A Report on the Status of Fetal and Infant Mortality Review in the United States 2015

U.S. Fetal and Infant Mortality Review Programs 2015 Status Report

Prepared by

National Center for Fatality Review and Prevention

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Introduction

Fetal and Infant Mortality Review (FIMR) is a community-based, action-oriented process to review fetal and infant deaths and make recommendations to spark systemic changes to prevent future similar deaths. All FIMR teams operate at the local level (usually the county) to examine medical, non-medical, and systems-related factors and circumstances contributing to fetal and infant deaths.

Among the various types of fatality reviews, the FIMR approach is unique because cases are de-identified; they may include a family interview to determine the family's perspective on factors that may have contributed to the infant's life and death; and many of the teams have a Community Action Team (CAT) that, after completion of the review, works to take the case review team's recommendations to action.

In late 2015, 177 FIMR teams were surveyed about their structure, process, and activities during 2015. One hundred and twenty-six local FIMR coordinators and 15 state FIMR coordinators from 26 states and Puerto Rico responded. This was the first such survey of its type of the FIMR field. Detailed results are set out in the 18 tables following the narrative. More detail about the survey process can be found on page 9.

FIMR program structure

Many FIMR teams are well established in their communities. When asked about the year of origin of their team, 42 of the respondents indicated their teams started in the 1990's; 58 stated they began their work in the 2000's, 19 of those within the last five years.

Almost three-quarters of respondents stated that their health department (whether state, county or city) is the lead agency for FIMR in their jurisdiction. Healthy Start is the lead for another 11% of responding programs, and the rest are led by a variety of agencies, such as perinatal coalitions/networks and hospitals.

Funding sources vary among the responding programs. Not surprisingly, the primary sources are state and federal MCH/Title V; local health departments; and other state funding. Eight programs responded that they are funded with federal Healthy Start dollars. For a variety of reasons, it was difficult to determine from the responses what the mean funding level is for state or local FIMR programs: some respondents were themselves unaware of the funding structure; not all programs answered the survey; and in some states the FIMR funding is subsumed in funding for all fatality reviews or is an indistinguishable portion of the state/federal MCH Title V budget. Two clear responses were from Florida, where each of the 11 FIMR programs gets $21,784 from state health department Title V funds and state general

revenue, and California, where approximately $500,000 of county health department dollars fund 16 local FIMR programs.

Selection of Deaths to Review and Review Structure: Most communities select cases for review based on risk and/or population factors such as vital statistics data and other information about the causes of infant mortality and how these statistics change over time. Many communities attempt to review all cases of fetal and infant death to give them a better picture overall of the community and its services and resources.

The selected de-identified cases are then abstracted by an individual, usually a nurse. In many teams, the case abstractor interviews the mother or other family member about the circumstances of the death, which can yield valuable information about social and environmental aspects surrounding the fetal or infant death. This information is included in the case abstract. The abstracts are then shared and discussed with the multidisciplinary case review team (CRT), which then makes recommendations for improvements in care and systems change. Many teams also utilize a second tier of review, the Community Action Team (CAT), that usually includes other community leaders. The CAT works to take the CRT recommendations to action.

Family Interviews: A unique feature of the core FIMR model is its focus on obtaining a family interview as part of the review process. The family interview provides their perspective of their baby's death and allows them to describe their experiences in their own words. Most family interviews are conducted with the birth mother. This yields information not usually captured in routinely collected health records. About half the responding teams report that they typically include information from an interview with a family member as part of their reviews. Respondents who replied they typically include an interview of a family member in their review (67 FIMR teams) were further asked to provide the percentage of their reviews in 2015 that included a completed interview. The median response of respondents who reported the percentage of reviews which include a family interview is 33%, and nine local programs report they interview family members in 100% of deaths they review.

Both respondents who use the family interviews and those who do not described reasons for their difficulties obtaining the interviews. The primary difficulty identified was finding the mother or other family member and obtaining agreement to the interview. Other reasons were lack of funding or staffing to conduct interviews, lack of training, and that certain cases did not need the interviews. Overall, respondents reported that obtaining the interviews is a major challenge.

Community Action Teams: As stated above, a unique feature of FIMR programs is the use of a Community Action Team as a second tier of review. While there may be some overlap in membership, the role of each team is quite distinct. The CRT acts as the information processer, reviews and analyzes the information collected in interviews and case abstractions, identifies gaps in care, and makes recommendations for how to improve systems and delivery of care. The CAT translates the CRT recommendations into strategies for action and participates in implementing interventions designed to address the identified problem.

