:

• Within Provider Groups and Organizations
• Between Providers and Organizations
• Across the Community

*For more in-depth information about the FIMR methodology, see: Buckley KA, Koontz AM, Casey S. Fetal and infant mortality review manual: a guide for communities. Washington, DC. American College of Obstetricians and Gynecologists, 1998. This document is available free of charge by writing NFIMR, 409 12th Street, Washington, DC 20024.
Lessons Learned from Nine FIMR Programs

1. Infant health is a measure of community well-being.

2. FIMR is a community coalition.

3. FIMR programs engage a diverse membership.

4. FIMR programs thrive on effective group process.

5. Action is key to FIMR.

6. FIMR programs take on a wide range of community actions.

7. FIMR programs build on existing community assets.

8. The FIMR process is a journey, not a destination.

9. FIMR programs use population based data.

10. FIMR programs communicate to the larger community.

11. FIMR programs recognize and celebrate the work of their team members.

12. FIMR programs and state Title V and Title X agencies benefit from close ties.
Lessons Learned from Nine FIMR Programs

Infant health is a measure of community well-being

Communities that have continued their FIMR efforts over time have learned that health for women, infants and families is not only health care or medical treatment for disease. They look outward to the community and see that healthy women, infants, and families are more likely to thrive in cohesive, culturally competent, and economically sound neighborhoods. Healthy communities nurture healthy families.

For this reason, these programs would tend to view a high infant mortality rate as a broad indicator of community and family distress. Poverty, social isolation, inadequate housing, poor nutrition, neighborhood disintegration and a host of other social and economic hardships contribute to death and disability. No one who participates in FIMR can fail to appreciate the impact of all of these factors on outcomes. As one public health expert explains the relationship:

“Infant mortality is not a health problem. Infant mortality is a social problem with health consequences.” (2)
This view is also consistent with community development theory:

- Individuals and families should be understood in the broadest context of their environment. Thus, when examining social problems (e.g., drug abuse, teen pregnancy, etc), teams consider the major forces in American life today that have an effect on these problems. Some of these forces may include racism, sexism, class elitism, and social and economic injustices.

- Community programs should be committed to addressing those components of local society that require change rather than simply improving ways to help families adapt to society’s ills. (3)

It also helps explain why FIMR programs engage in a range of community action. While their primary focus is developing community action strategies that improve health and human systems and resources, some take a step further. They begin to document and report larger societal problems to the community. They may also suggest actions that can affect the community’s overall well being by focusing on such issues as cultural and racial disparity, the family’s role and function, neighborhood safety, adequate housing and the community’s economic status. For example, the Aiken FIMR coordinator reports, "Gradually, we realized that infant mortality is not an isolated problem, but an indicator of deeper problems in the community: poverty, divisions of race and class, teen pregnancy, barriers to equal access to health care. The Task Force changed its focus to include these broader issues, and we changed our name to Growing into Life to reflect the broader mission." (4)
FIMR is a community coalition

A FIMR program is not a small, exclusive study group. Instead it is an inclusive, diverse coalition. Typically, the FIMR model relies upon a two-tiered system that leads from case review to community action. The total number of people participating in the two tiers may range from 30 to 50. Some FIMR programs like Aiken, SC, Saginaw, MI and San Diego, CA are much larger. Participants include but are not limited to: local obstetric, pediatric and family planning medical and nursing providers, public health officers, social service agencies, hospital administrators, educators, policy makers, elected officials, bereavement professionals, maternal and child health advocates, business leaders and community family members.

A coalition can be defined as:

“An organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently” (5) or

“…a group involving multiple sectors of the community, coming together to address community needs and solve community problems” (6)

The understanding that a FIMR program is a type of coalition has grown as the methodology has matured. In the early 1990s, the first FIMR demonstration programs put energy into the defining the process of medical data collection, home interview protocols and the actual case review. In those early years, FIMR programs also struggled to set their programs apart from other activities such as medical peer view, interagency quality assurance, institutional morbidity and mortality conferences, and quantitative research. Only after that initial groundwork had been laid, did programs begin to utilize the power of their FIMR teams as a means to action and systems change – as a coalition.

Also, many early FIMR program sponsors may not have had training in coalition building or group process. Most of the people behind successful FIMR programs that have operated for a long
time have had to learn the basic principles of these disciplines, identify team leaders who can put these principles to work and discover ways to harness the power that community-wide coalitions can wield.

FIMR programs that act as effective coalitions are able to:

✓ identify current health and other systems problems and enact needed community changes using the strength of their collective advocacy

✓ expand available services by cooperative programming and joint funding

✓ coordinate service systems by providing a unique forum for interagency networking and planning

✓ identify gaps in current health care and other service systems and cooperate to fill those gaps

✓ make the most of similar and diverse perspectives that members from varied cultural, professional and personal backgrounds bring to the process

✓ reduce interagency conflicts by squarely addressing issues of competition and turf, an especially important skill in a time of changing health care delivery systems and reduced resources

✓ make family issues more visible to policy makers, funders, the media and the broader community

✓ decrease costs by avoiding duplication of services

✓ conserve resources by identifying resource-saving opportunities (7, 8)
“When spider webs unite, they can tie up a lion.” – African proverb

We succeed TOGETHER. How do we organize hundreds of efforts, coalitions, and diverse initiatives? We immediately abandoned traditional hierarchical structures and instead envisioned ourselves as a web.

Growing into Life uses “webbing” as our operative metaphor for community action. A spider must repair its web each day, as we must deal with personnel, legal, and system change among agencies. The spider unhesitatingly extends its web to new anchoring spots as they appear. So do we incorporate new ideas, new strengths, and new people into our midst. The spider bundles up food for future meals, as we conserve our assets and seek new sources of support. Web complete, the spider’s feet are tuned to any vibration on the web, as we remain alert to immediate needs in our community. The spider’s web softly catches what falls to it. So we join together to protect those who might fall through the cracks in our complex societal systems. Finally, the spider extrudes its web silk from its body as we create a united community, knowing that the quality of our collaboration directly affects the quality of our lives.

Aiken has espoused the healthy community concept as the basic web. This is one in which citizens take increasing responsibility for their lifestyles, their neighborhoods, and their communities. A healthier community is one in which informed citizens actively participate in government decisions affecting their health care, education, employment, and environment.

A healthier community cares for its children and provides for its elders.

A healthier community entertains new ideas and cherishes commonly held values.

From: Aiken FIMR website (www.growing-into-life.com).
A FIMR team that is truly diverse is almost always able to identify significant problems in health care and related service systems. They are also able to produce high quality, community sensitive and culturally relevant FIMR actions to address them. A FIMR team that is too narrowly composed of members who are all the same profession, race, agency, or socioeconomic status will focus on small parts of the problems. They would fail to impact overall community service systems and resources.

Diversity of FIMR team membership is essential to ensure that the team’s recommendations and actions accurately reflect the community’s composition and need for acceptable services. Diversity also is key to securing long term, broad community support to move recommendations to action. Team membership should reflect both the community at large and the community most affected by high infant mortality rates.

“The Growing into Life FIMR Task Force...has built respect and friendship among races, between classes, around language barriers, and among those of differing political and economic interests.” Karen Papouchado, Aiken SC

When a FIMR program has a truly diverse membership, working together provide a unique opportunity for community members to come together and grow in understanding and appreciation of cultural beliefs and behaviors that differ from their own. The local program becomes a community model for respect and understanding. Friendship grows among diverse agencies and individuals who might never have met – except for FIMR. These relationships among team members become the basis for new partnerships that create positive change in the community.

The nine FIMR programs described here have cultivated interesting new members. These partners bring additional assets to the table and increase the pool of resources that move recommendations to action. These include representatives from: faith communities, the Alpha Kappa Alpha fraternity, the American Lung Association, United Way, the Kiwanis Club, Habitat for Humanity, local county
officials and state legislators, local fire and police departments, the Urban League, the Junior League, Planned Parenthood, the PTA, the SafeKids Network, YMCA, YWCA and the Zeta Phi Beta Sorority Stork Nest Program. A complete list of each of the nine FIMR program’s team members is included in their individual reports.

In turn, these new team members foster recruitment of additional local community contacts that can help move recommendations to action. Some of these new community allies include pharmacists, grocery store owners, parish nurses, beauticians, supervisors of local shopping malls and other businesses, bankers, laundromat managers, cable TV networks and radio station talk show hosts.

Finally, FIMR encourages diverse input through home interviews with all of families who has experienced a loss, if they agree. Not many other local, maternal and child health initiatives actively seek out such an extensive family voice as FIMR. Usually, the mother is the family member who is interviewed.

“Maternal interviews give a voice to the disenfranchised in my community, those without clout or power. FIMR provides a rare opportunity for the providers in a community to hear from the consumers.”

Patt Young, FIMR Interviewer, California FIMR Support Program.

The home interviewer then conveys the mother’s de-identified story to the FIMR team members. FIMR programs find that what mothers say almost always provides significant information about diverse populations in the community, the problems they face and their knowledge, attitudes and beliefs about health. It is also particularly important to the team’s understanding of whether or not services and community resources are available, accessible and culturally appropriate to the community.

“The process that brings together diverse people to learn from the story of a family that experienced a fetal or infant loss helps awaken both commitment and creativity.

Seth Foldy, MD, Commissioner of Health, Milwaukee, WI
FIMR programs thrive on effective group process

FIMR programs conduct their business and create community change through a series of ongoing meetings. Each meeting usually lasts from two to three hours. Over the long run, the quality and productivity of that meeting time may make or break a FIMR program. To keep team members engaged, FIMR meetings must be well run and be interesting, stimulating, and enjoyable. These meetings must also result in action. As one FIMR coordinator explains: “Our meetings are productive, positive and supportive. The community really welcomes the opportunity to come together!” (9)

To meet these criteria, FIMR meetings require competent leadership. Each and every team member must also pledge to do their part to make meetings effective. There is likely to be some conflict in FIMR team meetings. But, if it is well managed, members learn and benefit from it. Seasoned FIMR team members also become skilled at being able to compromise to move recommendations to action.

Leadership

FIMR team leaders come from many backgrounds. The FIMR programs described in this report include leaders who are city and county health officers, a high school principal, a former mayor and two Directors of Healthy Mothers/Healthy Babies Coalition. These effective leaders all have some common characteristics, including:

✔ proven administrative skills in working with groups, setting agendas, running efficient meetings, garnering resources and delegating responsibilities
✔ knowledge and skill in resolving group conflict
✔ a democratic, non-partisan (i.e., without personal, professional, or institutional agendas) leadership style
✔ Overall respect from all team members
✔ a degree of political knowledge and competence (10)

Resolving Conflict

To varying degrees, team members expect some conflict among the group as they develop their action agenda. Conflict may be a real part of FIMR meetings for at least two reasons.
First, FIMR teams can be expected to evolve through stages of group development, which occur in any small group. This development is likely to include some fairly active dissension. It is the FIMR leader’s job to be prepared for conflict and disagreement at any time, but especially during the ‘storming’ phase of group development. The more quickly and effectively any group, including the FIMR team, passes through that phase the better. (11) During the ‘storming’ phase, team ability to work collaboratively falls even below the beginning ‘forming’ phase. Team members also need to be prepared for dissension to reoccur. As new team members join the team and more experienced team members leave, some of the less productive group dynamics may resurface and need to be addressed again.

Second, FIMR programs make a deliberate effort to bring together diverse, energetic community agency directors and community leaders as well as outspoken community advocates and families. These members are bound to have different agendas and raise different points of view. Initially, they may not agree about which community

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**Stages of Coalition Development**

**Forming.**
As a coalition comes together, feelings can range from excitement and enthusiasm to fear and resistance. The overriding tone is usually cordial.

**Storming.**
After the formative stage, issues and agendas begin to surface. Slight to severe differences in the perception of facts, goals, methods, values, etc. are uncovered. Responses can range from withdrawing to overt fighting. The atmosphere is often chaotic.

**Norming.**
Members stop talking at each other and start listening to each other. Needs, benefits, and limitations of collaboration are realized. Roles and responsibilities are determined; agreements are made concerning ground rules and group procedures. Constructive compromises are found. The tone is usually relieved and hopeful.

**Performing.**
In this stage, the group produces. Members honor boundaries and agreements. Balance is maintained between content and process. Appropriate participation, respect, and commitment characterize the tone of meetings.

Adapted from: Centers for Disease Control and Prevention. The prevention marketing initiative: applying prevention marketing. 1996, p 58
actions are most needed. Long lasting FIMR programs tell us that conflict is not necessarily a bad development. Just the opposite – a lack of conflict may mean that the group does not represent enough diverse opinions to have a meaningful discussion. FIMR communities benefit when all members feel equal, are free to voice their opinions and can disagree with others in the team. However, effective FIMR teams establish ground rules early on that specify that disagreements should always focus on ideas not attacks on individuals.

**Compromise**

FIMR teams will work best when the group decides at the outset how they will reach agreement on controversial or sensitive actions. Longstanding team members say that they have come to realize that the development of a plan for community action will probably not promote the opinion of one faction or another on the team. More likely it will be compromise or middle ground among several different points of view.

FIMR programs consider compromise as one of the best ways to move from recommendation to action. Compromise encourages diverse, multi-professional, multicultural team members to come to a satisfactory workable plan and act for the community’s good. For example, over the years, when it was difficult to sort out which priorities should be included in their action agenda, the Saginaw FIMR sponsored several weekend retreats. During the retreats, the team members used the nominal group process to reach consensus about their FIMR action agenda.

### Sample Meeting Ground Rules

<table>
<thead>
<tr>
<th>We will:</th>
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<tbody>
<tr>
<td>• begin and end our meeting on time.</td>
</tr>
<tr>
<td>• listen respectfully.</td>
</tr>
<tr>
<td>• be tough on ideas not team members – no personal attacks.</td>
</tr>
<tr>
<td>• ensure that every participant has the opportunity to speak and that one person speaks at a time.</td>
</tr>
<tr>
<td>• use the nominal group process to resolve difficult decisions about prioritizing recommendations or actions. (See Appendix A)</td>
</tr>
<tr>
<td>• not tolerate the use of stereotypes and prejudicial comments.</td>
</tr>
<tr>
<td>• take responsibility, each and every one of us, for making our meetings effective.</td>
</tr>
</tbody>
</table>

Adapted from: A message to America from America’s communities. The Coalition for Healthier Cities and Communities. 2000. Chicago, Il:20
Action is key to FIMR

A long lasting FIMR program does not survive by just documenting shortfalls in community services and resources. It is an action-oriented, community problem solver. The trademark of the FIMR process is the ability to act to improve services and resources for women, infants, and families. Team members and sponsoring agencies know that their deliberations have produced improvements in the community. They have a sense of pride, accomplishment and ownership of the process. They remain eager to continue to participate. Successful FIMR actions also promote broad-based community ownership and pride in the local FIMR process, its actions and outcomes.

The action-oriented FIMR process is very much like other coalitions in terms of the role of action:

“The bottom line for sustaining a coalition ... would be the same as that for any other success community venture; that is, the capacity to act and have an impact on the community. Our experience is that long-lasting coalitions keep on acting – visibly, energetically and effectively.” (12)

Some FIMR actions can be accomplished in a short term time frame (less than one year) and some in the long term (more than one year). A simple strategy has helped team members sustain their energy and commitment to the FIMR process. While team members continue working to achieve complex, long-term actions, they also need to be able to point to some substantial short-term actions that they have accomplished. The usefulness of achieving short-term gains seems relevant for any coalition, including FIMR:

“Successful coalitions take actions that are doable and thus prove their effectiveness to themselves and their communities through concrete results. This often means that coalitions load experiments for success to guarantee early victories that will illustrate to themselves and the communities that change can occur.” (13)

One example of a ‘doable’ short-term activity that many FIMR programs across the country undertake is the development of a
community resource directory. In the first years of operation, six of the nine FIMR programs described in this document, developed and published a community resource directory. The directory is a real, tangible product that FIMR members can be proud of. This directory typically includes not only information about prenatal and pediatric services, but also information about preconceptional care, health education, housing, transportation, nutrition, mental health, services related to domestic violence, substance abuse and an array of additional community resources. It can be produced quickly and inexpensively. Increased referrals result when providers know exiting resources are available. Most FIMR programs that publish a service directory also update it every year or two. Thus, it continues to be an ongoing source of accomplishment for the team.

An important arena where FIMR actions are making a difference is SIDS risk reduction. Some of these actions can be short term, while
others are long term. Many local FIMR programs find that SIDS rates are higher in minority communities. When they talk to resident families, FIMR home interviewers may find out that the SIDS risk reduction messages are not reaching these communities or that SIDS risk reduction activities may not be culturally acceptable. FIMR programs can develop culturally acceptable messages and focus SIDS campaigns to the communities most at risk. For example, in the sections of Milwaukee chosen for FIMR reviews, the FIMR team noted that families – including African-American, Latino and Hmong residents - were less likely to place their infants on their back to sleep. The Health Department asked faith communities in these sections of Milwaukee to help them reach families with SIDS risk reduction messages. Nineteen parish nurses serving 24 parishes coordinated a church-based "Back to Sleep" campaign. Information on sleep position, safe bedding, smoking cessation, hyperthermia, and breastfeeding promotion was included. Because these nurses also integrated all of the SIDS risk reduction messages into their ongoing teaching plans, the risk reduction education effort will continue after the campaign ends.

Finally, an example of a long-term commitment that some FIMR programs undertake relates to improvement in the quality of obstetric and pediatric medical care. FIMR reviews are confidential and the names of providers and institutions are removed. Thus, FIMR programs always take a long range educational approach to improvement. FIMR strives to complement, not duplicate, existing professional peer reviews and institutional quality assurance programs. For example, both Humboldt County, CA and Saginaw, MI FIMR programs conduct an annual conference for medical professionals. These conferences focus on topics relevant to FIMR, such as preconceptional assessment, or medical management of preterm labor, gestational diabetes, substance abuse and/or neonatal resuscitation. These FIMR programs also use this training opportunity to augment knowledge about cultural competence or advocacy for other women’s health issues. Since these conferences are conducted each year, they not only foster continued physician support for FIMR findings and action agendas, but also, step by step, enhance the professional medical community’s knowledge and ability to provide high quality care.
Successful FIMR programs take on a wide range of community actions

Rather than choose a single focal point for action, long-term FIMR programs can point to a wide array of issues that they have identified and a comparable range of activities they have accomplished. They are flexible, capable of developing an action agenda on many different fronts at the same time and able to enact plans that change over time, as well. Types of actions generated by the nine FIMR programs featured in this document are detailed in Table 1.