Based on the survey responses, there appears to be minor confusion among respondents with respect to the wording of the question about whether they have a two-tiered structure (CRT and CAT), but their responses about their CATs' structure are clear: the CAT teams are more or less split evenly among CATs developed solely for the FIMR program; those that are part of existing community coalitions; and those that are a combination of both.

The membership on CRT and CAT teams varies among teams: the professions that are included on half or more of the teams are local health departments, social workers, obstetric/pediatric nurses; pediatricians; obstetricians; nurse home visitors; mental health professionals; child welfare workers; and educators.

Healthy Start Involvement with FIMR The Healthy Start Program is an initiative to eliminate disparities in perinatal outcomes through grants to project areas with high infant mortality. There are 100 Healthy Start programs in 35 states. Healthy Start participates in 36 of the responding teams. The other respondents indicated that Healthy Start either is not present in their community or is present but does not participate in FIMR. Respondents described a number of ways FIMR and Healthy Start collaborate including: FIMR findings may spur a community to apply for a Healthy Start grant; Healthy Start may fund FIMR in whole or part; Healthy Start members may serve on the FIMR Community Review Team (CRT) and or Community Action Team; FIMR may ask a Healthy Start Coalition to act as their FIMR Community Action Team; and/or Healthy Start may be the vehicle through which FIMR recommendations are implemented in communities.

Theories and Methodologies: Respondents were asked what theories or methodologies they use to inform their work. The 76 respondents who answered frequently listed the following: Life Course Theory, Perinatal Periods of Risk, Asset Based Community Development, and cultural competence in bereavement work.

FIMR Program Activities

Of those who answered the survey question, 'Are you currently reviewing cases?,' 119 answered 'yes,' and 8 said 'no.' Each of the 'no' respondents further indicated that the reason they answered 'no' was that there were no cases to review and not that they would not review cases that came to them. The responses indicate that the FIMR teams are active and are either reviewing cases or are prepared to do so.

One hundred forty-one respondents from 27 states and Puerto Rico provided the number of cases they reviewed in 2015; they totaled 2,937. Fetal deaths accounted for 35% of the total, although some programs reported fetal and infant deaths together. If a state coordinator reported a number of deaths reviewed that was different from that provided by the local teams, the local numbers were recorded for this report.

In addition to reviews, responses indicated that teams are very active in seeking solutions to prevent the types of deaths they review. Their responses are a rich repository of prevention initiatives, as indicated in the tables below:

- Table 3-1 (Community Education initiatives; 110 respondents);
- Table 3-2 (Service System improvement and linkages; 92 respondents);
- Table 3-3 (Policy/Advocacy activities; 85 respondents);
- Table 3-4 (Improved Practices, Programs and Policies; 87 respondents);
- Table 3-5 (Professional Training of Providers; 82 respondents); and
- Table 3-6 (One-on-One Counseling, Assessment, or provision of assistance/services; 82 respondents).

In addition, sixty-six teams (almost 50%) indicated that they communicate their actions and successes to their communities through a variety of news media, social media, and marketing campaigns.

The following are specific examples of successful interventions; more are listed in Appendix A.

Examples of interventions:

- In three counties in Florida, there was an increase in women presenting to their obstetrician or the local hospital's emergency departments with issues pertaining to dehydration. The team recommended that providers and home visitors teaching pregnant women about hydration should have a visual tool to utilize with the teaching. The strategy was implemented, and the number decreased of women presenting for dehydration to obstetrical offices and emergency departments.

- Due to the growing number of Newborn Abstinence Syndrome (NAS) births in Louisiana and a sense that the legislature wanted to get involved, FIMR intervened so that any decisions made by the legislature would be informed and promote the wellbeing of Louisiana's families. As a result, a study resolution passed the legislature in 2015 granting permission for the Perinatal Commission on the Prevention of Infant Mortality (the State-level FIMR action body) to conduct a study resolution on NAS.

- In Southern New Jersey, maternal obesity was at 43%. The FIMR recognized there was a lack of one-to-one nutritional support in PNC sites and recommended increased nutritional education at PNC sites by SNAP Ed and by Home Visiting programs in the county. SNAP Ed was put in place in FQHC's, and home visitors were trained to provide nutritional support.

FIMR Teams' Need for and Use of National Center for Fatality Review and Prevention Resources

In 2015, HRSA released a Funding Opportunity Announcement for a new Center that would combine FIMR and Child Death Review training, technical assistance, and data services. The result is the National Center for Fatality Review and Prevention at the Michigan Public Health Institute, which came into being on July 1, 2015. In addition to ongoing training and technical assistance to the field, HRSA has directed the Center to focus on creating a web-based FIMR

database; facilitating collaboration between FIMR and CDR; creating a website and portal where FIMR teams may post their outcomes; and developing a regional network of FIMR programs.