How do FIMR programs have the energy to identify so many issues and take action on several different fronts at once? The group motivation and passion for the betterment of woman, infants, and families creates the momentum. As one FIMR coordinator remarked: “…the interaction among diverse community participants generates ideas for action that might lie beyond the imagination and power of an individual provider or agency.” (14)

Many FIMR programs also divide into subcommittees to move multiple actions forward. Subcommittees can be standing or ad hoc. Standing committees remain part of the main work group. Saginaw FIMR has standing subcommittees on teen pregnancy, domestic violence, professional education, community education, legislation and community advocacy. San Diego has six subcommittees including preconception, access to care, adequacy of care, perinatal social support, infant safety and child care, and perinatal grief and bereavement counseling.

Ad hoc committees form to address a specific action issue and dissolve once that issue is satisfactorily addressed. Broward County has a special ad hoc subcommittee dedicated to find ongoing support to bring a pediatric pathologist to their community. When they are effective in getting that physician on board, they will disband. Humboldt County is currently working with a special ad hoc subcommittee to develop interventions to improve correct use of car safety seats for children.
### Table 1 FIMR Programs Take On Multiple Action Agendas

<table>
<thead>
<tr>
<th>General</th>
<th>Aiken, SC</th>
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<td>Conduct media campaigns</td>
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<td>Develop a community resource directory</td>
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<td>Implement substance abuse screening and treatment for pregnant and parenting women</td>
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<td>Implement standardized prenatal risk assessment protocols</td>
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<td>Promote SIDS Risk Reduction activities</td>
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<td>Implement prenatal smoking cessation programs</td>
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FIMR programs build on existing community assets

Two community development theorists contend that it is not good to focus solely on such negative factors as death, disability and social inequity. They suggest an empowering alternative: continue to review these issues and identify deficits, but also produce a side-by-side map of the community’s capacities, assets and skills. (See Figures 1 and 2) They believe that "every ...neighborhood is a place where individuals and organizations represent resources upon which to rebuild." (15)

Many of the people involved in FIMR programs may never have seen an assets map. However, creative FIMR solutions to local problems fit with the idea of assets development. The general concept is relevant to FIMR programs. They create change by affirming that all communities contain the know-how and building blocks to produce meaningful community action.

Effective FIMR programs do not have to wait for an external grant or another windfall from outside their community. They look with confidence to their community for the means to make action happen. As one FIMR coordinator explains, “We start with a community desire or need. Sometimes we find money to address a problem. Sometimes, we don’t. Even when we can’t fund an initiative, we stay on course. We use an asset building strategy. We can identify community leaders who bring their resources and strengths to the table.” (16)
Deficits Map

Figure 1

Reprint with permission from: Kretzman JP, McKnight JL. Building Communities from the inside out: a path toward finding and mobilizing a community’s assets. Chicago, IL. Institute for Policy Research, Northwestern University, 1993.
Figure 2

Assets Map

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A Decade of Lessons Learned
The FIMR process is a journey, not a destination.

Long lasting FIMR programs have all come to embrace the fact that improving service systems and community resources for women, infants, and families is not a one-time job. Rather than becoming discouraged that a problem that has been identified cannot be addressed fully in one single stroke, these programs realize that the most meaningful change frequently occurs a bit at a time. FIMR actions accomplished in one year often become the basis for building enhanced improvements down the road. A new FIMR action may advance and expand the previous actions.

The FIMR process is a type of continuous quality improvement (CQI). In discovering the benefits of incremental change, FIMR programs have validated one of CQI’s most important principles. The Japanese first used CQI after World War II and attribute their rapid post-war recovery to it. They believe that what they call Kaizen (small improvements made in the status quo as a result of ongoing efforts) add up to the biggest and best successes. Kaizen also calls for identifying and holding on to past improvements which then become the stepping stones to future progress. Kaizen is a principle that embraces a journey of change, not a race to a finish line.

This idea of Kaizen differs from more traditional Western thinking. Americans tend to believe that improvement only occurs through major discoveries that proceed in quantum leaps. Although FIMR programs do sometimes make a quantum leap in improving service systems, many FIMR actions come from slow steady progress. Much is accomplished a step at a time.

For example, Saginaw FIMR has taken both small and large steps to promote access and early enrollment in prenatal care. In 1991, the overall rate of late or no prenatal care in Saginaw was 26 percent. The Saginaw FIMR case reviews for the same year identified the following: 56 percent of all infant deaths involved less than adequate prenatal care; 10 percent of all infant deaths and 33 percent of African-American deaths were associated with no prenatal care; and the infant mortality rate was 10 times higher in women with no prenatal care.
As a first activity, FIMR members representing the local hospital studied their prenatal care appointment system. They found that the majority of women were calling early to enroll for care, but that there were long waiting periods for a first visit appointment. Saginaw FIMR concluded that the community needed more prenatal care providers to serve a growing number of clients. The hospital negotiated with the State University to increase the number of obstetric residents who would rotate through the hospital.

In 1992, FIMR, along with the Saginaw County Infant Mortality Coalition, launched an outreach initiative, Love Your Baby Day, to announce the expanded services and encourage early enrollment in prenatal care. Styled after a baby shower, women receive small vendor-donated gifts and education materials. FIMR volunteers made prenatal care appointments on site for women who needed them. This initiative has become an annual event and continues to the present.

In 1993, another barrier to early prenatal care that emerged from the home interviews was inadequate transportation. Most women from the highest risk areas in Saginaw had to take two buses to get to the hospital. Then they had to walk about one-half mile from the final stop to the prenatal care clinic. FIMR worked with the city’s Department of Transportation (DOT) to have a bus that went directly from the inner city neighborhood to the clinic. However, women still had to stand in the cold and snow waiting to board the bus. The team persuaded DOT to install two covered bus shelters with benches.

From 1994 to 1995, the FIMR team surveyed all postpartum patients to ascertain their satisfaction with prenatal care services. Based on these findings, FIMR has developed cultural competency training programs for prenatal care providers in the community.

In 1994, FIMR established that about 20 percent of women who received inadequate or no prenatal care and experienced an infant loss were using cocaine or alcohol. However, while the county had out-patient treatment options, the county had no in-patient facilities for treating pregnant women. As a result, a major community effort spearheaded by FIMR, in collaboration with the Saginaw County
Department of Health, the Saginaw Bay Substance Abuse Council, and the Department of Social Services, resulted in development of a residential treatment center for substance abusing pregnant women. FIMR also has expanded coordination with local substance abuse treatment centers to increase referrals for prenatal care.

In 1996, the FIMR reviews were beginning to identify pregnant women who were victims of domestic violence. These women often dropped out of prenatal care, missed appointments or did not receive any prenatal care. The FIMR team applied for and received two state grants to further study the problem of domestic violence during pregnancy. The pilot study found that one in three pregnant women seen in the clinic reported some type of abuse in their lifetime. The study also documented that 5 percent of pregnant women were being abused during the current pregnancy. Based on this information, an ad hoc Domestic Violence committee was funded to provide support and advocacy for abused women. Later this committee became a permanent Coordinated Response Team with members from law enforcement, health care, women’s advocates and social services agencies. FIMR was also instrumental in implementing standardized domestic violence screening and referrals in every prenatal care site in the county. The second grant supported a demonstration project to educate non-abused women on domestic violence and resources in the community.

In 1998, Saginaw FIMR applied for and received a federal Healthy Start Grant. FIMR findings related to access to prenatal care were instrumental in shaping the model that Saginaw is using. Components of the grant that are addressing access to care interventions suggested by FIMR include:

- Hiring two community Health Outreach Advocates to assist high risk women in removing barriers to care such as transportation and child care. Advocates make home visits, provide education and mentoring, can transport patients in their own vehicles, or give cab vouchers to women for any pregnancy related appointments or needs.

- Using a Risk Reduction coordinator on site at prenatal care clinics to assess women for barriers to care and assign an Advocate, as needed.

A Decade of Lessons Learned
Expanding prenatal clinic hours to Wednesday evenings and one Saturday morning a month at the federal Community Health Center which cares for about two-thirds of the high-risk pregnant patients in the project area.

Today the overall Saginaw County rate of inadequate or no prenatal care has decreased to 12%. However, Saginaw FIMR continues to work to hold the gains they have made over the past decade as well as develop new actions to improve access to prenatal care and ensure the quality of the service system.
FIMR programs use population based data

In choosing which recommendations to take to action, FIMR team members know that the qualitative information from the case reviews does not take the place of population-based data. Instead, FIMR information complements quantitative population based or vital statistics data. As one FIMR team epidemiologist explained, “The Infant Mortality Review Program permits us to go well beyond the analysis of vital records data, to reveal the underlying experiences, attitudes and medical histories of pregnant and parenting women and the offspring they have lost. Held up for inspection and review by a multidisciplinary Community Review Team committed to improving perinatal health outcomes in the community, this information provides a ‘window’ into the maternal and child health systems in the community.” (18)

Before FIMR programs move from recommendations to action, they find out whether their initial findings represent a real community-wide problem. A team may often uncover one piece of information that leads them to a further round of information gathering about community health. This strategy also lends additional credibility and validity to the FIMR action plan. FIMR programs may employ several sources to obtain additional information, including the following:

A review of a community’s population based information usually precedes the development of the FIMR action plan. The nine programs rely on their Health Department members or other epidemiologist to provide an overview of population based data. A thorough understanding of this information helps FIMR programs set priorities. As one FIMR coordinator explained: “... we have an epidemiologist on our case review team who keeps us up to date on the latest population-based maternal and child health data in our community. Then, we look for issues that occur frequently or patterns raised by the case reviews that fit with the overall population-based trends.” (19)

For example, over several years, Saginaw FIMR reviewed cases of very young teen mothers who experienced an infant loss. They wanted to know how this fit into the overall community profile. The number of infant deaths to teen mothers for any given year was small. The FIMR epidemiologist reviewed births and death certificate data over a twelve-
year period. He was able to document that teen pregnancy accounted
for 19% of infant deaths – a rate 20% higher than older women. The
black teen infant mortality rate was more than twice that of white
teens (21.1 versus 8.1). By looking at data over time, he also
discovered that 46% of women in Saginaw County had their first birth
as teens. These findings spurred the Saginaw FIMR to develop a
special subcommittee to address teen pregnancy issues. They now
focus on developing ongoing actions in high schools to promoting teen
sexual abstinence.

Another way effective FIMR programs gain additional information
is to survey community agencies responsible for service delivery to
determine what agency standards policies and practices are in place.
Broward County FIMR reviewed several cases in which preterm,
Medicaid eligible infants were discharged from the neonatal intensive
care unit. The babies subsequently were not enrolled in
Medicaid, did not return for well baby visits and died. Broward
County team members wanted to know if this was a problem for
the whole community. As a first step, they conducted a survey of
hospitals, neonatal intensive care units, families and pediatricians to
determine length of time for Medicaid eligible babies to become
enrolled. The survey documented a prolonged Medicaid application
process that delayed well baby visits for all Medicaid eligible
infants. With the survey information in hand, they were able to
approach their Health Care Administration and work with them to
streamline the process and decrease the wait time.

Other FIMR programs may conduct focus groups to understand the
consumer’s point of view or their satisfaction with services received.
San Diego County FIMR found that women at highest risk for poor
outcome could benefit from preconceptional care, but were not
receiving it. As a first step, they are conducting focus groups of
women of childbearing age in the area most at risk for poor out-
comes. FIMR team members want to ascertain what messages about
preconceptional health care would be most effective to these
women. Then, they plan to develop culturally appropriate health
education messages and a media campaign.

FIMR teams also have a basic understanding of the professional litera-
ture that deals with problems that influence health outcomes for women,
infants, and families. FIMR teams may come across a trend in the
reviews that reflects these problems. For example, Milwaukee FIMR reviews noted that many infants who died in any given year had parents who smoked and that these parents did not receive smoking cessation information or referrals. They reviewed the most current literature on smoking and pregnancy outcome. They found that smoking is one of the most preventable determinants of low birth weight and increases the risk of stillbirth. (20) Studies also show that passive smoking increases an infant’s risk of respiratory infection and is associated with increased incidence of SIDS. (21) As a result, Milwaukee FIMR has made smoking cessation media campaigns and programs a high priority.

As shown above, FIMR teams use many sources of information to move from recommendations to action. However, it is important to remember that the FIMR team members - in and of themselves - are a powerful source of information. Effective local FIMR programs include community legislators, leaders, service providers, advocates, and consumers. They represent the finest local expertise and experience. A FIMR team is a valid expert panel that can identify systems failures and the appropriate actions needed to correct them.

For example, in one community, a serious gap in services for one pregnant substance user could be an isolated event that has never occurred before or since. In another community, the same event could represent a serious problem warranting immediate change. Many times, the community experts on the review team will be able to draw on their in-depth knowledge of community service standards, policies and practices to make educated decisions about the importance of these events. The Southern New Jersey Perinatal Consortium reviewed a sentinel case in which 1) the mother was a substance abuser, 2) she received late or no prenatal care and 3) her infant was stillborn. They found that she was discharged from the hospital without a plan for follow-up or any referrals. The team experts knew that the hospitals in Camden had fully implemented high-quality postpartum follow-up standards and procedures for mothers who delivered healthy babies. As they discussed the case, team members immediately realized that their current standards did not include any provision for follow-up of mothers who experienced an infant loss. They were quickly able to work together to expand these protocols. Continued review of cases has documented that their action has eliminated that gap in care.
FIMR programs communicate to the larger community.

All nine FIMR programs described in this document have come to a similar decision about publicizing their efforts to the larger community. Each has developed ongoing, effective communication to the broader community as an ongoing part of their action plan. Coalition experts agree that “. . . publicity is not a burden one must shoulder, nor an extra-added frill, but it is a coalition necessity. A coalition imperative might not be too strong a phrase.” (22)

Such communication can:

- promote broad-based community ownership and pride in the local process
- helps recruit new and diverse team members for the future
- keep action stories on the community’s radar screen over time
- gain financial support and community buy in
- enhance visibility of issues and credibility of the program with policy makers, funders, and the media (23)

To achieve this visibility, many FIMR programs publish an official report. This report describes their recommendations, accomplishments, and their upcoming action agenda and is published at least every other year. The target audience for these reports can be the medical/public health community, the overall community, or both. The target audience determines the content and style of the report.

For example, the Humboldt County FIMR has been publishing a FIMR report every two years since 1990. The target audience is the entire community. One useful strategy that this FIMR team members uses to help the community understand their work is to consistently group the FIMR actions into seven specific categories. These categories include strengthening knowledge and skills, community education, training, interagency linkages, organizational practices, and policy/advocacy.
Instead of an annual report, Saginaw FIMR has developed another strategy to inform the community about FIMR findings and actions. They publish a one-page fact sheet of findings, recommendations, and action plans for each of their seven CRT subcommittees.

Many FIMR programs also publish a short, much less formal newsletter two to four times a year. The Broward County FIMR sees their newsletter as a crucial tool to get the word out to the 250 private pediatricians and obstetricians, representatives from nine delivering hospitals, hundreds of other physicians, nurses and health
educators as well as advocates, consumers, agencies, legislators and policy makers. The Saginaw FIMR program publishes a newsletter quarterly and mails it to over 10,000 community members. This publication keeps the whole Saginaw community informed about FIMR actions and the importance of the FIMR process to their community.

FIMR programs may also decide to distribute information on the program by placing a public service announcement on radio or television or issuing a press release to newspapers or magazines. Some, like the Aiken FIMR, have developed electronic web sites (www.growing-into-life.com).

Another extremely effective technique that many FIMR programs use to send out information relies upon the members. Each person reports the findings and actions annually to their respective member agencies and any other agencies with which they work. This technique typically reaches:

- local medical and specialty societies and their members
- local hospitals and hospital associations
- professional nursing organizations and their members
- social service organizations
- community-based organizations
- district health commissioners
- local elected officials
- health systems agency
- state health agency
- consumer organizations
- community leaders
- focus groups of consumers
- business leaders
- Civic groups
- school Boards
- clergy
- law enforcement officials
FIMR programs recognize and celebrate the work of their team members

In the long run, the ability of FIMR to produce meaningful community change relies on the continued enthusiasm and support of volunteer team members who do the work. Agencies sponsoring FIMR have all come to realize that showing appreciation for the volunteer team member’s work is key to keeping members engaged in taking recommendations to action. As one FIMR coordinator says, “We believe in thanking people for a job well done and believe that this too makes a difference in commitment to the process.” (24)

Another approach that has worked well for all coalitions, including FIMR, is to build in opportunities to celebrate the positive actions that the team members have produced. As one community development expert explains, “Coalition activities need to include fun and affirm the strengths and joys of the communities. Indeed, one of the great gifts of effective coalitions to their members and to their communities is the gift of hope that emerges from an optimistic coalition approach that affirms that many community problems can be effectively addressed.” (25)

Effective FIMR lead agencies take advantage of opportunities to publicly acknowledge the work of the team members to the community at large. For example, annual reports of Broward County, Milwaukee, Humboldt County and San Diego display the names and organizational affiliations of the team members who do the work of FIMR. Broward County FIMR gives members certificates of participation. Team members like to display these in their offices. This small token of recognition has come to mean a great deal to them.

What happens to team membership overtime? Some core team members will stay involved with the program over the long haul. As one FIMR coordinator explained, “We have wonderful FIMR members who believe in the process and continue to dedicate their time year after year.” (26)

Other FIMR team members can be expected to move out of the community, take new positions, retire or choose other volunteer activities. Recruitment of new, dynamic members is critical to sustaining FIMR action. As another FIMR director said, “One important lesson that we have learned is that we must keep bringing the community into our FIMR. FIMR needs fresh new people who are interested and passionate.” (27)
Local FIMR programs, state Title V (Maternal and Child Health) and Title X (Family Planning) agencies benefit from close partnerships. State Title V and Title X agencies understand state maternal and child health and family planning policies, programs and funding streams. FIMR programs have new and important information about local issues and service systems to share. From the beginning, State Title V and Title X agencies and the nine FIMR programs described in this document have networked, shared and problem solved. These FIMR programs also invite State Title V and Title X agency representatives to attend team meetings and forward reports to the state.

Examples of the ways both benefit include:

✔ A need identified by several very different FIMR programs in the same state may point to a need for statewide policy/program development. Conversely, statewide publicity about the need for one FIMR program’s action may help the state generate additional funding to address that issue.

✔ Unique findings from one particular FIMR community may provide insights that can enhance the ability of state staff to provide technical assistance or target funding to it.

✔ Vignettes or stories (with identifiers removed) about families who have lost an infant may be used by both state and local partners to illustrate breakdowns in systems of care. Vignettes or stories also provide a human face and may be compelling to local legislators or other policy makers than data or statistics.