In the first grant year, the National Center contracted with the American College of Obstetricians and Gynecologists to provide the FIMR technical assistance and training. In addition, the Center facilitated work groups on the FIMR database, health disparities, collaboration between CDR and FIMR, and data quality; and provided intensive TA to programs that requested assistance building collaboration between FIMR and CDR. It also published a newsletter and maintained an active listserv for FIMR programs and allies. In year two of the grant, FIMR technical assistance and training, as well as other FIMR support activities, will be provided directly by National Center staff, who will also continue the work groups and TA for FIMR/CDR collaborative efforts.

Respondents were asked to identify what they want from the Center. The most frequent responses were the new database; training, either in-person or through webinars; regional activities; regional and/or national meetings; increasing capacity for family interviews; and technical assistance regarding obtaining medical records and death notices, taking recommendations to action, and updating the abstraction tool.

FIMR and Child Death Review Collaboration

One of HRSA's areas of focus for the new Center is increasing collaboration between and among different types of fatality reviews. FIMR programs were asked to identify which fatality review processes operate in their communities and whether they collaborate with them. Of the 131 programs that responded to this question, all but 12 have Child Fatality Review in their communities, and 95 respondents indicated they participate in Child Fatality Reviews. Forty-one respondents indicated they participate in Maternal Mortality Reviews.

About half the programs that participate in Child Fatality Reviews described their collaboration to be staff work on CDR and FIMR processes and/or attendance at each other's meetings. Other means of collaboration listed by the teams are leadership of both in one organization and joint prevention messages.

Looking Forward to 2016-2017

National FIMR Reporting System: FIMR teams use a variety of data systems to enter information about their reviews and actions. Some use systems created by their state and/or community. Some use the non-web-based system developed by NFIMR. Others use a web-based database pilot developed in 2015 by ACOG, the State of Michigan, and MPHI. Still others use an Infant Enhancement Module that is also part of the existing MPHI web-based National Child Death Review-Case Reporting System (CDR-CRS). HRSA's goal is that there eventually be one web-based system used by all FIMRs, for consistency and aggregate data, and to facilitate

national reports. To that end, a workgroup of FIMR coordinators from around the country has been working with the National Center to develop a FIMR module to be integrated with the existing CDR-CRS system. The new module is expected to launch in fall 2017.

Regional FIMR Networks: The Center sponsors regular telephone conferences of FIMR coordinators, which are an opportunity for sharing best practices, celebrating successes, mutual problem solving, and support. In addition, the National Center plans to work with FIMR programs to create a regional structure and facilitate communication among programs within regions through teleconferences and other means.

With HRSA's strong focus on outcomes, the National Center will roll out a new website this year with a portal where FIMR (and CDR) programs will be encouraged to post their prevention activities and outcomes. The Center will also create a prevention playbook resource, including case studies of teams moving from reviews to action.

The Center also plans to provide regular webinars to the FIMR and CDR field; strengthen relationships with Healthy Start, both nationally and regionally; and continue to build relationships with national partners.

List of Tables Describing the Status of FIMR in the U.S. in 2015

Introduction

One hundred forty-one individuals responded to the survey. Seven of those did not report any current activity so were excluded from the analysis, leaving 134 respondents from 26 states and Puerto Rico.

Because all FIMR programs were queried, more than one FIMR program may have responded in individual states and both state and local FIMR coordinators responded to the surveys. The first three sections below include all responses. Section 4 gives only responses provided by state coordinators.

Section I – Overview of FIMR programs

Table 1-1: Number of persons responding by state

State	Number of Respondents	State	Number of Respondents
Alabama*	1	Montana*	31
California*	12	Nebraska	1
Colorado	1	Nevada	1
Delaware*	2	New Jersey*	4
Florida*	14	Ohio*	6
Illinois	1	Oklahoma*	1
Indiana*	4	Pennsylvania	1
Kansas	3	Tennessee*	5
Louisiana*	5	Texas	1
Maryland*	17	Utah	1
Michigan*	10	West Virginia	1
Mississippi	2	Wisconsin*	7
Missouri	1	Puerto Rico	1
		Number of states	**26 and Puerto Rico**
		Number of respondents**	**134**

* Indicates that a State Coordinator responded to the survey, often in addition to local program coordinators

** Alaska and Minnesota do not currently have FIMR programs but state health officials completed part of the survey.

Table 1-2: Administrative lead for FIMR

Agency Lead	Number of responses	Percent
State/County/City Health Department	103	76.9
Healthy Start	15	11.2
Regional perinatal network/prenatal/perinatal coalition	5	3.7
Hospital	1	0.7
Other	4	3.0
No Response	6	4.5
Total	134	100.0

"Other" responses (selected): Health Council; Child Death Review Commission under the Administrative Office of the Courts.

Table 1-3: Members of a federal Healthy Start program participate in FIMR team(s)

	Number of responses	Percent
Has Healthy Start and participates on Team	36	38.8
Has Healthy start but does not participate on team	16	
Community does not have a Healthy Start program	67	50.0
No Response	15	11.2
Total	134	100

Table 1-4: Current funding source(s) for FIMR programs

Responses are not mutually exclusive

	Number of responses	Percent of 134
State Title V	50	37.3
County/City Health Department	49	36.6
Other State Funding	24	17.9
Other	21	15.7
Federal MCHB	17	12.7
Unknown / No response	12	9.0
Federal Healthy Start	8	6.0
Foundation	6	4.5
March of Dimes	2	1.5

"Other" types of funding (selected): State funds (grants, Medicaid, general revenue funds), grants, and hospitals.

Section 2 – FIMR Process

Table 2-1. Theories or methods implemented in conjunction with FIMR

Responses are not mutually exclusive

	Number of responses	Percent of 86
Life Course Theory	54	62.8
Perinatal Periods of Risk	49	57.0
Asset Based Community Development	7	8.1
NFIMR Publications on Cultural Competence/ Bereavement support	35	40.7
NFIMR Team Cultural Competency Assessment	9	10.5
Other	8	9.3
No Response	48	

Table 2-2. Case review typically includes an interview with a family member(s)

	Number of responses	Percent
Yes	67	49.6
No	56	41.5
No Response	11	8.9
Total	134	100.0

Table 2-3. Percentage of reviews which include a family interview

The median is 33%. Nine respondents (16.7% of those who answered) indicated that they are able to obtain interviews on all cases reviewed.

Percentage of cases with a family interview	Number of responses	Percent
1 - 25%	20	29.9
26- 50%	20	29.9
51 - 75%	2	3.0
76 - 100%	12	17.9
No response	13	19.4
Total	67	100.0

Table 2-4. Profession and/or consumer role represented on Case Review Team and/or Community Action Team

Responses are not mutually exclusive

Profession/consumer role	Number of responses	Percent of 119
Local Health Departments	109	91.6
Social workers	94	79.0
Obstetric/pediatric nurses	85	71.4
Pediatricians	83	69.7
Obstetricians	82	68.9
Nurse Home Visitor Programs	71	59.7
Mental Health services	67	56.3
Child welfare	67	56.3
Educators	66	55.5
WIC	59	49.6
Substance abuse services	51	42.9
Hospital administrators	48	40.3
Perinatal-Infant grief professionals	48	40.3
Medical examiners	48	40.3
Community health workers	45	37.8
Maternal and Child Health coalitions and networks	42	35.3
Nutritionists	36	30.3
March Of Dimes	36	30.3
Family planning clinics	34	28.6
Healthy Start Coalitions	34	28.6
Religious leaders	32	26.9
Other	78	65.5
No response	15	53.8

"Other" professions / consumer roles (selected): Bereaved parent groups, elected officials, Healthy Mothers Healthy Babies

Section 3 – FIMR to action

Survey respondents were asked to describe FIMR team accomplishments over the past two years. The following 5 tables (Table 3-1 through Table 3-5) contain their responses.

Table 3-1. Community education to address a public heath message

Responses are not mutually exclusive

	Number of responses	Percent of 110
Met with community based organizations	69	62.7
Promote breastfeeding	57	51.8
Develop culturally relevant health education materials	41	37.3
Conduct a media campaign*	48	43.6
Publish an annual FIMR report	36	32.7
Hold a town health fair	23	20.9
Hold a FIMR town meeting	7	6.4
Publish a FIMR newsletter	7	6.4
Other**	50	45.5
No response	23	

* Topics listed for media campaigns included campaigns to encourage early and continuous prenatal care, promote prenatal alcohol and drug cessation, family planning or STD screening, addressing disparities in infant health and addressing the risks of prematurity.

** Topics listed under 'other' include safe sleep messaging, safe surrender, vehicle heat safety, and water safety.

Table 3-2. Service systems improvement activities and linkages to address the need for improved service systems and resources

Responses are not mutually exclusive

	Number of responses	Percent of 92
Improve bereavement referral services	58	63.0
Improve referral patterns among agencies	53	57.6
Eliminate a gap in MCH services	31	33.7
Partner with local MOD Prematurity Campaign	24	26.1
Streamline MCH Medicaid application processes	22	23.9
Eliminate gap in family planning services	16	17.4
Eliminate duplication of MCH services	15	16.3
Implement "one-stop-shopping" prenatal care	8	8.7
Improve/develop transportation routes to MCH services with the City or County Transportation Department	7	7.6
Develop 24/7 prenatal hotline	5	5.4
Increase public safety around MCH service sites in collaboration with City or County law enforcement	4	4.3
Other	17	18.5
No Response	42	

"Other" responses (selected): partnered with law enforcement, improve presence of nutritionist in WIC clinics.