✔ Common and individual concerns of FIMR programs and stories from mothers may clarify population-based data that states compile for their federal Title V or Title X reports.
Understanding What FIMR Can Accomplish: New Ideas

The primary yardstick that local FIMR programs use to measure their effectiveness is the community action they produce. However, many programs have experienced other advantages, which are more difficult to quantify. Knowing about community development and coalition building theory as well as the FIMR process may assist a community to further describe a local FIMR program and assess its effectiveness.

Describing FIMR Activities

Using a community development approach, the FIMR program’s activities could be detailed in each of these three areas. (28)

✔ The community’s capacity to act increased.

    FIMR team members learned more about important community issues.
    Some or all of the public learned about effective activities.
    People had opportunities to be heard in ways that expanded their influence.
    Commitments to act were secured from those in positions of influence.
    Broad-based coalitions of community leaders in support of productive activity were built.
The community’s pool of resources expanded.

- Effective or exceptional people in the community became more visible to potential supporters.
- The community’s efforts attracted funds or other resources.
- Allocation processes improved so that less money was wasted.
- Approaches identified made resources go further or have more impact.
- A broader base of voices helped determine the use of funds.

The community’s capacity building skills increased.

- Links among like minded groups or organizations grew stronger.
- New and emerging leaders received encouragement.
- The management and technical skills of organization partnerships grew stronger.
- The quality of service or level of practice in community service systems improved.

**Describing FIMR Team Interactions**

The enhanced interaction among community members may be a valuable product of the FIMR methodology. Today, coalition experts are calling this interaction the Law of Unanticipated Consequences. They say that when a diverse group of people come together in a coalition such as FIMR, they build both professional and personal relationships. Comprehensive information about community service systems and resources is also provided to the team members. These relationships and the in-depth knowledge about the community generate unexpected results among the team members themselves, new ways of thinking about the community, respect and understanding of cultures different from their own, and innovative partnerships to create new service systems and resources.

For example, two local people, unlikely to have ever met in the normal course of local affairs, come to a FIMR meeting. Over time, as they meet to discuss infant mortality issues, mutual respect and friendship grow:

- Some time later, A makes a referral to B.
- Or B writes a letter of support for A.
- Or A knows a program that can help B’s son improve his reading scores.
Or A is thinking about office remodeling, and B knows a good designer.

Or B makes a suggestion about improving services and A implements it.

Or A and B talk to C and decide to collaborate on a new project.

Or several years later, in another group entirely, A and B meet again, and that new group is more effective because of their previous relationship.

Simply by virtue of coming together and learning about the community, any coalition (including FIMR) builds unique partnerships, nourishes disparate alliances and creates the opportunity for these unanticipated, yet community-strengthening consequences to unfold.

**Using Self-Assessment Tools**

In 1997, the thirteen California FIMR programs developed a range of qualities that they felt was characteristic of long lasting FIMR programs (see p. 54). This tool could help other FIMR programs examine their effectiveness over time.

Two other community development and coalition experts offer some additional advice:

A simple self-evaluation strategy that captures member satisfaction with FIMR process and action outcomes could be done by: (30)

Conducting an annual survey to monitor the satisfaction of team members with the FIMR process (See Appendix B)

Keeping track of FIMR actions by maintaining separate diaries or event logs for each action.

Another more detailed qualitative analysis of how the FIMR process works could include questions such as the following: (31)

✔ At the process level:

- How many and what type of cases were reviewed?
- How many and what type of cases were not reviewed?
- What percent of total fetal and infant deaths were reviewed?
- How many and what percent of bereaved families agreed to a home interview?
## California FIMR Programs: Qualities of successful and less successful FIMR Programs - A self-assessment tool.

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<th>Less Successful</th>
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<td><strong>Successful actions and community impact</strong></td>
<td><strong>Little evidence of success</strong></td>
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<td>• FIMR can document a positive impact on local issues</td>
<td>• the process stalls at the point of prioritizing recommendations</td>
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<tr>
<td>• many solutions/changes have been implemented as a result of FIMR recommendations</td>
<td>• legal aspects of FIMR cannot be resolved</td>
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<tr>
<td>• FIMR is &quot;hooked into&quot; the community’s power structure</td>
<td>• FIMR cannot externalize findings because of malpractice concerns</td>
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<tr>
<td>• policy-makers participate in or are accessible to FIMR</td>
<td>• the process stalls at obtaining and abstracting medical record data</td>
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<td>• an Institutional and fiscal base of support sustains FIMR</td>
<td>• the primary FIMR focus is research or medical review</td>
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<td>• the community takes ownership of perinatal health problems and FIMR process</td>
<td>• personal or interagency agendas interfere with the program’s development</td>
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<td><strong>Successful process</strong></td>
<td>• the community resists the FIMR process and does not see its value</td>
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<tr>
<td>• the program contributes to the community’s capacity for assessment</td>
<td>• FIMR maintains a strict confidential process</td>
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<td>• FIMR has found problems and created solutions</td>
<td>• local institutions contribute to record abstractions</td>
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<tr>
<td>• People in the larger community know what &quot;F-I-M-R&quot; stands for and are proud of the process</td>
<td>• both human and fiscal resources support the program</td>
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<td>• the CRT communicates about process and recommendations with the CAT</td>
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How many times did the case review team meet?
Did the case review team make recommendations? What type?
Are team members satisfied with their participation in FIMR

✓ At the service delivery level:
  What services do women, infants, and families receive that they did not receive before?
  Are these services reaching the intended target population?
  How has the service delivery system been improved? In what way?
  Has the FIMR process improved the relationship between families and providers?

✓ At the systems level:
  Are team members upholding interagency agreements, sharing resources, and putting new patterns of service delivery systems in place?
  Are the community action team members identifying and implementing systems-level action? What kind?
  What changes, either across agencies or within individual agencies, has the FIMR process produced?
  Has FIMR produced any specific actions that maximize local resources and save money?
  How many volunteer hours do all team members donate annually?
Conclusion

Each local FIMR program has a unique history that depends on the community’s location and size, its economy, the diversity of the population, the local FIMR sponsor, the composition of FIMR teams, and the issues that families in the community face. On the other hand, as more locally distinct FIMR programs thrive, some common elements or lessons learned are also emerging.

The nine FIMR programs from around the country featured here had a wealth of pertinent ideas and practices in common. These shared elements relate both to the FIMR methodology and the strategies that have sustained them over time. Highlights include the following:

✓ The FIMR methodology can be a compelling type of local continuous quality improvement (CQI). As such, FIMR programs develop creative and innovative actions that improve service systems and resources for women, infants and families.

✓ The long-term viability of a FIMR program depends on its capacity to continue to develop meaningful community actions.

✓ FIMR programs seek out and include comprehensive input from the families who have suffered infant loss. Thus, FIMR sheds a new light on the relationship among fetal and infant mortality, community and family strengths and weaknesses, and larger societal issues.
First rate FIMR programs are coalitions with many diverse partners. They are able to represent all of the ethnic and cultural views in the community and become models of respect and understanding.

A FIMR program’s capacity to act is contingent on the ongoing good will and commitment of the team volunteers. In order to sustain their support over time, FIMR programs build in time to reward team members and celebrate a job well done.

Finally, FIMR programs that endure are continuously fostering broad-based, local ownership and support for the FIMR process. Promoting systematic and clear communication about program accomplishments to the larger community is key to that effort.

Programs tell us that other subtle advantages of FIMR are more difficult to capture, but are real – none the less. These include such disparate factors as increasing the community’s awareness about critical maternal and child health issues and generating a sense of hope in a community because it can, indeed, effectively address local issues.

As more FIMR programs maintain their efforts over time, more lessons learned will be discovered. Each community that begins a FIMR program today can benefit from a decade of lessons learned. It is hoped that this document will continue to foster networking and shared learning among FIMR programs. Such sharing has always been key for the men and women who implement FIMR.


3. Wolff TJ, Kaye G. From the ground up: a workbook on coalition building and community development. Amherst, Massachusetts: 1997:2—14, 15

4. Papachaudo, KD. www.growing-into-life.com

5. Wolff TJ, Kaye G. From the ground up: a workbook on coalition building and community development. Amherst, Massachusetts: 1997:14—15

6. Ibid


9. Interview with Barbara Bonner, FIMR Coordinator, San Diego County, April 18, 2000


A Decade of Lessons Learned


13. Ibid

14. Interview with Dr. Seth Foldy, Commissioner of Health, Milwaukee, Wisconsin, June 16, 1996

15. Kretzman JP, McKnight JL. Building communities from the inside out: a path towards finding and mobilizing a community’s assets. Chicago, IL. ACTA Publications, 1993:5

16. Interview with Karen Papachaudo, FIMR Director and Deputy Coroner, Aiken, South Carolina, May 25, 1997


19. Interview with Georgia Modreck, FIMR Director, Broward County, Florida, May 10, 2000


24. Interview with Dr. Rebecca Staufford, Director of Maternal and Child Health, Humboldt County, CA, May 25, 2000

25. Wolff, TJ. Sustainability of coalition In Area Health Education Center AHEC/Community Partners. Coalition building tip sheets. Amherst, MA: 2

26. Interview with Karen Papachaudo, Aiken, South Carolina, FIMR Director, May 15, 1999
27. Interview with Georgia Mondrek, FIMR Director, Broward County, Florida, May 10, 2000


Federal Maternal and Child Health Bureau


National FIMR Program (NFIMR)


American College of Obstetricians and Gynecologists, National Fetal and Infant Mortality Program. A report of projects funded by the federal Maternal and Child Health Bureau, the March of Dimes Birth Defects Foundation and ACOG District IV. Washington, DC: ACOG, 1995


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Ogden L, Shepard M, Smith WA. The prevention marketing initiative: applying prevention marketing. Centers for Disease Control and Prevention, February, 1996


Striffler N, Coughlin PA, Magrab PR. Communities can workbook series: developing collaborative services for children. Washington, DC: Georgetown University Child Development Center, 1994


Cultural Competency


Healthy Mothers, Healthy Babies Coalition. Unity through diversity. Washington, DC, 1993


Grief and Loss


California State Department of Health. A practical guide to the SIDS home visit. Sacramento, California, 1998


Nominal Group Process
The Nominal Group Process is a structured method of airing all of the issues and conducting a weighted vote to identify the priorities of any group. It requires a skilled facilitator, a recorder and a flip chart. The facilitator takes the group through the following steps:

- Each individual identifies, in writing, three to five needs or problems that s/he believes are the most important for the group to address.

- Each person shares one item from this list until all ideas are recorded on the flip chart. No discussion should be allowed during this time.

- Next, each item is clarified, as needed, and with permission of the group, items deemed duplicative can be removed and some items may be grouped. Each item or item cluster is numbered.

- Each person votes for the five items s/he believes are most important—the most important of the five is assigned a 5, and the least important is given a 1. After the ballots are collected, the sum of the priority scores for each item is multiplied by the number of times that item was selected. For example, if item #1 was selected three times with a score of a 5, a 2, and a 1, the sum of the priority scores (8) would be multiplied by 3 (the number of times selected) to give a total score of 24 for that item. Items are ranked on the basis of the total scores they receive.
Once the group has agreed on the key issues, based on the top three to five scored items, these items can be rated in terms of likelihood of success. Starting with an item that has the greatest possibility of success is usually important for the morale of the group.

Adapted from: Striffler N, Coughlin PA, Magreb PR. Communities can workbook series: developing collaborative services for children. Washington, DC: Georgetown University Child Development Center, 1994:27—29
## SAMPLE SATISFACTION SURVEY FOR COMMUNITY FIMR TEAM MEMBERS

We welcome your feedback on how well this FIMR team is doing. For each item, please circle the number that best shows your satisfaction with that aspect of the FIMR team. Provide additional comments if you wish.

**Your SATISFACTION with the PLANNING AND COMMUNITY ACTION**

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tr>
<td>1. Clarity of the mission for where the FIMR team should be going.</td>
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<td>2. Planning process used to prepare the FIMR team’s objectives.</td>
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<td>3. Follow through on FIMR team activities.</td>
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<td>4. Strength and competence of staff</td>
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<td>5. Processes used to assess the community’s needs</td>
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<td>6. Quality of FIMR collaborative actions</td>
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<td>7. Number of systems changes carried out by the FIMR team</td>
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Your SATISFACTION with the LEADERSHIP:

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<th>very dissatisfied</th>
<th>very satisfied</th>
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<tr>
<td>8. Strength and competence of FIMR team leadership</td>
<td>1 2 3 4 5</td>
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<td>9. Sensitivity to cultural issues</td>
<td>1 2 3 4 5</td>
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<td>10. Opportunities for FIMR team members to take leadership roles</td>
<td>1 2 3 4 5</td>
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<td>11. Willingness of members to take leadership</td>
<td>1 2 3 4 5</td>
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<td>12. Trust that FIMR team members afford each other</td>
<td>1 2 3 4 5</td>
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Comments:

Your SATISFACTION with the: COMMUNITY INVOLVEMENT IN THE FIMR TEAM:

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<th>very dissatisfied</th>
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<tr>
<td>13. Participation of influential people from key sectors of the community</td>
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<td>14. Participation of community residents</td>
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<td>15. Diversity of FIMR team membership</td>
<td>1 2 3 4 5</td>
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<td>16. Help given the community in meeting its needs</td>
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<td>17. Help given community groups to become better able to address and resolve their concerns</td>
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<td>18. Efforts in getting funding for community programs</td>
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Comments:
### Your SATISFACTION with the COMMUNICATION

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<td>19. Use of the media to promote awareness of FIMR's goals, actions, and accomplishments</td>
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<td>20. Communication among FIMR team members</td>
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<td>21. Communication between FIMR and the broader community</td>
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<td>22. Extent to which FIMR team members are listened to and heard</td>
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<td>23. Working relationships established with elected officials</td>
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<td>24. Information provided on FIMR issues and available resources</td>
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Comments:

### Your SATISFACTION with the PROGRESS AND OUTCOME:

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<td>25. Progress in meeting the FIMR objectives</td>
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<td>26. Success in generating resources for FIMR</td>
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<td>27. Fairness with which funds and opportunities are distributed</td>
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<td>28. Capacity of FIMR members to give support to each other</td>
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<td>29. Capacity of FIMR and its members to advocate effectively</td>
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<td>30. FIMR's contribution to improving health and human service systems in the community</td>
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Comments:

Adapted from: Kaye G, Wolff, T. From the ground up: A workbook on coalition Building and community development. AHEC. Amherst, MA: pp 180-183
FIMR is an Action-Oriented Community Process

“. . . Americans are a peculiar people. If, in a local community, a citizen becomes aware of a need that is not met he thereupon discusses the situation with his neighbors. Suddenly a committee comes into existence. The committee thereupon begins to operate on behalf of the need, and a new community function is established. It is like watching a miracle.”
—Alexis de Tocqueville, 1840
Growing Into Life Coalition, Aiken, South Carolina.

Issue: Aiken’s FIMR identified excessive deaths from preterm labor. Pregnant women whose prenatal care was covered under Medicaid received prenatal care from public health clinics until late in the pregnancy. These clinics were not staffed 24 hours a day, seven days a week. Women who experienced unusual signs or symptoms at night or on the weekend did not have a medical resource other than the emergency room.

Action: Aiken’s Growing Into Life Taskforce and the community hospital worked together to develop a 24-hour pregnancy careline to meet this need. This hotline rings into labor and delivery at Aiken Regional Medical Centers. An 800 number gives rural residents easy access to medical advice at any time. In its first two months of operation, a healthy baby was delivered by stat C-section with a placental abruption after the concerned mother called in and was advised to come to the hospital immediately. Her physician said that neither she nor the baby would have survived had she not come in when she did.

Issue: FIMR case reviews found excess infant mortality and low birth-weight babies in high-risk neighborhoods. FIMR also identified a need to increase early and continuous prenatal care in these same neighborhoods.
Action: Aiken’s developed a unique outreach program that capitalized on the positive relationship between its community-oriented policing program and citizens, MOMS and COPS (Managing our Maternity Services with Community-Oriented Policing Systems). Trained by public health nurses, community-oriented police officers provide prenatal and post partum outreach, education, and referrals to women living in their assigned high-risk neighborhoods. With a Mom’s and Cops referral women can avoid waiting in line to obtain health and human services. COPS officers take gifts to newborns and show parents how to avoid SIDS through proper bedding and infant positioning. They also check for smoke alarms. Nurses have found that officers can often find their clients who have missed appointments. Aiken’s infant mortality rate has dropped over 50%.

Chatham County Department of Health, Savannah, Georgia

Issue: Savannah Georgia’s FIMR found that many women developed urinary tract or sexually transmitted infections during their pregnancy. Sometimes they did not report symptoms to their physician and the infections were not treated.

Action: Savannah’s FIMR developed a brochure describing common urinary tract and sexually transmitted infections, the potential impact of each infection on the fetus, and community resources for diagnosis and treatment. A member of the case review team got the first printing run donated. FIMR and health department staff distributed the brochures in health and human service provider sites and in community sites such as laundromats and beauty shops. Savannah’s Junior League awarded FIMR a grant to print additional brochures to expand distribution and restock existing sites.

Issue: Police officers are trained to conduct a homicide investigation at a death scene and did not always consider SIDS as a possible cause of death. This perception affected how officers interacted with families and conducted their investigation.

Action: The FIMR case review team recommended that the community develop a sensitivity training curriculum for first
responders including police, Emergency Medical Technicians, and firefighters on the characteristics of SIDS and how to conduct an infant death scene investigation with sensitivity. A police officer, a genetic counselor, and the EMS director worked with the FIMR coordinator to develop a curriculum tailored to Savannah’s needs.

Content for the two hour training module discusses characteristics of SIDS and other infant deaths, describes how to conduct a SIDS investigation, and explores the impact of SIDS on the parents, family, friends, and first responders. A parent who experienced a SIDS death describes her perceptions of the investigation for participants. Resources to help first responders manage their own reaction to an infant death scene investigation are included in the module. To reinforce the curriculum content, instructors give first responders a wallet card. One side of the card describes characteristics of SIDS and infant deaths. The other side reinforces procedures to investigate infant death with sensitivity rather than from a homicide perspective.

Savannah’s FIMR program is now modifying the curriculum to use in continuing education for daycare center staff. This module will eliminate the investigative process and focus on SIDS, how to conduct a grief assessment, community resources, and how to take care of yourself and other center staff in the grief process.

**Healthy Mothers/Healthy Babies, Inc., Broward County, Florida**

Issue: The Healthy Mothers/Healthy Babies of Broward County’s FIMR Bereavement Task Force identified a need to provide a remembrance event for families who lost a baby through miscarriage, stillbirth or infant death.

Action: With strong support from families and the business community, the Task Force created a "Forget Me Not" garden and held a butterfly release. The County provided land in Tree Tops Park for a butterfly garden, prepared the soil and agreed to maintain the site. Local businesses (nurseries, home supply stores with garden centers, funeral homes) donated plants or cash to pay for other costs.