Table 3-3. Policy work and advocacy to connect FIMR to the political body that has the ability to make policy change and take action

Responses are not mutually exclusive

	Number of responses	Percent of 85
Report FIMR findings to State MCH Director	56	65.9
Report FIMR findings to Mayor, County Executive, and/or other officials on an annual basis	27	31.8
Initiate Mayoral or Gubernatorial proclamation of a day or week promoting MCH	13	15.3
Develop local or state legislation	13	15.3
Develop policy in collaboration with city or county law enforcement offices or emergency services	12	14.1
Include the Mayor or County Executive	12	14.1
Other	19	22.4
No Response	49	

"Other" responses (selected): MOA with US Military to allow record abstraction, report FIMR findings to the Board of Health. Responses for including the Mayor or County Executive include as a FIMR Community Action Team member, contributing to the FIMR annual report, and chairing a FIMR town meeting

Table 3-4. Improved practices, programs and policies that local providers or hospitals make to enhance their practices or program protocols.

Responses are not mutually exclusive

	Number of responses	Percent of 87
Enhance services to bereaved families	49	56.3
Implement screening for smoking	33	37.9
Implement screening for substance abuse	32	36.8
Implement screening for postpartum depression	31	35.6
Expand services to pregnant substance abusers	29	33.3
Implement screening for domestic violence	21	24.1
Expand hospital quality assurance standards	21	24.1
Expand family planning services	21	24.1
Initiate or expand public health case management	19	21.8
Implement standardized prenatal risk assessment	17	19.5
Improve cultural competency protocols	13	14.9
Expand services to homeless women and children	10	11.5
Other	12	14.9
No response	47	

"Other" responses (selected): Nutrition, diabetes screening early in pregnancy.

Table 3-5. Professional training including development of training or training materials for providers

Responses are not mutually exclusive

	Number of responses	Percent of 82
Implement SIDS training programs	41	50.0
Develop a community resource directory	34	41.5
Conduct provider training on use of screening tools (e.g., substance use, domestic violence, etc.)	28	34.1
Implement bereavement training	23	28.0
Conduct provider education programs (e.g., management of IUGR, diabetes in pregnancy, etc.)	18	22.0
Conduct provider training on prematurity/preterm labor management	17	20.7
Implement cultural competency training	11	13.4
Implement cultural competency assessment for FIMR team members	6	7.3
Other	20	24.4
No response	52	

"Other" responses (selected): Fetal Kick Counts, safe sleep initiatives, domestic Violence, and motivational interviewing.

Table 3-6. One-on-one counseling or assessment to provide health and safety information to individual women or families

Responses are not mutually exclusive

	Number of responses	Percent of 82
Provide cribs for safe sleep	52	63.4
Conduct infant car seat installation checks	33	40.2
Go into home to teach parenting skills	27	32.9
Go into home to teach signs and symptoms of preterm labor	26	31.7
Conduct home infant safety checks	18	22.0
Develop mother-to-mother bereavement support program	11	13.4
Go door-to-door and distribute SIDS risk reduction messages	10	12.2
Develop mother-to-mother parenting support program	10	12.2
Other	15	18.3
No response	52	

"Other" responses (selected): DOSE program for EMS providers, water safety education and life jackets, decrease unintended pregnancies.

Table 3-7. Communicating actions and successes to the community served

Sixty-six respondents (49.3%) indicated they communicate actions and successes to the community they serve through the following methods.

Responses are not mutually exclusive

	Number of responses	Percent of 66
Annual reports	45	68.2
Social media sites (Facebook, Twitter)	23	34.8
Community/neighborhood/county newspaper	14	21.2
City newspaper	10	15.2
Newsletter	10	15.2
Marketing campaigns	10	15.2
Television	8	12.1
Other	9	13.6
No Response	4	

"Other" responses (selected): Flyers/direct mailing, radio, yearly presentation.

Table 3-8. Monitoring program progress or success in taking recommendations to action

Ninety-three respondents (64.4%) indicated that they monitor the progress or success of taking recommendations to action. They indicated that they monitor it in the following ways.

Responses are not mutually exclusive.

	Number of Responses	Percent of 93
Ongoing review of FIMR cases	79	84.9
Feedback from FIMR team members	78	83.9
Feedback from other community leaders, agencies or individuals	58	62.4
Updates and reports from FIMR staff	53	57.0
Additional information from the health department	51	54.8
Conference/training evaluations	34	36.6
Questionnaires or surveys	31	33.3
Outside, local agency tracks progress	11	11.8
Other	6	6.5

"Other" responses (selected): look at annual FIMR trends using vital statistics, formal evaluation of Safe Baby program on SUIDS, and abusive head trauma reduction

Section 4 – State-level coordination

This section is based only on the responses of the 15 survey participants who are state-level coordinators.

Table 4-1. Functions of the state program

Responses are not mutually exclusive

	Number of Responses of 15
Technical assistance to local teams	11
Training of local teams	10
Data collection and reporting	9
Coordination of local teams	7
Coordinator of state team/board	6

Table 4-2. Functions of the state-level advisory board

Six of the 15 coordinators indicated they have a state-level advisory board

Responses are not mutually exclusive

	Number of responses of 6
Make formal recommendations	5
Reviews local findings	3
Write annual reports	2
Conduct state reviews	1

Appendix A

Actions Taken Because of FIMR in Selected States/Counties

Yolo County CA:
Problem: persistent and increasing presence of maternal mental health concerns in FIMR Cases. Recommendation: Develop a county wide collaborative to address maternal mental health concerns. Interventions: Collaborative created. Multiyear action plan created and parts carried out that include sustainability of the collaborative/stakeholder engagement, resource building and reducing stigma. OUTCOMES: successful awareness campaign in 2015 to reduce stigma that is growing in 2016. Blue Dot Campaign will be presented at the national 2016 PSI Conference. Joint Provider Mapping Project in progress by Yolo and Butte counties to assess needs of providers serving women along their lifecourse (primary care, Peds, and OB).

Humboldt County CA:
Problem: Many deaths reviewed included unsafe sleep environments.
Recommendation: All babies need a safe sleep environment.
Interventions: Movie Theatre Campaign.
Outcomes: I do not have data available from 2014 yet.

Problem: Maternal depression has been linked with attachment problems in infancy.
Recommendation: Improve attachment problems by educating the community on Perinatal Mood and Anxiety Disorders.
Interventions: Pec Indman, PhD addressed more than 225 community members at an all-day conference.
Outcomes: I am attempting to obtain data specific to Humboldt County on PSI, but have not been able to yet.

Alameda County CA:
Problem: many gaps in service for perinatal depression screening and referral. FIMR identified that many women are never screened during perinatal period.
Recommendation: Started perinatal depression screening and referral project at public health WIC sites.
Interventions: trained all WIC staff in screening and referral set up infrastructure for referral.
Outcomes: 10,000 women have been screened at WIC since beginning the project.
About 15% screen positive. About 20-30% of those accept referrals. We are working on evaluating the effectiveness of this intervention.

Contra Costa County CA:
Problem: Lack of referrals to substance abuse treatment, smoking cessation, nutrition counseling and other services was noted in cases of at-risk pregnant women.
Recommendation: Care coordination and referrals to specialty services, such as substance abuse treatments, should be made by providers and documented for at-risk mothers and infants should increase.
Interventions: Training of PNC providers on completion of importance of state sponsored referrals

Outcomes: Review of ongoing cases over the first year

Anne Arundel County MD:
We developed a website for both families and providers on issues relating to pregnancy and healthy babies- http://aahealthybabies.org/

We are now working on substance abuse in pregnancy with our birthing hospitals testing for substance abuse- http://aahealthybabies.org/pdf/PAdeathbrief.pdf

Cecil County Health MD:
Problem: There is a lack of prenatal care received by Hispanic population in our community, resulting in poor outcomes, including increased fetal deaths.
Recommendation: FIMR Team discussed the possibility of opening a free clinic for prenatal care to the Hispanic population that could not afford it.
Interventions: The free clinic is in the planning stage at this time. A plan is being formulated by using prior statistics collected to prove the need and be presented to the CEO of the local hospital as a possible funding source. Will also be presented to other local businesses including OB/GYN providers.
Outcomes: Still to be determined, if a free clinic can be established

Harford County MD:
Problem: Significant increase in number of substance exposed newborns (SEN) born at local hospital. Per DSS referrals, our county ranked 4 of 23 in 2014.
Recommendation: Develop a post partum referral process from local hospital discharges of SENs to LHD and DSS.
Intervention: Local hospital screens all deliveries and refers 100% of SENs to LHD and DSS.
Intervention: LHD implemented a small home visiting program for SENs and mothers to insure/refer to drug treatment, mental health, medical home for mom and baby, compliance with pediatric care/postpartum exam, parenting, supplies, community resources/safe sleep.
Outcome: Local hospital is referring 100% of SEN cases to DSS and LHD. DSS and LHD hold monthly multi-d meetings to review cases and develop plan for care.