*A Decade of Lessons Learned*
Bereavement support groups, area hospitals, and local news media all invited families to attend. Any family experiencing an infant death was welcome at the event.

Families brought a picnic lunch to the park, planted a blooming plant or tree, and released a live butterfly at the end of the day. Why chose a butterfly release for this event? "Butterflies depict the cycle of life—the birth and the death and the beauty of life while it lasts. What a caterpillar considers the end of the world, God considers a butterfly," explained FIMR Coordinator Georgia Modreck.

The success of the first year's event made it possible to "grow" the event during the second year. Potential sponsors could choose from a variety of levels for a cash donation (name on tee shirt, back cover of event book, business card ad in event book). With this additional funding, the Taskforce was able to make the event a little nicer for the families. Developed to provide families with a meaningful ceremony to remember their loved ones, the butterfly release is supported entirely by donations. Contact:

Issue: Many women entered prenatal care late or delivered with no prenatal care.

Action: Healthy Mothers/Healthy Babies of Broward County worked with an advertising agency to develop a social marketing campaign designed to encourage women to enroll early for prenatal care. Focus groups composed of women representing the target populations shared their perceptions about the images and words that "spoke to them about having a healthy baby."

Materials were developed for three specific populations, English, Spanish and Creole, using the language and models from that specific population. The campaign included bus cards, billboards and posters with pull-off information sheets. Messages encouraged women to "get good prenatal care" and to "see your doctor". Pull off sheets described signs and symptoms of pregnancy and where to go for prenatal care.
Healthy Mothers/Healthy Babies tracked response to the campaign by including a question asking "how did you find out about us?" on their intake form. Georgia Modreck reported that since the campaign's inception, "women are calling earlier in their pregnancy to begin prenatal care."

Humboldt County Health Department, Eureka, California

Issue: FIMR reviews found that car seats were not used or not used properly. Car seat use was lower in rural areas.

Action: While the number of traffic accident deaths was not high, the Humboldt County FIMR felt that these deaths might have been prevented with proper and consistent use of a car seat. To address this issue, FIMR developed a multi-disciplinary injury prevention subcommittee. Initially the subcommittee surveyed first responders to identify what they see at a traffic accident scene and to identify differences between rural and city incidents. The subcommittee conducted focus groups, talked with agencies, community members, and child care providers to identify the barriers to child passenger protection and best strategies to improve use of car seats.

One of the first steps in this initiative was to increase the number of car seat safety checks conducted by law enforcement people. This strategy raises awareness of consumers and generally increases appropriate use of car seats. As a result of sharing FIMR and child fatality review findings with the local law enforcement chiefs' group, several police departments have agreed to participate in car seat checkpoints.

FIMR plans to continue to work through the subcommittee and with other local partners to improve the car seat safety and injury prevention information offered in the community.

Issue: Interagency collaboration needs to improve for high-risk infants and high-risk pregnancies.

Action: A Humboldt County, California FIMR report identifying the risk factors contributing to infant mortality and findings from a study of Child Welfare Services led to the creation of the Humboldt
Healthy Families Collaborative (HHFC). Funded with a grant from the Irvine Foundation and additional funds from the federal Maternal and Child Health Bureau, this organization brings health and human service providers together regularly around the issue of home visiting. It provides training for home visitor staff, and fosters relationship building among its members.

HHFC developed a newborn risk summary instrument that gathers information for public health/community assessment on the needs of newborns and families. The four area hospitals complete risk summaries on 90% of newborns, resulting in consistent and higher quality referrals to Humboldt County Public Health Nursing and other agencies.

Native American families receive services from two systems of service: American Indian Health Services and other government services. FIMR case reviews identified areas where families would benefit from strengthening communications between these systems. As a result of these findings, representatives from both systems meet together to develop treatment and/or case management plans for Native American families with identified needs before their newborn infants are discharged from the hospital.

**Milwaukee Department of Health, Milwaukee, WI**

Issue: A significant percentage of FIMR reviewed deaths were due to SIDS associated with prone sleep position. Significant numbers of deaths occurred while sleeping on non-recommended surfaces or while sharing sleeping surfaces with another individual.

Action: FIMR launched a media SIDS risk reduction campaign using billboards and bus cards. However, in the sections of Milwaukee chosen for FIMR reviews, families were still less likely to place their infants on their back to sleep. The Health Department asked faith communities in these sections of Milwaukee to help them reach families with SIDS risk reduction messages. Nineteen parish nurses serving 24 parishes coordinated a church-based "Back to Sleep" campaign. Because these nurses also integrated the SIDS risk reduction message into their ongoing teaching plans, the risk reduction education effort will continue
after the campaign ends.

Issue: In reviewing FIMR cases, it became apparent that childcare providers needed to know about SIDS risk reduction messages. Some were not placing infants back to sleep. Also, some childcare settings were not smoke free.

Action: At first, the FIMR team could not find an effective way to reach all childcare providers with tailored SIDS risk reduction messages. Then, the Health Department FIMR members found a solution: every childcare provider had to come to the Health Department each year for a TB test. This test is mandatory to maintain their license. Now, the Health Department provides educational materials about SIDS risk reduction activities to all childcare providers at the time they are tested.

North Country Prenatal/Perinatal Council, Inc.

Issue: The NCPPC found that providers needed continuing education about prenatal risk assessment and follow-up of assessment information.

Action: The FIMR provider education recommendations were discussed with the perinatologist and neonatologist, in the Regional Perinatal Center in Syracuse, NY. These physicians then conducted ongoing, annual site visits to every hospitals in the tri-county area and provide training for local obstetrician/gynecologists and pediatricians. They disseminated these recommendations during their visits. These FIMR recommendations were also sent to the Obstetrical and Neonatal Nursing Coordinators at the Regional Perinatal Center because they also visit each hospital for perinatal nursing education. Continued review of cases documents increased use of risk assessments and follow-up on identified needs.

Issue: The North Country/Prenatal/Perinatal Council, Inc. identified the need for collaboration and networking opportunities among the service systems in their tri-county area of Jefferson, St. Lawrence and Lewis counties. FIMR case reviews reinforced that need and spurred the Council to action.
Action: The development and continuation of the Comprehensive Prenatal Case Management System for the three county area and the supporting data repository have been accomplished successfully over the past years. Seven agencies that provide prenatal case management (several with sites in all three counties) have signed formal linkage agreements to work collaboratively in delivering services to pregnant women. These seven agencies are: the public health departments of Jefferson, Lewis, and St. Lawrence counties, Planned Parenthood of Northern New York, Catholic Charities, North Country Children’s Clinic, and Samaritan Maternal Health Center/Woman to Woman. The major components of this system include:

1) the Universal Referral Form used by all seven agencies, as well as community based agencies to refer pregnant women and their families to services;
2) integrated data bases developed and installed at all seven agencies with quarterly data collection by NCPPC which allows for assessment of outcome trends, statistical quantification of service availability and barriers to access;
3) bimonthly meetings of participating agencies to determine intra-agency changes needed as well as to address inter-agency communications; and,
4) Birth Certificate Data Bases installed at the three public health departments and utilized by the Case Management Committee, Network Board, and regional health and human service professionals to determine trends and appropriate target areas for available funding.

Saginaw County Department of Health, Michigan

Issue: Saginaw’s FIMR program found domestic violence (DV) associated with 10-17% of reviewed deaths but, because that data was only collected incidentally, suspected that DV was underreported.

Action: Saginaw developed a strategy to enhance DV surveillance and improve response to suspected incidents.

Project coordinator Rosemary Fournier said, "DV is not an easy issue to deal with at the health provider level." Saginaw's FIMR
developed a three step approach to address this issue. Training for physician and nursing staff at Saginaw Cooperative Hospital's three prenatal care clinics covered basic aspects of DV and how to effectively screen patients. Screening consisted of asking every woman five questions, adapted from McFarlane's model (JAMA, 1992; 267: 3176), at each visit. Positive screening triggered a danger assessment and referral for intervention. The Saginaw FIMR developed a DV handbook covering local resources, mandated reporting, organizational protocols and assessment tools. They distributed the handbook to staff at participating prenatal clinics.

On April 1, 1996, Saginaw started their DV surveillance program. Three out of ten women (31%), among the 534 who delivered after the program began, reported abuse at some point in their lives. Five percent reported abuse during their current pregnancy. Nearly half of the abused women said that they had never told anyone about the abuse before.

Building upon findings from their initial DV program, Saginaw obtained grant funds for primary prevention activities (a series of four 15 minute sessions designed to increase awareness and knowledge among the prenatal care patients who did not screen positive for abuse) and secondary prevention (immediate referral to on-site DV prevention coordinator). With additional grant money Saginaw added to their Infant Mortality Coalition by creating a domestic violence sub-committee to focus on expanding provider education and increasing public awareness.

Issue: The Saginaw FIMR program was able to identify systems issues and to make changes at the community level. Expanding FIMR to other communities would be more likely to occur if "seed" money for start up costs was available.

Action: The Michigan Legislature allocated $450,000 to expand FIMR and strengthen the statewide analysis of FIMR findings and recommendations. A long-term member of the Saginaw Infant Mortality Coalition was elected to the state House of Representatives but remained involved with the local Saginaw FIMR. A staff member represented him at coalition meetings. FIMR
program staff also nurtured the relationship, providing updates and discussing identified issues. Recognizing the value FIMR added to Saginaw’s community health, this legislator was able to write and pass legislation allocating funds to expand the program to other areas of the state. Community health departments must apply for start-up FIMR funding. Grantees are encouraged to include their local legislators in the FIMR and to share the FIMR findings and recommendations with the legislators. This is an annual legislative allocation. Thus, FIMR programs must document their progress and outcomes each year to secure a renewal of funding.

San Diego County Health Department, California

Issue: FIMR identified a need for preconception education among consumers and providers. Each group had different needs in terms of content and how the educational message was delivered.

Action: Consumers needed educational materials targeted to their preferences and reading levels. FIMR received a $15,500 Cal-Works Program grant to conduct client focus groups to obtain input on the text and design of an easily readable, easily reproducible preconception brochure.

Nurses are primary patient educators for women of childbearing age. FIMR obtained a grant from the March of Dimes to conduct a Preconception Health Care course for nurses.

Issue: Half of the mothers whose babies died due to premature birth did not recognize the signs and symptoms of preterm labor.

Action: FIMR identified a need to improve patient education related to preterm labor. Based upon the FIMR findings and recommendations, the San Diego County Board of Supervisors allocated $150,000 over two fiscal years to the FIMR Program to conduct a Pregnancy Wellness and Preterm Labor Education Project.

The Not a Moment Too Soon Project will test several strategies for teaching preterm labor education in San Diego. One track will target pregnant women, reaching them during WIC visits in their second trimester. The other tracks will target gatekeepers - medical
office clerical and paraprofessional staff and staff from community based organizations - as the educator.

Initially San Diego's FIMR work group identified the existing preterm labor patient education programs and reviewed existing patient education materials. FIMR conducted a focus group to select the most effective parent education materials on the signs of preterm labor. Based upon the results of those focus groups, FIMR selected educational materials that matched the literacy level of the target population and were culturally and linguistically appropriate. Following a review by the medical steering committee, the materials were field tested. Revisions made as a result of the field test honed the focus to a single message.

To enhance patient learning, it is important to identify a trusted source to deliver the message and to reinforce the information at subsequent visits. FIMR trained medical office staff and the staff of community based organizations (CBO) about the warning signs and risks of preterm labor. Once trained, these staff can distribute the educational packets to pregnant women and stress preterm labor awareness at every visit.

After an evaluation to further refine the materials and strategy, San Diego plans to develop a train the trainer module for community based organizations. This should enable the Not a Moment Too Soon project to be institutionalized into the community. One area health plan has obtained funds to provide training for its medical center staff to replicate this program within their sites.

Southern New Jersey Perinatal Consortium

Issue: The Southern New Jersey Perinatal Consortium FIMR found that women with no prenatal care (NPC) who deliver a stillborn baby are lost to follow-up after discharge from urban hospitals. These women often had a history of substance abuse and did not routinely use the health care system.

Action: No follow-up protocol existed for this group although a protocol for no prenatal care women who deliver a healthy baby was in place. To address this problem the community network team
brought together the outreach agency, substance abuse providers and hospital representatives to develop a protocol built upon existing resources. Each organization formally approved the protocol and trained its staff to implement their component. Soon substance abuse counselors will provide home visits and, if possible, meet with women before they are discharged from the hospital. Outreach workers, with additional bereavement sensitivity training, also follow-up at home.

Issue: Because a stillbirth is a rare occurrence in the Southern New Jersey Perinatal Consortium service area, the FIMR found that physicians and hospital staff frequently did not get consents for an autopsy and inconsistently conducted a thorough evaluation of the fetus and mother. In addition, limited resources are available to pay for fetal autopsy.

Action: Southern New Jersey Perinatal Consortium FIMR clinical committee developed and distributed stillborn evaluation guidelines. This standing committee built upon existing guidelines from area hospitals. The guidelines list tests and procedures (e.g., DNA testing, x-ray, blood tests) for physicians to discuss with parents. Guidelines also offer suggestions for when to open this discussion and provide talking points about why it's important to conduct a stillborn evaluation. Camera ready brochures for patients outlining the decisions they need to make and local bereavement resources complete the provider packet. The Consortium distributed the guidelines to hospital OB department chairs and MCH nursing leaders. Follow-up surveys found that providers have used the guidelines.
Action is the hallmark of the FIMR process. Most FIMR programs have a two-tiered system that leads from review of cases to action and two teams, the case review team and the community action team:

The Case Review Team. Members of the case review team (CRT) represent a broad range of medicine and health professionals, organizations and public and private agencies (health, welfare, education and social services), consumers and MCH advocates. The CRT reviews the case summaries to identify barriers to care, gaps in services and trends in service delivery.

The Community Action Team. Typically, the CRT presents its recommendations to a team of individuals known as the community action team (CAT). The CAT is diverse and is composed of two types of members: those with the political will and fiscal resources to create both large and small system change and those who can define a community perspective on how best to create the desired change. The CAT translates the case review team recommendations into an action plan. They participate in implementing community action.

Community Change. As local problems are resolved and the health care, physical and social environment for families gets better, outcomes also improve.

The relationship between the CRT and the CAT is dynamic, action-oriented and results in new and creative solutions to community issues or problems.
This section contains interviews with FIMR coordinators from nine very different communities including Chatham County Health Department, Savannah, Georgia; Growing Into Life Coalition, Aiken, South Carolina; Healthy Mothers—Healthy Babies, Coalition of Broward County, Florida; Humboldt County Health Department, Eureka, California; Milwaukee Department of Health, Wisconsin; North Country Prenatal/Perinatal Council, Inc., Watertown, New York; Saginaw County Department of Health, Michigan; San Diego Health and Human Services Agency, California and Southern New Jersey Perinatal Consortium, Camden, New Jersey. The purpose of the interviews was twofold: to better appreciate how these programs take recommendations to action and to understand what has kept these programs going over time.

In order to elicit similar information from each program, we asked all of the FIMR coordinators to respond to the following standardized questions:

✔ How has your community sustained FIMR?
✔ How does your FIMR move from case reviews to community action?
✔ How do you prioritize the problems that will result in actions?
Do you connect the FIMR action plan to existing services and resources in the community?

How does your FIMR handle sensitive or controversial problems?

Once an action plan is finalized, how does the team implement the plan?

What is the relationship between the CAT and CRT in implementing action steps?

What is FIMR’s relationship to public health, private providers, community advocates and elected officials in the community?

How does the community at large learn about the actions that FIMR is proposing and has accomplished?

How does your FIMR relate to other mortality processes (e.g., SIDS, CFR)?

How do you check up on proposed actions to see whether or not they were implemented?

What types of actions has your FIMR implemented?

The answers to the above questions vary. Large cities such as Milwaukee, WI, and San Diego, CA differ somewhat in their approach from rural areas such as Humboldt County, CA. Programs that are sponsored by Health Departments, such as the one in Chatham County, GA, are a bit different than those sponsored by community coalitions, such as Healthy Mothers-Healthy Babies Coalition of Broward County, FL.

However, the FIMR methodology has grown and thrived in all nine of these divergent communities. The themes that unite them are community partnerships, local problem solving, and dedication to women, infants and families. The insights from these programs can help any community to begin or continue the FIMR methodology.
An interview with:
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Chatham County Health Department
P.O. Box 14257
Savannah, Georgia 31416
Phone: (912) 356-2170
Fax: (912) 356-2993

Chatham County FIMR Mission Statement
The Fetal and Infant Mortality Review is to identify risk factors that contribute to poor pregnancy outcomes and infant mortality, to improve the delivery of health care for women and children, and to eliminate the real and perceived barriers to health care so that women will actively seek the medical attention needed to ensure positive pregnancy outcomes.

Program Starting Date: 1994

About Our Community
Chatham County spans a geographic area of approximately 450 square miles. Within Chatham County are the following municipalities: Port Wentworth, Garden City, Bloomingdale, Pooler, Vernonberg, Thunderbolt, Tybee Island, and the City of Savannah.

According to the 1990 Census, Chatham County had a population of 216,935 of which 60.2 percent were white, 38.1 percent black, 1.3 percent Hispanic, and 0.4 percent other minorities.

While all women in Chatham County are served by FIMR, the target area or most at-risk population consists of a subsection of Chatham County and is an area slightly larger than the City of Savannah limits. It covers 393 square miles and includes areas documented to have the highest rates of domestic unrest, crime, unemployment, teen pregnancy, child abuse and infant mortal
How has your community sustained FIMR?

The FIMR office is located in the Chatham County Health Department. From 1994 to the present, the Youth Futures Authority, a grantee for the Healthy Start program, funds our FIMR. Also, the FIMR program was awarded a $5,000 grant from the March of Dimes for calendar year 1998. This money was beneficial in allowing me to supplement the limited funds available for conducting medical chart reviews and interviewing the families with pregnancy or infant loss. In addition to the grant money, one of the local malls in Savannah (Oglethorpe Mall) donates half of the cost of gift certificates for our incentive program that compensates women who participate in the home interview component. Just recently, Standard Register, a local printer, donated 1,000 copies of a pamphlet distributed for educational purposes to women of childbearing age.

How does your FIMR move from case reviews to implementation?

Our review process is two-tiered in that a Technical Work Group reviews all of cases. The work group consists of health care providers at the Health Department, who are involved in infant, child and maternal health, and meets quarterly. If they discover new issues or trends, then these are forwarded to the CRT.