Louisiana:
Problem: Growing number of NAS cases in Louisiana and a sense that legislature was going to get involved
Recommendation: Intervene so any decisions made by legislature would be informed and promote the wellbeing of Louisiana's families
Intervention: A study resolution passed legislature in 2015 granting permission for the Perinatal Commission on the Prevention of Infant Mortality (the State-level FIMR action body) to conduct a study resolution on NAS
Outcome: Study will be complete in March 2016.

Jacksonville FL:
Increase in sleep related deaths in homes where a crib and basinet were available. A limited survey was done to determine the reason parents were sleeping with their infants. The results of the survey indicated the parents felt "safer", we are expanding our survey to determine the population's definition of "safe sleep" and to determine the context of "safe,"

i.e., street violence, rodents/pests, or mother's comfort. In the meantime, we have been able to target education to overcome barriers to the infants not being placed in their own beds

Miami FL:
Problem: Insufficient bereavement support services for families who experienced a pregnancy or infant loss.
Recommendation: implementation of bereavement programs at hospitals and increase in bereavement support services
Interventions: training of community members (hospital staff, local organizations, general community) on Perinatal Bereavement.
Outcomes: o Between July 2011 and December 2015, our program conducted twenty-one (21) perinatal bereavement professional development seminars attended by four hundred seventy- eight (478) individuals

Capitol Area Health Start Coalition, FL:
FIMR recognized a need for preconception health and community education to African American girls, focusing on the importance of personal hygiene, healthy lifestyles and proper nutrition and has put a program, STRONGER Girls, to address these issues. It is currently at one school in a predominantly African American neighborhood. It is hoped that with additional funding, it can be expanded to other schools.

Healthy Start Coalition of Hardee, Highlands, and Polk Counties FL:
Problem: There was an increase of women presenting to their obstetrician or the local hospital's emergency rooms with issues pertaining to dehydration.
Recommendation: Provide the obstetricians, hospitals, and home visitors educational resources and tools to promote the importance of water consumption and staying hydrated during pregnancy.
Intervention: When teaching the pregnant women about hydration during pregnancy providers and home visitors would have a visual tool to utilize with the teaching.
Outcomes: The women presenting to obstetrician offices and local hospital emergency rooms for dehydration decreased.

Problem: There were issues presented during the CRT findings dealing with access to prenatal care for minority pregnant women.
Interventions: The committee created an educational tool to input in the local newspaper and at all local churches that had high population of minorities present. This tool provided information for ways women could access prenatal care. In addition, committee members met with the local transportation committee and implemented a bus stop near a local provider that was needed.
Outcomes: There was an increase in appointments completed for the local providers

Marion County Health Department IN:
Problem: Need for knowledge of home visitors about signs & symptoms of Neonatal abstinence Syndrome
Recommendation: NAS speaker for in-service of signs & symptoms of NAS
Intervention: Planning of in-service for home visitors of three community programs

Outcomes: Continued assessment of home visitor needs for substance use assessment and referrals for treatment options.

Chicago IL:
Problem: No perinatal loss support group on south side of Chicago.
Recommendation: Through a focus group meeting of parents, who had experienced a loss, the need for a support group on the mid-south side of Chicago was discussed. From this discussion it was determined that a support was indeed needed.
Intervention: Monthly support group meetings at one of the local charter high schools was started.
Outcomes: Monthly meetings held for one year at the local high school at no charge. One year later the school wanted to charge a rental fee for the space. The meeting site was changed to the hospital at no cost. Due to lack of staff to support the monthly meetings, meetings were changed to meet for Mother's/Father's Day and October Day of Remembrance. Families were referred to other support groups on the north, west side of Chicago and south suburbs. A graduate student who lives on the south side (Schweitzer Fellow) had experienced a fetal loss and wanted to be involved in working with families who had also experienced a loss. She was referred to FIMR from one of the north side support groups housed at a level three hospital. Through her networking with other agencies and community organizations, two meeting sites were located. The first meeting was December 12, 2015 at a local neighborhood community center. The Mother's/Father's Day and October National Day of Remembrance activities will continue along with the support group meetings.

Washoe County NV:
The Washoe County FIMR CAT Team is assisting with updating the resource directory (211) through the MCH coalition. In addition, efforts have been made to implement a media campaign to encourage early and regular prenatal care. The Community Action Team has initiated working with the District Attorney and hospitals to devise a system to collect baseline data that can be utilized to help develop a plan to address the issue of fetal drug exposure. The FIMR annual report was distributed to the FIMR Case Review Team and the Community Action Team. The report was also shared with the Maternal Child Health Advisory Board and the Washoe County District Board of Health. Evaluation of the actions are unavailable at this time as we are in the beginning phases of implementation.