We have a very cohesive review team with members who work together and truly share in the decision-making process. Every quarterly review results in some sort of recommendation from assuring that the mother gets the appropriate follow-up with members, often issues the home interviewer can handle, to educating providers on available services. All recommendations are implemented as soon as feasible after the review. Generally, a member of the work group or review team will take responsibility for putting the recommendation into action. For example, a recommendation was made by the Technical Work Group to develop a pamphlet to educate women on the risks to themselves and their unborn babies when sexually transmitted diseases and urinary tract infections are not identified and treated. A committee of members of the work group was assigned to work on this project. The pamphlet was finalized and was being distributed within the community a couple of months following the recommendation. A recommendation was made by the CRT to
develop a sensitivity training curriculum for first responders, including police, EMT’s, and firefighters, on how to identify the characteristics of SIDS and how to conduct a death scene investigation with sensitivity. A committee was formed within the CRT, and within three months the first training was held.

**How do you prioritize the problems that will result in actions?**

Many times we are able to implement multiple recommendations at the same time because members of the review team take individual responsibility for tackling one issue. An example would be when a recommendation was made to provide sensitivity training to all first responders, including police, EMT’s, firefighters and others who would be dispatched to a home when a baby has died. In the same review, mothers needed follow-up to receive education on risk factors such as obesity, inadequate prenatal care and other relevant issues that contribute to poor pregnancy outcomes. A police officer, the EMS director, and a genetic counselor assisted me in developing the training program. At the same time, the home interviewers took on the responsibility of contacting the mothers to follow through with the recommendations for education. The review team makes most decisions at its regular quarterly meetings.

**Do you connect the FIMR action plan to existing services and resources in the community?**

Absolutely. This is especially true for referrals since we have a strong network of agencies in partnership with FIMR. For example, there is a local medical group of resident physicians affiliated with our teaching hospital who have agreed to provide well and sick care for women and their children who reside at Safe Shelter for abused women. This care is provided to the women at no charge or on a sliding fee scale.

In addition, partnerships have been developed with Oglethorpe Mall, March of Dimes, Memorial Health University Medical Center, Housing Authority of Savannah, pediatric and OB/GYN offices, grocery stores, and pharmacies.

We were fortunate to be invited to present FIMR to the Georgia Perinatal Association this past year. With talk of expanding FIMR into other counties in Georgia, this was a good opportunity for us
How does your FIMR handle sensitive or controversial problems that need to be addressed?
Generally, members of the review team in their own agency address these issues through in-service training in their own agencies. An example of an issue was hospital staff who were inappropriately recording infant deaths on fetal death certificates. The hospital where the inconsistencies were being found provided in-house training for staff responsible for filling out fetal and infant death certificates.

Once an action plan is finalized, how does the team implement the plan?
Usually, the recommendation and implementation strategy is developed during the quarterly reviews. As noted earlier, a member of the team takes responsibility for implementation and then reports back to the team at the next quarterly meeting.

What is the relationship between the CAT and CRT in implementing action steps?
Actually, our group works as a unit. We have a technical work group that conducts the initial review to determine which issues should be held over for more intensive review. These issues are presented to the CRT. Should the work group make a recommendation, it is taken before the CRT for approval. Then we all work as one collective team.

What is FIMR’s relationship to public health, private providers, community advocates and elected officials in the community?
The members of the CRT represent a broad spectrum of the community. The chairman of the Chatham County Board of Health represents local government and a representative from the coroner’s office represents an elected official. There are several members of the CRT who work at the Chatham County Health Department, 10 private providers of medical services and three individuals who work in agencies that work for the good of the community such as Youth Futures Authority and Healthy Start Initiative. We also have consumers (SIDS parents) and care/service providers. We have a
diverse group of individuals who are very dedicated to FIMR and who can, through their association with the community, assure that we are successful.

**How does the community at large learn about the actions that FIMR is proposing and has accomplished?**

Material distributed by FIMR such as the At-Risk pamphlet and the Family Information Brochure are identified as FIMR literature. In addition, the March of Dimes grant was instrumental in making the community more aware of FIMR and the accomplishments made prior to the award of the grant and goals that FIMR had set. A report to the community was distributed in 1998 and an update to the report will be available for distribution soon. Also, three public service announcements about FIMR have been aired via radio.

**How do you check up on proposed actions to see whether they were implemented?**

There are updates on recommendations given quarterly at the regularly scheduled meetings and individuals and agencies that take responsibility for implementing action plans provide reports to me.

**How does your FIMR relate to other mortality processes (e.g., SIDS, CFR), when actions proposed may overlap with their activities?**

There is joint representation on CFR and FIMR. This is how we keep abreast of what CFR is doing. Often each group reviews the same case. However, the focus is different so this isn’t an overlap. Since the focus is different, duplication of recommendations or actions is not a problem. We don’t have a formal SIDS program so this is not an issue either.

**How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?**

We keep track and these recommendations are reintroduced when it is apparent that implementation would be beneficial for either the women and children in the community or the providers.
What types of actions has your FIMR implemented?
FIMR is great! These are some of the types of actions our community has implemented and we are very proud of them:

- Improve community bereavement services
- Develop new, relevant bereavement services for culturally diverse segments of the community
- Implement continuing education programs for providers
- Develop a community resource directory
- Increase collaboration among community services organizations
- Develop patient education material
- Conduct media campaigns
- Promote SIDS risk reduction activities
- Implement postpartum mother-to-mother support groups
- Reduce gaps in prenatal and/or pediatric services
- Eliminate duplication of prenatal or pediatric services

Chatham County Community Action Group Agency Members - The FIMR Community Action Team

Chatham County Board of Health
Chatham County Police Department
Consumers
Emergency Medical Services
Healthy Start Initiative
March of Dimes
Memorial Health University Medical Center
Obstetric and pediatric physicians in private practice
St. Joseph’s/Candler Hospital
The Coroner
The Department of Family and Children Services
Tidelands Community Mental Health/Mental Retardation/Substance Abuse Center
Youth Futures Authority
An interview with:
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kchado@cyber-smith.com

Aiken County FIMR Mission Statement
The goal of the FIMR group is to reduce fetal and infant deaths in Aiken County by addressing institutional, interagency, community and social problems implicated in these deaths. Reviews of fetal and infant deaths will be conducted for the purpose of:
• Identifying gaps in services accessed by or accessible to mothers and families
• Identifying actions that could help resolve access gaps
• Informing and educating appropriate providers and/or community leaders regarding these recommended actions and eliciting the support and assistance of these people

Program Starting Date: 1989

About Our Community
Aiken County is a large rural county approximately the size of Rhode Island. About 133,059 people live in the county; 62,344 of them are women. The county averages 2,000 live births each year. Aiken County’s infant mortality rate has dropped more than 50% from 12.8 in 1990—1992 to between 4.9 and 8.4 in 1993—1995 and to 4.9 in 1996. However, Kessner index figures still show that 26.5% of Aiken County’s pregnant women do not receive early and continuous prenatal care.
How has your community sustained FIMR?
Aiken County’s FIMR CRT is sponsored by the Lower Savannah Health District that funds the process at $8,000 annually. Aiken County FIMR team members have met quarterly to review cases since 1989. We have wonderful FIMR members who believe in the process and continue to dedicate their time to this year after year. We call our community action team the Growing Into Life (GIL) Coalition. The FIMR case review team discovers the newest and most relevant community issues and forwards them to GIL. This new information generates lots of interest and enthusiasm to address these new concerns.

How does your FIMR move from case reviews to community action?
Aiken County actually uses a three-tiered process of review. The CRT from the Health Department evaluates all of the cases and selects issues for the larger FIMR board to review. Then the FIMR board decides which issues to forward to the GIL. The GIL Task Force is a 150-member organization that has forged partnerships between the health department and the for-profit hospitals, between police officers and health care communities, between neighborhood associations and government officials, and between law enforcement and social service agencies.

During a case review, the FIMR team members categorize issues by responsibility—community, physician, agency, patient, etc. The FIMR team is in charge of resolving physician and agency issues. Patient and community issues are referred to Growing Into Life, the community arm of the FIMR group. FIMR CRT meetings are held just before the quarterly GIL meetings so recommendations can be transmitted immediately to the GIL team for action.

How do you prioritize the problems that will result in actions?
We just decide what to do, then we go ahead and do it. We have been working together for a long time now and have learned how to compromise for the good of the community-usually without bloodshed. One-time errors or agency referrals that were fumbled are noted. Agency systems issues are addressed by those organizations on the team responsible for them. Those organizations also develop steps to prevent a recurrence.
Other larger issues go forward to GIL where action plans are prepared. GIL interventions usually take longer to resolve than health or human service systems issues. These actions may involve long-term efforts, community wide education campaigns or complex partnerships. We start with a community desire or need. Sometimes we find money to address the issue. Sometimes, we don’t. Even when we can’t fund an action plan, we stay on course. We use an asset building strategy. We can identify community leaders who bring their resources and strengths to the table. The overall GIL philosophy is that GIL members work with any and all people or agencies that will work with them. Over time, the members have gotten beyond egos and titles.

**Do you connect the FIMR action plan to services in the community?**
Yes. Over the past two years we have developed process maps for all maternity, infant and child services in our community. Through this exhaustive mapping, we are able to pinpoint all existing maternal and child health services and recognize when a service is not available. We also have a community resource directory available on paper, in Braille and on the Internet.

**How does your FIMR handle sensitive or controversial problems that need to be addressed?**
In the beginning, we were told that sensitive physician issues would be the downfall of a FIMR group. We have come across some physician issues, and we have allowed the physicians who participate in FIMR and the hospital representatives to deal with those issues. We have been satisfied with the results. We pay strict attention to our confidentiality rules.

In other areas, we have gone to the public despite problems with sensitivity or controversy. We have discussed male predators, Sudden Infant Death Syndrome (SIDS) deaths that were positional asphyxia, teen pregnancy, battering during pregnancy and crack cocaine. In general, our citizens react very well to our alerts. Our mission is to save babies, not to avoid controversy.

**What is the relationship between the CRT and the CAT?**
They are separate entities, but the mission to serve our community unites them. What we say to each other over and over again is this:
“We can do anything as long as we don’t care who gets the credit.” We celebrate all individuals who make breakthroughs in solving or uncovering problems, but we speak with one voice when we address the public or confront difficult issues.

**What is FIMR’s relationship to public health, private providers, community advocates and elected officials in the community?**
We have public health officials, private providers and locally elected officials on the GIL team. We have over 150 members in our GIL – we are the community!

**How does the community at large learn about the actions that FIMR is proposing and has accomplished?**
Usually through the GIL. We are careful about over-publicizing FIMR actions unless we can really document effective change. However, it is equally important to report back to the community if we made a promise to take action. We are very outcome-based in Aiken and we certainly publicize improvements in our population-based data. In addition, several feature magazine and newspaper articles on our FIMR program were published after we won several national awards.

**How do you check up on proposed actions to see whether they were implemented?**
We have developed several ways to follow up on proposed actions. A list of action steps is included with the minutes of the FIMR meeting. These minutes are mailed out to members shortly after each meeting. The FIMR CRT also takes time to examine progress on patient and systems issues at each meeting. The Growing Into Life team asks about any system issues as well as community issues at its meetings, so few issues fall between the cracks. We also keep written notes on what we do. We check those notes by comparing them to the minutes of the FIMR meeting. The Health Department representative generally checks quarterly for progress notes from those involved in solving agency or physician issues.

**How does your FIMR relate to other mortality processes (e.g., SIDS, Child Fatality Review)?**
We ARE the local SIDS and the Child Fatality Review (CFR). So we get along just fine. Currently, there are some outstanding issues
with the state child fatality review board. Some FIMR members feel that the state group has become unnecessarily punitive and intrusive. We are monitoring that situation.

How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?
We kick ourselves and get moving on it. These issues will also show up in repeat ongoing case reviews. All of that brings home the importance of moving forward.

What types of actions has your FIMR implemented?
Over the last 12 years that we have been using the FIMR process, we have made enormous strides in improving our community through FIMR including:
• Improve community bereavement services
• Streamline prenatal and/or pediatric Medicaid application process
• Implement continuing education programs for providers
• Increase collaboration among community services organizations
• Develop patient education material
• Implement domestic violence screening and treatment
• Implement substance abuse screening and treatment for pregnant and parenting women
• Conduct media campaigns
• Promote SIDS risk reduction activities
• Implement prenatal smoking cessation programs
• Improve cultural competency in service delivery systems
• Implement prenatal screening for domestic violence
• Reduce gaps in prenatal and/or pediatric services
• Eliminate duplication of prenatal or pediatric services
• Improve transportation to service sites
• Implement community oriented police services (COPS) – in progress
• Develop local or state legislation
# Growing Into Life Committee—The FIMR Community Action Team

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<td>Cumbee Center to Assist Abused Persons</td>
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An interview with:
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Broward County FIMR Mission Statement:
To reduce infant mortality through an understanding of the occurrence of fetal and infant deaths in the community.
Objectives
• To develop a culturally sensitive system that provides accurate, timely and comprehensive information
• To identify limitations to utilization of services and barriers to care
• To identify geographic neighborhoods of high infant mortality and any relationship to race, ethnicity and economic status
• To build communication between health, social service, government and educational entities
• To establish community partnerships in targeting resources to reduce infant mortality
• To build networking relationships at the local, state and national levels

Program Starting Date: 1993

About Our Community
Broward County, which includes Fort Lauderdale and 27 smaller municipalities, is located between Palm Beach and Miami along Florida's east coast. With 1.4 million people, it is now the second most populated county in Florida. Broward County is also one of the fastest growing areas in the United States. The area's main industries are tourism, finance and health care. The population is
15.4% black and 8.6% Hispanic. The Haitian population also has increased since these 1990 census data. Immigration has widely affected the cultural climate, with increasing diversity challenging all social, economic and health systems.

The county has nearly 20,000 annual births. Approximately one-tenth of all births are to teenage mothers and about one-third of all babies born in the county belong to single parent families. Broward County also has a high ratio of white versus non-white infant deaths. In 1998, that ratio was nearly two to one (11.6 non-white infant deaths versus 6.3 white infant deaths per 1,000 live births). This disparity, perhaps more than any other factor, has given rise to our FIMR activities.

**How has your community sustained FIMR?**

This FIMR program was launched in September 1993 under the auspices of the Healthy Mothers-Healthy Babies Coalition of Broward County (HMHB) and the Broward Healthy Start Coalition, Inc., one of 30 state-funded coalitions in Florida focused on improving maternal and child health services. In addition to these state funds, in 1994, the program received a grant from NFIMR supported by the Robert Wood Johnson Foundation. The program has also received funding and in-kind local support from the local March of Dimes chapter, the Broward County Medical Association (BCMA) and the Broward County Public Health Unit (BCPHU). The lead agency in the undertaking is Healthy Mothers-Healthy Babies, where FIMR activities are housed. One important lesson that we have learned is that we must keep bringing the community into our FIMR. FIMR needs fresh new people who are interested and passionate.

**How does your FIMR move from case review to community action?**

FIMR has been adopted as a public health subcommittee of the Broward County Medical Association (BCMA). This association expedites access to medical records, and case reviews can be protected and held harmless under the state's statutes. Every month, about 20–25 fetal and infant death certificates are identified and matched with birth certificates. Summary information from the birth and death certificates is recorded. Four of these cases per month (evenly distributed between fetal and infant mortality) are randomly selected for in-depth review.
Every six months a special CRT meeting is held to review aggregate data, identify trends, and develop priorities for action. This information is passed along to the Community Action Group (CAG). The CAG ascertains patterns of contributing factors to infant mortality, and then develops recommendations and an action plan for implementation. The group meets quarterly to develop and monitor the FIMR action plan. Meetings are held at the BCMA and chaired by the FIMR program director.

**How do you prioritize the problems that will result in action?**

We do not have much trouble seeing what needs to be done. First, we have an epidemiologist on our case review team who keeps us up to date on the latest population-based maternal and child health data in our community. Then, we look for issues that occur frequently or patterns raised by the case reviews that fit with the overall population-based trends.

Also, our CRT is our community expert panel. Because of their expertise, the team members may be able to pinpoint a systems problem based solely on CRT trends or one sentinel event.

**Do you connect the FIMR action plan to services in the community?**

We have the right people at the table. They represent the major community planners and lead agencies. FIMR is in the mainstream of community awareness. Almost everyone in Broward County knows what F-I-M-R stands for.

**How does your FIMR handle sensitive or controversial problems?**

We have not seen much tension or ‘turfdom’ types of issues. Right from the start, our community really had a genuine interest in seeing improvements in services and resources for women, infants and families.

**What is the relationship between the CRT and the CAT?**

The teams are separate entities. They respect each other and are proud of the work that they have been able to do over the years. They work well together.
How does the community at large learn about the actions that the FIMR is proposing and has accomplished?

We go about marketing our success in two ways. First we publish a quarterly newsletter. We think the newsletter is a crucial tool to get the word out to the 250 private pediatricians and obstetricians, representatives from nine delivering hospitals, hundreds of other physicians, nurses and health educators as well as advocates, consumers, agencies, legislators and policy makers.

Secondly, we enlist the members of the case review team and community action team to disseminate our findings, proposed actions and action plans back to their respective agencies. The more you spread the word about what needs to get done, the faster action happens!

How do you check up on proposed actions to see that they are implemented?

We see positive changes resulting from FIMR in the ongoing records we abstract. We also hear about them from the mothers we interview. It is a really concrete way to document change. For example, when we first started to review cases, almost no hospital record had any documentation that mothers received bereavement services. Now we see over 80% have documentation of services received.

How does your FIMR relate to other mortality processes (e.g., SIDS, Child Fatality Review)?

Our community does not have a child fatality review (CFR). Broward County Child Protective Services is responsible for reviewing all infant deaths reported to the medical examiner. The medical examiner is also a member of our case review team.

SIDS services throughout the state of Florida have been defunded. Our FIMR program has taken on the responsibility of coordinating community bereavement services and resources so that all families can receive the help they need.
How do recommendations that have not been implemented feed back into the FIMR process when more cases are reviewed?
We never stagnate. Every six months, we check the trends emerging from our reviews. Based on those findings, the community action group checks the status of our action plan, updates the plan, and continuously moves forward.

What types of actions has your FIMR implemented?
We have done so much! It is amazing what a community can do when people work together. Here are some of the actions.

• Improve existing community bereavement services
• Develop new, relevant bereavement services for culturally diverse segments of the community
• Implement educational program for hospital staff who fill out vital statistics birth and death records
• Streamline pediatric Medicaid application process for newborns
• Develop a community resource directory
• Increase collaboration among community services organizations
• Develop patient education materials on fetal movement preterm labor, importance of HIV testing and preconceptional health
• Conduct media campaign on importance of early prenatal care (posters and public service announcements)
• Promote SIDS risk-reduction activities
• Implement prenatal smoking cessation programs
• Implement prenatal screening for domestic violence
• Reduce gaps in prenatal and/or pediatric services
• Other: secure funding for a pediatric pathologist
• Other: Our Bereavement Task Force is central to our FIMR mission
Broward County HM/HB – The FIMR Community Action Team

Broward County Healthy Start Coalition, Inc.
Broward Community Foundation
Broward County Human Services
Broward County Commission on Substance Abuse
Broward Regional Health Planning Council
Children’s Consortium
Children’s Diagnostic and Treatment Center
Children’s Services Board
March of Dimes Birth Defects Foundation
Memorial Hospital
State House of Representatives
Urban League
Zeta Phi Beta
Humboldt County, CA Fetal and Infant Mortality Review/Child Death Review Program

An interview with:
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Deputy Health Officer and
Nancy Keleher
FIMR/CDR Coordinator
Humboldt County Health Department
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Eureka, CA 95501
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Humboldt County FIMR/CDR Mission Statement
The purpose of the combined team is to investigate, in depth, the causes and circumstances around the death of fetuses, more than 20 weeks and/or 500 grams), infants and children up to age 17 years in Humboldt County and to make recommendations for change that will prevent future deaths to fetuses, infants and children. The real work of the team begins with ongoing implementation of its recommendations. The success of the team is therefore dependent on the good will and dedication of community partners in their commitment to improving the health and safety of our children.

Program Starting Date: 1991

About Our Community
Humboldt County is located on the California coast 90 miles south of the Oregon border and 200 miles north of San Francisco. With over 100 miles of rugged unspoiled coastline, hundreds of thousands of acres of coast redwood trees and farming areas, Humboldt County has a varied terrain. Eureka, a seaport with a population of 27,000, is the county seat.

Humboldt County’s population of 123,023 is primarily white, with American Indians making up the largest minority population (5.5%). While 17% of residents have incomes below the poverty level, nearly one quarter (24.4%) of children under age 18 are poor.
One in three (34%) Native Americans has an income below the poverty level. Humboldt County reported 1,457 live births and 13 infant deaths during 1998, which translates into an infant mortality rate of 8.9. Nearly 8 out of 10 (79%) mothers began prenatal care during the first trimester.

**How has your community sustained FIMR?**
Humboldt County was one of the first 11 FIMR programs funded by the California Department of Health. From 1991 to the present, we have received funding from the State Title Five Block Grant. That funding is ongoing. The process and its many successes and demonstrated usefulness seem to keep the members engaged. We also believe in thanking people for jobs well done and believe that this too makes a difference in commitment to the process.

**How does your FIMR move from case reviews to implementation?**
Recommendations come at the end of each case review meeting and the decision about implementation occurs at that time. Often, the appropriate individuals who can implement action are in the room. If not, we write a letter or contact the appropriate individual about following up on the issue.

We have seen that a completely different level of recommendation can come from a cluster of cases or a trend than from a single case. We keep track of important issues we find and prioritize actions based on these trends. For example, we have developed a subcommittee based on our finding of deaths related to improper use of infant car seats. This action was taken after looking at trends over time.

Many indirect changes also occur in the personal and professional lives of people serving as CRT members. These people are exposed to detailed information about how well their community serves mothers and babies. They have a better appreciation of their role in infant health and protection as well as of their colleagues’ roles. I also believe that significant changes in their practice at this level come about separate from the formal recommendations that the team members make.
How do you prioritize the problems that will result in actions? Typically there are more recommendations than there are resources to pursue them, so we also prioritize action. The CRT usually sets priorities, but we do not hesitate to take issues that don’t seem to belong to anyone on the team to the appropriate agency or group. It is a small enough community that we can find people and working together supportively comes naturally.

Do you connect the FIMR action plan to existing services and resources in the community? Absolutely, our team is very comprehensive and very representative of the entire maternal and child health service system in the county. Humboldt County is a small rural county and we are unlikely to find much new funding for our action agenda. We must find and mobilize existing community assets.

We rely on the employees from existing groups and agencies to carry the ball. Key members of the FIMR also get involved, especially if Health Department action is needed. Since we are now so long established and recognized in the community, a request or recommendation from the FIMR team is taken very seriously.

How does your FIMR handle sensitive or controversial problems that need to be addressed? On a case-by-case basis, with the expertise available to the FIMR team. We are also mindful of issues related to confidentiality. Often, if there are concerns, I, as the FIMR chair, will do further review of the medical records or other information outside of the meeting and come back for further discussion.

What is the relationship between the case review team and the community action team? Our FIMR program works somewhat differently than most. Our community is quite small. Members of the FIMR CRT, the FIMR CAT and the Child Death Review would wind up being the same people. So we have combined the functions of the two FIMR teams and the Child Death Review team into one. In our community, the case review team members and the Health Department are the leaders in taking recommendations to action. The CAT is good at marketing FIMR successes, spreading the word about our plans and emphasizing the importance of recommendations and actions to the larger community.

A Decade of Lessons Learned
How does the community at large learn about the actions that FIMR is proposing and has accomplished?

We publish a written report to the community at large every other year to let everyone know about our findings, recommendations and successes that have occurred since the last report. Members of the community action team also report our recommendations back to their respective agencies.

How do you check up on proposed actions to see whether they were implemented?

Staff keeps track and follows progress.

How does your FIMR relate to other mortality processes (e.g., SIDS, Child Fatality Review)?

Our FIMR team is actually a combined Child Death Review (CDR) and FIMR team. We do have a SIDS program sponsored by the Health Department. Public Health Nursing represents the Sudden Infant Death Syndrome (SIDS) program on our FIMR team.

How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?

Usually the FIMR team will note a recurring theme that has not been addressed as the team members review ongoing cases.

What types of actions has your FIMR implemented?

We have been able to accomplish so much for the community through FIMR. Our community respects FIMR findings and takes action. Here are just some of the actions we have implemented.

• Improve community bereavement services
• Implement continuing education programs for providers
• Develop a community resource directory
• Increase collaboration among community services organizations
• Develop patient education material
• Implement domestic violence screening and treatment
• Implement substance abuse screening and treatment for pregnant and parenting women (in progress)
• Conduct media campaigns
• Promote SIDS risk reduction activities
• Implement prenatal smoking cessation programs
• Improve cultural competency in service delivery systems
• Promote fire safety awareness; install fire detectors
• Develop local or state legislation

N.B. We are involved in these activities, but although all are supported by FIMR, not all of the actions being taken are necessarily the direct result of FIMR recommendations.

Humboldt County FIMR/CDR Team Members - The FIMR Community Action Team

Humboldt County Alcohol and Other Drugs
Humboldt Child Care Council
Humboldt County Sheriff’s Department
Center for Women’s Health Care
Redwood Coast Regional Center
Fortuna Police Department
Hoopa Human Services
Northcountry Clinic
Eureka Pediatrics
Eureka Police Department
Health Education Department
Humboldt County Health Department
North Coast Emergency Medical Services
Jerold Phelps Community Hospital
Humboldt County Coroner’s Department
St. Joseph and Redwood Hospital Emergency Department
Arcata Police Department
Humboldt County Child Welfare Department
Humboldt County Mental Health Department
General Hospital Emergency Department
Whole Child Interagency Council
Women’s Resource Center
An Interview with:
Seth Foldy, MD
Commissioner of Health
FIMR Director
Milwaukee Department of Health
Zeidler Municipal Building
841 North Broadway
Milwaukee, WI 53201
Phone:  (414) 286-2900
Fax:  (414) 286-5990

Milwaukee FIMR Mission Statement
To understand issues related to disparities in infant health outcomes in inner city Milwaukee and work together as a community to affect change.

Program Starting Date: 1994

About our Community
Milwaukee has a 1990 population of 628,088. It is the largest city in Wisconsin and the 17th largest city in the United States. Its racial makeup was 63% white, 31% black, and 6% "other." In 1998, Milwaukee had 11,000 live births.

About one-third of the population lives within the central city area, which is the target area for the FIMR program. It is here where a majority of the city's diverse ethnic groups reside, as well as a high proportion of poor and single-parent families. Infant mortality in this central city area averaged 13.2 deaths per 1,000 live births for the five-year period from 1990—94 much worse than in the city as a whole (11.9/1,000) and the state (8.0/1000). The rate for whites has decreased for over a decade, but that for non-whites the rate has remained steady at about 17.9/1,000. In 2000, we have become aware that areas outside the FIMR target area are also seeing a rise in infant mortality rates, particularly northwest parts of the city.
There are seven hospitals with labor and delivery services within the city limits, three of which deliver approximately 90% of families within the FIMR target area (due to Medicaid HMO affiliation and location). The area's largest indigent care facility, Milwaukee County Hospital, closed in 1996. This forced change in the way many families obtained care. Children's Hospital (located outside city limits in Milwaukee County) is a major supporter of this FIMR program. It has one of the three neonatal intensive care units in the area. It also is home to the Child Protection Center, where the FIMR program office was located from 1994 through 1996. Today, FIMR is housed in the Office of Vital Statistics within our Health Department. This makes it much easier to identify cases and, of course, locate birth and death records.

Milwaukee is rich with resources for health and human services planning and service delivery, including many of the organizations represented on the FIMR teams. It has an exceptionally strong local health department and a well-developed system of public nursing with home visitation. Another resource is its strong civic mindedness and sense of community. The city’s many community-based organizations and advocacy groups are taking an active role in implementing FIMR activities.

**How has your community sustained FIMR?**

Milwaukee has been committed to the FIMR process. However, our city has had quite a long and up-hill battle in beginning and continuing FIMR. Perhaps others can learn from our struggles.

In the late 1980s, the state of Wisconsin and the March of Dimes Birth Defects Foundation jointly funded a program to study Native American infant mortality. That program generated interest in the FIMR process. Local officials applied for a Robert Wood Johnson Foundation FIMR grant. The first proposal was not funded, but we did not give up. We resubmitted the proposal with a stronger community base and received the grant award in 1993. Then our FIMR program had somewhat of a start-up delay due to a 10-month search to hire the FIMR coordinator. Once the coordinator was on board, we moved forward to recruit and train community-based home interviewers. This was a labor-intensive process that we have not been able to continue. Today, public health nurses from the health department conduct our home interviews.
In 1996, the Robert Wood Johnson Foundation funding ended, just as our FIMR program had laid all of the ground work, trained the interviewers and was beginning to review cases. The City Health Department was able to partner with the Wisconsin State Title V agency to continue funding through 1997. The southeast state region of the March of Dimes Birth Defects Foundation also contributed to our efforts. During that year, FIMR reviewed a random sample of cases from the 101 census tracts that compromise the FIMR target area. We wrote a report and held a citywide conference to publicize our findings in 1997.

At the end of 1997, State Title V funding for FIMR concluded. In July 1998, we produced a second report titled *A Pledge for Infant Survival: Milwaukee’s Call to Action*. After that, we lost our FIMR coordinator and were not able to continue the reviews. However, we still were determined to try to continue FIMR. Then, the City Health Department was able to partner with the Black Health Coalition of Wisconsin to apply for a federal Healthy Start grant. This grant application included funding for FIMR. The fact that FIMR had already mobilized the community to take action to reduce infant mortality in the highest risk areas was a strong selling point for that grant. The grant was approved for funding. We are now beginning to review cases once again and move forward with our city’s efforts to improve services and resources to women, infants and families through FIMR.

**How does your FIMR move from case review to community action?**
The CRT meets about eight times a year. It is a truly diverse group that represents our community. Members include representatives of the Milwaukee Health Department, the University of Wisconsin Medical School Department of Ob/Gyn, the federal Healthy Start program, the medical examiner's office, Children's Hospital of Wisconsin, the Wisconsin Sudden Infant Death Center, the Black Health Coalition, the Latino Health Organization, and the state Division of Health Maternal and Child Health branch. Also included are WIC and social service representatives, a parent who has experienced an infant death, a prenatal care coordination provider, and an alcohol and drug abuse counselor from Milwaukee Women’s Center.
Summary information from case reviews is presented on an annual basis to the federal Healthy Start Consortium. The Consortium develops action plans to move our recommendations forward.

**How do you prioritize the problems that will result in actions?**
It is a group effort. Everyone participates. After the first two years of reviews, it was really clear to us that there were four main prevention goals that everyone could do something about: 1) prenatal smoking cessation/infant smoke-free environment, 2) SIDS risk reduction activities/Back to Sleep campaign, 3) need for early enrollment in prenatal care and 4) preconceptional counseling and family planning.

**Do you connect the FIMR action plan to existing services and resources in the community?**
One of the most gratifying outcomes of our actions is to see the number of different agencies and institutions that have incorporated our action plan into their routine educational protocols and procedures. We can feel confident that our work will go on because it has become a solid part of the way many different agencies do things in our community.

**How does your FIMR handle sensitive or controversial problems that need to be addressed?**
We have a large and culturally diverse city. There are many competing interests and sensitive issues. However, we are used to working together. The FIMR experience has also enhanced that spirit of cooperation. We just move forward trying to know and respect each other’s point of view.

**What is the relationship between the CAT and CRT in implementing action steps?**
They work well together. We are very pleased to be integrating our recommendations into the Healthy Start Consortium. This way we can assure that the actions that emerge will be culturally competent, family friendly and specific to the needs of our city. The endorsement of the consortium is also very important in making sure that the actions proposed are acceptable and credible to the community.
How does the community at large learn about the actions that FIMR is proposing and has accomplished?
The Time-Warner Cable Company donated staff time and production costs to produce and run a public service announcement (PSA) about our four important FIMR action messages. I also take advantage of frequent local radio and television interviews to talk about infant smoke-free environments. Another strong partner in Milwaukee is the American Lung Association (ALA). They have put our smoking cessation messages on billboards and buses citywide. Parish nurses now promote our action agenda in the faith community. Many agencies also promote our messages through their home visiting programs and prenatal classes.

We also found that there may be some untapped opportunities to get the message out to a larger community within our own Health Department. For example, we realized that the Department is routinely testing all city childcare providers for tuberculosis each year. This testing is needed to maintain their license. Since they are a captive audience, we now give out information about Back to Sleep and smoke-free infant environment while they are getting tested.

How do you check up on proposed actions to see whether they were implemented?
Continuing review of cases gives us an overview of our successes. We also partnered with the University of Wisconsin to try to survey the community at risk to determine baseline knowledge about practices related to SIDS risk reduction activities within the target communities. We are also investigating birth records for information regarding prenatal care use and tobacco use.

How does your FIMR relate to other mortality processes (e.g., SIDS, CFR), when actions proposed may overlap with their activities?
The director of the Wisconsin SIDS Center is a member of our CRT. We have input related to grief and loss and SIDS risk reduction at each meeting. Our FIMR coordinator sits on the CFR team. The medical examiner also sits on both the FIMR and CFR reviews and keeps us current on CFR issues.
How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?
The continued case review is a good barometer of change or lack thereof. As an epidemiologist, I would also like to see additional documentation of changes in knowledge, attitudes and beliefs in the target FIMR community related to our four action plans. We are working on that.

What types of actions has your FIMR implemented?
Our FIMR findings really rallied the community. Many diverse partners worked to implement our action agenda. Here are a few of the highlights of our successes:
• Improve community bereavement services
• Develop new, relevant bereavement services for culturally diverse segments of the community
• Streamline prenatal and/or pediatric Medicaid application process
• Implement continuing education programs for providers
• Increase collaboration among community services organizations
• Develop patient education material
• Revised policies and procedures for substance abuse screening and treatment for pregnant and parenting women
• Conduct media campaigns (FIMR action PSA)
• Promote SIDS risk reduction activities
• Implement prenatal smoking cessation programs
• Improve cultural competency in service delivery systems
• Reduce gaps in prenatal and/or pediatric services
• Eliminate duplication of prenatal or pediatric services
• Other: Raise the awareness of diverse community sectors
The Milwaukee Healthy Start/Healthy Beginnings Consortium Agency Members - The FIMR Community Action Team

Community members (N = 42)
Institutions and agency members
Bureau of Public Health, State of Wisconsin
   Children’s Hospital
   Sixteenth Street Clinic
   Private Industry Council
   WIC Program
   Healthcare for the Homeless
   Froedtert Memorial Hospital
   Cameron Management and Consultants
   Mary Mahoney Health Services
   Hillside Family Resource Center
   ASHA Family Services
   New Horizon Center
   March of Dimes Birth Defects Foundation
   Milwaukee Health Department
   Latino Health Organization
   Milwaukee Public Schools
   Milwaukee Foundation
   MAXIMUS
   Wisconsin SIDS Program
   Refugee Consulting Services, Inc.
   Milwaukee Women’s Health Center
   Milwaukee Common Council
   St. Joseph Hospital
   Prime Care
   La Causa
   Planned Parenthood of Wisconsin
   Milwaukee Adolescent Health Program
   Aurora Healthcare
   Sinai Samaritan Health Center
   Creative Marketing Services
   Mohammad Mosque Mullah
   Milwaukee County Supervisor
   1290 AM Radio Station
   St. Mary’s Hospital
   NBNA Milwaukee Chapter
   Medical College of Wisconsin
   Hmong Educational Advancements

A Decade of Lessons Learned
The North Country Prenatal/Perinatal Council
Infant Mortality Review Program

An interview with
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Penny A. Ingham, MPH current FIMR Coordinator
Executive Director
North Country Prenatal/Perinatal Council
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NCPPC FIMR Mission Statement

NCPPC will continue to conduct FIMR to monitor infant deaths, review cases, support families and implement recommendations proposed from reviews. We will also facilitate the education of consumers and health and human service providers on mutable risk factors associated with infant morbidity and mortality, such as the correlation between smoking and SIDS.

FIMR Starting Date: 1994

About Our Community
The tri-county area of Jefferson, St. Lawrence and Lewis County comprises the North Country. All three counties are east of Lake Ontario. These three counties have long, snowy winters with sometimes as much as 100 inches of snow. The main industries are wholesale/retail trade, service jobs and farming. At nearly 2,700 square miles, St. Lawrence is the largest county in all of New York State, and accounts for more than half (51.3%) of the North Country’s total square mileage. The total population of the three counties is approximately 255,510 (1997 estimates), a 2.3% increase from 1990. In addition to population growth, the increase is also partly attributable to the influx of individuals to the region as a result of the re-activation of the Fort Drum military base (Jefferson County) in 1990.
The North Country is predominately rural, with nearly two-thirds of the population residing in rural areas (1990 Census). All three counties meet federal and state definitions of rural areas, and 7 of the 9 hospitals in the North Country are eligible for rural reimbursement rates to meet the "special needs of hospitals serving remote and sparsely populated areas" (Public Health Law, section 700.02).