Canton OH:
Problem: Lack of safe sleep education in the hospitals
Recommendation: reeducate nurses on safe sleep and provide an education check list prior to mother’s discharge from Hospital
Interventions: Both local hospitals provide uniform safe sleep education and sleep sacks prior to mother and babies’ discharge.

Problem: late prenatal care and poor outcomes
Recommendation: push for and increase on centering pregnancy care
Interventions: local push to increase enrollment in centering prenatal care at one local hospital. The other local hospital is working to set up a centering pregnancy care program

Missouri:
We have established a collective impact initiative in our community called Flourish St. Louis to address infant mortality by bringing diverse sectors together in new ways. FIMR will help provide data and critical information about factors contributing to infant and fetal deaths that can lead to best practices and adoption of key policies.

Dallas TX:
Problem: Mothers reporting a desire and need for more consistent prenatal education.
Recommendations: Find and promote existing prenatal education in the community.
Intervention: Promote the text4baby app through the Community Action Network (DHS version of CAT).
Outcome: Review of text4baby statistics showed increase of users by 1600% from 52 to 830 individuals in a 6-month period. The county was recognized for the most participants in the state of Texas.

Problem: 51% of FIMR mothers were overweight and of that number 62% were obese.
Recommendation: Collaborate with providers at a women's community clinic to provide screening, education, care coordination and referrals to specialty services.
Intervention: Create a program at women's community clinic to screen for obesity, provide education, follow-up and care coordination through the use of the "Someday Starts Now" tool.
Outcome: Ongoing, since the beginning of the program six months ago.

Anaconda Deer Lodge County Public Health MT:
Problem: Lack of referrals and resources for parenting skills, substance abuse / cessation, at risk population factors.
Recommendation: care coordination, create and coordinate referrals among resources, establish Parents as Teachers home visiting program, and other home visiting programs;
Interventions: training of PCP, other community organizations on referral system and importance of programs
Outcomes: starting to build home visiting culture with increase in referrals
We are a high risk community which is starting to build a system of programs and resources to reduce social determinants of health and other risk factor.

Mississippi Department of Health:
Problem: Lack of referrals by providers to Family Planning through the health department
Recommendation: All women in prenatal classes and postpartum are referred to Family Planning
Interventions: Training of PNC providers at every CRT meeting
Outcomes: Review of ongoing cases show an increase in referrals to FP as noted on the medical records.

Problem: Initial chart reviews in 2012 showed High rates of SIDS cases
Recommendation: FIMR RN review with coroners to verify SIDS vs asphyxia/overlay
Interventions: Proposed expanded trainings of coroners at state meetings; met with

county coroners and their assistants on a quarterly basis first two years. Met with state Medical Examiners.
Outcomes: Cases are correctly designated

Problem: Lack of consistent Infant Safe Sleep information being given to new parents/grandparents/foster parents
Recommendation: Collaborate with MS SIDS Alliance to provide standardization of training.
Interventions: Nine delivering hospitals visited in collaboration with MS SIDS Alliance to provide standardization of training. MS SIDS Alliance provided public recognition of hospitals completing the following: All MCH hospital staff trained with the NICHD/March of Dimes CE program; all parents to view the NICHD Infant Safe Sleep video and sign form acknowledging that they saw DVD (or declined)
Outcomes: All 10 hospitals completed the above; FIMR involved with public recognition of 2 of the hospitals. MS State office also providing books for all new parents on safe sleep.
Interventions: Trainings completed; parents instructed and viewed DVDs OUTCOMES: SUIDs decreasing, although much still to do.

Problem: Public awareness of infant safe sleep lacking.
Recommendation: Conduct a one- day CE Infant Safe Sleep Conference
Interventions: Conference conducted in November 2014, 165 attendees included nurses, social workers, faith based, community leaders, foster parents, child care workers
Outcomes: Train the trainer programs continuing; faith based meeting with 8 faith leaders trained and provided with pack n plays.

Puerto Rico:
Problem: In the 2009-2011 reviews 69% received early prenatal care
Recommendation and Intervention: By recommendation of the FIMR Review Team, findings and recommendations were shared in presentations to health care providers in 2 main conferences
Outcomes: Upon review of the 2012-2015 cases there was an increase to 89% receiving prenatal care. PNC in PR has improved over the years. By 2014, VS data shows that about 86% of live births in PR, their mothers initiated PNC during the first trimester of pregnancy. Average Annual Percent Change (AAPC) trend analysis shows a significant increase of 0.6% since 2005 (81.5%).