The North Country Prenatal/Perinatal Council (NCPPC) is a non-profit, community based organization led by a Board of Directors of North Country residents. New York State Department of Health originally funded NCPPC. The Council functions as a regional coordinating body whose objective is to promote universal and timely access to prenatal/perinatal services in order to improve the health of women, children and families in Jefferson, Lewis and St. Lawrence counties. The council is one of 14 perinatal networks in New York State.

The Council aims to accomplish this through increased coordination of existing health and human services, through identification of gaps in service, and by researching funding and writing grants to bridge those documented gaps. The Council provides a system through which consumers and providers of health and human services can work together to enhance service planning and assessment, implementation, and evaluation. FIMR is an ongoing Council program. Other NCPPC services include but are not limited to the following:

- Information and Referral Services—For both consumers and providers including breastfeeding, smoking cessation, parenting and teen sexuality.
- Case Management Coordination System—to facilitate the coordination of services to pregnant women.
- Managed Care Initiatives—to collaborate with consumers, providers, businesses and others in assessing managed care knowledge and receptivity in the North Country.

**How has your community sustained FIMR?**
From 1994 to the 2000, our FIMR has had a small amount of steady funding from New York State Department of Health. At the end of 2000, our state funding was discontinued, but we will sustain our FIMR with existing community resources.
How does your community move from case review to action?
The three counties each have a separate case review team and review all cases that occur in their respective counties. In 1998, there were 6 infant deaths in Jefferson County, 5 in Lewis County and 8 in St. Lawrence. The FIMR coordinator attends all case review team meetings in each county. The counties decide what their individual recommendations should be and come together in Watertown to iron out which recommendations are common to all three. These recommendations are then forwarded to the NCPPC. Our North Country community based council is a natural action team where FIMR can report their recommendations and expect to see change happen. (See NCPPC graph on next page.)

How do you prioritize the problems that will result in actions?
The three committees meet yearly. They review progress towards actions proposed in the previous year and study the new recommendations. We have not had much trouble prioritizing the problems. The decision is by consensus. We also review population-based infant mortality data to help us decide where we should focus our efforts.

Do you connect the FIMR action plan to existing services and resources in the community?
We are unique in that our FIMR is a tri-county effort. We have been very effective in linking FIMR actions to many different services and resources throughout this tri-county area. The action plan is connected to existing services and resources on a local, county and regional level. For example, all FIMR provider education recommendations are referred to the perinatologist and neonatologist in our Regional Perinatal Center in Syracuse, NY. These physicians conduct ongoing, annual site visits to our county hospitals and provide training for local obstetrician/gynecologists and pediatricians. They disseminate our recommendations during these visits. All FIMR nursing education recommendations are sent to the Obstetrical and Neonatal Nursing Coordinators at the Regional Perinatal Center as they also visit each hospital for perinatal nursing education.
NCPCC, Inc. of
Jefferson, Lewis, and St. Lawrence Counties
Infant Mortality Review

County Public Health Departments IMR Nurses
(Bereavement, Assessment, & Data Collection)

N.C.P.P.C., Inc. Outreach Coordinator
(Data Input, Death Information, Case Distribution)

Community Review Team
Case Review and Recommendations

Interventions for
Health Care Providers
C.N.Y Regional Perinatal Program Committee
& Directors of Public Health & Network News (NCPPC Publication)

Consumer Outreach Education
N.C.P.P.C., Inc. Outreach & Education Committee & Tri-County Breastfeeding Coalition

Gaps/Services
N.C.P.P.C., Inc. Case Management & Tri-County Board

A Decade of Lessons Learned
How does your FIMR handle sensitive or controversial problems that need to be addressed?
Depending on the type of issue, specific team members (medicine, nursing, etc.) and/or the FIMR Coordinator work behind the scene to effect change. Confidentiality is key and we are very careful to preserve it. If the problem still is not resolved, we may brainstorm about an issue in a general, de-identified manner with our Regional State Health Department representative. She has been very helpful in our review process and we have worked closely with her from the beginning.

Once an action plan is finalized, how does the team implement the plan?
The FIMR Coordinator keeps track of the action plan and checks up on agencies, individuals or professionals that are working on a piece of the action. Progress toward action is reviewed at each CRT meeting. We have developed a special form for tracking the action results. I would be glad to share it with other FIMRs.

What is the relationship between the CAT & CRT in implementing action steps?
If problems cannot be solved by our tri-county team members, then they are forwarded to the Perinatal Council. If something needs to be done and the responsible party is not a CRT team member or not on the NCPPC, we can take it directly to that agency. As the concurrent Executive Director of NCPPC, as well as the FIMR coordinator, recommendations for improvement coming from us are taken very seriously. The need for action is always disseminated to appropriate service delivery systems.

What is FIMR’s relationship to public health, private providers, community advocates, elected officials in the community?
We are the community. We have very broad membership in our CRT! Public Health, private providers, community advocates, DSS, Fort Drum providers all participate. We also work closely with our local March of Dimes chapter. The March of Dimes and FIMR make great partners. Also, every two years, we share our written FIMR reports with the elected officials as well as to anyone who would like them. These reports also contributed to our success in several grant applications.
How does the community at large learn about the actions that FIMR is proposing and has accomplished?
A news release is published when each FIMR report is ready to be shared. Copies of the report are sent to all on NCPPC’s mailing list which is very extensive.

How do you check up on proposed actions to see whether they were implemented?
The FIMR coordinator keeps tract of who is working on what. So far, this strategy has been effective.

How does your FIMR relate to other mortality processes (e.g., SIDS, CFR), when actions proposed may overlap with their activities?
Representatives from these other reviews are either a part of the CRT teams or sit on the NCPPC. They are an integral part of the FIMR process and we also support their activities as well.

How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?
FIMR has really helped us develop a seamless service delivery system for woman, infants and families. Here are just a few of the types of action that we have developed:
- Improve community bereavement services.
- Develop new, relevant bereavement services for culturally diverse segments of the community.
- Implement continuing education programs for providers.
- Maintain a community resource directory.
- Increase collaboration among community services organizations.
- Develop community education material.
- Implement domestic violence screening and treatment.
- Implement substance abuse screening and treatment for pregnant and parenting women.
- Conduct media campaigns.
- Promote SIDS Risk Reduction activities.
- Implement prenatal smoking cessation programs.
- Improve cultural competency in service delivery systems.
- Implement postpartum mother to mother support groups.
- Implement prenatal screening for domestic violence.
- Reduce gaps in prenatal and/or pediatric services.
• Eliminate duplication of prenatal or pediatric services.
• Promote fire safety awareness, install fire detectors.
• Increased referrals for genetic counseling, nutrition services.

**NCPBC Agency Members - The FIMR Community Action Team**

- Augsbury Institute
- Carthage Area Hospital
- Carthage High School
- Catholic Charities
- Central New York Regional Perinatal
- Central New York HSA, Inc.
- Community Action Planning Council of Jefferson County
- Crouse Hospital – Perinatal Center
- Hand In Hand Early Childhood Center
- Jefferson County Department of Social Services
  - Jefferson Community College
  - Jefferson County Public Health
  - Lewis County Public Health
  - Lewis County General Hospital
- Lewis County Department of Social Services
- Lewis County Council on Alcoholism & Substance Abuse
- New York State Department of Health
- North Country Children’s Clinic
- North Country Genetics Service
- Planned Parenthood of NNY
- Samaritan Medical Center
- St. Lawrence County Department of Social Services
- St. Lawrence County Maternal Care Center
- The ARC Oneida-Lewis Chapter NYSARC, Inc.
- USA MEDDAC
- Woman to Woman (Samaritan Medical Center)
An interview with:
Peter Vasilenko, Ph.D. and Saginaw FIMR CRT Member
Director of Community Research
Michigan State University
Rosemary Fournier, RN BSN Current Michigan State FIMR Coordinator
Former Saginaw FIMR Coordinator
Phone: (517) 583-6986
Fax: (517) 583-3841

Saginaw County FIMR Mission Statement
To reduce infant morbidity and mortality in Saginaw County by enhancing the perinatal care system and developing comprehensive programs to improve the lives and health of moms, babies and families.

Program Starting Date: 1991

About Our Community
Saginaw County is located just west of Michigan’s "thumb," It has the state’s farthest north medical center and is a referral point for a 14-county area as well as the city of Saginaw. The city of Saginaw has a population of 70,000, about half of whom are either black or Hispanic. The county has 211,000 residents, about one quarter of whom are members of racial or ethnic minority groups. The Saginaw region is an area of huge racial and ethnic disparities in infant mortality rates. In 1989, when attention was being focused on the issue, the white infant mortality rate in Saginaw was the lowest in the state (4.5 per 1,000), while the black infant mortality rate, at seven times that (31.6 per 1,000), was the highest in the state.

The Saginaw County Infant Mortality Coalition (SCIMC), which serves as one of four collaborating agencies for the program, was formed in 1990 to call attention to the problem. Its 60 members,
representing 40 community organizations, have been meeting monthly for the past eleven years. It is to this group that the FIMR recommendations are forwarded for community response and action. The other three collaborating agencies for the grant are the Saginaw County Medical Society, the Saginaw County Department of Public Health and the Michigan Department of Public Health.

How has your community sustained FIMR?
Over the past nine years, Saginaw FIMR has had several sources of funding. Initially, between 1991 and 1994, we received a grant from NFIMR supported with funds from the March of Dimes Birth Defects Foundation and the federal Maternal and Child Health Bureau (MCHB). Then, Saginaw FIMR staff successfully competed for a federal Family Health Continuum grant. This federal MCHB demonstration grant lasted from 1994 to 1997. Most recently, Saginaw received a federal Healthy Start grant, which includes funding for FIMR. Whenever one of the four FIMR agency sponsors writes a new grant, we include support for FIMR as one of the parameters of measuring outcome and success.

How does your FIMR move from case reviews to action?
The FIMR program tries to review all infant deaths every year, not just a sampling. About 20—30 cases are reviewed each year, depending on the complexity of the cases and the actual infant death rate. Generally, the goal is to have the previous year’s deaths reviewed by the start of the new year (i.e., all 1998 deaths are reviewed by December 1999).

The Saginaw County Infant Mortality Coalition (SCIMC), in place and active in the community since 1990, is often the mechanism used to move recommendations to action. The SCIMC helps connect the FIMR action plans to existing services and resources in the community. Thus duplication and gaps in services can be avoided. The SCIMC, with over 60 members, that represents 40 some agencies provide service to pregnant and parenting families in the county. Seven subcommittees address various FIMR recommendations, including:
1. Teen pregnancy
2. Domestic violence
3. Postneonatal death
4. Professional education
5. Community education
6. Legislation
7. Newsletter

We also act to implement recommendations. Depending on the action (education, policy changes or public awareness) we may take findings and recommendations from the case reviews and disseminate the information and suggest actions to the appropriate community agencies. We also compile general and specific statistics and present them regularly to SCIMC.

**How do you prioritize the problems that will result in action?**
When a problem or issue continues to appear repeatedly in reviews, it is given immediate attention. SCIMC has strategic planning sessions for this purpose. We also have had several formal retreats specifically for the purpose of prioritizing a FIMR action agenda. The coalition may use the Nominal Group Process to reach consensus in difficult decisions.

**How do you connect the FIMR action plan to existing services and resources in the community?**
Members of the Community Advisory Committee come from the community and represent the cultural diversity of Saginaw County. These committee members advise both the SCIMC and the FHC project on our programs and activities aimed at infant mortality reduction.

Regular professional educational sessions are provided at the Ob/Gyn departmental meetings and during the family practice and pediatric grand rounds on an as needed basis at least twice each year.

**How do you handle sensitive or controversial problems?**
First, strictest confidentiality is always maintained, so recommendations and actions are never targeted toward a particular provider or institution. This approach has engendered tremendous confidence and support from the medical and service communities. Because of the proven track record of the SCIMC and SCHI, we have not run into too many obstacles in handling sensitive issues.
Because of the nature of SCHI’s educational approach to problem solving, FIMR is already a process for getting the message across in a non-threatening and non-judgmental way.

A current example of the controversial problems that we deal with is co-sleeping or bed sharing as it relates to positional asphyxia and Sudden Infant Death Syndrome (SIDS). We are dealing with this issue by providing education about it. We also made an agreement to do more research and data gathering while working out a health education message to the larger community.

How does FIMR implement the action plan?
Once a problem has been identified through the FIMR reviews, we review population-based data about the issue to see if it is community-wide. From the results of the research done through SCIMC and the core FIMR team, we develop a plan of action for the community to develop awareness of the issue: how it has affected our community. If possible, we also try to convey how the issue has affected the nation at large and our state and county. With the above seven subcommittees, we determine the best way to take action and disseminate information about issues.

What is the relationship between the CAT and CRT in implementing action steps?
The CRT regularly reports their findings and recommendations to SCIMC (our community action team). Depending on the action, the community in general has "ownership" of the proposed action. If the action is something specific to be implemented in the school, then the schools have ownership. The SCIMC is the conduit to the community, linking the Family Independence Agency (FIA), the home institutions, schools, hospitals, prenatal care providers, etc.

What is FIMR’s relationship to public health personnel, private providers, community advocates and elected officials in the community?
We have an excellent relationship with public health. We have private providers who participate in the review process, sit on the SCIMC, and request in-service education for their staff about the issues that have been identified and actions being implemented. Community advocates participate in the SCIMC and sit on the committees that interest them. These members of the community are
vital to the distribution of information to the grassroots of the community. They are instrumental in the identification and implementation of a plan that will work in this community based on the values and beliefs of the members. The elected officials in this community are not only aware of the work being done; they participate in the review process, offer information and expertise when requested, and accept and implement the recommendations of the FIMR board. One member of the coalition is a state representative. He keeps the interests of the FIMR and SCIMC at heart and is a tremendous asset at the state level.

In 1999, as a part of the federal Healthy Start program, we also developed a consumer consortium group. The members include parents, clergy and actual consumers of Healthy Start services. We now present FIMR findings to them every month. They advise us on ways to develop culturally competent services and educational messages.

In partnership with Michigan State Title V representatives, we took the lead to form a FIMR networking group. The group is composed of the State Title V representatives, the three new communities setting up FIMR, the Michigan SIDS Alliance and us. This group meets monthly to share successes and challenges.

How does the community at large learn about the actions that FIMR is proposing and has accomplished?
The community at large learns about the FIMR activities through the SCIMC education process (in-services for the health care community and educational activities for the community) press releases, media coverage of events and statistics, public service announcements, communication by community advocates, church bulletins, schools, individual education or counseling in the clinics, and support services in the community. The SCIMC also publishes a quarterly newsletter, with a mailing list of over 10,000, that includes other service providers and the general community.

How do you check up on proposed actions to see whether they were implemented?
In this community, we, as the FIMR core team members, play a large role in the implementation process. Frequently we personally implement the action. We also have monthly SCIMC meetings.
where the subcommittees report on the actions that are taking place in the community to reduce mortality.

**How does your FIMR relate to other mortality processes?**
The Saginaw FIMR has provided technical assistance to numerous other FIMR projects in Michigan as well as many projects across the country. Several core FIMR team members regularly participate on the hospital’s Death Review Team and Quality Assurance Committee. The Saginaw FIMR has discussed expanding to Child Death Review but does not want to compromise or dilute the continuous quality assurance process of FIMR.

**How does your FIMR monitor the progress of recommendations?**
We keep a log of recommendations not yet implemented. They are discussed at each meeting until they are completed. We also continue to review the literature to see if new or better strategies to address the problem emerge. If that happens, we can modify the action that was recommended to be consistent with the most current research. Our committee, however, moves forward in a very timely fashion. Very few recommendations for action remain in our log.

**What types of actions has your FIMR implemented?**
Over the past decade, our community has been able to make significant changes in the service systems for women, infants and families through FIMR including the following:

- Improve community bereavement services
- Streamline prenatal and/or pediatric Medicaid application process
- Implement continuing education programs for providers
- Implement standardized prenatal risk assessment protocols
- Increase collaboration among community services organizations
- Develop patient education material
- Implement domestic violence screening and treatment
- Implement substance abuse screening and treatment for pregnant and parenting women
- Conduct media campaigns
- Promote SIDS risk reduction activities
- Implement prenatal smoking cessation programs
- Improve cultural competency in service delivery systems
- Implement prenatal screening for domestic violence
- Reduce gaps in prenatal and/or pediatric services
• Eliminate duplication of prenatal or pediatric services
• Improve transportation to service sites
• Implement community oriented police services (COPS) – in progress
• Develop local or state legislation

Saginaw County Infant Mortality Committee Member Agencies - The FIMR Community Action Team

BlueCare Network
Olsten Health Services
CAN Council
Child and Family Service
Community Choice of Michigan
County Mental Health
County Youth Protection Council
Diocese of Saginaw
Family Independence Agency
Frank, Forster Attorneys
Healthy Start
Health Delivery, Inc.
Health Plus of Michigan
Janes Street Academic Center
Lactation Consultant
March of Dimes
MIC Clinic
Michigan Council for Maternal & Child Health
Michigan Dept. Education, Office of Equity
Michigan State University Center for Urban Affairs
Michigan Council for Maternal & Child Health
Michigan State University Extension
Parent Resource Center
Probate Court Juvenile Division
Saginaw Community Foundation
Saginaw Cooperative Hospitals, Inc.
Saginaw County Child Development Centers, Inc.
Saginaw County Department of Public Health
Saginaw County Medical Society
Saginaw General Hospital
Saginaw Odyssey House, Inc.
Saginaw Police Department
Saginaw Psychological Services, Inc.
Saginaw Riverside Kiwanis
Saginaw Valley State University Department of Psychology
Sickle Cell Program
St. Luke’s Hospital Family Birth Center
Teen Parent Services
Underground Railroad
United Way of Saginaw County
Valley Ob/Gyn
Women’s Ob/Gyn
San Diego, California
Fetal and Infant Mortality Review Program

An Interview with:
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San Diego FIMR Mission Statement
To reduce the fetal and infant mortality rate in San Diego County by developing a coordinated countywide plan for action. To implement a successful plan for action, health care providers, social service agencies, health plans, government, community-based organization, parents and community members must join together to develop and implement the solutions necessary to make a difference.

Program Starting Date: 1994

About Our Community
San Diego County is located in the southwest corner of California, adjacent to the Mexican border. The county’s topography is diverse with miles of coastal beaches, agricultural inland valleys, historic mountain areas and desert. San Diego City, with a population of 1,110,549, is home to one of United State’s largest naval bases and is the county seat.

San Diego County’s population of 2,828,300 is primarily white, with Latinos making up the largest minority population (20.4%). While 11% of the population has incomes below the poverty level, 16% of children under age 18 are poor. In female headed households with children under age 18, over one-third (35%) are poor. San Diego reported 43,422 live births during 1998 and 224 infant deaths, an infant mortality rate of 5.2. Nearly 8 out of 10
(79%) women began prenatal care during the first trimester of pregnancy. San Diego County has 18 birthing hospitals, 22 privately owned community clinics and one children’s hospital, all currently providing maternal and infant care.

How has your community sustained FIMR?
FIMR was initially funded entirely by County of San Diego Health and Human Services Agency (HHSA) with funds from the Vital Records Improvement Program (VRIP). VRIP had a state surcharge on certified copies of birth and death certificates. This surcharge originally supported our FIMR. In 1996, VRIP was amended so that funds could only be used to improve the automated vital records system. We then sought and received funding from HHSA’s realignment fund. Realignment monies are dollars returned by the state to the counties to "realign" sales tax revenues.

Today, the County of San Diego FIMR Program is housed administratively and physically in the Children, Youth and Family (CYF) division of HHSA. FIMR is a partnership between HHSA and the San Diego State University Foundation (SDSUF)’s Institute for Public Health. All FIMR staff are SDSUF employees. Funding for the program comes from two sources, 85% from HHSA (state realignment money) and 15% from a grant from the State Title V agency.

How does your FIMR move from case reviews to implementation?
Our FIMR uses a two-tiered model. The Case Review Work Group meets once a month to review anonymous case summaries to develop findings as to the contributory factors in each case, and to make recommendations for change in the overall system of care. Our community action team is called the "FIMR Community Partners." That whole group meets together quarterly. The group also has divided into six subcommittees which meet monthly. These subcommittees include:

1. Preconception Planning and Pre-Pregnancy Health
2. Access to Perinatal and Infant Health Care
3. Adequacy of Perinatal and Infant Health Care
4. Perinatal Social Support
5. Infant Safety in Childcare (this group meets quarterly)
6. Perinatal Grief and Bereavement Support Service
The technical panel had recommended expanded home visiting services for medically and/or socially high-risk families since the panel began meeting. The Access to Care, Adequacy of Care and Perinatal Social Support work groups worked collaboratively to integrate their individual action items into a coordinated FIMR action plan. The FIMR action plan is, in turn, being coordinated with the County’s new Family Support Home Visiting Program. FIMR will provide education for the home visitors in preterm labor, other danger signs of pregnancy, Shaken Baby Syndrome, and SIDS. Other infant safety issues are under development by the Childcare Work Group, specifically food preparation, i.e., heating bottles in microwaves. Perinatal Social Support is also beginning discussions with the Children’s Services Bureau to develop ways to identify pregnant women who have active cases with CSB. The goal is to give priority to these mothers for home visitor services to ensure the safety and well-being of the infant born after removal of the older siblings. Our proposed San Diego Consortium for Perinatal Grief and Bereavement Support is the primary priority project for which we do not currently have funding. The plan is to continue designing the project while seeking a funding source.

**How do you prioritize the problems that will result in actions?**
The six CAT work groups set priorities for actions from the recommendations that relate specifically to their charge. The CAT steering committee coordinates the activities of the work groups to prevent duplication of effort and multiple FIMR contacts with the community. Community surveys are a good example of that coordination activity. All surveys must go to the steering committee (which meets monthly) to determine if any other work group is planning a similar survey. If that is the case, attempts are made to blend multiple surveys into a single data collection tool.

**Do you connect the FIMR action plan to existing services and resources in the community?**
We try to make sure they are involved in FIMR. There are six health-care systems providing maternal and infant care in San Diego County: Sharp Healthcare, Scripps Healthcare, UCSD Healthcare, Kaiser and the US Naval Medical Center. There are representatives to FIMR from all six systems scattered across the six FIMR work
groups. There are also representatives from some of the community clinics, though not as many as we would like. San Diego also has a Regional Perinatal System (RPS). This program is part of the state’s regional perinatal initiative to coordinate maternal and infant transports and other state MCH initiatives. The RPS director serves on FIMR’s technical panel.

All CAT work groups have adopted two principles that help them stay connected to the community and existing service systems:

- Use existing community resources — do not "re-invent the wheel"
- Incorporate community input into the design of a community intervention whenever possible

FIMR also collaborates with many of its other community partners on special projects such as:

- Technical support for a speaker from the Neighborhood House Early Head Start Program
- Healthy lifestyle information for a youth campaign by the March of Dimes
- Community presentations for the YMCA Childcare Resource Center on Shaken Baby and SIDS
- Presentations to the County Probation "Watch" program for pregnant teens on formal and informal probation
- Presentations about FIMR for the Community Health Improvement Partners (CHIP, a hospital coalition mandated by state law)

Work group 5 (Childcare) is our best example of utilizing existing services and coalitions. San Diego has a well-established childcare community. Members of existing coalitions such as the San Diego Childcare and Development Planning Council and the Work-Life Coalition belong to FIMR’s Childcare work group. Those members take FIMR’s action items to the community coalitions and monitor implementation of those actions.

Here is an example of one of our FIMR childcare recommendations:

Ensure that childcare providers receive education about Shaken Baby Syndrome and the Back to Sleep Campaign.
The community coalitions took our recommendation very seriously. They are now working with Community Childcare licensing (a County agency) to provide education packets and training sessions for all new childcare workers as they apply for their licenses. This process is ongoing for all workers. Therefore, this training has become a part of how we do things in the county and will continue.

How does your FIMR handle sensitive or controversial problems that need to be addressed?
This is a very large county with many service delivery systems and complex problems. Sensitive and/or controversial issues related to the administration of our FIMR are handled very carefully. We are mindful of the need to maintain strict confidentiality. My county supervisor and I may discuss them privately to decide how to proceed. If necessary, we may consult other Health Department leaders. If the matter is a community issue, it will be discussed internally first. Then, if appropriate, it will be discussed at the steering committee.

Once an action plan is finalized, how does the team implement the plan?
The six individual work groups implement the plans. They have become experts at tapping into our community’s assets. The March of Dimes Birth Defects Foundation is an active partner and has helped us each step along the way.

What is the relationship between the CAT and CRT in implementing action steps?
The technical panel and the CAT are independent bodies. The CAT work groups "own" the action plan jointly with FIMR. FIMR is responsible to HHSA and ultimately to the County Board of Supervisors for the activities detailed in the plan.

The CAT work groups have each developed their own portions of the overall action plan. They are then responsible for seeking funding, if necessary, convening community meetings and overseeing the actual implementation.
What is FIMR’s relationship to public health, private providers, community advocates and elected officials in the community?

FIMR has always had the active support of the County of San Diego Board of Supervisors. FIMR is one of the few forums in which personnel from the many competing health care systems in our community can come together to work towards a common maternal and child health care goal. Our meetings are productive, positive and supportive. The community really welcomes the opportunity to come together.

The power of so many different agencies working together through FIMR helped us attract grant funds too, including:

- $15,500 Cal-Works Program grant to conduct client focus groups to obtain customer input on the text and design of an easily readable, easily reproducible preconception brochure
- A grant from Sharp Health Care Foundation to replicate the FIMR preterm labor program within the Sharp Health Care system
- A grant from the March of Dimes to conduct a Preconception Health Care course for nurses

How does the community at large learn about the actions that FIMR is proposing and has accomplished?

Recommendations from the technical panel are transmitted via a formal report to the CAT. The report is also published and circulated throughout the entire community. The report helps the overall community to learn about the issues that we find. Our first report was titled *Saving Babies Lives: A Call to Action* (1998). A second report is planned for this fall.

How do you check up on proposed actions to see whether they were implemented?

We have the right people at the table. Members of our CRT and CAT are real community experts. They know when changes are taking place. Also, we can see progress from the continued review of cases.
How does your FIMR relate to other mortality processes (e.g., SIDS, CFR), when actions proposed may overlap with their activities?
Public Health nurses who do SIDS home visits are members of a case review team. A FIMR work group on perinatal bereavement issues is also working on providing and coordinating services for all families who have a fetal or infant loss. Our community’s pediatric pathologist is a member of both FIMR and CFR and keeps us informed about current CFR issues and concerns.

How do recommendations that have not yet been implemented feed back into the FIMR process when more cases are reviewed?
FIMR staff keep track of what has been accomplished and what still needs to be done. We update the CAT at each meeting.

What types of actions has your FIMR implemented?
Our FIMR has accomplished many positive actions. There is so much that our community can do when we work together, including:

- Improve community bereavement services
- Develop new, relevant bereavement services for culturally diverse segments of the community
- Streamline prenatal and/or pediatric Medicaid application process
- Implement continuing education programs for providers
- Develop a community resource directory
- Increase collaboration among community services organizations
- Develop patient education material
- Conduct media campaigns
- Promote SIDS risk reduction activities
- Improve cultural competency in service delivery systems
- Reduce gaps in prenatal and/or pediatric services
- Eliminate duplication of prenatal or pediatric services
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<td>Sharp Mary Birch Hospital for Women</td>
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<td>State of California, Community Care Licensing</td>
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<td>YMCA Childcare Resource Service</td>
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Southern New Jersey Perinatal Consortium (SNJPC)  
Fetal and Infant Mortality Review Program

An interview with  
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FIMR Coordinator  
Director, Regional Prevention Programs  
Kevon Office Center  
2500 McClellan Avenue Suite 110  
Pennsauken, NJ 08109-4613  
Phone: (856) 665-6000  
Fax: (856) 665-7711

SNJPC FIMR Mission Statement  
To reduce fetal and infant deaths in our region by cataloging the local public health systems issues that contribute to them and effect local strategies and policies to improve birth outcomes.

Program Starting Date: 1994

About Our Community  
New Jersey had to cope with a significant fluctuation in its annual births over the past decade. The number climbed from fewer than 100,000 in the 1980s to more than 120,000 in 1992, and currently lies at around 111,000. Nearly one-quarter of all children under five years of age are members of racial minority groups, and one in nine children under age 18 (11%) lives below the poverty level.

The state's racial and ethnic mix is 80% white, 14.5% African American. The black infant mortality rate, at about 14 deaths per 1,000 live births (14/1,000), is more than three times that of whites (5/1,000). Medicaid reimbursement is very low and the number of women going without prenatal care is increasing, according to state officials. The state's maternal and child health (MCH) efforts are largely directed towards reducing the racial disparity in infant mortality by improving birth outcomes among African American women. FIMR is seen as one of the strategies. Funding for FIMR activities has been included in the state's application for Title V block grant funding.
New Jersey is divided into seven maternal and child health regions. Each region has a maternal and child health consortium or nonprofit organization that oversees regional aspects of MCH services. The consortia were started in the early 1990s with grant funding from the Robert Wood Johnson Foundation. Their purpose is to take perinatal regionalization a step beyond hospital based planning and regional transport systems, and into community planning and systems design. The consortia are responsible for developing a detailed plan for regional perinatal and pediatric services, conducting professional education and infant follow-up, and monitoring quality of care. FIMR is ultimately seen as fitting into this latter function.

Established in 1982, SNJPC is the state's oldest consortium. It covers a seven-county region comprising 40% of the state's land area and nearly one-quarter of its annual births (over 21,000 per year). There are rural communities, suburban towns and cities, including two of 10 New Jersey cities (Camden City and Atlantic City) that have been targeted for their high levels of infant mortality, low birth weight (LBW), teen pregnancy, and incidence of no prenatal care. The isolated rural counties in the region also have their share of problems, including fetal mortality rates twice as high as in the rest of the state.

SNJPC was the first New Jersey region to pilot FIMR. We chose Camden City as the community in our region to start the FIMR reviews. Camden is an area with many of the problems often seen in urban settings. As economic development stalled in the 1990's, unemployment, poverty, crime and drug use escalated. Camden has been ranked fifth in the nation for "most distressed city."
This rank reflects the large numbers of city residents living in poverty. It is not surprising, then, that the health and well-being of the city’s most vulnerable citizens has suffered, as well. At 3.3%, the birthrate of VLBW infants is more than double the statewide average. One-third of births are to women receiving no or inadequate prenatal care. Births to African Americans and Latinas accounted for 53% and 37% of the births respectively. Fully 44% of births are to teen mothers. Seventy-five percent of births were to unmarried women. In 1997 the infant mortality rate was 18 compared with the statewide average rates of 6.4.
How has your community sustained FIMR?
From 1994 through 1996, our FIMR program was supported by a grant from the NFIMR through the Robert Wood Johnson Foundation. From 1996–1997, we were able to obtain state funds to keep our program going. In 1997, the FIMR program was incorporated into core SNJPC MCH regional activities. Healthy Start in Camden provides a small amount of support to help us abstract medical records. Other than that funding, we just keep it going with the staff and resources that we have.

How does your community move from case review to community action?
Case review has been going on at our Camden City FIMR site since January 1995. The case review team meets every other month. The team includes the usual array of medical experts (obstetricians, perinatologists, pediatricians and neonatologists). Many of them serve in more than one official capacity. For example, the pediatrician who chairs the team also is medical director of a federally qualified health center and sits on the state board of medical examiners. We also include case review team representatives from WIC, the state Department of Youth and Family Services, the New Jersey SIDS Resource Center, substance abuse treatment programs, and area hospitals.

Since 1987, our Healthy Mothers/Healthy Babies Coalition (HM/HB) has been conducting community education programs, most of them directed towards prevention and improved access to care. We report the case review team's findings and recommendations for developing community strategies and advocating policy changes to the HM/HB Coalition.

The SNJPC FIMR was the first project of its kind in New Jersey. The state Department of Health and Senior Services saw what we could accomplish at the regional level and expanded the program. Since our program began, three more regions have started FIMR. In the future, it looks like the state will move forward to institutionalize FIMR in all seven MCH regions.

Also, the City of Camden applied for and received a federal Healthy Start grant. Our FIMR needs assessment, findings and
recommendations were very helpful in developing that proposal. We now work closely with them as we move recommendations to action.

How do you prioritize the problems that will result in actions? The HM/HB Coalition prioritizes findings and recommendations. They are responsible for taking recommendations to action. Since the overall Coalition has more than 300 members from the whole community, we are able to create a powerful action plan to address most of our recommendations. Partnering with HM/HB has been a great way to move recommendations to action. The organization is a real community asset. I would encourage all FIMR programs to reach out and work closely with their local HM/HB Coalitions.

Do you connect the FIMR action plan to existing services and resources in the community? Between our case review team and the HM/HB Coalition, we capture representatives from almost all of the existing services and resources in our community. Camden’s HM/HB Coalition acts as the consortium that guides Camden’s federal Healthy Start program. Efforts to increase consumer participation in this health care initiative have also further assured that our plans really meet the needs of the community.

How does your FIMR handle sensitive or controversial problems that need to be addressed? First of all, we maintain strict confidentiality at all CRT meetings. We make a special point of discouraging individual provider team members from speaking out about information they may know about a case but do not see in our FIMR medical data abstraction. Having said that, I can say that we have not had any really sensitive or controversial issues in all of the years we have been meeting. The confidentiality of FIMR reviews is the cornerstone of our program.

Once an action plan is finalized, how does the team implement the plan? HM/HB has several standing committees, such as the Prenatal Substance Abuse Committee. Recommendations from the overall HM/HB Board are forwarded to the appropriate subcommittee with a charge to create an action agenda and move it forward. If there is
a recommendation that does not fit into the existing HM/HB structure, an ad hoc committee is created and works until it completes its task.

**What is the relationship between the CAT and CRT in implementing action steps?**
The CAT and the CRT are two independent bodies, but their commitment to women, infants and families in Camden ties them together and creates a strong sense of unity. As the FIMR coordinator, I provide feedback that maintains the link between the two groups. Also, some members of our CRT are also active members of HM/HB so there is networking at that level too.

**What is FIMR’s relationship to public health, private providers, community advocates and elected officials in the community?**
Our FIMR team and the HM/HB Coalition are composed of public health leaders, private providers, community advocates, consumers and many others. So, we ARE the community. Elected officials are aware of and support the HM/HB Coalition agendas and activities.

We also work closely with our local chapter of the March of Dimes. They have been another important partner and have helped us develop and publish several patient education materials, including one about preterm labor prevention.

**How does the community at large learn about the actions that FIMR is proposing and has accomplished?**
We publish FIMR recommendations and actions in our regional MCH newsletter and in the Camden Healthy Start newsletter. These publications reach about 1,000 providers, advocates and consumers.

**How do you check up on proposed actions to see whether they were implemented?**
This is not really a problem. Our teams are so tied into what is happening community wide that we get frequent feedback from them. I also keep track of successful community actions.

**How does your FIMR relate to other mortality processes (e.g., SIDS, CFR), when actions proposed may overlap with their activities?**
I am also a regular member of the CFR team and report any general, de-identified concerns from one review team to the other.
representative from the SIDS program is a member of our FIMR case review team. Several case review team members (physicians, nurses, social workers, and substance abuse counselors) sit on the statewide maternal mortality review team.

How do recommendations that have not yet been implemented feedback into the FIMR process when more cases are reviewed?
I keep a log of all the recommendations that the case review team proposes and the actions HM/HB is working on. It’s my job to share this with the teams on a regular basis. Also, continued review of cases is a good way to see if systems are changing for the better.

What are the types of successful actions your FIMR has implemented?
Our FIMR team and HM/HB Coalition work hard and are dedicated to making improvements in MCH systems in Camden. We realize we can make a difference. Here are some of the actions we have accomplished:

- Improve community bereavement services
- Implement continuing education programs for providers
- Develop a community resource directory
- Implement standardized prenatal risk assessment protocols
- Increase collaboration among community services organizations
- Develop patient education material
- Implement substance abuse screening and treatment for pregnant and parenting women
- Promote SIDS risk reduction activities
- Improve cultural competency in service delivery systems
- Reduce gaps in prenatal and/or pediatric services
- Eliminate duplication of prenatal or pediatric services
- Improve transportation to service sites
- Improve neighborhood safety and housing
- Other: develop the document titled Stillborn Infant Perinatal Guidelines
Healthy Mothers/ Healthy Babies Coalition – The FIMR Community Action Team

Our HM/HB Coalition is composed of over 300 members representing community agencies, institutions, professionals, advocates and consumers. Our FIMR case review team reports our findings to the standing Evaluation Committee of the HM/HB Coalition which includes the following agency members:

Camden AHEC
Cooper House Intensive Outpatient Program
Osborn Family Health Center, Our Lady of Lourdes MC
The Alcove, West Jersey Health Systems
Healthy Mothers/Healthy Babies Coalition
West Jersey Health Systems – Community Health Services
Health Visions
Sikora Center, Inc. (Substance Abuse Treatment)
Horizon Mercy (MCO)
Camden County Board of Social Services
Planned Parenthood
School Based Youth Services, Camden High School
The Cooper Health System
East Camden Middle School
Family Counseling Service
Woodland Community Substance Abuse Initiative, Woodland Presbyterian Church